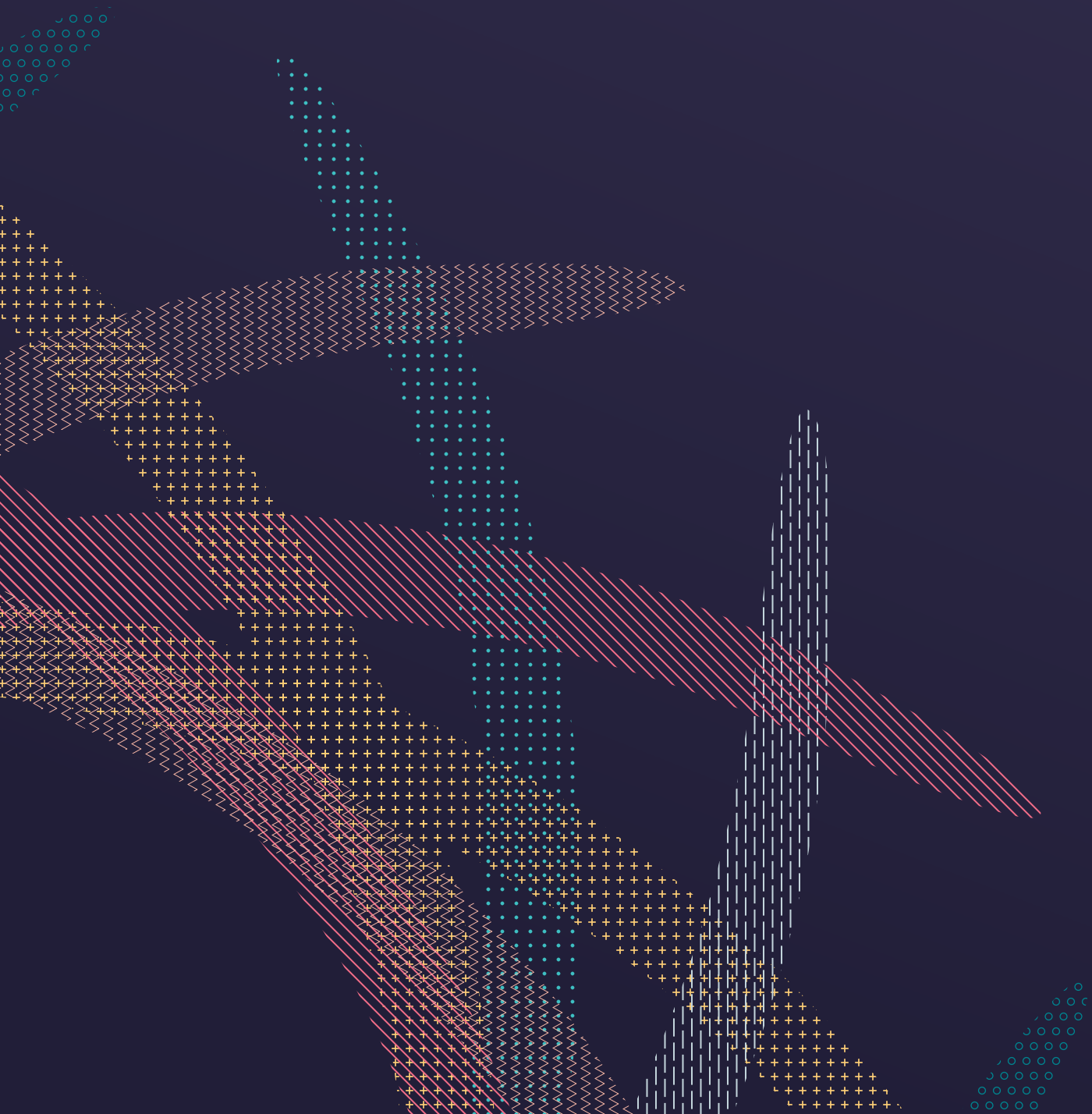
Royal Commission into
Victoria's Mental Health System

Final Report

Summary

Plain language version



Royal Commission into
Victoria's Mental Health System

Summary

Penny Armytage AM

Chair

Professor Allan Fels AO

Commissioner

Dr Alex Cockram

Commissioner

Professor Bernadette McSherry

Commissioner

Summary

Published February 2021

The Royal Commission into Victoria's Mental Health System, Melbourne Victoria, authorised and published this document.

This plain language report is a simplified version of the *Final Report*. The content and ideas presented in this report are similar, however, they are not the direct words of the Commissioners.

The images in this document only show models and examples of settings. They don't necessarily show actual services, facilities or participants. If the image is of a specific person or place, the document will say that. This document may include images of Aboriginal and Torres Strait Islander peoples who have died.

In this document, 'Aboriginal' means both Aboriginal and Torres Strait Islander peoples. We use 'Indigenous' or 'Koori/Koorie' when it's part of the title of a report, program or quote.

ISBN 978-1-925789-76-8 **(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>.

A note on content

The Royal Commission thanks everyone that contributed their personal stories and opinions to this inquiry. We particularly want to thank:

- people with lived experience of mental illness and psychological distress
- families, carers and supporters
- people who work in the mental health sector.

Some of these stories and the Commission's recommendations include information that could be distressing. You might want to think about how and when you read this report.

Aboriginal readers please note that this report may contain photos, quotes and names of people who have died.

If you're upset by any content in this report or if you or a loved one need support, these services may be able to help:

- if you're not in immediate danger but you need help, call **NURSE-ON-CALL** on **1300 60 60 24**
- for crisis support, contact **Lifeline** on **13 11 14**
- for support, contact **Beyond Blue** on **1300 224 636**
- if you're looking for a mental health service, visit the **Better Health Channel website** <www.betterhealth.vic.gov.au>
- **if you're in a situation that is harmful or life-threatening, contact emergency services immediately on triple zero (000).**

You can find a note on the words and terminology used in this document in the front of the Commission's Final Report.

Summary

Summary

In February 2019, the Governor of the State of Victoria formally set up the Royal Commission into Victoria's Mental Health System. The Victorian Government asked for the Royal Commission because the state's mental health system was failing to support those who needed it. The Premier, the Hon. Daniel Andrews MP[1] – as well as people living with mental illness or psychological distress, families, carers and supporters and those working in the system – described it as 'broken'. Ms Honor Eastly, a witness who spoke to the Commission, said:

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

People shared some positive experiences with the Commission, such as compassionate and empathetic workers supporting them. As one person said, 'I was lucky to find the treating doctor that I have. She's saved my life dozens of times through compassionate, evidence-based care.'[3]

Despite the goodwill and hard work of many people, Victoria's mental health system has deteriorated for many reasons. In November 2019, the Commission's Interim Report found that:

- the system had failed to live up to expectations
- wasn't prepared for existing and future challenges.

Good mental health and wellbeing have been a low priority of governments and the community.

Most of us will experience poor mental health or mental illness at some point in our lives. This can be directly or indirectly through someone we care about. Each year, around one in five Victorians will experience mental illness.[4] Almost half of Victorians will experience mental illness during their life.[5] It's estimated that 3 per cent of people living in Victoria experience 'severe' mental illness, such as schizophrenia or bipolar disorder.[6] That's more than 200,000 people.

Every person must be able to access a well-resourced, compassionate and responsive mental health and wellbeing system. This includes friends, loved ones, families, neighbours and colleagues. Yet people often described being turned away from services because they didn't meet the requirements for treatment. One person described how this affected them:

> **Reaching out for help and admitting you believe you could have an issue is hard enough in itself. But going through that difficult process to then be turned away from treatment makes the anxiety about reaching out even worse for fear of being told you aren't worthy of treatment. Turning people away because they 'aren't sick enough' … sends a message that there is a level that needs to be achieved before you're allowed to get better.[7]**

Good mental health and wellbeing is not just being free from mental illness. It's being able to fully take part in society. This means we must pay attention to a range of things related to poor mental health. This includes psychological, biological and social factors, which can all change over a person's life. Health is not the only priority in supporting good mental health and wellbeing. Many things shape people's mental health and wellbeing including:

- other social services, such as housing, education and justice
- the places people live
- where people work
- where people connect with other people.

Victoria needs to be a place where people look out for each other. It needs to be a place where we build social connections and treat others with empathy.

The Commission has set out how Victoria's mental health and wellbeing system should be redesigned. To achieve this vision, the whole system will need to work together. Everyone involved in the system will need to work together and share responsibility including:

- governments
- service providers
- community groups
- advocates
- people with lived experience of mental illness or psychological distress
- families, carers and supporters.

1. Why we need change

The current system isn't able to support the different needs of people living with mental illness or psychological distress, families and supporters. It's definitely not able to cope with unexpected issues that may come up.

Due to the limitations of the system, people can often not access services when they need them. The system mostly runs in crisis mode, which means that it reacts to mental health crises instead of preventing them. The system is complex and disconnected. People who manage to get into it find it very difficult to use. People get frustrated and distressed trying to find the right mental health services for them or someone else. A mother shared her challenges with the Commission:

> **As a single mother who had to work full time to keep a roof over my girls' heads, navigating the service system has been so difficult. This has taken a huge emotional and financial toll on me as I have not been able to progress my career due to my caring requirements, which will severely impact the amount of super I have to retire on. Disconnected, poorly promoted services with overly tight eligibility criteria meant that only some aspects of my girls' multiple and complex needs could be addressed.**[8]

The system's failures go back to when and how it started. In the 19th and 20th centuries, people living with mental illness were separated from the rest of the community and moved to institutions. Governments started to get rid of these institutions from the 1980s. They wanted to move towards a community-based model of care. There has been social change since then, including more of a focus on protecting and promoting human rights. However, Victoria's mental health system hasn't kept up with these changes. It has moved away from the goal of a community-based system. It now relies too heavily on hospital-based services and emergency departments.

'Power imbalances' that disadvantage people with lived experience of mental illness are still noticeable. For example, supported decision-making principles and practices are not regularly used. Supported decision-making is where a person is supported to make their own decisions and tell people about their preferences. People are still having their human rights violated through seclusion, restraint and compulsory treatment.

Ms Lucy Barker, a witness who spoke to the Commission, shared her experiences of seclusion, restraint and compulsory treatment:

> **The thing with compulsory treatment is that the measures that are taken are extreme. You wouldn't treat anybody else that way, but because you are perceived to have a mental illness, you can be restrained to a bed for hours or thrown in a seclusion room or chucked in the back of a divvy van or jabbed in the butt, and then knocked unconscious for a day. It's that kind of stuff that makes compulsory treatment terrible. Yes, your life was saved, but to what extent? I now have significant trauma from compulsory treatment.**[9]

This history of treating people living with mental illness as unimportant and unvalued members of the community is shown in many of the challenges the mental health system faces. These challenges include:

- not enough investment in the system
- not being able to meet increasing demand for services
- no system planning.

