



Royal Commission into
Victoria's Mental Health System

Interim Report

November 2019

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Chair

Professor Allan Fels AO
Commissioner

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**Royal Commission into
Victoria's Mental Health System**



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The Hon. Linda Dessau AC
Governor of the State of Victoria
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Your Excellency

In accordance with the Letters Patent dated 22 February 2019, we have the honour of presenting to you the interim report and recommendations of the Royal Commission into Victoria's Mental Health System.

Yours sincerely

Penny Armytage
Chairperson

Professor Allan Fels AO
Commissioner

Dr Alex Cockram
Commissioner

Professor Bernadette McSherry
Commissioner

27 November 2019

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.

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Foreword

At the heart of an inclusive and humane society is a mental health system where people who are living with mental illness—families, friends, neighbours, colleagues—are supported to live full and contributing lives.

Victoria's mental health system has, however, failed to aid those who are most in need of high-quality treatment, care and support. The following experience resonates with us:

An often-repeated explanation is that the system has 'cracks' and that people will fall through them. I don't know if [we were] just unlucky to continually step on those cracks, or if the cracks are so wide that you cannot avoid them.¹

Once admired as the most progressive in our nation, the state's mental health system has catastrophically failed to live up to expectations. Past ambitions have not been realised or upheld, and the system is woefully unprepared for current and future mental health challenges.

For too long mental health has been relegated to the shadows within the broader health system. Historical underinvestment and increasing demand mean that services can no longer respond adequately to people living with mental illness, their families and carers. People do not receive the support they need when they need it. Many are left to exist on the margins; many feel unbearably alone and defeated when the right services are not available to them; and some take their own lives.

There has been some progress, but stigma, discrimination and prejudice remain pervasive influences on the lives of people living with mental illness. As a community, we have struggled to understand mental illness and the varying ways people experience it. Some might say we have lacked the empathy to support people who are struggling. In part, this would explain why good mental health has remained so low on the agenda for public investment and why complacency and meagre expectations have stifled reform.

This Royal Commission into Victoria's Mental Health System was established because there is now widespread acknowledgement that our mental health services have reached crisis point. The Commission has received extensive feedback about the magnitude of existing problems.

In calling for the Royal Commission, the current Victorian Government signalled that psychological distress and mental illness should be given due recognition as fundamental health and social concerns. The Victorian Government has made a commitment to implementing all of the Commission's recommendations.

Some of the most powerful evidence the Commission has heard came from the personal experiences of people living with mental illness, their families and carers. We have witnessed extraordinary determination as people revisit painful memories in the hope of shaping a better future for themselves and others.

Service providers, non-government organisations, representative bodies and all levels of government have participated willingly, openly and collaboratively in our work.

It is reassuring that the concerns and aspirations expressed by people living with mental illness, their families and carers are largely mirrored by the views of those who work in and have responsibility for the mental health system.

Agreement on the need for change is widespread.

The goodwill the Commission has witnessed has encouraged us to do more than fix the problems that beset the mental health system at present—transformational change is needed. If we are to build a system that will meet society's needs and can keep pace with an ever-evolving world, then we must accept what one person told us: 'We don't want to fill in the potholes, we want a new road'.²

Although the Commission is in the early stages of its reform work, what we can say is that well-resourced community mental health services—based on collaborative, multidisciplinary models of care—will be at the centre of a redesigned system.

Our vision is for a system of genuinely staged care that matches individuals' changing needs. Mental health services must work seamlessly with primary care services at one end and acute services at the other so that people no longer fall through cracks between different levels and types of services. In this redesigned system, people living with poor mental health, their families and carers will be at the forefront, listened to and valued as active contributors and leaders.

The Commission's work is far from complete; we are barely at the halfway point. Our initial recommendations, as put forward in this interim report, do not fully describe the systemic changes that are needed. Instead, we have taken the opportunity of developing this report to recommend changes aimed at redressing urgent problems and preparing the ground for further reform.

The Commission's final report is due by 31 October 2020. In it we will present a comprehensive set of recommendations that will lead to a fundamental redesign of Victoria's mental health system for future generations. The Commission will continue to involve people living with mental illness, families and carers in developing and redesigning a future system.

Our legal obligations and powers as a Royal Commission are extremely serious, and we feel a great sense of responsibility. Our work—the way we examine and consider matters—will continue to be rigorous.

We extend our gratitude to all who have contributed to and shaped our thinking on our endeavours so far. We have drawn on a diverse range of views and advice to support our work. This has required careful deliberations to inform the development of this interim report.

We thank the people living with mental illness, families and carers who have told us of their personal experiences and aspirations; your voices are central to our work.

We thank the mental health workers and organisations for their thoughtful contributions. We are buoyed by every participant's hope for a high-quality, equitable and responsive mental health system.

We thank all who have contributed to the development and writing of this interim report. We have received invaluable assistance from the Commission's CEO and staff, specialist advisers to the Commission, and the Expert Advisory Committee. We also acknowledge Senior Counsel Assisting Lisa Nichols QC (now the Honourable Justice Nichols of the Supreme Court of Victoria) and Junior Counsel Georgina Coghlan and Fiona Batten. This report represents a collective effort.

We are conscious that we carry the hopes of many people. We feel the weight of this, but we will not avoid the challenge. We know what is at stake, and we will continue to work hard to redesign a mental health system that promotes good mental health and addresses the needs of people living with mental illness, families and carers now and into the future.

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



Penny Armytage
Chairperson



Professor Allan Fels AO
Commissioner



Dr Alex Cockram
Commissioner



Professor Bernadette McSherry
Commissioner

27 November 2019



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- 1 Anonymous 404, *Submission to the RCMHS: SUB.0002.0028.0238*, 2019, p. 1.
 - 2 RCMHS, *Melbourne Community Consultation – May 2019*.

A note on content

The Royal Commission offers deepest thanks to people with lived experience of mental illness and psychological distress, their families and carers and members of the workforce who have contributed their personal stories and perspectives to this inquiry.

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

Aboriginal readers are advised that this report might 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:

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

Terminology and language

Language is powerful, and words have differing meanings for different people.

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

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 also acknowledges that language can be deeply contested and nuanced. Although at all times trying to use inclusive language, the Commission is conscious that not everyone will agree with the terminology used. Following is a list of terms the Commission has chosen to use throughout this report, largely on the basis of ensuring alignment with its Letters Patent.

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, irrespective of whether they have a formal diagnosis, who have accessed 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 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. 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 illness	<p>A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.</p> <p>The Commission uses the above definition of mental illness consistent with the <i>Mental Health Act 2014</i> (Vic) and 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'.</p>

Poor mental health	Combined term for referring to mental illness and psychological distress.
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 <i>Balit Murrup, Victoria's Aboriginal social and emotional wellbeing framework</i> .

The Commission departs from these terms only 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 'mental illness' or 'poor mental health'. Terms such as 'disorder' can be pathologising and stigmatising, so the Commission retains them only if used by others to convey specific meaning.

Personal stories and case studies

During its work so far, the Commission has heard from people with lived experience, families and carers, members of the workforce, organisations, experts and members of the broader Victorian community through consultations, submissions and public hearings.

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

With the permission of the individuals involved, these have been modified for privacy and confidentiality where appropriate.

Part One

Introduction

Chapter 1

The Commission's work to date

This chapter provides a brief summary of the Commission's work to date. It outlines the purpose of the Commission, the Commission's vision for the future of mental health in Victoria and the approach taken so far in conducting community consultations, seeking submissions, holding public hearings and targeted engagement, and undertaking research and analysis.

1.1 The Commission's purpose

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.

In establishing the Commission, the Governor finalised the terms of reference that reflect the voices of more than 8,000 people who helped to shape the task laid before the Commission. The Governor appointed Penny Armytage as the Chair of the Commission and Dr Alex Cockram, Professor Allan Fels AO and Professor Bernadette McSherry as Commissioners.

On the day the Commission was established, the Premier, the Hon. Daniel Andrews MP, said the mental health system 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'.¹

The terms of reference require 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'.² (Appendix A shows the Commission's Letters Patent.)

The Commission was asked to deliver an interim report by 30 November 2019 and a final report by 31 October 2020. The Victorian Government has made a public commitment to implement all the Commission's recommendations.³

Consistent with the terms of reference, the Commission established the eight-member Expert Advisory Committee, chaired by Professor Patrick McGorry AO. Other members of the committee are Professor James Ogloff AM, Ms Anne Doherty, Dr Gerry Naughtin, Ms Erandathie Jayakody, Mr Julian Gardner AM, Ms Honor Eastly and Mr Jim Williamson.

The committee brings a wealth of experience to the Commission, including lived experience and extensive professional and sector experience with Victoria's mental health system.

1.1.1 The interim report

This interim report is the product of the Commission's efforts to date. It should be considered in the context of work that will continue until late 2020 in preparation for delivering the final report.

The interim report offers an opportunity to discuss what the Commission has heard and considered so far, with a view to preparing the community—including workers, non-government organisations, service providers and governments—for a new approach to mental health.

Community consultations, online and written submissions, roundtable discussions, consultations with the Expert Advisory Committee, public hearings, data and research have all contributed to the Commission's work. From these sources the Commission has identified important themes and individual and system needs, which form the basis of the current recommendations. The Commission will continue to consider this material, which will inform the final report. It will, however, be complemented by information derived from further hearings, consultations and research in 2020.

Many inquiry participants have impressed on the Commission the need for changes to the mental health system, and the Commission is mindful of the hope of so many that this inquiry will lead to positive reforms.

The depth of problems throughout Victoria's mental health system is clear. The shortcomings prevent people from getting the support they need when they need it, despite the best efforts of many working in the sector. The only way to make a positive difference for Victorians and for them to enjoy good mental health is through full-scale, fundamental changes to mental health services across the state.

Reform on this scale cannot be achieved overnight. The Commission must take time to consider what is needed to create a new system—one that responds to the needs of all Victorians now and in the future.

The majority of the Commission's recommendations for change will appear in the final report in October 2020. They will call for major system redesign and collective efforts from the mental health and related sectors, government and the Victorian community. One person put it succinctly at a community consultation: 'don't be reactive to a broken system to try to fix it; develop a system that won't break'.⁴

The recommendations put forward in this interim report focus on preparing the way for a new approach to mental health treatment, care and support in Victoria. They respond to some of the most pressing challenges faced by those of us with poor mental health, family members and carers and those working in the sector. The report also discusses some of the building blocks that will promote and support the large-scale change that is to come. The recommendations contained in this report do not presuppose the properties of a redesigned system, and this allows the Commission to think ambitiously about what a future mental health system for Victoria will include.

1.1.2 Guiding principles

In designing a new mental health system, the Commission has developed a set of principles (see Box 1.1). These principles have guided the Commission's work to date; they reflect the Commission's current aspirations as it continues its work towards preparing a final report and recommendations for reform.

Box 1.1

Guiding principles for Victoria's mental health system

The Royal Commission acknowledges that mental health 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 system in which:

1. The inherent dignity of people living with mental illness is respected, and necessary holistic support is provided to ensure their full and effective participation in society.
2. Family members and carers of people living with mental illness 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 system and at all levels of government.
5. Responsive, high-quality, mental health services attract a skilled and diverse workforce.
6. People living with mental illness, their family members and carers, as well as local communities, are central to the planning and delivery of mental health treatment, care and support services.
7. Mental health services use continuing research, evaluation and innovation to respond to community needs now and into the future.

These principles are in large part based on the many contributions made to the Commission to date, as well as relevant international documents such as the UN 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's *Carers Recognition Act 2010*.

1.2 The Commission's approach

In the nine months to date (see Figure 1.1) the Commission has conducted its inquiry through consultations, submissions, hearings, its own research and analysis, and by drawing on the contributions of leading experts.

The Victorian community has made more than 8,200 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.

The Commission is deeply appreciative of people's willingness to give expression to their experiences and to share their expertise. These perspectives are central to the Commission's deliberations and recommendations.

1.2.1 Community consultations

One of the Commission's first acts was to go out and listen to people in communities throughout the state. The consultations were open to everyone. More than 1,650 people attended 61 sessions in 21 locations in regional, rural and metropolitan Victoria during April and May 2019 (see Figure 1.2).

The consultations focused on three broad 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?

People were also given an opportunity to raise any other topics they wanted the Commission to consider.

A wide variety of people attended the consultations. The Commission was humbled by people's willingness to share their experiences of living with poor mental health, caring for someone living with mental illness or working in the mental health sector. A number came to tell of losing someone they loved to suicide. Some had described their experiences in previous forums; others were engaging in a formal consultation process for the first time.

People often brought with them multiple perspectives; among them were individuals with a lived experience of poor mental health who were also carers and/or working in the mental health system.

The Commission heard from many people working in acute, community and specialist services. Their perspectives were strengthened by the participation of GPs, 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. Peer workers and counsellors including from the Victorian Mental Illness Awareness Council and Tandem, supported the consultations.

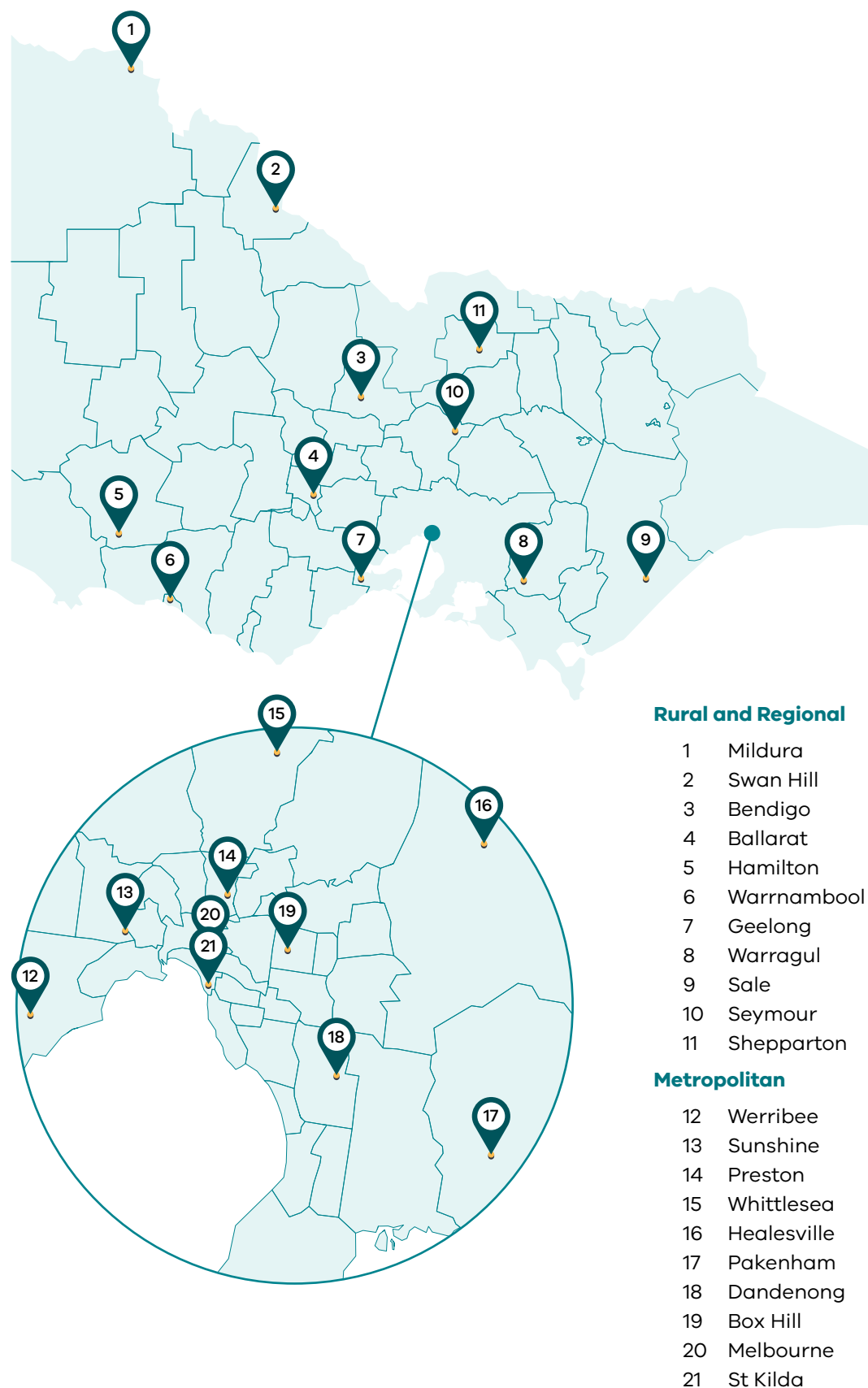
Box 1.2 reflects on a consultation held in Shepparton in May.

Figure 1.1: Conduct to date

Royal Commission into Victoria's Mental Health System



Figure 1.2: Royal Commission community consultation locations



Box 1.2

Shepparton community consultations

On 16 May 2019 Commissioners met with people from Shepparton and surrounding areas. They gained insights into the generosity of people who were prepared to speak of very real and raw experiences with others at their table, to open themselves up to the experience of participation and connection, which they considered a step to changing things for the future.

One woman talked about one of her trips to hospital and how a small act of kindness can make a big difference:

For the first time in 10 years as a client in the system I had someone treat me kindly in the waiting room. To have someone come over and ask if they could make me a cup of tea was incredible ... to have someone at the point of entry empathise with me and communicate with me made a big difference.

A local man brought along a much-loved dog that had belonged to his daughter. He had lived experience of trauma and mental illness, and his daughter had died by suicide. He wanted to contribute and help bring change to the mental health system and didn't want to leave his daughter's dog alone at home.