These challenges exist partly because of the stigma and discrimination around mental illness. Community attitudes stop governments from investing in good mental health and wellbeing.

The Victorian Auditor-General[10] has recently reviewed Victoria's mental health system[11] and the Government has made efforts to improve it. However, the system still needs urgent changes made.

1.1 Designing a new system

The Commission's Interim Report sets out nine recommendations for a new approach to mental health and wellbeing treatment, care and support. The Victorian Government has started applying these recommendations.

This report builds on these key reforms. It explains system-wide changes that will create a mental health and wellbeing system that is up-to-date and flexible. The report is made up of five volumes:

- *Volume 1: A new approach to mental health and wellbeing in Victoria*
- *Volume 2: Collaboration to support good mental health and wellbeing*
- *Volume 3: Promoting inclusion and addressing inequities*
- *Volume 4: The fundamentals for enduring reform*
- *Volume 5: Transforming the system—innovation and implementation.*

Across these volumes, the Commission sets out 65 recommendations to improve Victoria's mental health system. Some of the recommendations focus on creating new structures to support a sustainable mental health and wellbeing system. Some concentrate on making sure that treatment, care and support are available and accessible. Others focus on redesigning services to move to a community-based model that benefits the people that use it. Some recommendations are a first for Victoria, such as:

- setting up projects that people with lived experience of mental illness or psychological distress will lead
- creating roles for lived experience leaders throughout the system.

Some challenge the system's traditional focus on medical treatment alone. These recommendations highlight the importance of community and places in shaping mental health and wellbeing.

New Local Mental Health and Wellbeing Services will take over most of the current demand on area mental health services. Looking ahead, new Area Mental Health and Wellbeing Services will have more resources. Combined with increased investment in service delivery, this will mean that Area Mental Health and Wellbeing Services will be able to offer more responsive services to people with higher needs. They can also be more flexible to support people as their needs and strengths change.

Together, these reforms go further than making individual improvements to the existing system. These changes will completely change how mental health and wellbeing treatment, care and support is provided in Victoria.

2. Major themes

To understand the strengths, challenges and future needs of the system, the Commission talked to:

- people living with mental illness or psychological distress
- families, carers and supporters
- mental health workers
- researchers
- service providers and others.

Figure 1 shows an overview of the Commission's consultation.

The Commission's consultation process also included Victoria's diverse communities, such as:

- Aboriginal people
- LGBTIQ+ people
- people from culturally diverse communities.

These consultations included:

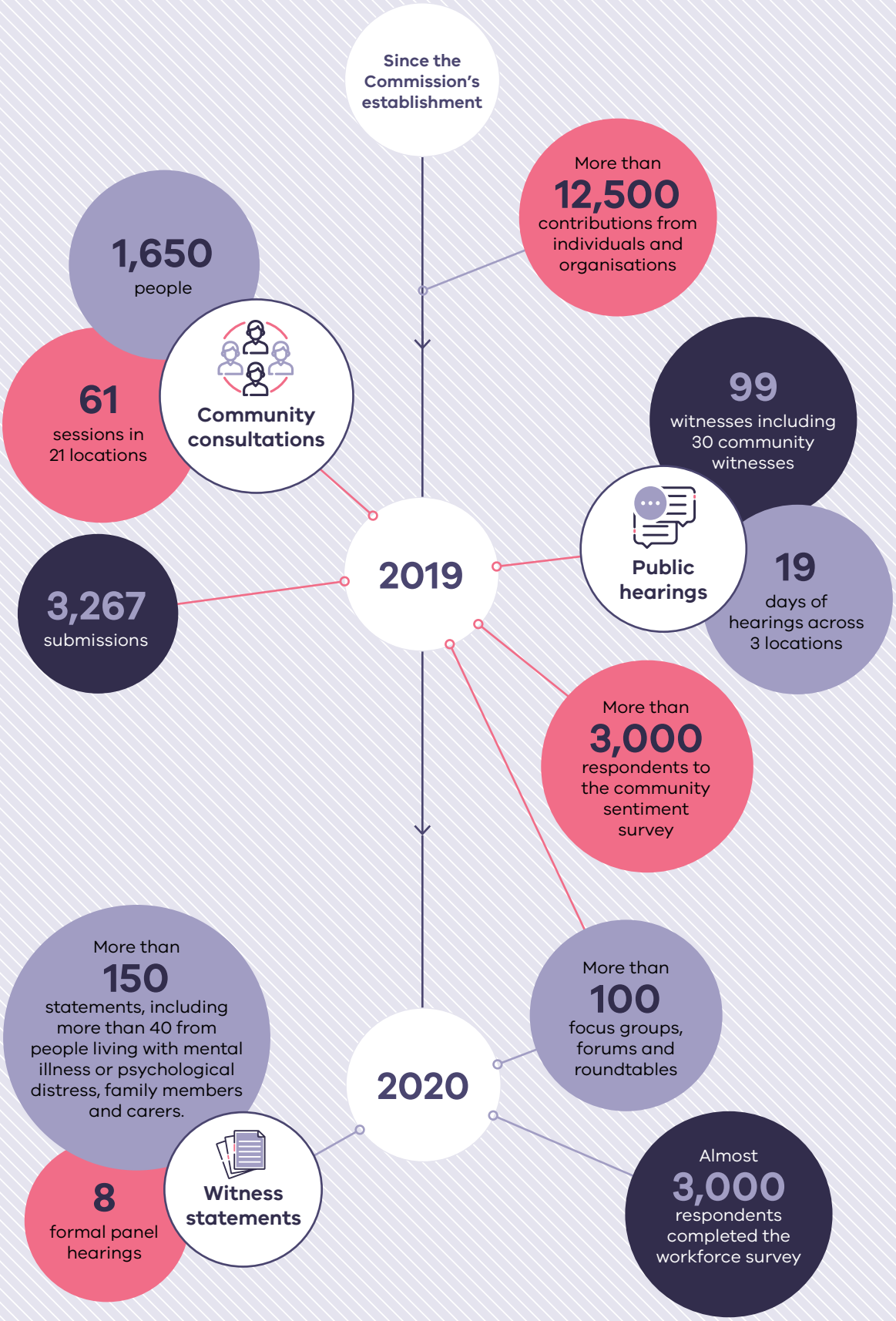
- public hearing days, particularly for people from these communities
- roundtables and focus groups with members of these communities
- detailed submissions.

For example, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) supported the Commission by developing the Balit Durn Durn report. VACCHO consulted with more than 100 people to help understand how the mental health system affects Aboriginal people. The report looked at the power of Aboriginal culture. It explained 'ways to build strength, resilience, connectedness and identity in Aboriginal people and Communities to create essential pathways for fostering positive mental health and wellbeing'.[12]

Some of the most powerful contributions to the Commission were from people with lived experience. People came forward to share personal experiences about how the system has failed and sometimes harmed them. The Commission is deeply grateful to everyone who shared their experiences.

The Commission knows that it carries the hopes of many people. We recognise this responsibility and have been supported by people's desire to create a better future. You can see this shared purpose in the Commission's reforms.

Figure 1: Facts and figures



Throughout the Commission's consultation and research, major themes became clear. These themes shaped the Commission's recommendations. They were about the mental health system itself, people's experiences, how people can be supported outside the system, and the importance of community and places.

- **Demand has overtaken capacity.** The system is overwhelmed and can't keep up with the number of people looking for treatment, care and support. This is clear at all levels of the system, from individual mental health professionals to acute and emergency services. One person with lived experience of mental illness explained how the system is overstretched:

> the most affected … are left to navigate an overburdened and essentially dysfunctional system. … I feel like the public system is battling to not fall apart itself, that its crisis reflects on us.[13]

- **Community-based services are undersupplied.** Many people can't access treatment, care and support close to their homes. There's a large gap between what's needed and the number of hours of community-based services that public specialist mental health services provide (Figure 2).
- **The system has become imbalanced and relies too much on medication.** Services rely on medication as the main, or sometimes only, treatment people can receive. This is because of system-wide challenges like under-resourcing, which has caused an imbalance. There is not enough focus on therapeutic interventions and recovery-centred treatment, care and support.
- **There is a 'missing middle'.** A large and growing group of people have needs that are too 'complex', too 'severe' and too 'enduring' for primary care to support it alone. However, these needs are not 'severe' enough for specialist mental health services. As a result, people aren't getting enough treatment, care and support, or none at all. Ms Amelia Morris, a witness who spoke to the Commission, said:

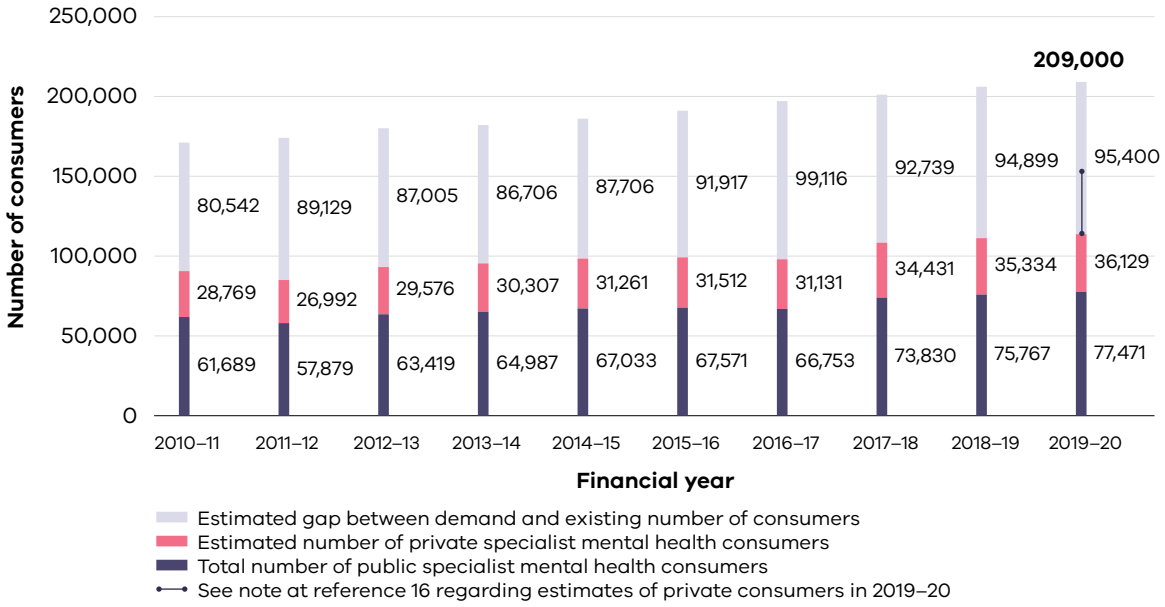
> One of the main problems I encountered with the mental health system was that when I asked for help, it felt like there was nothing there. The narrative around mental health seems to repeat the same message—'don't be afraid to ask for help'. The problem comes when you ask, there doesn't appear to be any answer. It's so heartbreaking when you finally work up the courage to voice the horrible things that you're experiencing, but there's nothing there to help you.[14]

- **Getting help is difficult.** People can't access the services they need. Those who do manage to get into the system find it hard to navigate. People living with mental illness or psychological distress have to wait a long time to access services. They also frequently become more unwell while they wait. More and more often a person has to be in major distress or crisis before they can get treatment, care and support. One person told the Commission:

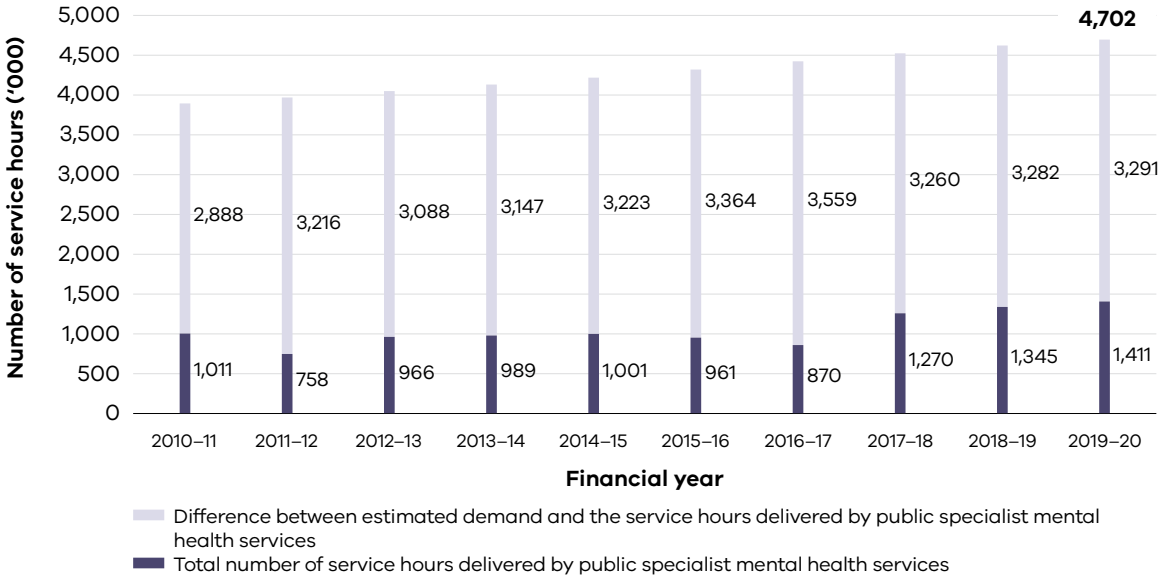
> I personally have asked for help from all the promoted channels and been turned away as I was not suicidal enough … Surely if someone has the courage to ask for help, Australia has the resources to help.[15]

Figure 2: 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[16]

A. Consumers



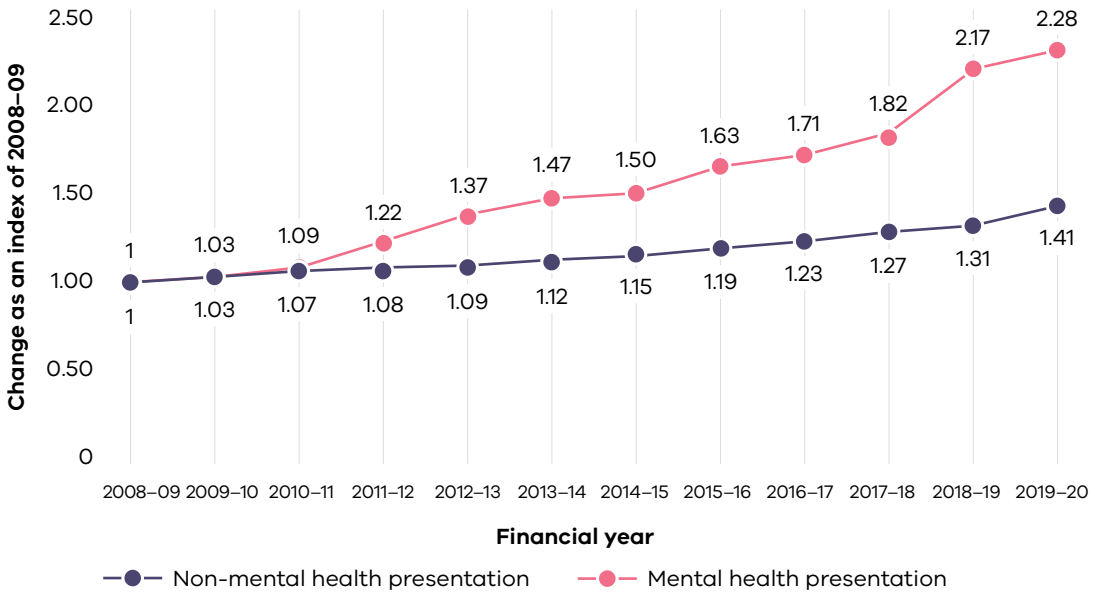
B. Service hours



- **Access to services is not fair.** Poverty and disadvantage make it even more difficult for people to access services. A high number of people living with mental illness have low incomes and no private health insurance. For many, this makes access to primary care (for example, through a GP) difficult to afford. Catchment areas that decide access to services also create a 'postcode lottery'. This means that people have to access specialist services within their catchment, unless the service they need isn't available in their catchment area. Where people live also affects how difficult it is to access services. This is often worse for people in rural and regional areas.
- **The system is driven by crisis.** Due to limited services, many people only receive treatment, care and support when they are in crisis. This means that people don't get the therapeutic and wellbeing supports they need when it would make the most difference.
- **Emergency departments are used as entry points.** The system is:
  - complex
  - hard to navigate
  - doesn't have enough accessible and appropriate services.

  This means that people don't get the right treatment, care and support when and where it would help them the most. A lack of community-based mental health services may have caused the increase in the number of people going to emergency departments for mental health reasons (Figure 3).

Figure 3: Change in the number of emergency department presentations, by mental health status, Victoria, 2008–09 to 2019–20[17]



- **There is a patchwork of services that don't meet local needs.** The types of services available vary a lot. What's available often depends on old funding arrangements instead of what the community needs. There are too many different service models and this causes confusion and inefficiency.
- **Mental health services aren't working well with other services.** People living with mental illness and other conditions, such as poor physical health, disability or substance use or addiction, can find it particularly hard to access services. These services are often not integrated enough to meet people's needs and preferences. Mr Michael Silva, a witness who spoke to the Commission, shared the experience of his brother:

> Alan has a dual diagnosis of bipolar disorder (with psychotic episodes) and addiction to alcohol and drugs. … We have never had an experience in the public mental health system of Alan being treated in an integrated way with respect to his dual diagnosis … The psychiatrists will only see you for your mental health issues … [they] may say that you should not take the drugs or smoke marijuana, but that is about the extent of the integration.[18]

- **The points of view and experiences of people with lived experience of mental illness or psychological distress are overlooked.** The experiences, points of view and expertise of people with lived experience of mental illness or psychological distress are not valued, understood or recognised. There are few opportunities for people with lived experience to lead, take part in and encourage change. The mental health system falls behind other social sectors in this. Ms Cath Roper, Consumer Academic of the Centre for Psychiatric Nursing at the University of Melbourne, told the Commission about the importance of shifting these power imbalances:

> We need approaches in which we deliberately and proactively try to understand issues around power. We need to think consciously about whose voice might be the thinnest or the hardest to hear (and that approach will usually help the consumer).[19]

- **Families, carers and supporters are left out.** There are about 60,000 Victorians who care for someone living with mental illness.[20] Families, carers and supporters can feel excluded by the system. They are often left out of consultation that would help them in their caring role. Many families, carers and supporters need their own supports too, but aren't able to access them. There isn't enough access to information about treatment, care and support to help families, carers and supporters.
- **There isn't enough focus on promoting good mental health and wellbeing.** There are large personal, community and economic costs caused by poor mental health. As is the 'burden of disease' from mental illness. The 'burden of disease' is the effect a disease or injury has on a population. This is worked out by measuring how much of a healthy life has been lost, either through early death or living with disability. Victoria has a higher 'burden of disease' from mental illnesses than most other Australian states and territories. In 2015, the 'burden of disease' from mental illnesses was worked out to be 26.5 years lost per 1,000 people in the Victorian population.[21] In its Interim Report, the Commission estimated that the economic cost of poor mental health to Victoria is $14.2 billion a year.[22] There isn't enough focus on promoting good mental health and wellbeing, or preventing mental illness. Opportunities to make sure government and the community are focussed on these issues are also missed.

- **Communities and places don't properly support good mental health and wellbeing.** The overriding focus on the 'mental health system' means that the social issues that affect mental health and wellbeing aren't recognised. This focus also downplays how important communities, workplaces and education settings are in creating good mental health and wellbeing. System leaders need to better support these places and settings to support good mental health and wellbeing.
- **There isn't enough focus on the early years.** The system can be slow to meet the mental health and wellbeing needs of infants and children under the age of 12. As well as the needs of prospective or new parents. The system mainly focuses on young people and adults. Parents find it difficult to access services and navigate the system. While families experience long wait times and face stigma when looking for help for themselves or their children. By not focussing on these early years, the system misses an opportunity to improve the mental health and wellbeing of future generations.
- **Younger people are negatively affected.** Younger people can experience mental illness when they:

  – take part in higher education and employment
  – form relationships
  – set out on adult life.

  A United States study estimates that 75 per cent of all lifetime cases of anxiety, mood, impulse control and substance use disorders appear by the age of 24.[23] There is a strong case for investing in the mental health and wellbeing of young people.