There was a peer worker from the Victorian Mental Illness Awareness Council who sat with a man whose family had recently experienced significant trauma—just to be there with him.

A number of people were so interested in the conversation that after attending the first 90 minute session they stayed for the next one.

There was often a sense of shared frustration and desperation about people's experiences with the system, but there was also a collective desire to see things change for the better. Many people had in common a consistent sentiment—that if they could change the system to enable just one person to avoid having the experience they had, then it was worth it. As someone said at the consultation:

Relationships and partnerships are the key to embedding service delivery. Community has a role to play. This conversation shouldn't just be about what services can do but what the community can do.

1.2.2 Submissions

On 18 April 2019 the Commission called for submissions in response to its terms of reference. The closing date for these submissions was 11 weeks later on 5 July 2019.

Information about the call for submissions was made available in English, easy English and 16 languages other than English, with priority given to the most commonly spoken languages and the languages of newly arrived communities.

The call for submissions allowed for flexibility in the format of submissions so people could tell the Commission about their story or perspective in the way that best suited them. 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. People were also given the option of making brief comments in response to a short questionnaire.

The Commission helped 52 people make a supported submission by phone or face to face. Several organisations also helped people make submissions, including the Victorian Mental Illness Awareness Council and Tandem.

The Commission received 3,267 submissions (see Figure 1.3).

The submissions covered a wide variety of topics, reflecting the breadth of the terms of reference, the range of people's experiences and the complexity of the factors that influence the mental health system.

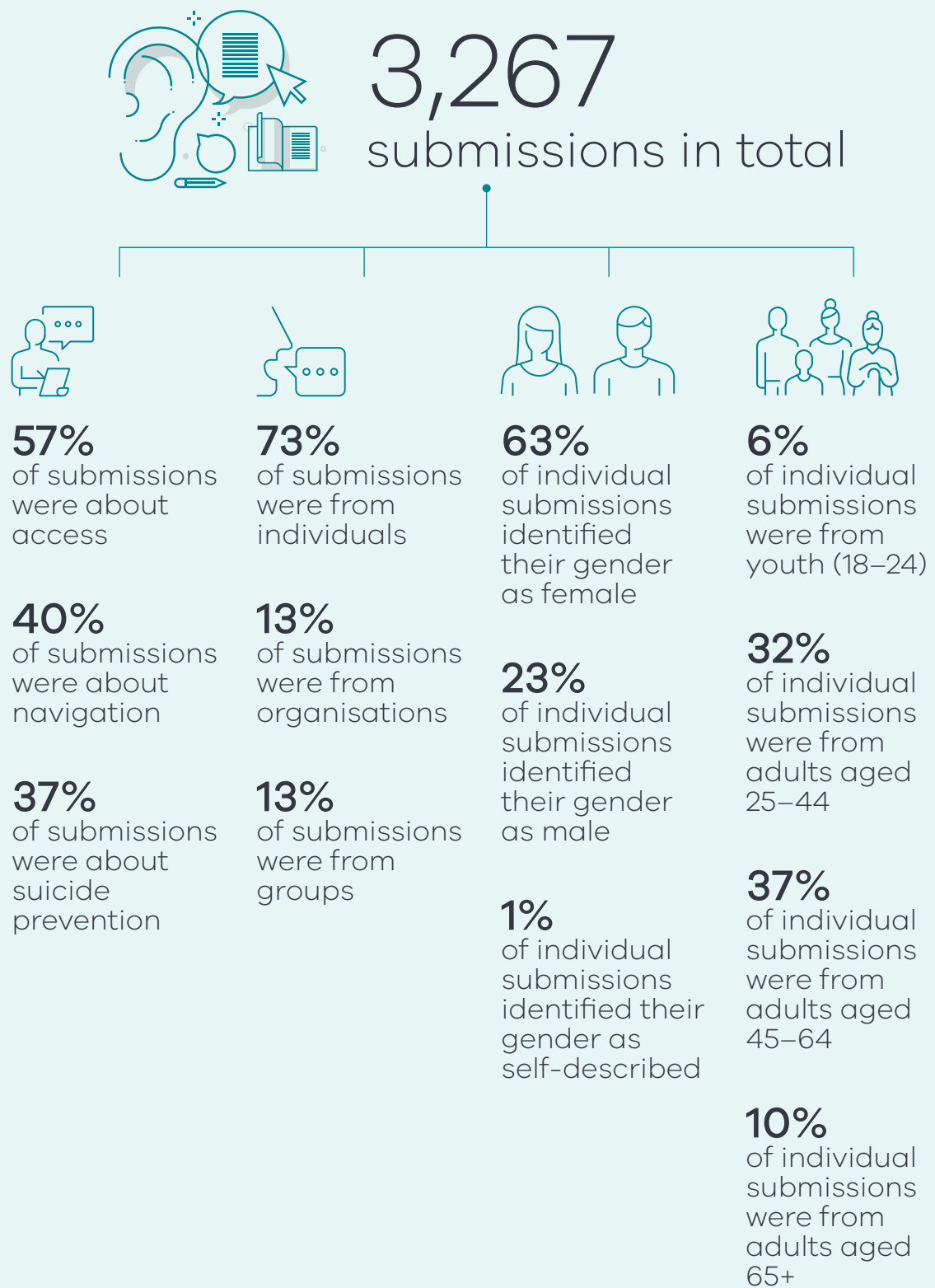
Some organisations and individuals went to great lengths to develop their submissions, taking considerable care with their responses. Some individual submissions included artwork, books, DVDs, excerpts from personal diaries and video content. Some people dealt with a single idea; others told a detailed story. Some organisations made multiple submissions on topics relating to their areas of expertise. Other groups consulted widely with colleagues or members throughout Victoria when preparing their submission.

Individuals could choose for their submission to be treated in one of several ways:

- *Public.* The submission could be published on the Commission's website and referred to in its reports.
- *Anonymous.* The submission would be de-identified but could then be published and quoted from in the Commission's reports.
- *Restricted.* The submission is confidential; the Commission can take it into account in its work, but it is not to be published or quoted from.

The Commission has published all public submissions online. The Commission has also redacted and published anonymous submissions. Brief comments and confidential submissions have not been published but inform the Commission's analysis.

The Commission reserved the right to remove or redact parts of a submission for privacy, legal or other reasons.

Figure 1.3: Submissions received by the Commission

Note: the percentages above do not in all cases total 100 per cent, due to missing or not stated values or rounding. In some cases more than one response could be selected.

1.2.3 Hearings

From 2 to 26 July 2019 the Commission held public hearings. These hearings took place at Melbourne Town Hall, with additional days in Maryborough in rural Victoria and at the Aborigines Advancement League in the Melbourne suburb of Thornbury (see Box 1.3).

The Commission heard from 99 witnesses. The 30 community witnesses spoke about their lived experience—18 from personal experience and 12 from the perspective of being carers and family members of people living with mental illness. The Commission also heard from mental health professionals, police officers, paramedics and leaders in research, service management and education. As with the community consultations, a number of witnesses brought multiple perspectives to their evidence, having worked in the mental health system and also having lived experience. The topics explored in hearings were done so in some depth but not extensively in scope. The topics were:

- stigma
- prevention and early intervention
- access to and navigation of the mental health system
- families and carers
- rural and regional
- Aboriginal and Torres Strait Islander people
- LGBTIQ+ and culturally and linguistically diverse communities
- community resilience
- suicide prevention
- prioritisation and governance of mental health services.

The hearings were powerful and informative but by no means accomplished a complete examination of all issues in the mental health system. The hearings assisted the Commission to begin addressing its terms of reference and reflected a range of key themes from community consultations, submissions and the literature. Most of the hearings were open to the public and livestreamed via the Commission's website. Witness statements and transcripts from the hearings are available on the website.

Although most of the hearings were open to the public and livestreamed, the evidence of some witnesses was the subject of a non-publication order. This meant that identifying information about a witness could not be published. On a small number of occasions, the hearings were closed to the public to protect the privacy of witnesses and their families.

1.2.4 Targeted engagement

The Commission has also held meetings, interviews, roundtables and workshops with a range of experts, representatives of peak bodies, people with lived experience and service providers.

From August to October 2019 the Commission convened a series of roundtables and workshops to examine information and questions raised in community consultations, submissions and content from the public hearings. Facilitated by Commissioners, these dedicated sessions invited experts, representatives of peak bodies, people with lived experience and service



Box 1.3

Hearing day at the Aborigines Advancement League

On 16 July 2019 the Commission held a day of hearings at the Aborigines Advancement League in Thornbury. 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 Dja Wurrung and Boonwurrung was the first witness to appear before the Commission that day. She reflected that when Aboriginal people speak about 'our health, we don't do it in isolation'.⁵ The Commission heard about the importance of understanding that Aboriginal concepts of mental health are holistic and shaped by connections to culture, land, extended kinship, ancestors and spirituality. Aunty Nellie Flagg went on to say:

The [mental health] system does not understand Aboriginal spirituality [...] My family has been afraid of people judging them for their mental health issues. They have been afraid to talk about it for fear of being labelled mental or being unable to hold a job.⁶

providers to engage in focused discussions about workforce development and the mental health needs of particular communities and groups.

Through roundtables and meetings, the Commission has examined key issues and opportunities with people with lived experience of mental illness, their families and carers. Making recommendations to shape the future of a fit-for-purpose mental health system relies on the participation of those who need, use and are affected by it.

Special advisers

Ms Cath Roper, a consumer academic from the Centre for Psychiatric Nursing at the University of Melbourne, has supported the Commission as an adviser to the Commission's chief executive officer. The Commission appreciates Ms Roper's advice and generosity.

In addition to advice to the Commission, Ms Roper worked with three other consumer leaders—Wanda Bennetts, Alison Hall and Simon Katterl—to provide lived experience training to Commission staff.

The Commission also engaged Ms Nicole Cassar to advise on consulting with Aboriginal services and communities and to help examine the needs of Aboriginal people throughout Victoria in terms of improving social and emotional wellbeing.

The Commission will ensure that its work in 2020 continues to be closely informed by advice from people with lived experience.

1.2.5 Research and analysis

In recognition of the scale of the policy task before it, the Commission established a broad approach to research and analysis. In addition to the many sources of information already described, to date the Commission has informed itself in various other ways:

- requesting and assessing documents from government and other sources
- conducting literature reviews and other desktop research, including an analysis of existing studies
- commissioning research support from leading data, academic and policy organisations
- conducting a survey completed by each area mental health service
- convening specialist expert advisory committees to inform specific activity such as economic analysis
- going on site visits
- commissioning a study into community attitudes about mental health and Victoria's mental health system
- establishing the necessary data capability to use and analyse Victorian data, with future capability to include Commonwealth data.

1.3 Navigating the report

The Commission offers this interim report in six parts. These parts cover the topics the Commission has examined so far and culminate in a series of recommendations that seek to address immediate needs and begin paving the way for a reformed mental health system.

- **Part One** explores the current state of mental health in Victoria. Here, the Commission defines key concepts such as wellbeing, recovery and the full continuum of mental illness and how people experience it differently.
- **Part Two** lays out the history and nature of the current Victorian mental health system. It also highlights the structural problems the Commission has identified, examines how the mental health workforce currently operates and looks at the challenges it faces.
- **Part Three** focuses on several themes the Commission has examined to date. It tells the story of a system difficult to find and get into. It outlines how consumer experiences of the system can be poor and how difficult this can be for the families, carers and others providing support to those living with mental illness or experiencing poor mental health. It describes how the experiences of rural and regional Victorians are both similar and different. And it highlights the most tragic toll of all—when a person experiencing psychological distress or poor mental health takes their own life.
- **Part Four** quantifies the economic cost of mental health and puts forward a case for increased investment in mental health services in Victoria.
- **Part Five** offers nine recommendations to lay the foundations for future reform:
 - establishing the Victorian Collaborative Centre for Mental Health and Wellbeing
 - expanding acute services in targeted areas
 - increasing investment in suicide prevention
 - expanding Aboriginal social and emotional wellbeing services
 - designing and delivering Victoria’s first lived experienced–led service
 - supporting lived experience workforces
 - ensuring workforce readiness for future reforms
 - establishing a new approach to mental health investment
 - setting up a Mental Health Implementation Office to drive the initial effort.

Chapter 22 looks to the future, laying out the Commission’s next steps for its final year of operation.

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- 1 The Age, ‘Commissioners Named in Bid to fix State’s “broken” Mental Health System’ 24 February 2019, p.2.
 - 2 Victorian Government, ‘Royal Commission into Victoria’s Mental Health System - Terms of Reference’, 2019, p.1.
 - 3 Victorian Government, ‘Announcement: Royal Commission into Mental Health Speech’, 24 October 2018, p.4.
 - 4 RCMHS, Pakenham Community Consultation – April 2019.
 - 5 Witness statement of Aunty Nellie Flagg, 9 July 2019, para 35.
 - 6 Witness statement of Aunty Nellie Flagg, paras 36 and 39.

Chapter 2

Overview of mental health in Victoria

Experiences of poor mental health are personal and varied, influenced by a range of interrelating factors. These include social factors such as the communities people identify with, personal experiences such as trauma, and demographics such as gender and age.

This chapter focuses on the estimated prevalence of mental illness and sets out the range of factors that may shape poor mental health. It also outlines the different ways people experience poor mental health across social groups, noting there are many layers to people's identities and experiences.

2.1 The meaning of mental health and mental illness

'Mental health' is a term open to many interpretations. The World Health Organization defines it as:

... a state of well-being in which [an] individual realises [their] own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community.¹

In Australia the National Mental Health and Suicide Prevention Plan, now in its fifth cycle, has taken a similarly inclusive approach by describing mental health as not simply the absence of mental illness but creating the conditions in which individuals can achieve their potential.²

Many experts describe a continuum of mental health:

... where [good] mental health is at one end of the spectrum—represented by feeling good and functioning well—while [mental illness is] at the other end—represented by symptoms that affect people's thoughts, feelings or behaviour.³

The 'continuum' concept is useful but does not fully capture the complexity of mental health and the different expressions of mental illness. For example, having a mental illness that requires substantial support from services does not mean a person cannot experience social and emotional wellbeing. Equally, the absence of a mental illness does not mean a person will always experience good mental health.

'Mental illness' is defined in the *Mental Health Act 2014* (Vic) as 'a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory'.⁴ Medical professional associations have classified different expressions of mental illnesses into different 'diagnoses', intended to reflect clusters of behavioural, cognitive and affective symptoms or observable traits.⁵

It is recognised, however, that there are contested views about the validity of mental illness diagnoses and even whether people's experiences should be labelled an 'illness'. The Commission acknowledges that experiences of poor mental health are personal and that some people do not find diagnoses a helpful way of understanding their lived experiences. For others, a diagnosis provides clarity about previously misunderstood feelings or experiences and opens pathways to treatment and recovery.

Mental illnesses are sometimes described as mild, moderate or severe.⁶ This language is not accepted by all, but the Commission has adopted it to help with understanding how variably mental illness is experienced and how it can result in different interactions with the various components of the mental health system. However, the Commission notes that the 'mild, moderate or severe' classification risks overlooking the dynamic and fluctuating nature of many people's experience of poor mental health over the course of their lives.

The Commission has received feedback that consumers of Victorian's mental health services too often receive 'one-size-fits-all' mental health care that does not meet their individual needs or seek to understand unique identities and experiences, including needs relating to physical health, disability, sexuality and culture.

Most importantly though, the Commission heard that when people's needs are understood and responded to, many people living with mental illness can and do thrive—and in so doing provide great hope and inspiration to others who may be having an episodic or longstanding experience of poor mental health.

2.2 Mental illness in Victoria

2.2.1 Estimated prevalence

Box 2.1 outlines the different terms used in this report to describe the extent and impact of mental illness. These are based on standard concepts used by epidemiologists.

It is difficult to measure the extent of mental illness in Victoria's diverse and changing communities, along with changes over time. This is partly because of a lack of consistent data collection and reporting and the different definitions of mental illness that are used.

Therefore, drawing conclusions on the incidence or prevalence of mental illness in Australia should be done with caution. Variations between states and territories reflect a complex interaction of demographic factors and socioeconomic and environmental differences.

Taking this into account, the National Mental Health Service Planning Framework suggests that approximately 20 per cent of Victorians will experience a mental illness in any given year.⁶

Box 2.1**Quantifying the extent and impact of mental illness**

When the Commission discusses 'incidence' it refers to the number of new episodes or cases of mental illness occurring during a given period.

When the Commission talks about 'prevalence' it refers to the estimated amount of people experiencing mental illness in the population at a given time. It is an indicator of how widespread mental illness is, taking into account that some people will have a diagnosed mental illness while others may not.

When the Commission refers to 'burden of disease' it refers to the estimated impact of prevalence on an individual or the population. Burden of disease analysis measures the impact of disease and injury by counting the combined years of healthy life lost either through premature death or as a result of living with disability due to illness or injury. Rather than just counting the prevalence of deaths and disease, this analysis considers the age at death and the severity of disease to estimate the total health loss. The contribution of various modifiable risk factors to the burden of disease is also estimated. Information about the burden of disease and injury helps monitor population health and provides an evidence base for health policy and service planning.⁷

When the Commission refers to 'diagnosis' it means a formal medical diagnosis related to an individual. This may apply to either a specific episode of care or in relation to ongoing treatment, care and support. Rates of diagnoses (for example, changes in the incidence of a particular mental illness) may increase without any changes to overall estimated prevalence due to population or other socio-demographic changes.