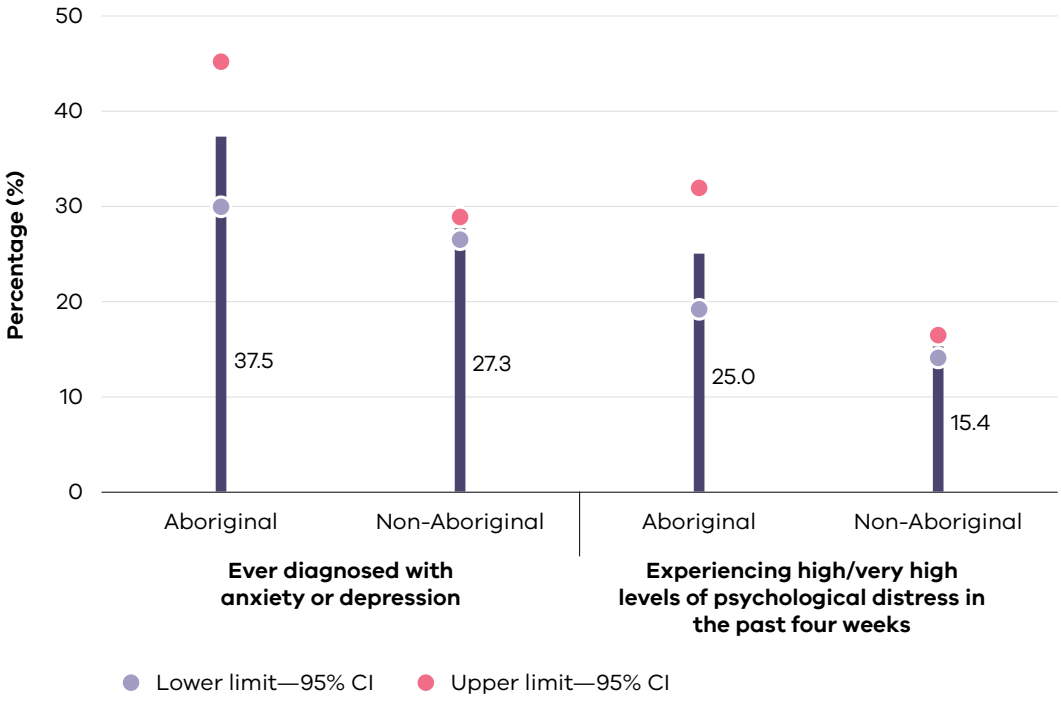
- **There is a large service gap for older Victorians.** Victoria's population is ageing. In the next three decades, the number of Victorians aged 65 years and over is estimated to double. Going up from 1.05 million (as of 30 June 2020) to 2.13 million by 30 June 2051.[24] This means that Victoria will also likely see an increase in the number of older Victorians living with mental illness.[25] Yet, currently, increasing demand and lack of services for older adults means that those who do ask for support are often turned away.[26]
- **Trauma is unseen.** The close relationship between trauma and mental illness and the need for trauma-informed mental health treatment, care and support are starting to be understood. However, there is still a lot of work to be done. The system needs to provide more holistic approaches. It also needs to be responsive to trauma and the possibility for people to be retraumatised. A failing system can itself cause trauma.
- **The focus on personal recovery needs to be strengthened.** The current system focuses mostly on the goal of 'clinical recovery'. This means that it focuses on a person's symptoms decreasing. However, the central focus needs to be on 'personal recovery'. People with lived experience developed this idea through the consumer movement. Personal recovery means being able to create a meaningful life, with or without mental health challenges. As Ms Erandathie Jayakody, a witness who spoke to the Commission, explained:

  > [Mental illness] does not have to be a lifelong sentence that limits your life. With the right supports and learnings the condition can be managed and a person can lead a full and meaningful life.
  >
  > At the heart of a recovery-oriented approach is a recognition of the most basic human desire to have control of one's own life and future, and the belief that people with mental health challenges have the ability and autonomy to achieve that.[27]

Rick Corney's personal story on page 16 illustrates the importance of recovery and community.

- **Culturally safe services aren't always available to Aboriginal communities in Victoria.** Aboriginal communities continue to live with the effects of trauma connected to colonisation and post-invasion policies like those that caused the Stolen Generation.[28] Everyday stress to do with social exclusion can have ongoing negative effects on Aboriginal Victorians' mental health and wellbeing. Victorian data shows that depression and anxiety is more common among Aboriginal Victorians than among non-Aboriginal Victorians (refer to Figure 4).

Figure 4: Proportion of the Aboriginal and non-Aboriginal adult population ever diagnosed with anxiety or depression or with high/very high levels of psychological distress in the past four weeks, Victoria, 2017[29]



- **Some groups face further barriers.** Extra issues affect the experiences of some people living with mental illness, including:

  - Aboriginal people
  - LGBTIQ+ people
  - refugees
  - asylum seekers
  - people from culturally diverse backgrounds
  - people living with disability.

  People from these groups face a range of barriers when seeking treatment, care and support. The mental health system doesn't currently deliver safe, responsive or inclusive care for many people from diverse groups.

- **Mental illness and unstable housing.** The changeable nature of mental illness can increase the chance people will experience unstable housing. For example, they may be forced to move accommodation, or may not be sure about where they will live.[30] Many people living with mental illness also live in poor accommodation. The Commission's recommendations include longer-term housing reform. However, resolving Victoria's housing crisis will need an ongoing government-wide response that goes beyond this inquiry.

Personal story:

Rick Corney

Rick first experienced mental health challenges when he was 28 years old. After several involuntary hospitalisations, he was diagnosed with schizophrenia.

> It was devastating. I didn't understand the illness … I lost all hope of being well.

After his diagnosis, Rick became clinically depressed and suicidal. He credits his mum with the fact that he is still here today. He says she played an important role in supporting him throughout his treatment.

> She went beyond and above what I thought possible.
>
> I look back now … there was no carer's network when she was supporting me.

Support also came directly from Rick's community after a friend of his mum's told members of the local cricket club about his situation. Rick believes the community at the cricket club was critical to his recovery.

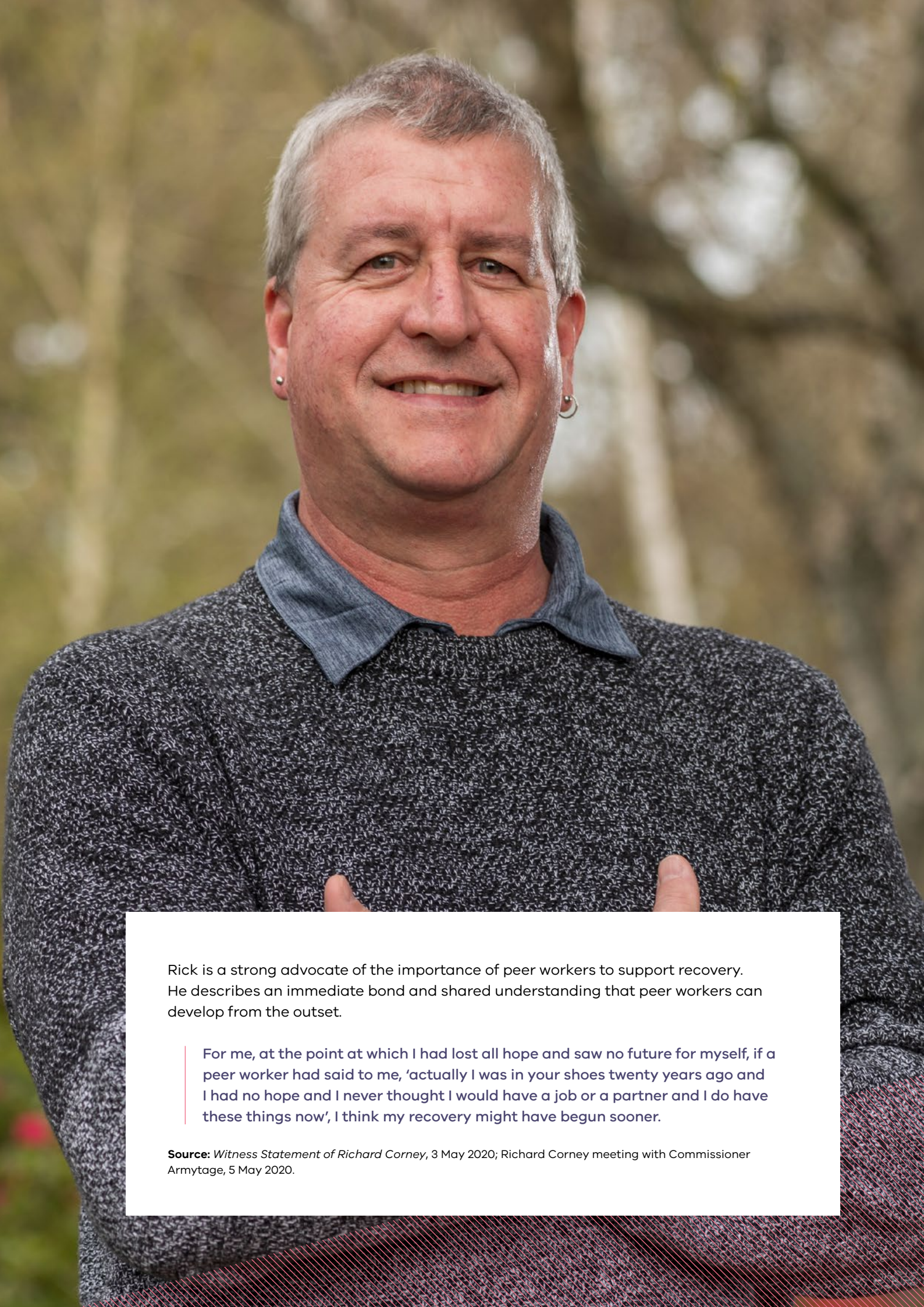
> They ended up coming and picking me up every Saturday to take me to the cricket. The first season I was so unwell and couldn't play, so they sat me behind the bar and the only thing I said was '$2.50 thanks', every time I sold a beer … We still laugh about that today, and about how far I've come.

While in the early days Rick experienced some stigma at the club, he believes this came from a lack of understanding about mental illness. Over time, instead of being the face of mental illness, he moved to being the face of what recovery can look like.

> the cricket club has taken their learning out of my experience which has helped raise awareness. It has been really powerful … now people are able to talk about issues they are facing without feeling as though they are going through things alone and keep things hidden like I did.

Rick is now a peer worker at a mental health service in Ballarat. He sees his story as a powerful message to share with others to inspire them, showing that 'anything is possible'.

> The fact that I'm here … kicking these goals and doing what I'm doing now … is a testimony to what recovery is about, and it's the gold standard of how life can change.



Rick is a strong advocate of the importance of peer workers to support recovery. He describes an immediate bond and shared understanding that peer workers can develop from the outset.

> For me, at the point at which I had lost all hope and saw no future for myself, if a peer worker had said to me, 'actually I was in your shoes twenty years ago and I had no hope and I never thought I would have a job or a partner and I do have these things now', I think my recovery might have begun sooner.

Source: *Witness Statement of Richard Corney*, 3 May 2020; Richard Corney meeting with Commissioner Armytage, 5 May 2020.

- **People in the criminal justice system don't get the support they need.** People living with mental illness are over-represented in the criminal justice system. How the criminal justice system and the mental health system work together is poorly managed.[31] It's also affected by how many people can access the mental health system at one time. This means people can't get the services they need when and where they would have the greatest benefit. As a result, the justice system often becomes the provider of mental health services, or the 'provider of last resort'.[32]
- **The experience of poor mental health and wellbeing is different in rural and regional areas.** People living in rural and regional areas can face a number of challenges to accessing treatment, care and support. These challenges can include stigma and a lack of local services. The numbers of people experiencing mental illness is generally the same as in metropolitan Melbourne. However, suicide rates are higher in rural and regional Victoria than in the city. Also, while the whole system goes through workforce shortages, these are often more noticeable in rural and regional areas.
- **Stigma and discrimination are always there.** Stigma is much like racism and other forms of prejudice. It can stop people living with mental illness or psychological distress from looking for support. It can make social isolation and loneliness worse. It can also be a barrier to finding and staying in a job. Finally, it can be an obstacle to recovery that keeps people from fully taking part in society. Discrimination is widespread and can affect many areas of life, such as:

  – difficulties accessing health care
  – not being supported at work
  – leaving people socially and economically excluded from society.

- **Good mental health and wellbeing are not given priority.** In the past, mental health and wellbeing hasn't being given priority in government decisions because of:

  – community attitudes, stigma and discrimination
  – competing political priorities
  – a lack of consistent advocacy.

  System leadership is weak and responsibility for how the system is managed isn't clear. It also seems that mental health hasn't been a priority within the health system itself.

- **Suicide is far-reaching.** Sadly, in 2019 there were 718 deaths by suicide in Victoria.[33] Suicide has a ripple effect across the community. It touches loved ones, friends, families and colleagues in profound and enduring ways. Some groups in the community are affected by suicide more than others, such as:

  – men
  – people living in rural and regional areas
  – Aboriginal people
  – LGBTIQ+ people.

  Ms Katerina Kouselas, bereaved by the suicide of her husband, told the Commission:

> We had been married for 32 years when Bill passed away. I will never come to terms with that. We were together since we were 18, we have a beautiful daughter, Natalie, and it took my life away and my heart and it will never be okay.[34]

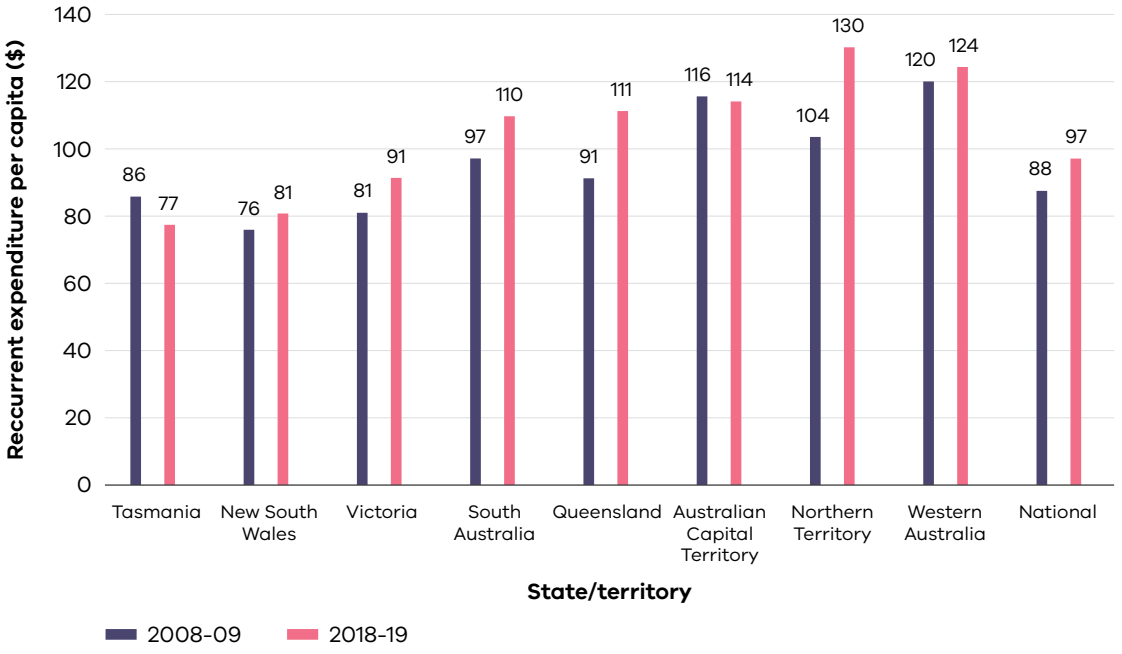
There are many complex issues related to suicide and these can often overlap. Current efforts need to move away from a single health response to a community- and government-wide approach.

- **The system's foundations need to change.** A range of structural issues have contributed to a system that is uncoordinated with large service gaps, including:
  - poor processes for measuring outcomes
  - poor system planning
  - weak monitoring of service providers
  - not working efficiently with the Australian Government.
- There isn't enough investment in the system. In the past, Victoria's investment in mental health has been low compared with the rest of Australia (refer to Figure 5). Investment in mental health per person is also poor compared with physical health. The Honourable Professor Kevin Bell AM QC, Director of The Castan Centre for Human Rights Law, Monash University, giving personal evidence, talked about how unacceptable this is:

> In human rights terms, this is a matter of obligation, not policy. Victoria is not like a developing nation where lack of resources is an explanation for under-investment in health.[35]

Money is one measure, but of great concern is the human toll that goes with a broken system.

Figure 5: Recurrent expenditure per capita ($) on state and territory community mental health services, constant prices, states and territories, 2008–09 and 2018–19[36]



- Regulation and oversight is complex and unclear. Many consumers have experienced a lack of dignity, empathy and choice in the mental health system.[37] Many have also said they feel unsafe.[38] There have been many efforts to encourage improving quality and safety, but they haven't lasted.
- **Dignity is often ignored and human rights are violated.** Many people who access mental health services aren't treated with dignity or respect. They're also not involved in making decisions about their own treatment, care and support. Restrictive practices and compulsory treatment are used too often. One person shared their experience with the Commission, saying that '[s]eclusion is barbaric. Worse than prison. You are penalised for being unwell.'[39]
- **The workforce is under-resourced.** The mental health workforce is diverse but there are serious shortages. These are more noticeable in some specialities and in rural and regional areas. Though workers are committed and competent, many have struggled to perform their best in a crisis-driven system. Teams feel overworked and under-resourced:

> In my workplace … the team is very burnt out and mentally exhausted, and we will talk about how when we have our days off, no one has energy to do anything … and people keep turning up to work, because of not letting the team down.[40]

- **The value of lived experience work is starting to be recognised but faces challenges.** There is great potential to expand and support lived experience workforces. These workforces, however, have unique challenges including:

  – stigma and discrimination
  – lack of infrastructure and support
  – lack of acceptance as a profession.

  Making the most of the value of this workforce will need services to promote, support and empower lived experience workers.

- **The system is outdated.** The mental health system has failed to keep up with people's changing needs for up-to-date treatment, care and support. The system hasn't encouraged innovation. It doesn't follow the latest evidence about effective treatment, care and support. It has also not kept up with the developments in digital technology, which could improve peoples' experiences and outcomes.

3. Transformation and reform

To look at how these challenges might be tackled, the Commission used a system-design approach. This approach is based on working with people with lived experience. From this, the Commission developed a path for the reform using seven guiding principles. You can find these principles in Figure 6.

Figure 6: Guiding principles for Victoria's mental health and wellbeing system

Guiding principles for Victoria's mental health and wellbeing system

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

The Royal Commission imagines a mental health and wellbeing system where:

1	The dignity of people living with mental illness or psychological distress is respected and necessary holistic support is provided to make sure people can take part fully in society.
2	Family members, carers and supporters of people living with mental illness or psychological distress are recognised and supported.
3	Comprehensive mental health treatment, care and support services are provided equally to those who need them. And they are provided as close as possible to where people live—including in rural areas.
4	Collaboration and communication happen between services within and outside of 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 stress, 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 ongoing research, evaluation and innovation to meet community needs now and into the future.

Note: These principles are based on:

- the many contributions made to the Commission
- 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)
- legislation such as the Australian Government's *Carers Recognition Act 2010.*

The Commission's recommendations are based on transformational reform. The Commission has a vision for a balanced system where mental health and wellbeing treatment, care and support are provided in:

- the community
- hospital
- other residential settings.

These reforms aim to rebalance the system so that more services will:

- be delivered in community settings
- go beyond a health response to a more holistic approach to good mental health and wellbeing across the community.

The Commission's 65 recommendations in this Final Report (and the nine in the Interim Report) support this. An overview of major reform areas are summarised in the following pages. Each area is grouped around four key features of the future mental health and wellbeing system.

3.1 A responsive and integrated system with community at its heart

The future mental health and wellbeing system will be built around a community-based model of care. Where people will access treatment, care and support close to their homes and in their communities.

We recognise that people experience mental health and wellbeing differently. So, the reformed system will offer comprehensive and varied services that a multidisciplinary workforce delivers.

People will access services based on their strengths and needs. The Commission chose to focus on these characteristics instead of labels, because labels can be stigmatising and discriminatory. Figure 7 shows five 'consumer streams' across a range of mental health and wellbeing treatment, care and support. This recognises that people's needs often change over time and will, therefore, move between streams.

The service system will have six levels. The top level is aimed at the largest number of people and the lowest level, statewide services, the fewest—see Figure 7. At each level, teams will increase in specialisation. Each level will work with the next level and service providers will work together. Three levels will be reformed:

- Local Mental Health and Wellbeing Services (50 to 60 new Adult and Older Adult Local Mental Health and Wellbeing Services with dedicated local services for infants, children and families, and young people)
- 22 Adult and Older Adult Area Mental Health and Wellbeing Services
- 13 Infant, Child and Youth Area Mental Health and Wellbeing Services and statewide services.