Prevalence of mild, moderate and severe mental illness

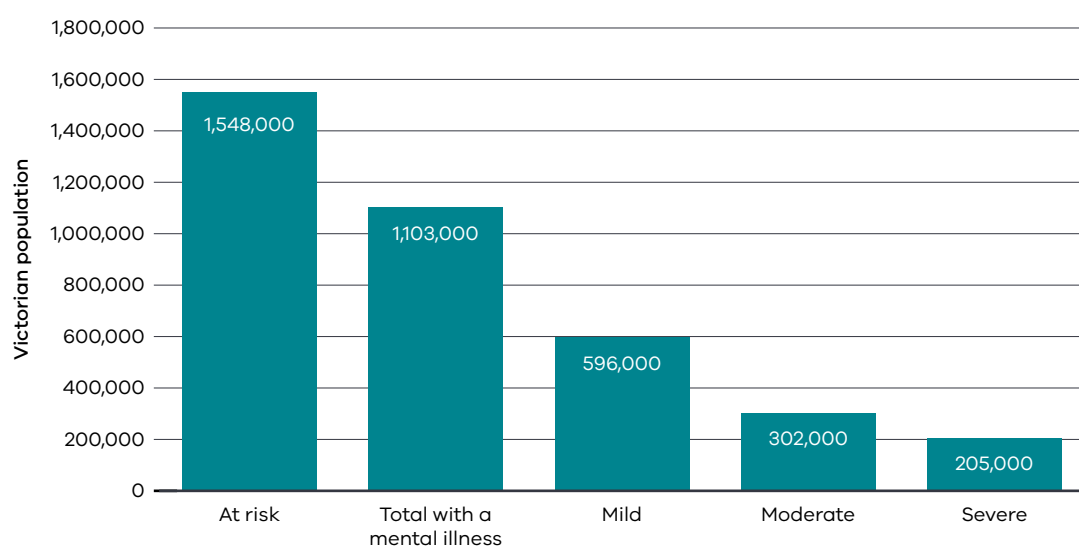
Figure 2.1 shows the levels of mild, moderate and severe mental illness in Victoria. Drawing on the National Mental Health Service Planning Framework, the Commission estimates that in each year in Victoria there are:⁸

- approximately 205,000 people who will experience a severe mental illness and may benefit from multidisciplinary clinical interventions, periods of inpatient care and potential coordination with other social and community supports such as housing and income support
- approximately 302,000 people who will experience a moderate mental illness and may benefit from clinical services supported by primary care and psychiatric intervention when required

- approximately 596,000 people who will experience a mild mental illness and may benefit from low-intensity, face-to-face services, including online resources and psychological services where required.

In addition, approximately 1.5 million people may be at risk of developing a mental illness, in that they are showing early symptoms of, or have previously experienced, a mental illness. This group might use self-help resources and low-intensity interventions, including those available online.⁹

Figure 2.1: Estimated prevalence of mental illness in Victoria, 2019



Level of need and services required

At risk groups

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

Mild mental illness

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

Moderate mental illness

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

Severe mental illness

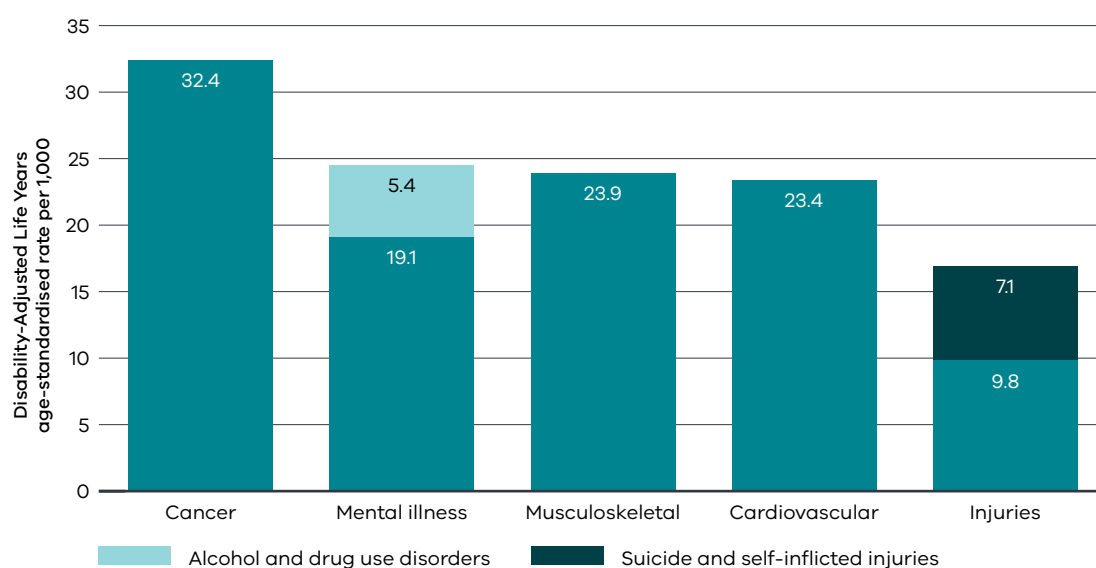
Clinical care using a combination of GP care, psychiatrists, mental health nurses, and allied health professionals. Inpatient services / Pharmacotherapy / Psychosocial support services / Coordinated multiagency services for those with severe and complex illness.

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

2.2.2 'Burden of disease'

Mental illness, and injury from suicide or self-harm, contributes significantly to what epidemiologists call the 'burden of disease' in Australia. The Australian Institute of Health and Welfare estimates that mental 'disorders' (excluding substance use disorders), and suicide and self-inflicted injuries make up 26.2 years lost per 1,000 population (19.1 and 7.1 respectively) (Figure 2.2).¹⁰

Figure 2.2: Top five burden of disease groups in Australia, 2015
(Disability-Adjusted Life Years age-standardised rate per 1,000)



Age-standardised rates

The Australian Burden of Disease Study 2015 compares the rate of disease burden between different population groups and different time periods using age-standardised rates. Age-standardised rates allow a like-for-like comparison.

First, the age-standardised rate expresses the burden in terms of the number of years lost per 1,000 population (the 'rate' part) to remove differences in burden that are due to differences in the size of two populations.

Second, it adjusts for differences in the age structure between the two populations. The burden of both living with illness and dying from disease is influenced by age. Different population groups (for example, males versus females, 2003 versus 2015 population) have a different composition of age groups. For example, the 2015 Australian population had a higher proportion of older Australians aged 65 and over (15 per cent) than the 2003 population (13 per cent).

Using age-standardised rates ensures the rate of each comparison group is based on a standard population with consistent age structure (to remove differences in burden due to differences in age composition) and allows for accurate comparison of disease burden between two groups.

Source: Australian Institute of Health and Welfare. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Australian Burden of Disease series no. 19. Cat. No. BOD 22. Canberra: AIHW. National Estimates of Australia, 2019 data tables. Table 1B. Disease group and Table 1C. Disease.

The proportion of the burden relating to alcohol and other drug use disorders, and the proportion relating to suicide and self-inflicted injuries were derived using the disease table rather than the disease group table.

Cancer includes cancer and other neoplasms; mental illness includes mental and substance use disorders; and injuries includes suicide and self-inflicted injuries.

For further information see:

<<https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/burden-of-disease/data/>>

Victoria has a higher estimated burden of disease from mental illnesses than most other states and territories. According to the Australian Institute of Health and Welfare, Victoria's age-standardised burden is marginally greater than the national average and has also not improved over time. As Figure 2.3 shows, compared with other states and territories in 2011 and 2015, the burden was higher in Victoria. In 2015 it was estimated to be 26.5 years lost per 1,000 population compared with 23.7 in New South Wales and 23.0 in Queensland.¹¹

Figure 2.3: Total burden of mental health conditions (Disability-Adjusted Life Years age-standardised rate per 1,000), by state and territory in 2011 and 2015



Source: Australian Institute of Health and Welfare. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Australian Burden of Disease series no. 19. Cat. no. BOD 22. Canberra: AIHW. State and Territory Estimates for Australia, 2019 data tables. Table 1B. Disease group.

Mental health conditions includes mental and substance use disorders.

Comparing the burden of disease from mental health conditions by jurisdiction requires some caution, as confidence intervals are not available due to the complex methodology used to derive burden of disease measures such as disability-adjusted life years.

For further information see:

<https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/burden-of-disease/data/>

2.2.3 Trends in diagnosis

This section outlines trends in diagnoses of different types of mental illnesses. As noted earlier, some people do not find diagnostic models of mental illness helpful. It is also important to note that trends in diagnoses do not necessarily reflect changes in the underlying prevalence of mental illness. For example, increased awareness of, and help-seeking for, mental illness could lead to more diagnoses.

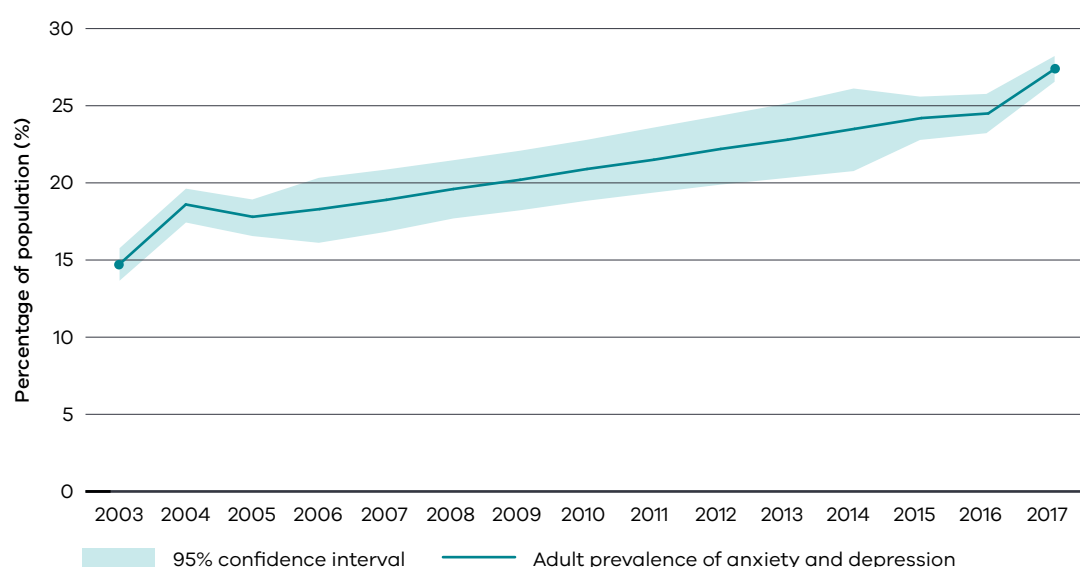
However, population health surveys suggest that the prevalence of mental illness may be increasing. The National Health Survey measures the proportion of people who reported currently experiencing the symptoms of a mental illness and that their symptoms have lasted, or are expected to last, for at least six months.¹² The survey findings indicate that from 2014–15 to 2017–18 the number of Victorians experiencing a mental illness or behavioural

problem increased from 17.5 per cent to 20.2 per cent.¹³ This is largely consistent with other jurisdictions: New South Wales reported an increase from 17.8 per cent to 19.1 per cent,¹⁴ and Queensland increased from 18.1 per cent to 22.7 per cent.¹⁵

Anxiety and depression

The most common forms of diagnosed mental illnesses are anxiety disorders and affective disorders such as depression.¹⁶ The Victorian Population Health Survey measures the proportion of adult Victorians who have ever been diagnosed with an anxiety disorder or depression—this increased from 14.7 per cent in 2003 to 27.4 per cent in 2017 (see Figure 2.4).¹⁷ These figures include people who have been diagnosed but are not currently experiencing symptoms and excludes people who have not been diagnosed but are experiencing symptoms.

Figure 2.4: Proportion of adult population (> 18 years) who were ever diagnosed with anxiety or depression in Victoria, between 2003 and 2017



Source: Analysis by the Commission based on the Department of Health and Human Services. Victorian Population Health Survey 2016 and 2017.

Estimates for 2006 to 2014 are based on ordinary least squares regression of prevalence (%) data, from 2003 to 2005 and 2015 to 2016, on time (years).

Changes to the survey methodology in 2015 means that the surveys conducted after 2015 are not comparable with those conducted prior to and including 2014. This has impacted on the time series analyses.

However, in the 2016 Victorian Population Health Survey Report potential changes in the prevalence over time for selected key health indicators have been modelled from 2005 to 2016.

Data was age-standardised to the 2011 Victorian population.

Psychotic and other severe mental illnesses

The term 'psychotic disorders' refers to a diverse group of illnesses in which people experience distortions of thinking, perception and emotional response.¹⁸ Psychotic illnesses usually have their onset in late adolescence and early adulthood, which are critical times in the transition to adulthood, and typically have severe impacts on people's lives.¹⁹ The most common form of psychotic illness is schizophrenia, but psychosis can also occur in some forms of depression, bipolar and other disorders.²⁰

The 2010 National Survey of Psychotic Illnesses estimated the prevalence of psychotic disorders based on people with psychosis who were in contact with public specialist mental health services in Australia in March 2010 and the 11 months prior. Over the 12-month period, the prevalence of psychotic disorders in Australia was estimated at 4.5 cases per 1,000 population.²¹

The National Mental Health Services Planning Framework estimates that 3.1 per cent of the population experiences a severe mental illness,²² equating to approximately 205,000 Victorians. In addition to people experiencing psychotic illnesses, 'severe mental illness' includes people severely affected by major depressive or anxiety disorders, eating disorders, bipolar disorders or personality disorders.²³

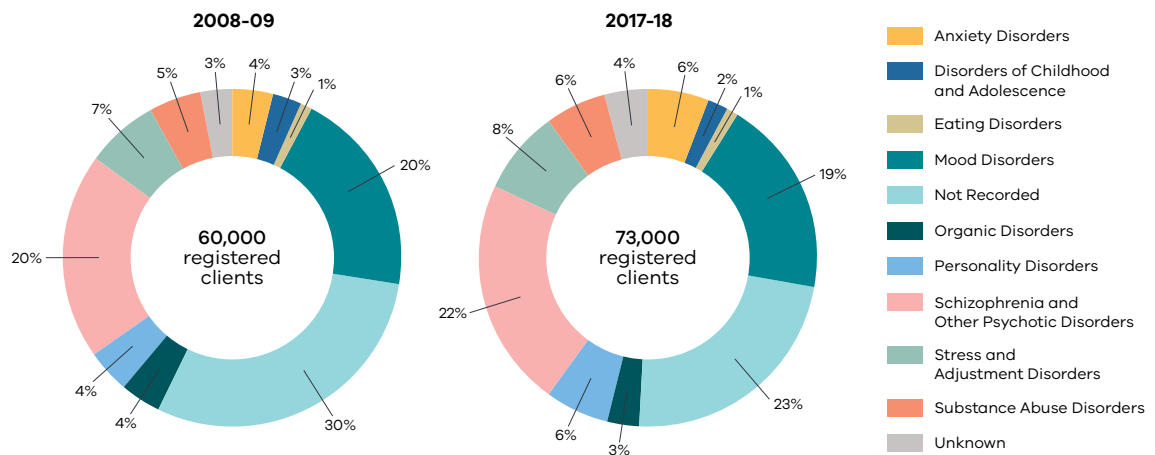
Consumers of public specialist clinical mental health services

An analysis of registered mental health consumers²⁴ treated in the Victorian mental health system indicates trends in consumers' principal diagnoses for certain mental illnesses (Figure 2.5). For example, of people using Victoria's mental health system, there has been:

- an 11.1 per cent annual increase in the number of reported eating disorders from 2008–09 to 2017–18, the largest increase of all disorders
- a steady increase in the proportion of principal diagnoses of anxiety-related conditions, from 4 per cent in 2008–09 to 6.3 per cent in 2017–18
- a stable proportion of principal diagnoses of depression and other mood-affective conditions over the same period (19.9 per cent in 2008–09 to 18.9 per cent in 2017–18)
- an increase in the proportion of personality disorders, from 3.6 per cent in 2008–09 to 6.3 per cent in 2017–18
- comparatively stable diagnoses of schizophrenia and other psychotic conditions between 2008–09 and 2017–18.²⁵

It should be noted that these data only reflect people who are making use of Victoria's public clinical mental health system. The data might be useful in picking up emerging trends for some mental illnesses but must be treated with caution when making broader assumptions about overall trends in diagnosis and prevalence.

Figure 2.5: Principal diagnosis trends of people treated by the public specialist mental health system, Victoria, 2008–09 and 2017–18



Source: Department of Health and Human Services. Client Management Interface / Operational Data Store, 2008–09 and 2017–18.

Organic disorders typically refer to mental health conditions due to brain damage and dysfunction and to physical disease, rather than to psychiatric illness.

Clients with a 'not recorded' diagnosis mainly reflect the community services, as admitted clients will have diagnosis recorded.

Since 2014–15, data quality improvements have reduced the proportion of 'not recorded' diagnosis.

Not recorded includes cases where diagnosis was not recorded due to collection error or the case did not warrant the allocation of a diagnosis.

Methodology to derive principal diagnosis based on the Department of Health and Human Services Mental Health Services Annual Report approach.

2.2.4 Co-occurring conditions

Poor mental health is often not an isolated health concern for those experiencing it. The links between poor mental health and poor physical health or disability are multidimensional. The experience of mental illness—and associated disadvantages and treatment side effects—can undermine people's physical health, while the experience of physical health problems or disabilities can contribute to or exacerbate mental illness.

Across Australia, more than half the people living with mental and behavioural conditions have a coexisting chronic condition.²⁶ Mental Health Victoria and the Victorian Healthcare Association informed the Commission that people living with mental illness are significantly more likely to experience poorer physical health, including chronic health conditions, than those without mental illness.²⁷

A study from Western Australia estimated that people with a mental illness had a lower life expectancy of 10–16 years, with 77.7 per cent of excess deaths attributable to physical health conditions.²⁸ International evidence indicates that people living with severe mental illness have higher mortality rates than the general population, with a life expectancy gap of 10–20 years. Data from 2006 indicates that psychotic disorders have been associated with a shortening of life expectancy of up to 22.5 years.²⁹

Among people living with schizophrenia and related illnesses, the biggest cause of early death is cardiovascular disease caused by obesity, smoking and lack of exercise—not suicide. A review of global evidence on physical health and mental illness suggested that mental illness was associated with a risk of obesity, diabetes and cardiovascular disease between 1.4 and 2.0 times higher than the rest of the population.³⁰ St Vincent's Hospital Melbourne highlights that this is exacerbated by some antipsychotic medications, which can contribute to significant weight gain.³¹

Additionally, a review of recent evidence (including systematic reviews and meta-analyses) showed an association between post-traumatic stress disorder and various physical conditions including gastrointestinal, dermatological, musculoskeletal, neurological and cardiorespiratory disorders.³²

Despite the high prevalence of physical comorbidities, international evidence finds that people living with severe mental illness have two times as many healthcare contacts as the general population but receive fewer physical health checks and screenings.³³ In Australia, evidence suggests that monitoring practices for physical health conditions for people living with mental illness are ad hoc, despite recommendations that physical issues are monitored routinely.³⁴

Because of the close relationship between mental health and physical health, many of the interventions designed to promote good mental health also promote good physical health.³⁵ However, there are recognised limitations in the extent to which mental health services in Australia have developed effective models of care to support people living with mental illness and co-occurring physical health issues.³⁶

Effective management of mental illness in primary care is critical to good physical health outcomes for people living with mental illness. A national survey of GPs in 2018 revealed that 'patients talk to their GP about mental health more than any other health issue',³⁷ and that 'mental health continues to be the number one health issue causing GPs the most concern for the future'.³⁸

At the same time as people living with mental illness are at higher risk of developing physical illness, people living with chronic physical disorders or disabilities are at higher risk of poor mental health.³⁹ People with disabilities are more likely to experience social and economic inequalities that are major contributors to poor mental health, including challenges accessing health care and support services.⁴⁰ People with disabilities may also experience high rates of violence, abuse and neglect—18 per cent of people with disability report being victims of physical or threatened violence compared with 10 per cent of people without disability.⁴¹

People with disability or restrictive long-term health conditions also have higher than average rates of mental and behavioural conditions, with estimates of prevalence as high as 57.9 per cent for people with profound or severe 'core activity' limitations and 42.2 per cent for people with other disabilities or restrictive long-term health conditions. This compares with only 13.7 per cent for people without these conditions.⁴²

The Commission received evidence that mental health and wellbeing is a significant issue for members of Victoria's deaf and hard-of-hearing community. Deaf people may feel marginalised from their families, face employment difficulties and feel unable to develop social and leisure activities in the broader community. Over time, mental health issues can develop and have an impact on quality of life.⁴³

2.2.5 Dual disability

People living with mental illness may also live with co-occurring disabilities such as intellectual disability or an acquired brain injury. Similarly, the National Mental Health Consumer and Carer Forum reported that people with intellectual disabilities may have biological, psychological or social risk factors that make them more vulnerable to developing mental illnesses.⁴⁴

This section considers people living with a dual disability—that is, a mental illness alongside an acquired or neurodevelopmental disability (such as an intellectual disability, autism spectrum disorder, attention-deficit/hyperactivity disorder or a communication disorder).⁴⁵

Reports on the prevalence of people living with a dual disability vary. The Australian Institute of Health and Welfare found that 57 per cent of people aged under 65 years with intellectual disability also had a psychiatric disability in 2003.⁴⁶ In 2012 the University of New South Wales estimated that, 'at any one time, 20–40 per cent of people with an [intellectual disability] will be experiencing a mental disorder of some kind'.⁴⁷

It is likely, however, that the prevalence of dual disability is underestimated. This is largely due to mental illness being under-diagnosed or overlooked in people with an intellectual disability, particularly for those with limited communication abilities.⁴⁸

The prevalence and type of mental illness may also vary across the different forms of disability or neurodevelopmental conditions. For example, research indicates that people with autism are particularly vulnerable to mental illnesses such as anxiety and depression, especially in late adolescence.⁴⁹

2.2.6 Relationship with alcohol and other drugs

Poor mental health frequently occurs in conjunction with the misuse of alcohol and other drugs. The relationship is complex: alcohol and other drug misuse can be a cause or a consequence of mental illness. The two can also mutually influence each other—with use of alcohol or other drugs maintaining or exacerbating poor mental health and mental illness or the other way around.⁵⁰

Studies indicate that more than one-third of people with an alcohol or other drug use problem are also living with mental illness.⁵¹ The Australian Institute of Health and Welfare has estimated that the combination of 'mental health' and 'substance abuse' was one of the highest burden of disease groups in 2015.⁵² Among those with alcohol and other drug use problems, 35 per cent were also living with mood disorders (such as depression) or anxiety disorders.⁵³

Poor mental health is particularly common among people who use illicit drugs. Among people who had used any illicit drug in the previous month, 22 per cent experienced psychological distress compared with 10 per cent among people not using illicit drugs. Levels of poor mental health are particularly high among methamphetamine users.⁵⁴

The combination can reduce a person's prospects of recovery compared with someone who has just one of these conditions.⁵⁵

2.3 The many factors that shape mental health

The causes of poor mental health are multifaceted, and the development of mental illness is influenced by personal attributes and people's social, cultural, economic and physical environments.⁵⁶ In turn, social factors such as family and social connections can influence how well people recover from mental illness.

The relative roles of different factors vary between individuals and for different stages of life.⁵⁷ For example, for some people, depression might be the result of exposure to stressful life events, whereas for others genetic predisposition might play a role.

This section explores the factors that can influence mental health and the development of various types of mental illness.

2.3.1 Social determinants

The role of social determinants⁵⁸ in increasing or decreasing the prospect of psychological distress and mental illness is well established, and an appreciation of the impact of social determinants on mental health is neither new nor limited to Australia.⁵⁹

Social determinants that contribute to mental health include the person's social and cultural characteristics, environmental events and neighbourhood, economic and demographic factors.⁶⁰

The World Health Organization's Mental Health Action Plan consistently acknowledges the need to take account of social determinants as one of its key objectives in responding to mental health concerns.⁶¹

The Victorian Mental Illness Awareness Council told the Commission:

The right to health includes the right to access the social determinants that prevent health problems, and for mental health this means we need to build a society that is safe, equitable, respectful and inclusive. We recognise this is an enormous mission, but it must be the foundational business for any long-term mental health strategy if we want genuine progress.⁶²

In common with other health concerns, social disadvantage (such as poverty), gender discrimination, poor social status, family violence and physical ill-health are among the important determinants of mental illness.⁶³ Additionally, some of the most powerful causes of inequalities in access to mental health services are the social conditions in which people are born, grow, work, live and age, as well as the systems that shape daily life.⁶⁴

People with socioeconomic disadvantage disproportionately experience mental illness.⁶⁵ There is evidence that such disadvantage has an influence from early in life. Indicators of low socioeconomic status—commonly measured by household income, parental education and parental occupational status—are associated with higher rates of mental illness in children and adolescents.⁶⁶ Children and adolescents in low-income families, and whose parents or carers have lower levels of education and experience higher rates of unemployment than other Australians, also have higher rates of poor mental health.⁶⁷ Young people in families

in the lowest income bracket have almost double the rates of mental disorders than young people in families in the highest income bracket.⁶⁸

Further, socioeconomic deprivation in neighbourhoods is strongly associated with increased prevalence of psychotic disorders and depression.⁶⁹ For younger people aged 10–20 years, neighbourhood socioeconomic deprivation is associated with common mental health conditions.⁷⁰ The 2017 Victorian Population Health Survey also found higher proportions of men and women with high or very high levels of psychological distress who did not complete high school, were not in the labour force and had a total household income of less than \$40,000 compared with the proportion in all adult Victorians.⁷¹ People who experience socioeconomic disadvantage may be more likely to be exposed to other forms of trauma such as violence and homelessness, and are more likely to experience social exclusion and isolation.⁷²

Social determinants can affect the mental health of children and young people in particular—for example, children who experience adversity⁷³ or trauma in childhood including through child abuse and neglect,⁷⁴ family violence, the mental illness of their parents or other caregivers, and bullying.⁷⁵ Children of parents with significant mental illness are twice as likely to develop their own mental health issue.⁷⁶ Compared with children living in the least disadvantaged areas, children living in the most socioeconomically disadvantaged locations are approximately twice as likely to be developmentally vulnerable.⁷⁷

In addition to factors that influence poor mental health, social determinants can act as protective factors that promote and protect good mental health.⁷⁸ A VicHealth-commissioned evidence review describes protective factors such as social capital and social supports.⁷⁹ This review highlighted evidence indicating that children and adolescents benefit from community social capital, including positive parent–child relationships, extended family support, social support networks including religious communities, and strong neighbourhoods and schools.⁸⁰

Responding to the social determinants of mental illness therefore involves much more than the mental health system. There is evidence that housing, employment, education, wealth and income, locations, access to services (broadly considered because of Australia's geography to include transport and accommodation) and cultural background all have an impact on people's experiences of poor or good mental health.⁸¹

2.3.2 Biogenetic factors

Biogenetic factors—including biological, neurobiological, genetic and epigenetic factors—contribute to mental health. 'Neurobiology' refers to the biological mechanisms of the nervous system and how they influence behaviour; 'genes' refers to the DNA people inherit; and 'epigenetics' refers to the factors that influence how those genes present themselves. The complexity of mental illnesses and their contributing factors, however, suggests that attribution to any one of these factors alone is not possible.

Research indicates that biology plays a role in some mental illnesses. For example, the Commission has also been told of the complex relationship between genetic and biological factors and how they might influence some problematic drug use.⁸² The genetic correlates of mental illnesses such as schizophrenia, anxiety and eating disorders have been well studied.⁸³ Additionally, research is being conducted into how biological factors contribute to relapses

during treatment for alcohol dependency.⁸⁴ There could also be a range of genetic, biological and other factors that contribute to perinatal depression in women.⁸⁵ As with each of these examples, mental health outcomes are also influenced by societal factors such as gender-based expectations and stereotypes.⁸⁶ This highlights the importance of acknowledging the complex, multidimensional way in which genetic determinants interact with social determinants to affect mental health.⁸⁷

The relationship between mental health, biology and neurobiology is complex. The 2016 Royal Commission into Family Violence was told that living with the chronic stress that is so often experienced in situations of family violence can lead to biological and neurobiological changes. These in turn can contribute to poor mental and physical health.⁸⁸ This potentially recursive relationship between biology, neurobiology and mental health illustrates the complexity involved in understanding the causes of mental illness.

This Commission has heard of the ways in which people's understanding of the causes of mental illness affect their perceptions of mental illness—and, indeed, the willingness of those experiencing such illness to seek help. For example, if people believe mental illness is caused by a chemical imbalance, they might be more likely to perceive a person diagnosed with a mental illness as dangerous or unpredictable.⁸⁹

2.3.3 Sex and gender

Gender can also be an important social determinant of mental health. Social, economic and environmental factors can be experienced differently across genders.⁹⁰ Gendered stereotypes and expectations, alongside broader structural gender inequalities, can play a central role in influencing mental health outcomes.

Reported rates of poor mental health vary across genders. The 2017 Victorian Population Health Survey found that the proportion of women with high or very high levels of psychological distress was higher than for men, at 18.0 per cent and 12.8 per cent respectively.⁹¹

Further, the 2017–18 National Health Survey estimated that mental illness and behavioural problems were more prevalent in Victorian women, at 23.7 per cent, than Victorian men, at 16.7 per cent.⁹²

Among young people aged 4–17 years, however, the overall prevalence of mental illness was higher among males than females, according to the second Australian Child and Adolescent Survey of Mental Health and Wellbeing.⁹³

Victorian data show that a greater proportion of girls aged 0–17 years are being diagnosed with more eating, personality, mood and anxiety disorders, while a greater proportion of boys are being diagnosed with disorders relating to psychological development and disorders that manifest at a younger age.⁹⁴

Social and economic determinants of mental health are experienced differently by people who identify as women or men. For example, economically, women on average are more likely to live in poorer households,⁹⁵ be paid less for the same work and undertake approximately twice the amount of unpaid care work than men.⁹⁶ The National Workplace Gender Equality Agency marks this through the 'Equal Pay Day' rate, with Australian women having to work an extra 59 days a year to earn the same pay as men for doing the same work.⁹⁷ Further, women

are more likely to experience sexual violence as adults and any abuse as children, whereas men are more likely to experience physical violence as adults.⁹⁸ Men tend to report higher levels of loneliness than women, particularly if living alone (39 per cent of men compared with 12 per cent of women).⁹⁹

There is also evidence that access to and experiences with mental health services on average differ for men and women. For example, women experiencing mental illness are on average more likely to see a GP or other health professional (for example, a complementary or alternative therapist) than men.¹⁰⁰

2.3.4 Trauma

There is a growing understanding of the close relationship between trauma, poor mental health and mental illness, and increasing recognition of the need for trauma-informed mental health treatment, care and support.

Everyone experiences stress and adversity in their lives. However, trauma refers to an acute event, or chronic series of events, or a set of circumstances that overwhelm an individual's resources to cope, frequently leading to a sense of fear, vulnerability and helplessness.¹⁰¹ How individuals respond to trauma varies—two people may be exposed to the same acute event or chronic series of events and be affected in different ways.¹⁰²

Research indicates that exposure to multiple or chronic traumatic events, especially in childhood and adolescence, can have a greater negative effect on mental health.¹⁰³

Trauma experienced earlier in life may have longer lasting and more challenging consequences for the person's mental health.¹⁰⁴ Experiencing trauma in childhood, whether it is neglect or physical, emotional or sexual abuse, or exposure to family or community violence, can be particularly damaging.¹⁰⁵

Many people living with mental illness have high rates of abuse and trauma, which can have a wide range of biological, psychological and social consequences.¹⁰⁶ Many people living with severe mental illness also meet the criteria for post-traumatic stress disorder, even if this is undiagnosed.¹⁰⁷ In addition, having a history of trauma can make it more challenging to recover from mental illness. For example, people living with mental illness who have experienced abuse are more likely to self-harm, have longer and more frequent hospital admissions, and are prescribed higher levels of medication.¹⁰⁸

Feedback provided at the Commission's community consultations highlighted the barriers that trauma survivors can experience in accessing appropriate diagnosis and treatment. For example, in a discussion about this issue at the Commission's Geelong consultation, participants said:

They prioritise the people labelled with schizophrenia and bipolar, but if it's trauma you're put way down the list.

... trauma and its impact is too often denied, silenced, minimised, ignored and diminished. People are instead told they have a broken brain, a chemical imbalance, or there's something wrong with them. That's a disgraceful way to treat people.

I was denied access to trauma therapy on account of [...] misdiagnosis five times.
I was made to feel like there was something wrong with me.

It's not all about pills for people who have had trauma. They need to do talking therapy.¹⁰⁹

In Ballarat, participants also shared concerns about how re-experiencing traumatic events in mental health services, such as being restrained or secluded, may lead to a reluctance to seek help in the future.¹¹⁰

To respond appropriately, services need to understand the impact of trauma and the capacity to respond through trauma-informed care. Services also need to ensure practice does not result in re-traumatisation. For example, research has shown that the experiences of psychosis combined with traumatic experiences of involuntary admission and treatments are associated with developing post-traumatic stress disorder.¹¹¹

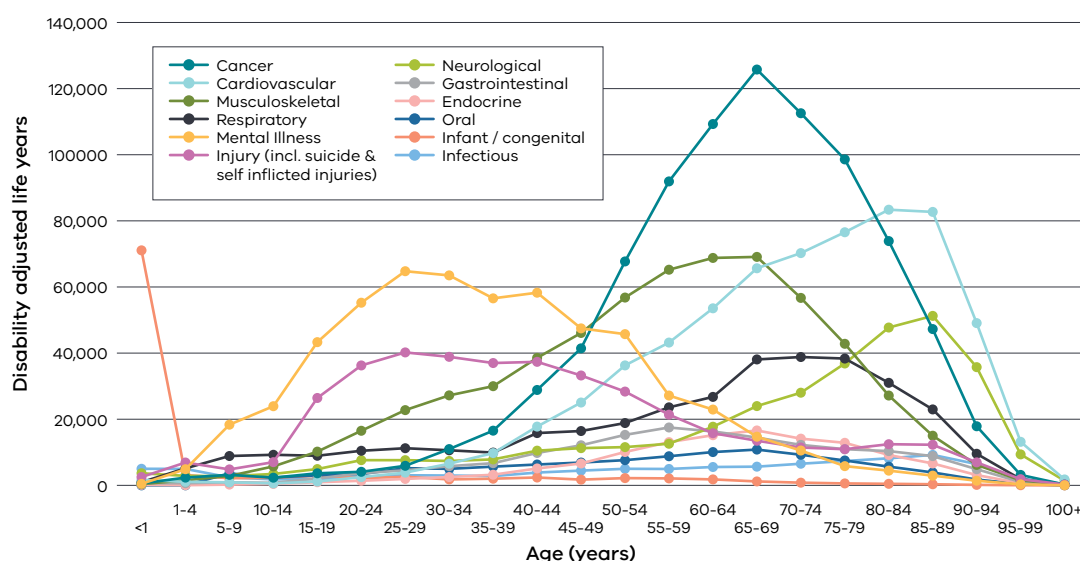
2.3.5 Stage of life

Poor mental health has varying impacts across age groups, driven by different factors that people can experience over the course of their lives.