Primary and secondary mental health and related services will be supported through further consultation with consumers, providers of those services, and models of comprehensive shared care.

Wherever possible, people will be supported to get services through Local Mental Health and Wellbeing Services, close to their communities. People will access these services either directly or with a referral. Through planned pathways between different types of services, people will have planned and dependable access to services.

New Adult and Older Adult Local Mental Health and Wellbeing Services will be accessible to more people than they are now. They will need to deliver three core functions to make sure their services respond to people's needs. As shown in Figure 7, these functions will include treatments and therapies. They will also include expanded wellbeing supports. Services will deliver these functions based on the question 'how can we help?'. This will enable services to support people from their first contact to their last contact with the services.

When a person has higher levels of need, a medical practitioner or Local Mental Health and Wellbeing Service will be able to refer them to an Area Mental Health and Wellbeing Service. (There will be 22 Adult and Older Adult Area Mental Health and Wellbeing Services and 13 Infant, Child and Youth Area Mental Health and Wellbeing Services.) These services will provide high-intensity and complex support responses and will have multidisciplinary teams. They will have to deliver all of the core functions to people who need more intense treatment, care and support than local services can provide.

A public health service (or public hospital) and a non-government organisation that provides wellbeing supports will deliver Area Mental Health and Wellbeing Services together. These services will be open for longer. They will respond to crisis calls from anyone in the community 24 hours a day, seven days a week.

If they need it, people living with mental illness who have ongoing, intensive needs will receive community-based treatment, care and support from Area Mental Health and Wellbeing Services. This will be based on actively working with the community outside the hospital, including an outreach program.

The expertise of statewide services will be available to people and other service providers. The distance people need to travel to access these services will also be as short as possible. There will be new links between statewide services and the Collaborative Centre for Mental Health and Wellbeing, which the Commission recommended in the Interim Report. This will take advantage of the centre's research and knowledge-sharing abilities. To access statewide services, people will need a referral from an Area Mental Health and Wellbeing Service. The Department of Health and statewide services will set up policies that explain how to manage referrals.

Services will provide treatment, care and support that suit people's age and stage of development. There won't be any more strict age-based eligibility criteria. One mental health and wellbeing system for infants, children and youths will be set up. It will provide treatment, care and support for newborns to 25-year-olds that suit their stage of development.

The Infant, Child and Youth Area Mental Health and Wellbeing Services will include two service streams:

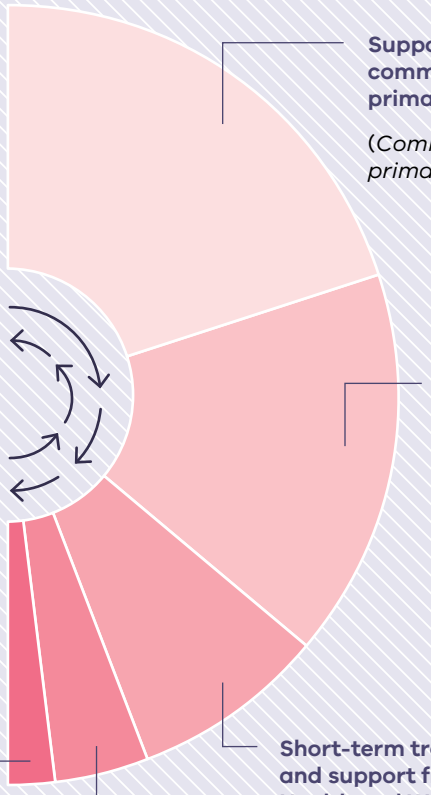
- Infant, Child and Family Area Mental Health and Wellbeing Services (from birth to 11 years old)
- Youth Area Mental Health and Wellbeing Services (12–25 years old).

The Government will commission Aboriginal community-controlled health organisations. They will deliver social and emotional wellbeing services for children and young people. The services will be culturally appropriate and family-oriented.

Figure 7: Community mental health and wellbeing system: consumer streams, age-based streams, services within each level and core functions

At any given point in time, a person living with mental illness or experiencing psychological distress will need:

Consumer streams



Support from their communities and primary care services

(*Communities and primary care* stream)

People can move between streams at any point in time, according to their needs

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 Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services

(*Short-term treatment, care and support* stream)

Ongoing intensive treatment, care and support from Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services

(*Ongoing intensive treatment, care and support* stream)

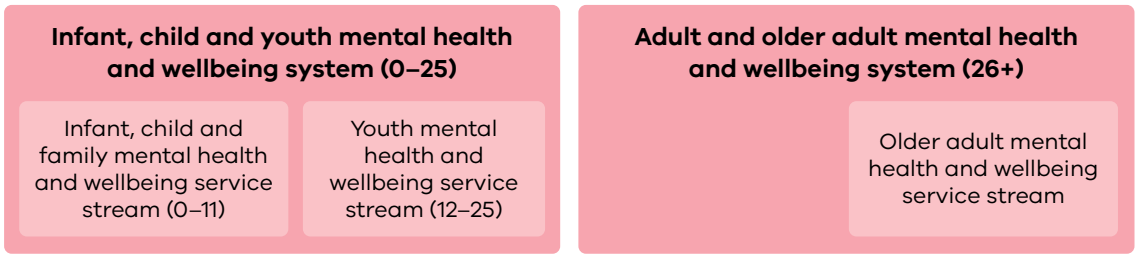
Ongoing treatment, care and support from Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services

(*Ongoing treatment, care and support* stream)

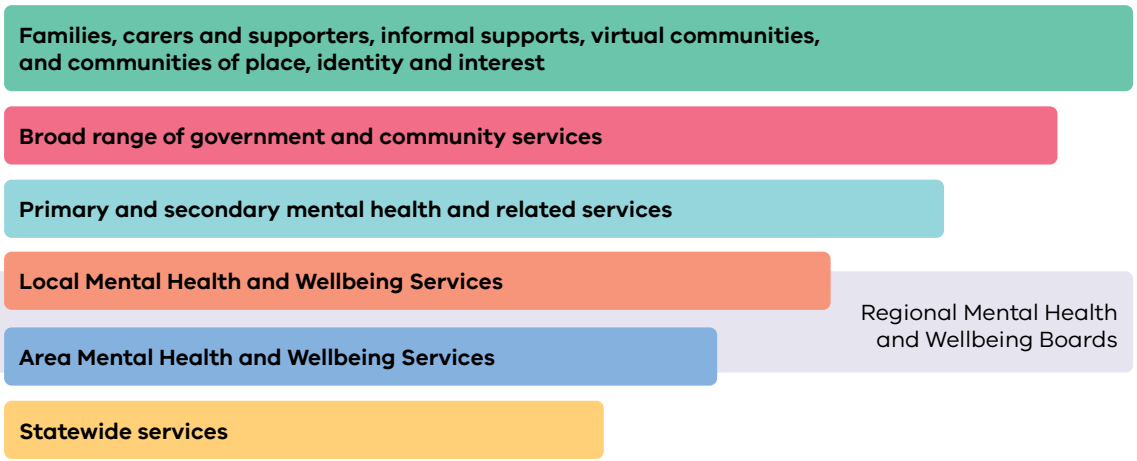
Services provided across two age-based systems

Six levels in a responsive and integrated system

Community mental health and wellbeing services delivering three core functions



Developmentally appropriate transitions will be applied between age-based systems and service streams



Core functions of community mental health and wellbeing services

Core function 1: Integrated treatment, care and support across four components:

- **a** **Treatments and therapies**
- **b** **Wellbeing supports**
- **c** **Education, peer support and self-help**
- **d** **Care planning and coordination**

Core function 2: Services to help people find and access treatment, care and support and, in area services, respond to crises 24 hours a day, seven days a week.

Core function 3: Support for primary and secondary services through secondary consultation with providers of those services, primary consultation with their consumers, and a formal model of comprehensive shared care.

These services will be delivered across a range of modes (telehealth and digital technologies; in centres and clinics; and in visits to people's homes or other settings, including through assertive outreach) and will be accessible and responsive to the diversity of their local community.

Community mental health and wellbeing services will include a wide range of support and service providers. For example, current area mental health services, non-government organisations, community health services, private providers, new consumer-led providers, and primary and secondary services. People will access services by going to site-based services, through digital platforms and during visits in their home or community.

Strict catchments, where people can only receive specialist services based on their place of residence, will be removed. Service providers will never turn people away because of where they live.

The system will be designed around eight regions. Over time, there will be new regional governance structures, which will be known as Regional Mental Health and Wellbeing Boards.

These structures will help plan and organise mental health and wellbeing services so that they respond to community needs and improve outcomes. These structures will also help mental health and wellbeing services work with other services outside of the system. For example, Victorian Government and Australian Government funded services. In each region, there will be a multiagency panel to coordinate services for people living with mental illness who may need ongoing intensive treatment, care and support.

In these regions, the Regional Boards will use new ways of commissioning and contracting to encourage more integrated service delivery. This will be for:

- people who need ongoing intensive treatment, care and support
- people who need short-term treatment, care and support and are in the 'missing middle'.

Regional Boards will organise 'demonstration projects' in each region. This will test new ways of commissioning and organising. It will also promote innovation and best practice.

In the new mental health and wellbeing system, most people will receive treatment, care and support through community-based services. There will be less reliance on hospital and crisis-based services. However, hospital and residential services will still play an important role by supporting people who need highly specialised or acute care. New models of care and a better range of choices will be available to people who need these bed-based services. This includes:

- a new rehabilitation pathway for people who need ongoing intensive treatment, care and support
- new models of multidisciplinary care.

Bed-based services will be delivered in a range of settings. For example, people's homes and specialised community and hospital environments. People who are in hospital to get help for their mental health will be separated by gender. This will help to reduce gender-based violence in those facilities.

There will be a complete mental health crisis system that will be based on compassion and respect. For people in crisis, police and ambulance callouts and visits to emergency departments won't be the only options anymore. New safe spaces run by other people with lived experience of mental illness will be available for people going through different levels of distress or crisis. People will be able to stay safe and access support in these spaces.

There will be a new agency that people with lived experience of mental illness or psychological distress will lead. This agency will support the development of organisations and services that are led by and for people with lived experience of mental illness or psychological distress.

Families, carers and supporters will be recognised as central to the mental health and wellbeing system. They make a large contribution to the wellbeing of the people they care for or support. The value of families, carers and supporters will be promoted in the system. Family- and carer-led centres will also be set up to support them and respond to their needs. Ms Anna Wilson's personal story shows the important role families, carers and supporters can play, and the challenges they face with the current system. See page 30.