As shown in Figure 2.6, the burden of mental illness increases in people's early years, peaking for those aged between 25 and 29 years and persisting through adulthood.¹¹² Mental illness accounts for a greater burden in younger cohorts, while chronic illness (including cancer, cardiovascular and musculoskeletal diseases) is a greater burden for older cohorts.

Young people experience the highest burden of mental illness due to age of onset and how this disrupts the early, crucial years of their lives. In terms of prevalence, adults aged 25–64 years comprise the vast majority of people living with mental illness, and more than 110,000 Victorian adults in this age range live with serious mental illness.¹¹³ Older people experience different and equally concerning challenges to their mental health, with evidence showing that increased levels of chronic illness and social isolation are significant contributors.¹¹⁴

Unlike most other health conditions, the incidence of mental illness does not increase with age. But there is still a sizeable and growing proportion of the adult community who experience mental illness.¹¹⁵

Figure 2.6: Australian burden of disease by disease group and age, 2015

Source: Calculation by the Commission based on the Australian Institute of Health and Welfare 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Australian Burden of Disease series no. 19. Cat. no. BOD 22. Canberra: AIHW. National Estimates of Australia, 2019 data table. Table 2.A Total (5yrs).

Cancer includes cancer and other neoplasms; mental illness includes mental and substance use disorders; and injuries includes suicide and self inflicted injuries.

For further information see:

<<http://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/burden-of-disease/data>>

Children and young people

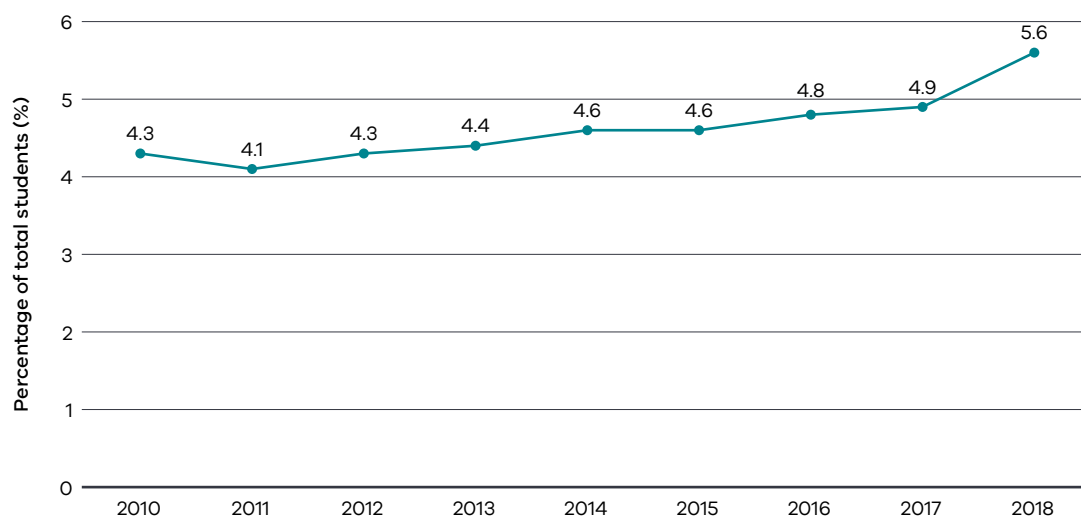
Mental illness can interrupt formative, developmental experiences and, if left unresolved, can create long-term, even lifelong, consequences.¹¹⁶ About half of all lifetime cases of anxiety, mood, impulse-control and substance use disorders manifest by the age of 14, and 75 per cent emerge by the age of 24.¹¹⁷

The statistics about poor mental health for young people are concerning. Around one in seven children and young people aged 4–17 years of age¹¹⁸ and one in three females or one in five males aged 15–24 years will experience a mental illness each year.¹¹⁹ One in eight 18–24-year-olds experience high to very high levels of psychological distress.¹²⁰ More than one-quarter of mental health-related emergency department presentations in 2017–18 in Victoria were for people aged under 25 years.¹²¹

Exposure to factors that affect a person's mental health begins in infancy. A considerable amount of research explores the importance of the environment and early experiences on a developing infant.¹²²

At school entry, almost a quarter of Victorian children are rated as being developmentally vulnerable, or at risk, in the domains of social competence (22.8 per cent) and emotional maturity (22.5 per cent). The number of those entering school with emotional or behavioural difficulties has steadily increased since 2011 (Figure 2.7).

Figure 2.7: The proportion of children at school entry with emotional or behavioural difficulties, Victoria, 2010 to 2018



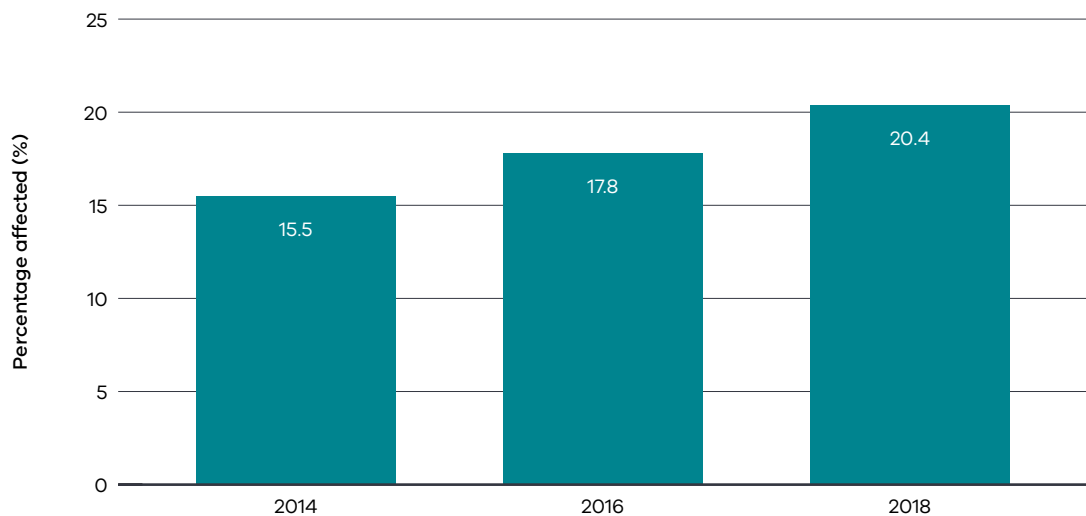
Source: Department of Education and Training. Student Entrant Health Questionnaire 2010 to 2018. VCAMS Indicator 10.1.

Proportion of children on entry to primary school who complete the Student Entrant Health Questionnaire of children who scored 17 or above on the total difficulties scale of the Strengths and Difficulties Questionnaire in the School Entrant Health Questionnaire.

For more information, refer to <<https://www.education.vic.gov.au/about/research/Pages/vcamsindicator.aspx>>

One in five Victorian school students show high levels of psychological distress (Figure 2.8).¹²³ One in eight Victorian parents reported being concerned about their child's emotional and psychological health on entry to secondary school.¹²⁴ In the past year, approximately 72 per cent of secondary school staff reported self-harm having occurred in schools.¹²⁵ The Department of Education and Training reports that (in 2017) 40 per cent of all presentations to the Doctors in Secondary Schools program related to mental illness.¹²⁶

Figure 2.8: Proportion of young people who showed high levels of psychological distress (depressive symptoms), Victoria, 2014 to 2018



Source: Department of Education and Training. Victorian Student Health and Wellbeing Survey (VSHAWS) also known as 'About You' 2014 to 2018. VCAMS Indicator 10.8.

Proportion of students in Years 5, 8 and 11 who showed a high level of depressive symptoms on the International Youth Development Study Short Version Moods and Feelings scale.

For more information, refer to <<https://www.education.vic.gov.au/about/research/Pages/vcamsindicator.aspx/>>

The 2014 Mission Australia Youth Survey found that 19.1 per cent of Victorian young people (aged 15–17) had probable serious mental ill-health. Nationally, 30 per cent of females, and approximately 21 per cent of males, aged 15–24 experience a mental health condition—the highest of any age group.¹²⁷ Younger people experiencing mental illness do so during a crucial period of life when they are acquiring an education, forming important social relationships, establishing a work life and setting a course for their later income-earning ability.

Some groups of children and young people disproportionately experience poor mental health, psychological distress or mental illness. Some are disproportionately at risk of intentional self-harm and suicidal behaviour, such as Aboriginal and Torres Strait Islander young people, young people who identify as LGBTIQ+, young people in out-of-home care, young people with a disability and young people living in rural and remote areas.¹²⁸

According to the Costs of Youth Homelessness in Australia report, 53 per cent of homeless youth in Australia reported having been diagnosed with at least one mental health condition in their lifetime (twice the rate of the general youth population). But young people who are experiencing homelessness often struggle to access and afford mental health services.¹²⁹

In 2017, 53 per cent of young people in custody presented with a mental health issue and 30 per cent had a history of self-harm or suicidal ideation. In addition, 37 per cent had been subject to a child protection order and 70 per cent had experienced abuse, trauma or neglect.¹³⁰

Children and young people in the child protection and out-of-home care systems experience high rates of developmental and mental health problems¹³¹ for complex reasons associated with insecure attachments and the cumulative effects of childhood maltreatment.¹³²

In a national study of Australian youth, 11 per cent of 12–17-year-olds reported self-harm in the previous 12 months.¹³³ This compares with a third of out-of-home care leavers who participated in a different study who reported that they had thought about self-harm in the previous 12 months; a quarter had hurt themselves on purpose; and a quarter reported that they had seriously considered suicide.¹³⁴

According to a recent inquiry by the Commission for Children and Young People into children who died by suicide and where known to child protection services, 83 per cent of the 35 children reviewed had a diagnosis of or suspected mental illness, and 89 per cent had at least one recorded contact with a mental health service.¹³⁵

Aboriginal children are over-represented in out-of-home care in Victoria,¹³⁶ and a 2016 review found that more than one in five experienced mental health problems and 8 per cent were under the age of 5 years.¹³⁷

Mental health is a growing concern to young Victorians. The 2018 Mission Australia Youth Survey found that 43 per cent of young Victorians consider mental health the most important concern in Australia (ahead of alcohol and drugs and equity and discrimination)—the first time in 17 years that mental health topped the survey. In comparison, concerns such as the environment (9.2 per cent) and the economy (11.6 per cent) were further down the list.¹³⁸

Older people

As people age and transition into later life, they can be faced with a different set of challenges to their mental health. For example, retirement, the onset of chronic illness, grieving the loss of a loved one and moving into residential aged care can all be times of heightened stress. As people age, experiences of social isolation and feelings of loneliness can also pose mental health challenges.¹³⁹

Evidence suggests that one in five Victorians aged 65 years or older experience mental and behavioural conditions,¹⁴⁰ which is consistent with the total population.¹⁴¹ Rates of depression in people living in residential aged care settings have been found to be three to four times higher than elderly people living in the community.¹⁴² Older people from migrant and refugee communities are at greater risk of experiencing depression and anxiety due to social isolation and language barriers,¹⁴³ including reverting to their first language. In smaller communities, older women can become isolated when their spouse passes away.¹⁴⁴

Older people also experience high rates of suicide, particularly among men over the age of 85.¹⁴⁵ In 2015 the Australian Institute of Health and Welfare reported that 'most, but not all, older people who die by suicide have a diagnosable mental disorder at the time of death—most commonly severe depression'.¹⁴⁶ Other risk factors for suicide in later life are a history of traumatic life events, substance abuse, social isolation and physical illness.¹⁴⁷

2.4 Mental health in specific social groups

The Letters Patent require the Commission to inquire into the mental health outcomes of different cohorts and explore how they could be improved. Victoria is experiencing social and demographic change. Between 2011 and 2016 the population of Aboriginal people in Victoria increased by almost 10,000, growing from 37,992 to 47,788.¹⁴⁸ About 4,000 refugees settle in Victoria each year, and an estimated 10,000 asylum seekers are living in the state, waiting for a determination on their refugee status.¹⁴⁹ Because of the lack of comprehensive, publicly available data, it is difficult to estimate the total LGBTIQ+ population in Australia. However, it is estimated that approximately 11 per cent of Australians could be of diverse sexual orientation, sex or gender identity.¹⁵⁰

The factors shaping, and the prevalence of, different forms of mental illness can be different across social groups. This is influenced by a range of factors and is in many cases exacerbated by an unresponsive mental health system, which the Commission explores later in this report.

2.4.1 Aboriginal and Torres Strait Islander peoples

The impact of colonisation, racism, discrimination, marginalisation and the compounding impact of intergenerational trauma have had a profound and enduring impact on mental health outcomes for Aboriginal people.

These factors contribute to Aboriginal people experiencing higher rates of mental illness than non-Aboriginal Victorians.¹⁵¹ Childhood and family adversity within Aboriginal communities is also significantly higher than in non-Aboriginal communities.¹⁵²

Unresolved intergenerational trauma, along with social exclusion and economic disadvantage are factors that are contributing to the over-representation of Aboriginal people in the criminal justice, prison, family violence, child protection and mental health systems.¹⁵³

A proportion of Aboriginal people are at higher risk of experiencing intergenerational effects of trauma and mental illness. Among the most vulnerable are members of the Stolen Generation, children in out-of-home care and those with a history of incarceration.¹⁵⁴ Almost half (47 per cent) of Aboriginal people in Victoria have a relative who was forcibly removed under the Stolen Generation policies.¹⁵⁵ Around 40 per cent of people of the Stolen Generation aged 50 years or older experience mental illness attributed to the trauma of removal.¹⁵⁶

Mental illnesses and substance use disorders have been estimated to account for as much as 14 per cent of the health gap.¹⁵⁷ Research indicates that one in three Aboriginal people experience high or very high levels of psychological distress—almost three times the rate for non-Aboriginal people.¹⁵⁸ One study found that twice as many Aboriginal adolescents (18–24 years) as non-Aboriginal adolescents experience significant psychological distress.¹⁵⁹

Dr Graham Gee, a Clinical Psychologist and Senior Research Fellow at the Murdoch Children's Research Institute, called for a greater focus on developing effective treatment models for Aboriginal children and adolescents.¹⁶⁰ Culturally specific tools and models of care are required to meet the unique developmental and cultural needs of Aboriginal children.¹⁶¹ For example, responses to the social and emotional wellbeing of Aboriginal children must account for and draw on the strengths of Aboriginal family and community structures.¹⁶²

2.4.2 People from culturally diverse backgrounds

People from culturally diverse backgrounds often have to deal with multiple, intersecting factors that can negatively affect their mental health and their access to services.

The lived experience of people from migrant backgrounds in Australia can also have repercussions for their mental health. Racism remains a part of the everyday experience of far too many Victorians and has a particularly profound impact on some newer migrant groups such as Muslim-Australians and African-Australians. Negative media portrayals and vilifying statements by some public figures and politicians also contribute to feelings of victimisation and isolation.¹⁶³

Although the 2017–18 National Health Survey found that the prevalence of mental illness among people who spoke a language other than English at home was less than that among the general population (13 per cent compared with 21.7 per cent),¹⁶⁴ these results do not necessarily reflect the experiences of all people from culturally diverse backgrounds. Limitations in research methodology might affect the validity of available data and the ability to make comparisons between cohorts, potentially leading to underestimates of the true level of poor mental health in culturally diverse communities.¹⁶⁵

For example, obstacles to gaining access to services and differences in help-seeking behaviour must be taken into consideration.¹⁶⁶ There also may be stigma attached to seeking out mental health services in some culturally diverse communities.¹⁶⁷

Research indicates that refugees and asylum seekers may experience mental illness and suicidal behaviour at higher rates than the general Australian population.¹⁶⁸ Refugees and advocates both told the Commission about the challenges and higher incidence of poor mental health among this cohort.¹⁶⁹

People from refugee backgrounds can have complex and multiple mental health problems related to past traumatic experiences.¹⁷⁰ One study found populations of people with a refugee background reported significantly higher levels of moderate to high psychological distress (46 per cent for females and 35 per cent for males) compared with the Australian-born population (11 per cent for females and 7 per cent for males).¹⁷¹ This is partly explained by experiences of trauma, stressful migration and additional barriers to obtaining culturally appropriate services.¹⁷²

Some international students arriving in Australia to undertake university courses are also at higher risk for experiencing challenges to their mental health.¹⁷³ This growing group of visitors to Australia arrive to an unfamiliar culture, away from their families and friends, at an age when people generally are more likely to experience poor mental health. As well as the usual challenges for young people starting a tertiary course, international students face challenges studying and socialising in English, which is often not their first language. Other challenges relate to experiencing unfamiliar academic practices, the need to acquire new skills to manage day-to-day living in Australia, and the tendency of some cultural groups to delay professional help-seeking for mental health problems.¹⁷⁴

2.4.3 People who identify as LGBTIQ+

Victorians who identify as lesbian, gay, bisexual, trans and gender diverse, intersex, queer or questioning experience disproportionate rates of mental illness and suicide compared with the wider Victorian community. The risks were articulated in the following submission:

The moment someone realises they are LGBTIQ (but have yet to tell anyone else) is a high-risk period as the person struggles to consider disclosing to others and the potential response from family, friends, co-workers and the broader community. Coming out is often a gradual and ongoing process. Some never choose to come out at all, leaving them vulnerable to isolation, fear of being 'outed' against their will, and internalised stigma. It is often assumed that coming out occurs while young, but people continue to come out later in life. Indeed, people come out repeatedly throughout life as they meet new people.¹⁷⁵

The LGBTIQ+ community encompasses a great diversity of identities and experiences. The abbreviation itself is inclusive of a range of sexualities, genders and sex characteristics and has evolved over time. It is viewed and experienced differently by different members of the community. It is not 'official' and other terms are also used.

The Commission was told that stigma affects the mental health of those identifying as LGBTIQ+, especially young people.¹⁷⁶ In many parts of the Western world homosexuality was itself considered a mental illness until the 1970s, and being trans or gender diverse was listed in the Diagnostic and Statistical Manual of Mental Disorders until 2018.

The 2017 Victorian Population Health Survey found that the proportion of the adult LGBTIQ+ population ever diagnosed with anxiety or depression is 44.8 per cent compared with 27.4 per cent of the total Victorian population. Further, 24.4 per cent of the adult LGBTIQ+ population reported high to very high levels of psychological distress in 2017 compared with 15.4 per cent of the total Victorian population.¹⁷⁷

Importantly, elevated levels of mental illness and suicidality are not due to sexuality or gender identity but to discrimination and exclusion as key determinants of mental health. This is sometimes referred to as 'minority stress'. For example:

... it is not our gender identity, our sexuality or our intersex variation that is the cause of our mental health, it is actually the discrimination that we experience, the isolation, the family rejection that is the cause of that.¹⁷⁸

... when social commentators talk about transgender children and demonise or vilify them, they're really projecting that view to the adult audience and to try and create fear within that adult audience, but the people that get hurt the most are the trans children who are experiencing it in that very personal way.¹⁷⁹

LGBTIQ+ people appear to be over-represented in terms of family violence and violence in the community and are subjected to levels of stereotyping and vilification not endured by other sections of the population.

Available information about mental health and the LGBTIQ+ community presents an alarming picture:

- LGBTIQ+ people experience higher rates of suicidality than their peers and are more likely to attempt suicide.¹⁸⁰
- Three times as many (19.2 per cent) gay, lesbian and bisexual people have a mood-affective disorder than non-LGBTIQ+ people (6 per cent).¹⁸¹
- Lesbian, gay and bisexual Australians are twice as likely as non-LGBTIQ+ Australians to have no contact with family or only minimal contact with little support.¹⁸²
- A study of the mental health of trans young people aged 14–25 years living in Australia in 2017 found very high rates of being diagnosed with depression (75 per cent), anxiety (72 per cent), post-traumatic stress disorder (25 per cent) or an eating disorder (23 per cent). Further, the majority reported self-harming (80 per cent), and nearly half reported attempting suicide (48 per cent).¹⁸³
Associate Professor Michelle Telfer, General Paediatrician, Adolescent Medicine Physician and Head of the Department of Adolescent Medicine, The Royal Children's Hospital noted that trans young people experience 'higher levels of stigma, discrimination, social isolation, exclusion, marginalisation, family rejection, bullying, harassment, and abuse'.¹⁸⁴
- A study by the LGBTIQ+ Health Alliance in 2016 found that, compared with the general population, LGBTIQ+ people 16 years of age or older are nearly three times more likely to be diagnosed with depression in their lifetime.¹⁸⁵

Moreover, there appears to be a reluctance among LGBTIQ+ people to use mental health services, often because of previous negative experiences with the system. Research undertaken by the Lifeline Research Foundation shows that more than 71 per cent of LGBTIQ+ participants chose not to use a crisis support service during their most recent personal or mental health crisis.¹⁸⁶

Identifying many of the issues affecting LGBTIQ+ Victorians remains problematic due to a lack of adequate, reliable data and research. There are often gaps such as in relation to the full extent of LGBTIQ+ identification in suicide data and statistics.¹⁸⁷

2.4.4 People living in rural and regional communities

The prevalence of mental illness and psychological distress in Victoria's rural and regional areas is comparable to that of people living in metropolitan areas. However, there is evidence that rates of suicide and self-harm in rural and regional communities are much higher than in metropolitan areas.¹⁸⁸

People living in rural and regional areas experience a range of factors that may have protective or negative impacts on their mental health such as higher levels of community wellbeing and life satisfaction¹⁸⁹ but poorer access to services. They may also experience increased socioeconomic disadvantage, social isolation and poorer health outcomes than those in urban areas.

The experiences of people living in rural and regional areas are explored in detail in Chapter 10.

2.4.5 Adults in the criminal justice system

In 2018 'Victoria's imprisonment rate stood at 119 prisoners per 100,000 people',¹⁹⁰ nearly double the rate of 62 per 100,000 in 1998.¹⁹¹

The latest survey of prisoner health of those in Australian prisons indicates that 61 per cent of people entering Victorian prisons had a diagnosed mental illness,¹⁹² and 35 per cent of Victorian prisoners were referred to a prison mental health service.¹⁹³ The Victorian Institute of Forensic Mental Health, known as 'Forensicare', suggests the rates of mental illness are three times higher than among the general population, with prisoners 10–15 times more likely to have a psychotic disorder.¹⁹⁴ Forensicare submitted that, '[s]adly, it is not uncommon for some people to have the first opportunity to access mental health assessment and services when they enter the justice system'.¹⁹⁵

The Federation of Community Legal Centres submitted that the reason for the disproportionate prevalence of mental illness among prisoners is twofold: 'prisons are difficult places for many to maintain good mental health, and people who experience mental illness are at increased risk of being criminalised'.¹⁹⁶

The Australian Institute of Health and Welfare found in 2015 that people in prison often have long-term complex health needs, including higher rates of 'mental health conditions' than the general population.¹⁹⁷ In a 2019 report the institute estimated that around two in five prison entrants (40 per cent) and prison dischargees (37 per cent) reported a previous diagnosis of a mental illness, including alcohol and other drug use disorders.¹⁹⁸ It also estimated that 65 per cent of female prison entrants reported a history of a mental illness in comparison with 35 per cent of male prison entrants.¹⁹⁹ The Victorian Ombudsman reported that, in 2015, 54 per cent of people in prison had a history of suicide attempts or self-harm.²⁰⁰

Mental Health Victoria and the Mental Health Legal Centre submitted that the prison environment can affect different people in different ways. They proposed that:

... for many people living with mental illness prison is a challengingly restrictive environment and incarceration can have a debilitating impact on their mental health and well-being.²⁰¹

They also noted, however, that prison may have a positive impact on some people's mental health in that 'prison can offer the routine and structure, and security of food and shelter, that enable them to stabilise their mental health'.²⁰²

Ms Mary Pershall, witness before the Commission, had a similar perspective in relation to the experience of her daughter. Ms Pershall described that as a result of the routine, structure and community within prison, as well as the access to mental health care, her daughter's 'mental health is better than it has been since she started school'.²⁰³

The Commission will consider in detail issues relating to people living with mental illness and the forensic mental health system and the criminal justice system. This will include engaging with adults and young people in custody.

2.4.6 Intersectionality

Although poor mental health can differently impact certain social groups, the Commission recognises that people have layers to their identity. Everyone is more than just their cultural background or their gender.

'Intersectionality' is a way to understand and respond to the diversity of Victoria's population. The Victorian Government's 2019 Inclusion and Equity Statement, developed in response to the Royal Commission into Family Violence, defines 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.²⁰⁴

All Victorians are entitled to comprehensive, high-quality mental health services. These services must be culturally appropriate, safe, inclusive and valued by the people who use them. Too often, Victorians receive mental health care that does not meet their needs or seek to understand their experiences. These unique needs and experiences are shaped by overlapping identities and associated structures of power, privilege and disadvantage. For example, the Commission acknowledges that services need to understand 'where there might be intersections of particular aspects relating to identity'—for example, people who identify as transgender or gender diverse and live with autism spectrum disorder.²⁰⁵

A range of organisations have called for an intersectionality framework for mental health that is grounded in the social determinants of health and empowers services, workers and systems to 'see the whole person'—not just a diagnosis or label.²⁰⁶

2.5 Perspectives on mental health

Mental illness is experienced across Victoria, with wide and varied impacts. Some people live with mental illness for their entire lives; others can experience mental illness for a short time only. For some, their illness can come to dominate and define their lives; for others it will be an intermittent interruption, an episodic experience or perhaps an isolated event. Mental illness can affect people's quality of life and their ability to thrive in a community. It can be life changing and, tragically, for some, life ending. With the right supports and services, people can also be enabled to lead their own recoveries and live full and meaningful lives on their own terms.

Mental illness has an impact on every Victorian in some way, directly or indirectly. Every year almost one in five Victorians—more than 1.1 million people—experiences mental illness.²⁰⁷ It is possible that, for everyone, someone close to them—a family member, loved one, friend, work colleague, social acquaintance—or they themselves will experience a period of poor mental health at some time in their life.

The difficulties posed by mental illness and psychological distress can culminate, tragically, in suicide. Although the rate of suicide is generally lower in Victoria than in other parts of Australia, the Commission was told that more than 700 Victorian lives were lost to suicide in 2018.²⁰⁸ Nationally, suicide was the leading cause of death for Australians aged between 15 and 44 years in 2018.²⁰⁹ More than 75 per cent of those who suicide are men.²¹⁰ While the suicide rate is relatively stable—and increasing in frequency as the population grows—there has been no

significant improvement in the suicide rate in the past decade. Chapter 11 examines suicide, and Chapter 15 looks at suicide prevention through assertive outreach in more detail.

2.5.1 Community perspectives on safety

Despite increased awareness of mental illness, sometimes public discourse heightens perceptions of people living with mental illness as being dangerous. Some of it stems from fear or ignorance of what mental illness is and how many people it affects.²¹¹

At a societal level this can manifest in the promulgation of stigmatising and discriminatory attitudes; at the policy level, this contributes to risk-averse policies. Where people do not have a personal connection to mental illness, either through living with mental illness themselves or through the experience of someone they know, their understanding may be more influenced by public portrayals.²¹²

The nature and extent of the association between mental illness and offending behaviours is not clear.²¹³ It is important to note that an association (or correlation) is not the same as causation:

... most people with mental illnesses are not violent, most violent offenders are not mentally ill, and the strongest risk factors for violence (e.g., past violence) are shared by those with and without mental illnesses.²¹⁴

A recent study concluded there is ‘limited evidence that mental health problems are independent predictors of violence when accounting for other factors, such as substance use or previous violence’.²¹⁵ Research also indicates that violent victimisation of people with severe mental illness occurs more frequently than their committing acts of violence.²¹⁶

Even so, people living with mental illness can be affected by a changing social and policy context that has pivoted towards a community safety agenda. Recent tragic events—such as the Bourke Street incident in January 2017—have heightened this focus and resulted in successive legislative reforms intended to strengthen community safety protections. Increases in government investment have also occurred, particularly in the police and corrective service portfolios.²¹⁷

For example, the Victorian Government sought advice on how Victoria’s bail system should be reformed to ‘best manage risk and to maximise community safety’.²¹⁸ Between 2013 and 2017, similar reviews were conducted relating to Victoria’s parole, post-sentencing supervision and counter-terrorism laws, all in response to specific events.²¹⁹ Government responses to these reviews progressively strengthened the state’s mandatory and minimum sentencing, bail and parole laws.²²⁰ For example, the ‘paramount consideration’ for the Adult Parole Board in deciding to grant or cancel parole is ‘the safety and protection of the community’.²²¹

The visibility of these reforms, coupled with associated media coverage, may continue to inadvertently feed perceptions of fear in the community towards people living with mental illness. The Commission recognises that there has been a significant amount of work in relation to safe, accurate and appropriate media reporting of mental illness. However, the Commission was told that there remain many reports of stigmatising content about mental illness—material believed to be ‘inaccurate, irresponsible or offensive’.²²²

The Commission will continue to consider the role and implications of a focus on risk and personal safety in mental health and community safety policy in 2020. The Commission believes this work is important to properly inform public discourse and responses to and support for people living with mental illness in Victoria.

2.5.2 Stigma and discrimination

Stigmatising and discriminatory attitudes manifest in structural stigma (such as discriminatory policies),²²³ public stigma (attitudes towards people living with mental illness)²²⁴ and self-stigma (internalising stigmatising attitudes where a person can come to agree with stigmatising views and apply it to themselves).²²⁵ This can result in people living with mental illness being discriminated against when trying to access housing, employment and education opportunities.

Despite some progress, stigma and discrimination in relation to mental illness continues. Some of this reflects the state's history of responding to mental illness—in particular, through institutionalisation.

Box 2.2 considers the definition of stigma and discrimination.

Box 2.2

Stigma and discrimination

The World Health Organization describes 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'.²²⁶ Another well-recognised understanding of stigma considers stigma to be the 'co-occurrence of labelling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised'.²²⁷

While the words 'stigma' and 'discrimination' are often used interchangeably, they are related but different concepts. Stigmatising attitudes can be seen as the personal beliefs held by an individual, whereas discrimination is the behaviour or perceived behaviour.²²⁸ Many consider that stigma should instead be recognised as discrimination. One witness observed:

Stigma is the word that we commonly use. I don't think it's strong enough and I don't think it's accurate enough—what exists in society is discrimination against a legitimate set of medical conditions.²²⁹

Stigma and discrimination have a profoundly negative impact on the lives of people living with mental illness. Stigma and discrimination can be a key deterrent for people seeking help—many people prefer to keep their mental illness hidden rather than seeking care or treatment.²³⁰

Even when people do access help, negative attitudes and discriminatory behaviours regarding mental illness can exacerbate poor mental and physical health. The Commission has heard that consumers have been ‘treated dismissively, judged and not listened to, particularly in regard to their personal history and treatment [preferences]’.²³¹

Stigmatising attitudes can often culminate in exclusionary and discriminatory behaviour, seriously impacting on the wellbeing of people living with mental illness—for example, social exclusion from friends and families, and discrimination in searching for employment, in the workplace, and in providing goods and services such as health insurance.²³²

2.5.3 The impact on families and carers

Families and carers play a significant role in providing care and support to people living with mental illness. Balancing caring responsibilities can be challenging, and have profound impacts.²³³

The increasingly stretched mental health system has meant that families and carers have an ever-growing role. Approximately 58,000 Victorians care for an adult with mental illness, and about 5,600 of them are under 25 years of age.²³⁴ Families and carers undertake a breadth of responsibilities—they are advocates, primary carers, financial managers, counsellors, case workers, cleaners and friends.

The social and emotional toll of caring can be heavy.²³⁵ One study of Australians found that carers experience the lowest collective wellbeing of the groups identified.²³⁶ Another found that more than half of family carers whose children were experiencing a first-episode psychosis suffered a level of anxiety or depression that could meet criteria for a ‘psychiatric illness’.²³⁷ Other studies have found that one quarter of carers have high or very high levels of psychological distress,²³⁸ carers can participate less in activities outside of home²³⁹ and become more isolated from their social networks.²⁴⁰

Caring for a loved one can also affect carers’ employment and work. The weekly median income of carers is reported to be 42 per cent lower than that of non-carers,²⁴¹ and more than one-third of carers are concerned about job loss because of their caring role.²⁴²

The employment and educational opportunities of young carers can be adversely affected by their caring role. One study showed that 71.4 per cent of 15–24-year-old carers are studying or in paid work; this compares with 91.3 per cent of their non-carer counterparts.²⁴³

The Commission has been told about a lack of support for the needs of families and carers including: limited education and information to better enable people to support the people they care for; barriers to accessing supports because of fear of separation or limited information; and limited financial support.

Further, while some programs are inclusive of families and carers, families and carers often feel excluded from the treatment of their loved ones. As Tandem, the Victorian peak body representing family and friends supporting people living with mental illness, reported to the Commission, not to consider the voice of families and carers is to ignore the experience of a motivated, skilled and committed part of the community in the search to improve the delivery of care.²⁴⁴

The experience of families and carers is considered in detail in Chapters 8 and 9.

2.6 Wellbeing and recovery

Most importantly, many people living with a mental illness can and do recover. With the right services and supports people are enabled to lead their own recovery and lead a full and contributing life.

In this sense, recovery is referred to as personal recovery. Author Bill Anthony says it is:

... a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. Recovery from mental illness involves much more than recovery from the illness itself.²⁴⁵

As outlined in the Victorian Government's 2011 Framework for Recovery-Oriented Practice, there is no single description or definition of recovery. Personal recovery encompasses notions of self-determination, self-management, personal growth, empowerment, advocacy, choice and meaningful social engagement free of stigma and discrimination.²⁴⁶

Recovery is a human process—an ongoing experience, not an end point or cure. It is a journey rarely taken alone; it is nonlinear and brings achievements and setbacks. Personal recovery is ultimately about creating and living a meaningful life in a community of choice, with or without the presence of mental illness. Mental health services have a crucial role in creating an environment that supports and does not interfere with people's recovery efforts.²⁴⁷

In redesigning the mental health system, the Commission will be guided by a strong focus on developing the service models, cultures and workforce skills to enable recovery-oriented treatment, care and support.

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Part Two

Victoria's mental health system



Chapter 3

Victoria's mental health system

Every day, a range of services and providers offer treatment, care and support to people experiencing mental illness or psychological distress. As outlined in Figure 3.1, these services include GPs, psychiatrists, psychosocial support services, public specialist mental health services and emergency services.

Beyond the services that are directly involved in providing mental health treatment, care and support, many other services respond in various ways to people living with poor mental health. These include a range of health, social and community services such as general health, advocacy, employment and housing services.