The new system will support the mental health and wellbeing of the next generations. It will do this through one infant, child and youth mental health and wellbeing system for newborns to 25-year-olds.

Community perinatal mental health teams will support new parents and people about to become parents. A responsive and integrated service stream will support children from birth to 11 years and their families. This stream will focus on the start of life and the early years.

Victoria's young people, aged 12–25 years, will be supported to grow into adults with good mental health and wellbeing. A new youth mental health and wellbeing service stream will be set up. Youth services will be reformed and expanded in line with the core functions of community mental health and wellbeing services.

The new mental health and wellbeing system will offer different types of treatment, care and support. It will recognise the different preferences of consumers, families, carers and supporters. A statewide trauma centre will help deliver the best possible mental health outcomes for people who have experienced trauma. A statewide service for people living with mental illness and substance use or addiction will also be set up, and there will be reforms that lead to integrated treatment, care and support.

Supporting good mental health and wellbeing extends further than the mental health and wellbeing system. This means there needs to be a focus on other service systems and how they can work together. For example, stable housing can make a big change in someone's life, because it brings purpose, hope and opportunity.[41] The Victorian Government has a 10-year social and affordable housing strategy. In this strategy, people living with mental illness are recognised as a priority population. This means that young people living with mental illness and experiencing unstable housing or homelessness will be given supported housing places.

3.2 A system set up to promote inclusion and tackle inequality

The future mental health and wellbeing system will be responsive to people and populations in Victoria with the greatest need. It will provide services that are safe, tailored and localised. The system will change so that services are available to everyone. It will support those who may be experiencing disadvantage. To make this reform, we need to look past the system and examine the different factors that shape mental health and wellbeing. Mrs Lucinda Brogden AM, Chair of the National Mental Health Commission, told the Commission:

> **Some of the most powerful root causes of health inequalities are the social conditions in which people are born, grow, work, live and age, as well as the systems that shape the conditions of daily life. These conditions are collectively referred to as the social determinants of health.[42]**

Personal story:

Anna Wilson

Anna* is the carer for her 27-year-old son Harold.* Anna said that they have always been close. She said that Harold sends her phone messages saying 'love you Mum'.

> He was a beautiful little boy, who would often pick flowers for me on his way home from school. He had beautiful school reports, about how kind, gentle, polite and well-mannered he was.

Harold has been diagnosed with schizophrenia, post-traumatic stress disorder and alcohol dependency. Anna said that over the nine years she has tried to get treatment for Harold, his condition has gotten worse.

> My son experienced his first psychotic episode in 2014 … Since Harold has been suffering from mental illness, it has been nine long torturous years struggling to get help. I have been forced to watch my beautiful boy's life deteriorate in front of my eyes.

Anna said that it's been hard being a carer trying to get help from the public mental health system in crisis situations.

> I have felt so disempowered and exhausted from constantly battling to get my son the support and care he needs.
>
> I have been pushed aside because staff are busy. Mental health workers have said to me 'I can't talk now' or 'I'll let you go now'. I've felt like saying 'I don't want to be let go'.

Anna said she has tried to call emergency and crisis services about Harold, but that help is only provided in the worst situations.

> There have been thousands of phone calls, between 20 to 50 calls on some days, yet I have been unable to get my son the help he needs. Sometimes, the situation has to be really drastic before you are taken seriously, and help is provided. I've had to talk to the Mental Health Complaints Commissioner, the Office of the Chief Psychiatrist and, at times, I have had to threaten legal action because otherwise you just don't get listened to. It shouldn't have to be like this.

Anna did speak positively of how police have responded to Harold. In particular, there was one time they came after a neighbour reported a disturbance.

> Although the policeman was assertive, he was also compassionate, empathetic and listened to Harold. Harold really opened up his heart to him. He showed the policeman all the scars on his arms and the cuts he'd made a couple of days earlier, talked about … how his cat was missing. One of the policeman said to Harold 'I know, I've lost a cat too, it's really hard' …
>
> The police and some public service officers have been fantastic … and in my experience far more supportive and responsive than the [crisis assessment and treatment] team.

Anna would like to see improved crisis services so that police are not the main contact for people who need specialised treatment. She would also like to see more hospital beds available and better support for people who are discharged from a service. Anna also wants shorter waiting lists for services that provide long-term rehabilitation.

> I want my son to learn to be independent and to be able to live in his own home. I'm scared that after I pass away, he will end up on the street. It breaks my heart …

Anna described how caring affects her own health and wellbeing and leaves her feeling drained. She would like carers to receive more support and chances to have a break.

She also said that the mental health system needs more compassion.

> the system, the services and the workforce need to be more compassionate and understanding of the immense pain and stress that families and people like my son are experiencing. Workers need patience and understanding to properly engage with people with mental illness.

Source: *Witness Statement of 'Anna Wilson' (pseudonym)*, 2 July 2020.

Note: *Names have been changed in accordance with an order made by the Commission.

The Commission imagines a system that focuses on improved mental health and wellbeing outcomes for consumers, families, carers and supporters. A *Mental Health and Wellbeing Outcomes Framework* will create responsibility for mental health and wellbeing outcomes across services and government. It will guide the transformation of the system and challenge it to address inequality.

The Commission hopes that Victorians will have the best mental health and wellbeing possible. It's committed to:

- defending human rights
- promoting good mental health and wellbeing.

There will be appropriate and continued investment in leading, coordinating and delivering prevention and promotion activities across the state.

These activities will focus on:

- human rights
- reducing imbalances in mental health and wellbeing outcomes.

The Victorian Government will work with Victoria's diverse communities and set new expectations of services. This will mean the needs of Victoria's diverse communities will be recognised and responded to. For example, there will be stronger support for LGBTIQ+ people to navigate and access the system. Victorians will be able to get appropriate mental health information. It won't matter if English is their second language or how well they hear. And it won't matter what their literacy level is or their neurocognitive ability. Supports to improve the social and emotional wellbeing of Aboriginal children and young people will be increased, and Aboriginal community-controlled health organisations will deliver healing centres. This will build on reforms outlined in the Commission's Interim Report.

Good mental health and wellbeing is a shared priority across the community. Wellbeing is influenced by interactions and connections with people. This means that inequality must also be tackled where people live, work and play. 'Community collectives' will be set up to bring together community leaders and members to promote social connection and inclusion.

Regional Boards will commission Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services.

They will:

- make sure that these services respond to the needs of local communities
- recognise the strengths and challenges of each region
- remove differences in service access and mental health and wellbeing outcomes across rural and regional communities.

They will do this by expanding services and making strategies to attract and keep more mental health workers.

Many parts of the system will work together to tackle stigma and discrimination. This will create the conditions needed to support good mental health and wellbeing. Anti-stigma programs will be developed, put in place and assessed. People will also have better access to legal protection from mental health discrimination.

3.3 Rebuilding confidence by making mental health a priority and through collaboration

To keep the new mental health and wellbeing system going, it needs strong foundations. These are about:

- effective leadership, governance and oversight, responsibility and collaboration across governments and communities
- making sure that people with lived experience of mental illness or psychological distress are leading and working with others in reform work.

Ms Mary O'Hagan MNZM, former New Zealand Mental Health Commissioner and current Manager of Mental Wellbeing at Te Hiringa Hauora, New Zealand, gave personal evidence to the Commission. She stressed:

> **the reforms we need are not about 'giving greater voice' to people with lived experience. Rather, we need to transform the system from within, so that those voices are central to the discourses and are deeply heard.**[43]

The Victorian Government will set up a new independent Mental Health and Wellbeing Commission. It will hold the Government responsible for:

- how well the mental health and wellbeing system works
- carrying out the Commission's recommendations.

As part of making oversight stronger, the new Commission will be able to start its own investigations into relevant matters. It will also be responsible for responding to complaints.

To make mental health and wellbeing a higher priority for government, system governance will be made stronger. There will be a Chief Officer for Mental Health and Wellbeing. They will lead the Mental Health and Wellbeing Division in the Department of Health, and their role will be defined in legislation.

The leadership of people with lived experience will be critical to the system. The new Mental Health and Wellbeing Commission will include Commissioners with:

- lived experience of mental illness or psychological distress
- lived experience as a family member or carer.

The new Commission will also support people with lived experience of mental illness or psychological distress to fully take part in decision making about the issues that affect their lives. It will also promote the role, value and inclusion of families, carers and supporters.

An important part of improving people's experiences and outcomes is making sure that mental health and wellbeing services are safe and high quality. The Victorian Government will set up a Mental Health Improvement Unit in Safer Care Victoria. This will help improve quality and safety through modern and multidisciplinary approaches in services. The unit will focus on reducing the use of seclusion, restraint and compulsory treatment. It will also focus on reducing gender-based violence, particularly in inpatient settings.

The Victorian Government will commission services in new ways to meet the different needs of people living with mental illness or psychological distress, families, carers and supporters. Investment in mental health and wellbeing will be made a priority. The Commission has asked the Victorian Government to look at ways of making this happen. There will also be large changes to the way services are planned, funded and checked. This will make sure that services meet people's expectations and are providing the outcomes that are most important to consumers, families, carers and supporters.

Collaboration across governments and sectors will be an important part of responding to the different factors that shape people's mental health and wellbeing. These factors include education and justice settings, workplaces and social networks. This is especially important for suicide prevention and response, because many factors are connected with suicide. Working towards zero suicides[44] will need all governments and the community to take part. A new Suicide Prevention and Response Office will help make it work.

The new mental health and wellbeing system will be supported by legislation – a new Mental Health and Wellbeing Act. The new Act will promote good mental health and wellbeing.

3.4 Modern and flexible services

Modern and flexible service delivery is an important part of improving the experiences and outcomes of people living with mental illness or psychological distress, families, carers and supporters. This includes people today and the generations to come. There will need to be a completely different approach. The new system will need to adapt to changing expectations, trends and new challenges.

To deliver these reforms the workforce must be sustainable. The workforce will change so that it's diverse, large enough and has the skills and experience to deliver effective treatment, care and support. The ability of the workforce will be improved through new ways of working. There will also be increased support for workforce wellbeing, practice and learning and professional development activities.

In a modern mental health and wellbeing system, consumers' human rights are respected every step of the way. Consumers are supported to make decisions that affect their own lives. Real changes will be made to practices and cultures, making sure that consumers' human rights are defended. This includes work to greatly reduce the use of seclusion and restraint, eventually ending these practices. It also includes work to greatly reduce the use of compulsory treatment so it's only used as a last resort.