All these services have a role in supporting people living with mental illness and—given the interrelationships between poor mental health and other health and social determinants—can potentially help prevent the onset or exacerbation of poor mental health.

Helping people who are distressed or living with mental illness is not the sole preserve of formal services. Personal resources—for example, support from people's families, friends and communities—are perhaps even more important in preventing poor mental health and supporting recovery from mental illness. Self-care also plays a crucial role in building resilience and enabling people to take care of their own mental health and wellbeing.¹

Bearing in mind this context, this chapter gives an overview of the main types of services that make up the mental health system and indicates the forms of treatment, care and support they provide. Appendix B describes the mental health service system in more detail and provides information about other health, social and community services that may assist people living with mental illness.

3.1 Key service types

Figure 3.1 outlines the various services that provide mental health treatment, care and support. Figure 3.1 also shows the relationship of these services to personal, family, social and community resources that may be important in maintaining good mental health and contribute to people's recovery if they become unwell.

The Commission's terms of reference provide the following definition of the mental health system in Victoria:

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.²

The service groupings shown in Figures 3.1 and 3.2 are for descriptive purposes only and represent a simplified version of mental health and related services. Indeed, one of the most salient features of the mental health system is its complexity. Services have different target groups—often defined by age, location or severity of illness—and are provided by many different organisations, under different administrative and governance arrangements, and using funding from several sources. As discussed in Chapter 7, mental health services can be more or less accessible depending on a person's income, private insurance status, distance from the service and other factors.

Within the broad service types listed in the figures, there are many service elements. These vary from area to area and are constantly evolving. New service elements are added to the system, and other elements are eroded over time as a result of funding or workforce changes.

To provide a sense of the scale of the services in Victoria's mental health system, Figure 3.3 shows the estimated funding for various service types and Figure 3.4 shows the estimated number of people using those services. These figures show that most people access mental health treatment, care and support in primary care services, usually via a GP. The next most commonly used service is psychologists or other allied health providers subsidised by the Medicare Benefits Schedule. However, the largest amount of funding in the Victorian system—almost half the overall funding—goes to public specialist mental health services, which are targeted at people who are severely affected by mental illness.

Many people use more than one type of service. Some people benefit from seeing different service providers for different aspects of their treatment, and others move back and forwards between providers as their needs change. For example, a person might see a GP regularly to manage their medication but require specialist mental health services in times of crisis or an acute episode of their illness.

The main types of services that provide mental health treatment, care and support are briefly outlined below.

3.1.1 Primary care and general counselling services

Primary care services are delivered in many settings. They include general practice and integrated care services, such as headspace, which provide mental health services alongside primary health and social supports. They are often the first point of contact for people experiencing mental health challenges.

GPs are the biggest part of this service grouping. Some GPs work in public services such as community centres or headspace, but most commonly they are in private practice. They play an important role in preventing, detecting, diagnosing and treating mental illness, and in coordinating care from other providers. Their role includes developing mental health care plans and referring people for psychological therapies (where private practitioners are available) that attract a rebate under the Medical Benefits Schedule.

There are also a range of telephone and face-to-face counselling services that help people to manage challenges to their mental health and wellbeing. While their functions and targeting vary, telephone 'helplines' generally provide support, advice and referral to other services where necessary. For example, Lifeline runs a crisis telephone line and a nightly online Crisis Support Chat service, operated by volunteers.³ Beyond Blue operates a 24-hour support service delivered by trained mental health professionals.⁴

General counselling services are offered in many workplaces, schools, universities, community health centres and integrated care services.

Primary Health Networks sometimes coordinate primary health services in local areas. The Commonwealth Government originally established these networks to: plan and commission primary health services to meet the needs of specific populations; increase the efficiency and effectiveness of medical services; and improve the coordination of care.⁵

Services commissioned by Primary Health Networks vary but can include: referral and support services; primary and specialist consultation services; capacity-building activities; prevention and early intervention services; and services to reduce the harm associated with alcohol and other drugs.⁶

3.1.2 Clinical treatment and psychosocial support services

The category 'clinical treatment and psychosocial support services' (see Figure 3.2) is a grouping of services that encompasses the following:

- *Clinical services provided by public and private psychiatrists and allied health providers such as psychologists, social workers and occupational therapists.* These practitioners work in a range of settings including: private hospital mental health inpatient services; other bed-based services (such as residential aged care, alcohol and other drug treatment facilities, crisis and short-term accommodation); private practice; community health centres; and integrated care services. Services include general counselling and psychological interventions such as cognitive behaviour therapy.
- *Psychosocial supports, which are focused on rehabilitation, wellbeing and community participation.* These include a range of services that help people to manage their self-care, improve their social connections and participate in work or leisure activities, and services targeted to people who are severely affected by mental illness accessed via the National Disability Insurance Scheme and non-government service providers. Examples include assistance with managing daily household tasks (such as meal planning, shopping and cleaning), group recreation and leisure activities, and supported independent living services.

Figure 3.1: Mental health treatment, care and support in Victoria



Health, social and community services

Services in Victoria's mental health system



Primary care and
general counselling
services



Clinical treatment
and psychosocial
support services



Public specialist
mental health
services



Emergency and
crisis services

Different services are available across different geographic areas

Different services are available for different age cohorts

Services are operated by and/or work with general health services (e.g. hospitals)

Education
services

Justice services
(e.g. prisons,
corrections,
youth justice)

Health services
provided in justice
and corrections
settings

Aged care
services

Disability
services

Income support and
financial counselling
services

Child and family
services

Police and
emergency
services

Workplace
support services

Family violence
and sexual
assault services

Mental health
promotion and
prevention

Legal and
court services

Employment
services

Housing and
homelessness
services

Advocacy
services

Guardianship
services

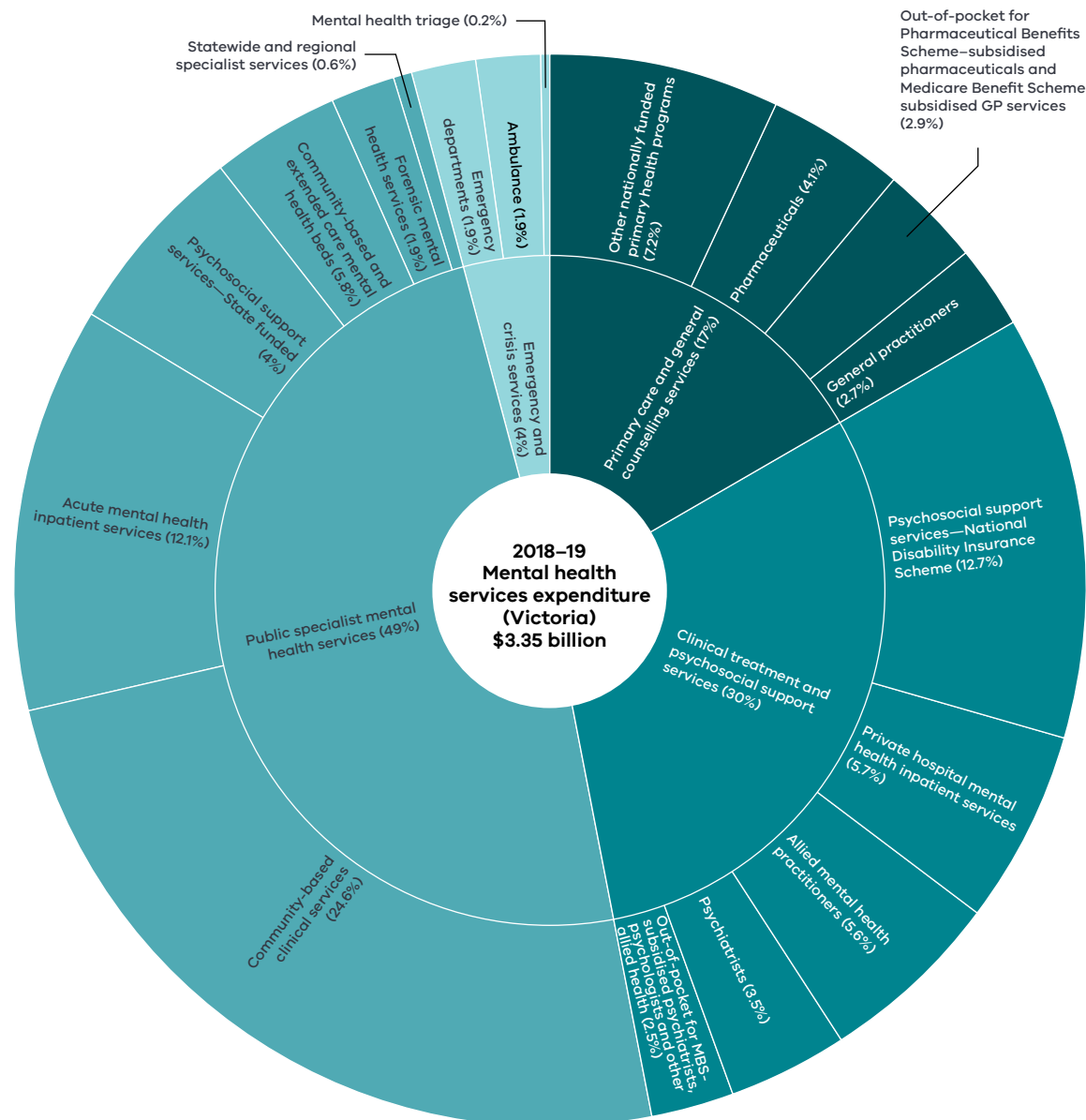
Alcohol and
other drug
services

Figure 3.2: Services in Victoria's Mental Health System





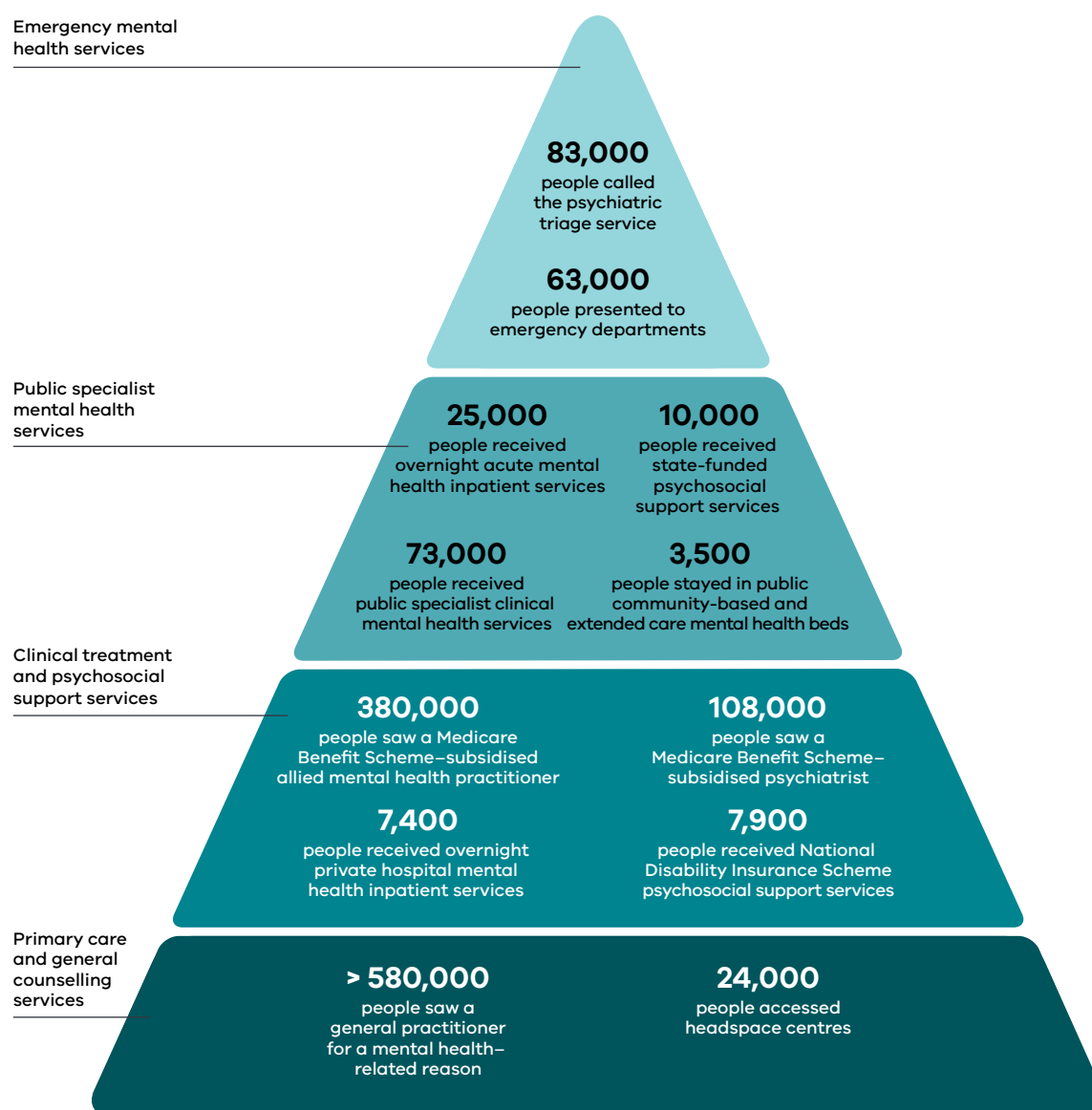
Figure 3.3: Estimated funding of all services in Victoria's mental health system, all sources, 2018–19



Source: Calculation by the Commission. See Appendix C: Background to economic analysis for details of the assumptions and data sources used.

This is an estimate of 2018–19 expenditure on mental health services in Victoria. It does not represent the overall cost of poor mental health, outlined in Chapter 12. The following is included in the Chapter 12 estimate but not this figure: forgone wages, unpaid care, lost productivity, employers' insurance and support costs, related government services costs, Commonwealth funding for national programs that do not relate to service delivery (e.g. research and the National Mental Health Commission) and Victorian Government costs for corporate and service planning staffing, and research. These estimates are based on the best available data. As a result, some of the figures represent 2018–19 State Budget funding, while others represent actual expenditure from 2016–17 or 2017–18 that have been escalated to a 2018–19 level using Victorian consumer price index data.

Figure 3.4: Estimated number of people accessing a selection of services in Victoria's mental health system, 2017–18



Source: Department of Health and Human Services. Integrated Data Resource, Client Management Interface / Operational Data Store, Victorian Admitted Episodes Dataset, Victorian Emergency Minimum Dataset 2017–18; Department of Health and Human Services. Triage Minimum Dataset 2017–18; Australian Institute of Health and Welfare. Mental Health Services in Australia. Medicare Subsidised Mental Health-Related Services 2017–18. Table MBS.3; Department of Treasury and Finance, Budget Paper 3 2019–20; Headspace National Youth Mental Health Foundation Annual Report 2017–18.

There may be underreporting of mental health services by GPs. The number of people accessing MBS-subsidised services by provider type may not sum to the total because a person may receive more than one type of service but will be counted only once in the total.

3.1.3 Public specialist mental health services

Victorian public specialist mental health services (shown in Figure 3.1 and Figure 3.2) are targeted to people experiencing severe mental illness. The Victorian Government is responsible for 'stewardship' of these services, including through legislation, policy and commissioning.

Clinical services within the public specialist mental health system are provided by area mental health services, and a range of statewide or regional specialist services. The Victorian Institute of Forensic Mental Health (a statutory authority created under the *Mental Health Act 2014* (Vic) and known as Forensicare) also provides clinical services. These are the only services permitted to provide compulsory treatment.⁷

Area mental health services are delivered under the governance of public health services throughout the state. The services they provide include: acute mental health treatment in hospital inpatient units; bed-based mental health services in the community; community-based clinical mental health services provided in clinics, by telephone and on an outreach basis to locations in the community; and consultation-liaison psychiatry.⁸

Area mental health services are aged-based and location based.⁹ The service framework established in the 1990s¹⁰ included 13 child and adolescent area mental health services for people aged under 18,¹¹ 21 adult area mental health services for people aged 16–64¹² and 17 aged persons area mental health services for people over 65.¹³ These services operate within geographic boundaries and, ordinarily, a person must live within the boundary of the 'catchment' to access the service. While the catchments have remained largely unchanged, age groupings and services now vary across the system. For example, in some areas, child and youth services extend to consumers up to the age of 25.

Statewide specialist mental health services include mother and baby units, eating disorder services, dual-diagnosis services (for people experiencing both mental illness and substance abuse), transcultural mental health services, and services providing treatment for people with a personality disorder.

Forensic mental health services provide treatment, care and support to people living with mental illness who have come into contact with the criminal justice system.¹⁴ These services are delivered by Forensicare.¹⁵

Consultation-liaison psychiatry teams work with other practitioners treating people living with mental illness in general hospitals, as well as providing direct support to people who have been admitted to a general hospital setting and may require services and supports related to mental illness.¹⁶

Public specialist mental health services have traditionally included psychosocial support services (known as mental health community support services) as well clinical services. However, many mental health community support services have transitioned to the NDIS, leaving the Victorian Government with responsibility for a relatively small range of psychosocial support services.¹⁷ In 2018–19 the Victorian Government provided interim funding for new psychosocial support services for people who previously received support but who are not eligible for the NDIS.¹⁸

3.1.4 Emergency and crisis services

Emergency and crisis services provide assessment, observation and, in the case of emergency departments and ambulance services, clinical treatment for people experiencing acute mental illness or a crisis affecting their mental health.

As discussed in Chapter 7, police and ambulance services are increasingly the first responders to people experiencing mental health crises or acute symptoms of mental illness. While police do not provide direct mental health services, they are an important part of the broader service system response for people living with mental illness. Police and ambulance emergency services triage and respond to mental health-related incidents or callouts, starting with a call to triple zero.