Digital technology will help the system work effectively. To make system access, continuity of care and navigation better, service providers will need to provide basic digital functions. They will receive support to do this. A new approach to information management will help collect

and share information across the system effectively, safely and efficiently. This new approach will be set up in partnership with consumers.

The system will continue to change and respond to the expectations of people living with mental illness or psychological distress, families, carers and supporters. Innovation in treatment, care and support will be promoted through a mental health and wellbeing innovation fund. Services will also be helped to carry out and test new approaches. There will be a strong focus on testing and applying new treatments and models of care in services that are led and produced with people with lived experience of mental illness or psychological distress. Providers of all new mental health and wellbeing programs will need to agree to the assessment before they are funded.

4. Making the Commission's ambitions a reality

Although the Commission has finished, some of the most important work will now begin. The transformed mental health and wellbeing system described in this report will only happen if implementation is done properly. Government needs to be committed to delivering this vision and keep working in the right direction.

This will not be easy. The system and the causes of poor mental health are complex. However, the Commission has consulted widely to redesign the system. It has recommended practical reforms that reflect the needs and expectations of people living with mental illness or psychological distress, families, carers and supporters.

It's very important that people who are implementing the recommendations don't repeat the Commission's consultations. This would disrespect those who have already shared their experiences, analysis and ideas.

The Commission's inquiry into the mental health system is not the first one like it. But, unlike earlier inquiries, there is a real commitment to following through. The Victorian Government has said it will put in place all of the Commission's recommendations.[45] The 2020–21 State Budget gave extensive funding for the reforms recommended in the Commission's Interim Report.

The Commission has had a special opportunity to review the system as a whole. It has also been able to engage with many people. This has helped it to understand the system's failures and to find opportunities for lasting reform.

During the inquiry, the Australian Government has shown more interest in good mental health and wellbeing. For example, there has been the Productivity Commission's *Mental Health* report. And the Prime Minister's National Suicide Prevention Adviser has worked to develop a government-wide approach to suicide prevention and response.

The public has also been talking more about good mental health and wellbeing. This has been particularly obvious during the COVID-19 pandemic, which has had broad social and economic impacts for Victorians. The world is still learning about how the pandemic has

affected people's mental health and wellbeing. However, some research suggests there may be increased rates of depression and anxiety. There may also be increased substance use and suicidal thoughts.[46] It's encouraging that more people are talking about mental health. These impacts show how important it is to keep focusing on making the system better.

The public has placed great trust in us to reform the mental health system. We have been humbled by the number of people who have connected with us to share their ideas about a new system, as well as their hopes. This has helped us create our vision for a future mental health and wellbeing system. This hope must be central to making our vision a reality.

Strong and committed leadership is needed across governments and services. It's also needed from people with lived experience of mental illness or psychological distress, families, carers and supporters. All levels of government, service providers, the workforce, related systems and the community must work together.

The Commission has looked into the system for nearly two years. It has set out the reforms needed to deliver a new mental health and wellbeing system. There are many reasons to hope that this time, there will be effective and lasting reform.

The Victorian public's optimism and desire for change gives implementers an opportunity to create reform that will last. All partners in delivering this reform must rise to the challenge. The Commission's inquiry is over. Now, it's time for action.

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

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

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

4 Commission analysis of Department of Health (Commonwealth), National Mental Health Service Planning Framework; and Department of Environment, Land, Water and Planning, Victoria in Future 2019, June 2019.

5 Australian Bureau of Statistics, 4326.0 National Survey of Mental Health and Wellbeing: Summary of Results, 2007, <www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4326.0Main+Features32007?OpenDocument>, [accessed 23 June 2020].

6 National Mental Health Service Planning Framework, *Introduction to the NMHSPF,* 2019, p. 10.

7 Anonymous, *Brief Comments to the RCVMHS: SUB.0001.0031.0024,* 2019, p. 4.

8 Leigh Garde, *Brief Comments to the RCVMHS: SUB.0001.0029.0014,* 2019, p. 5.

9 *Witness Statement of 'Lucy Barker' (pseudonym),* 29 June 2020, para. 31.

10 Victorian Auditor-General's Office, *Access to Mental Health Services,* 2019; Victorian Auditor-General's Office, *Child and Youth Mental Health,* 2019.

11 For example, Department of Health and Human Services, Victoria's 10–Year Mental Health Plan, 2015; Commonwealth Department of Health, *The Fifth National Mental Health and Suicide Prevention Plan,* 2017.

12 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report,* 2020, p. 10.

13 Anonymous 221, *Submission to the RCVMHS: SUB:0002.0028.0395,* 2019, p. 1.

14 *Witness Statement of Amelia Morris,* 29 June 2019, para. 20.

15 Anonymous, *Brief Comments to the RCVMHS: SUB.0001.0032.0028,* 2019, p. 4.

16 **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 2020, cat. no. 3101.0, Canberra; Department of Health and Human Services, Client Management Interface/Operational Data Store 2010–11 to 2019–20. **Notes:** 2010–11, 2012–13, 2015–16 and 2016–17 data collection was affected by protected industrial action. The collection of non-clinical and administrative data (public specialist mental health services) was affected, with impacts on the recording of community mental health service activity and client outcome measures. A. Consumers: The estimated number of private clients using the private system is based on the proportion of overall people admitted to a private hospital in Victoria for a mental health reason between 2010–11 and 2018–19. There may be consumers receiving mental health services in both public and private specialist services that are double counted. There may also be people receiving specialist mental health services from other private providers that are not counted with this methodology. This analysis does not include 'unregistered clients'. Each year there are a number of contacts delivered to consumers that are not registered in the Client Management Interface/ Operational Data Store which in 2019–20 was 16 per cent of total contacts. For 2019–20, there are two alternative estimates of the number of private specialist mental health consumers. First, 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.

17 **Sources:** Department of Health and Human Services, Integrated Data Resource, Victorian Emergency Minimum Dataset 2008–09 to 2018–19; Department of Health and Human Services, Victorian Emergency Minimum Dataset 2019–20. **Notes:** Mental health-related emergency department presentation defined as: (a) the presentation resulted in an admission to a mental health bed (inpatient or residential), or (b) the presentation received a mental health-related diagnosis ('F' codes, or selected 'R' and 'Z' codes R410, R418, R443, R455, R4581, Z046, Z590, Z609, Z630, Z658, Z765), or (c) the presentation was defined to be 'Intentional self-harm', or (d) the presentation involved interaction with a mental health practitioner. Data excludes the Albury campus of Albury Wodonga Health. The Commission's definition of mental health-related emergency department presentation may differ slightly from the definition used by the Department of Health and Human Services. .

18 *Witness Statement of 'Michael Silva' (pseudonym),* 22 June 2020, paras. 5 and 51.

19 *Witness Statement of Cath Roper,* 2 June 2020, para. 90.

20 Department of Health and Human Services, Victoria's Mental Health Services Annual Report 2019–20, 2020, p. 34.

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

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

23 *Witness Statement of Professor Patrick McGorry AO,* 2 July 2019, para. 21; Ronald C Kessler and others, 'Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication', *Archives of General Psychiatry,* 62.6 (2005), 593–602 (p. 593).

24 Commission analysis of Department of Environment, Land, Water and Planning, *Victoria in Future 2019.*

25 National Ageing Research Institute, *Submission to the RCVMHS: SUB.0002.0024.0049,* 2019, p. 4.

26 Commissioner for Senior Victorians, *Submission to the RCVMHS: SUB.1000.0001.1667,* 2019, p. 7; 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. 15; RCVMHS, *Aged Persons Mental Health Services Roundtable: Record of Proceedings,* 2020.

27 *Witness Statement of Erandathie Jayakody,* 4 June 2020, paras. 38–39.

28 Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027,* 2017, p. 10; Graham Gee and others, 'Chapter 4: Aboriginal and Torres Strait Islander Social and Emotional Wellbeing', in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Canberra: Commonwealth of Australia, 2014), pp. 55–68 (p. 62).

29 **Source:** Victorian Agency for Health Information, Mental Health and Wellbeing—Victorian Population Health Survey 2017 (preliminary draft and unpublished). **Notes:** Data is age-standardised to the 2011 Victorian population. Lower limit/Upper limit is the 95 per cent confidence interval lower and upper limits. Psychological distress based on the Kessler 10 scale.

30 Nicola Brackertz and others, *Trajectories: The Interplay Between Housing and Mental Health Pathways* (AHURI Limited and Mind Australia, 2020), p. 20; Dr Nicola Brackertz, Alex Wilkinson, and Jim Davison, *Housing, Homelessness and Mental Health: Towards Systems Change* (Australian Housing and Urban Research Institute, 2018), p. 16; *Witness Statement of Professor Karen Fisher,* 5 May 2020, para. 8.

31 *Witness Statement of Peta McCammon,* 13 August 2020, para. 13; *Witness Statement of Distinguished Professor James Ogloff AM,* 6 August 2020, p. 106.

32 *Witness Statement of Peta McCammon,* para. 13.

33 Coroners Court of Victoria, Monthly Suicide Data Report: November 2020 Update, 2020, p. 3.

34 *Evidence of Katerina Kouselas,* 23 July 2019, p. 1513.

35 *Witness Statement of the Honourable Professor Kevin Bell AM QC,* 26 August 2020, para. 27.

36 **Source:** Australian Institute of Health and Welfare, Mental Health Services in Australia: Expenditure on Mental Health Services 2018–19, Table EXP.4. **Note:** Funding includes both Commonwealth and state and territory government contributions..

37 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 225.

38 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 236.

39 RCVMHS, *Box Hill Community Consultation—May 2019.*

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

41 Ellie Fossey, Carol Harvey and Fiona McDermott, 'Housing and Support Narratives of People Experiencing Mental Health Issues: Making My Place, My Home', *Frontiers in Psychiatry,* 10:939 (2020), 1–14 (p. 1); National Mental Health Commission, *A Contributing Life: The 2012 National Report Card on Mental Health and Suicide Prevention,* 2012, p. 59.

42 *Witness Statement of Lucinda Brogden AM,* 11 May 2020, para. 8.

43 *Witness Statement of Mary O'Hagan,* 16 June 2020, para. 112.

44 *Working towards zero suicides* is supported by the Victorian and Commonwealth government: National Suicide Prevention Project Reference Group, *National Suicide Prevention Strategy for Australia's Health System: 2020–2023,* 2020, p. v.

45 Victorian Government, Announcement: Royal Commission into Mental Health Speech, 24 October 2018, p. 4.

46 Mark É. Czeisler and others, 'Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24–30, 2020', *MMWR. Morbidity and Mortality Weekly Report,* 69.32 (2020), 1049–57 (p. 1053).