Joint initiatives between area mental health services and emergency services operate in some areas of the state. The Police, Ambulance and Clinical Early Response, or PACER, service is the best-known example.

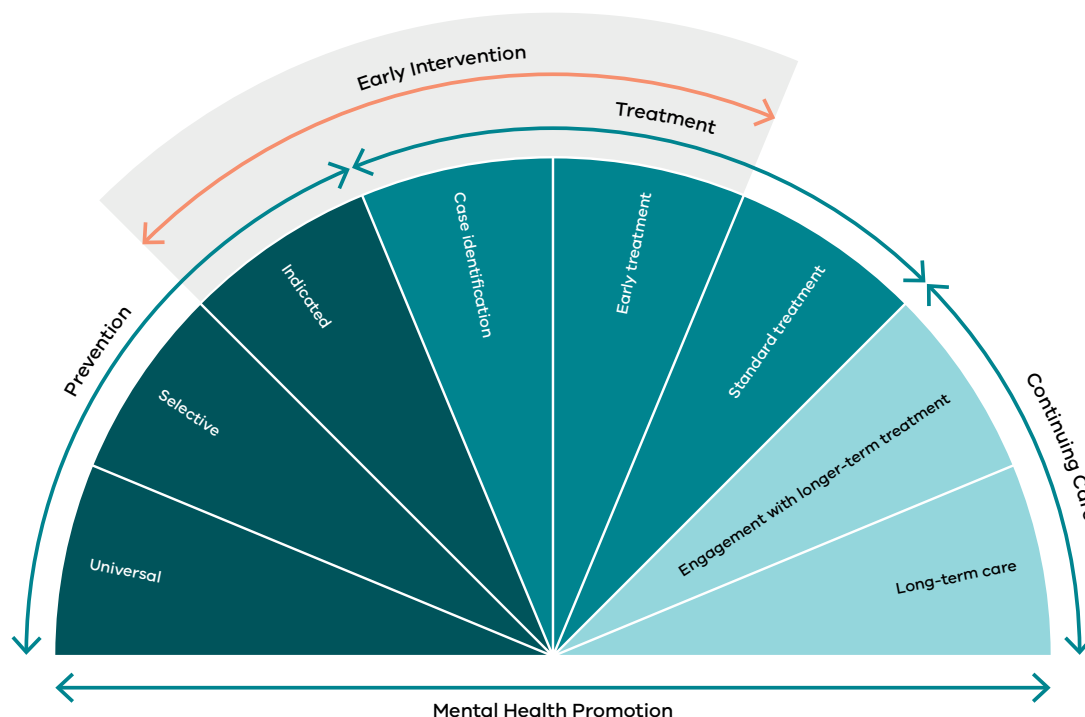
Chapter 7 describes the significant growth over the past decade in the number of people presenting to hospital emergency departments with mental health-related needs. Some emergency departments have specialised 'psychiatric assessment and planning units' or 'mental health and alcohol and other drug hubs' providing dedicated areas for assessing and treating people.

Responding to people experiencing mental health crises is also a function of mental health triage services, which are a component of public specialist mental health services. Most triage in mental health services is conducted over the telephone. The triage clinician's decisions determine whether the person requires further assessment and treatment and, if so, the type and urgency of the response required.¹⁹ The Statewide Mental Health Triage Scale is used to record the decision, which can include mobilising a response from police or ambulance services, or a referral to an emergency department or a mental health crisis assessment and treatment team in the community.²⁰

3.2 Spectrum of interventions

Across the mental health system, there is a spectrum of treatment, care and support—ranging from efforts to prevent mental illness in the general population to long-term care of people with established mental illness. Figure 3.5 depicts this spectrum.

Figure 3.5: Mental health promotion, prevention, early intervention and care



Source: Emerging Minds. Prevention and Early Intervention <<https://emergingminds.com.au/our-work/prevention-and-early-intervention/>> [accessed 1 November 2019]; Adapted from Patricia J. Mrazek and Robert J. Haggerty, *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research* (Washington, D.C.: National Academies Press, 1994).

Prevention programs can be universal (targeting the whole population), selective (designed to reach specific groups of people who may be more disproportionately affected by mental illness) or indicated (targeted at people who have minimal but detectable symptoms of mental illness).²¹

Universal and selective prevention are similar to mental health promotion. However, while preventing mental illness typically focuses on its direct causes,²² mental health promotion seeks to address the broad range of social, cultural and economic factors that influence mental health.²³ In practice, many prevention and promotion activities overlap.²⁴

Mental health promotion works by empowering people and communities with the knowledge and tools they need to change behaviour and create environments that support mental health and wellbeing.²⁵ Many individuals and local communities are engaged in activities to raise awareness and promote the importance of good mental health. Alongside these, the Commonwealth and Victorian governments fund a range of mental health promotion activities.²⁶ For example, VicHealth (a statutory body of the Victorian Government) promotes mental health and wellbeing across workplaces, digital and online environments, sports and physical activity settings, schools, and in the arts.²⁷

Early intervention includes prevention and early treatment. Early intervention can involve equipping people to deal with the signs and symptoms of illness or distress²⁸ and 'helping people as soon as possible once mental distress is identified'²⁹ to improve the prospect of recovery (for example, following exposure to trauma).³⁰ The Commission has heard much about the need to rebalance the role of public specialist mental health services so early intervention is more central to their work.

Early intervention spans the life course,³¹ which means there are opportunities to intervene early in the onset of mental illness regardless of age. However, the Commission has heard that early intervention in emerging mental health problems during childhood and youth can be particularly powerful in preventing or reducing the severity of mental illness in adulthood.³² Early intervention services include programs aimed at: supporting early childhood parental behaviours;³³ supporting children in families where a parent has a mental illness;³⁴ providing early treatment for anorexia;³⁵ addressing adolescent substance use;³⁶ and treating early psychosis.³⁷ There is evidence that such programs are effective in delaying and reducing the impact of mental illness.³⁸

The spectrum continues to treatment and continuing care, which primarily occur in clinical settings across the four types of mental health services shown in Figure 3.1 and 3.2.

3.3 Patchworked and fragmented services

The purpose of the mental health system has been described in different ways. Victoria's 10-year Mental Health Plan describes a single goal:

... that all Victorians experience their best possible health, including mental health. The Victorian Government is committed to creating a healthier, fairer and more inclusive society. That means good mental health for everyone, particularly people who are disadvantaged and vulnerable. It means that people living with mental illness get the same respect and opportunities as everyone else.³⁹

The National Mental Health Commission framed the main purpose of the mental health system in a slightly different way in its 2014 Contributing Lives report:

Even the most disadvantaged should be able to lead a *contributing life*. This can mean many things. It can mean a fulfilling life enriched with close connections to family and friends, good health and wellbeing to allow those connections to be enjoyed, having something to do each day that provides meaning and purpose—whether it be a job, supporting others or volunteering, and a home to live in, free from financial stress and uncertainty.⁴⁰

While Figure 3.1 may give the impression of a complete, coherent and navigable system of services designed to meet these goals, it should not. While the figure lays out the broad components of Victoria's mental health system, it is important to recognise that the system is not comprehensive—there are service gaps, insufficient services to meet demand, and inequities in who can access services. There is also insufficient integration between services in the mental health system and broader health, social and community services.

As discussed throughout this interim report, public and private mental health services are unevenly distributed and are often scarce in rural areas. Due to the complexity of the system, it is hard for people to know what services might be suitable and to navigate between different services. Further, as the Commission has heard consistently, services are too often unresponsive to the needs of people who seek help.

3.4 Missing steps in the continuum of care

The major framework for mental health systems in Australia today is the 'stepped care model'. As described in the Fifth National Mental Health and Suicide Prevention Plan, agreed to by the Commonwealth and all state and territory governments, stepped care approaches 'define the various levels of need, based on best available epidemiological evidence, along with the services required at each level'.⁴¹ Stepped care relates resource usage to individual and population need, beginning with a focus on self-care and individual community wellbeing, and advancing through various steps of resourcing based on stratification of need.⁴² One key element of a stepped care model, depicted in Figure 3.6, is that it attempts to align the highest cost care with those with the highest level of need.⁴³

Figure 3.6: A stepped care model for mental health, where services are matched to individual need, as outlined by the Fifth National Mental Health and Suicide Prevention Plan, 2017



Source: Australian Health Ministers. Fifth National Mental Health Plan. Canberra: Commonwealth of Australia, 2017.
 Estimates of prevalence derived from National Mental Health Service Planning Framework modelling (unpublished)

The service types shown in Figure 3.2 do provide increasing intensity (that is, services in the left column are generally less resource intensive than those in right-hand columns).

In reality, although Victoria's mental health system may have some features of a stepped care model, there are large gaps between different types of services—meaning that consumers frequently experience poorly coordinated and discontinuous care.

The Victorian Government recognised in its submission to the Commission that Victoria has 'not been able to achieve a true model of stepped care'.⁴⁴ The government's submission identifies two major deficiencies that place Victoria's mental health system at odds with a true stepped care model:

The system's heavy focus on inpatient and crisis care means that we are missing opportunities to intervene earlier using an evidence-based approach.⁴⁵

For a person trying to access mental health treatment and support, unclear referral pathways and inadequate coordination can result in them being bounced around the system—or missing out on the care they need altogether.⁴⁶

The result is a system that is increasingly crisis-driven and reactive, that can create a 'revolving door effect', and that sees interventions failing to address the underlying causes of mental illness. The barriers to accessing treatment, care and support in Victoria's current mental health system are explored further in Chapter 7 of this report.

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 - 18 Victorian Government, *Submission to the RCMHS: SUB.5000.0001.0001*, p. 8.
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Chapter 4

Origins of the current system

Reflecting on the history that has led to the current state of the mental health system in Victoria is critical in considering how the future mental health system is designed. Learning from past mistakes and preserving the features that are valued, amid an ever-changing context, are important to framing pragmatic and sustainable reform.

The interpretation of this history must be considered from the perspectives of people living with mental illness, families and carers—in understanding both how the system has failed people and the positive features that have been advocated for.

The previous decades reflect significant social change, including deinstitutionalisation, strengthened human rights and the growth of the consumer movement, that has led to the promotion of recovery-oriented and trauma-informed practices and strengthened 'choice and control' in the disability sector. The Commission's analysis must be considered within this context so that reform not only meets current shortfalls but is responsive and adaptable for future generations.

This chapter discusses Victoria's mental health system and the historical, social and political factors that have influenced it, including deinstitutionalisation, the legal framework and changes in mental health service delivery.

4.1 The unrealised vision of deinstitutionalisation

Mental health services have a long history in Australia, with most states establishing 'asylums' in the mid-1800s. The asylums were premised on the concept that the best way to 'care for people with mental illness was in a protected, segregated environment'.¹ This approach began to dismantle in the 20th century as it started to be seen as paternalistic and dehumanising. Whether these attitudes have been systemically eroded, however, is considered throughout the report.

4.1.1 History of deinstitutionalisation

Victoria's current mental health system reflects the 20th century movement generally referred to as 'deinstitutionalisation', which developed in the United States after World War II.² The word describes the movement away from standalone asylum-style institutions towards integrated, community-based care backed by specialist hospital services.³

In Victoria the system has its origins in the era of asylums in the 1840s. These were established for people with severe mental illness or disabilities; some of whom were committed to such institutions.

The first permanent facility built for treating people with mental illnesses and disabilities was the Yarra Bend Asylum, opened in 1848.⁴ Located in what is now inner suburban Fairfield, the asylum was just beyond where the Thomas Embling Hospital (a forensic mental health facility) is now located. A solitary bluestone gatepost is its only visible reminder. Before Yarra Bend was established, some people living with mental illness were accommodated in gaols.⁵

Other large institutions followed including asylums at Kew, Ballarat, Ararat, Beechworth and Sunbury.⁶ The term 'asylum' was abandoned in the early 1900s in favour of 'hospital', and institutions moved to a model of care that involved more than just detention. Aradale at Ararat, Mayday Hills at Beechworth and Willsmere at Kew were later incarnations of the old asylums. Other facilities, such as Larundel Psychiatric Hospital at Bundoora, came later again. Many of these institutions were run by the state and were built in rural settings, often with farms attached with the aim of providing treatment in a natural environment and therapy through occupation. They were still, however, environments that impinged on people's individual freedoms.

By the second half of the 20th century, maladministration, under-resourcing, overcrowding, abuse and harassment were common in psychiatric institutions across Australia.⁷ There was also widespread ignorance about mental illness and stigma attached to people living with mental illness,⁸ which still prevails today.

Several factors encouraged deinstitutionalisation. These included the introduction of antipsychotic and other medications in the 1950s,⁹ the underfunding of state institutions, the uncovering of inhumane treatment and abuse that occurred within those institutions,¹⁰ and the development of community psychiatry.¹¹

By the 1980s, in addition to the large psychiatric institutions, general hospitals and aged care facilities were also providing mental health services. Psychiatric institutions provided care for people with severe mental illness (particularly psychosis), while general hospital wards focused on treating high-prevalence disorders such as depression and anxiety. Other services treated children and young people. The private system also offered treatment.

In March 1983 the New South Wales Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled ('the Richmond inquiry') recommended that the New South Wales Government 'fund and/or provide services which maintain clients in their normal community environment' and 'progressively reduce the size and number of [public psychiatric hospitals] by decentralizing the services they provide'.¹²

The Richmond Report prompted major reforms, not just in New South Wales but also in Victoria from the mid-1980s onwards. In 1988 Victoria closed the Willsmere Psychiatric Hospital (originally the Kew Asylum, opened in 1872). This was the first closure of a standalone psychiatric hospital in Australia.¹³ A driver for deinstitutionalisation in Victoria was to humanise care and improve services for people living with mental illness.¹⁴

Although there was community concern about the abuses uncovered in psychiatric institutions,¹⁵ support for deinstitutionalisation was not universal. Some were apprehensive about the implications of people living with mental illness moving into the community and the possibility of inadequate care being provided for them.¹⁶

4.1.2 The national mental health agenda

Nevertheless, there was enough social and economic pressure to compel governments to rethink the effectiveness, and for some the humanity, of confining people living with mental illness to institutions.

By the early 1990s all Australian governments had come together to agree on the need for reform as a matter of national priority. The cooperation marked the first of many national approaches to mental health. State and territory health ministers, with acknowledgement from the Commonwealth, agreed to the goal of closing standalone psychiatric institutions and providing necessary inpatient care in psychiatric wards co-located with general hospitals. In April 1992 all Australian health ministers agreed to the National Mental Health Strategy for an initial period of five years.¹⁷

National cooperation has been evident through successive national mental health plans since then. The Council of Australian Governments Health Council endorsed the Fifth National Mental Health and Suicide Prevention Plan, and its supplementary implementation plan, on 4 August 2017.

National inquiries have also influenced the development of and reforms to Victoria's mental health system, albeit with varying practical and long-lasting effect. In 1993 the Human Rights and Equal Opportunity Commission conducted its National Inquiry into the Human Rights of People with Mental Illness and found numerous and serious breaches of human rights.¹⁸ Among subsequent national inquiries are those of the Mental Health Council of Australia, the Brain and Mind Research Institute and the Human Rights and Equal Opportunity Commission;¹⁹ the Senate Select Committee on Mental Health;²⁰ and the National Mental Health Commission.²¹

Strikingly, many issues raised throughout these inquiries are still relevant today. The Obsessive Hope Disorder Report proposes that, since the Human Rights and Equal Opportunity Commission 1993 inquiry, the same problems still exist, and good intentions have not led to effective and sustained improvements.²² Examining why reforms have not been implemented or sustained is one of the Commission's key considerations as recommendations for pragmatic and sustainable change are developed.

4.1.3 Victoria's 1994 mental health framework

In the context of the national movement to dismantle institutions, in 1994 the Victorian Government released a statewide framework for 'mainstreaming' mental health services within the health sector, with a focus on funding and providing community treatment and support.²³ The philosophy was that:

A comprehensive mental health service must encompass services which cater for both acute episodes and long-term care. It should include inpatient, community, and home-based care options. Integration of service delivery is required to ensure continuity of care so that clients can move between service elements as their needs change and receive the most appropriate service response at any time.²⁴

The framework proclaimed that improvements in facilities, treatment and care for people living with mental illness were to be among the highest priorities for the Victorian Government. The benchmark for mainstreaming arrangements was that the same high standards as were expected in the general health system were expected for mental health.²⁵ The aim was to decrease the reliance on separate psychiatric hospitals, expand general hospital psychiatric units and develop treatment and other services available in community-based settings.²⁶

As part of this, adult mental health services were established on a local area basis across Victoria, with each linked to a general hospital.²⁷ With the exception of forensic mental health services, between 1994 and 1995 the general health system took over management of all government-run mental health services, generally referred to as 'mainstreaming'.

The reform was large in scale and prominence. The Commission was told, the then health minister, the Hon. Marie Tehan, announced that she was 'prepared to be judged on her performance as health minister by what was achieved solely in mental health'.²⁸

Equity and improved quality was accompanied by an economic incentive for these reforms because state-run institutions were expensive to maintain. The Hon. Robert Knowles AO, a former Victorian minister whose responsibilities included the health and aged care portfolios, told the Commission that the government determined that it could in fact 'deliver more services, and better care, for less money'.²⁹

The program needed major capital investment—new acute, subacute and other residential services had to be constructed and premises built or leased for community-based services.³⁰ This was facilitated by the Commonwealth-funded Building Better Cities Program, a national initiative to promote urban development and sustainability that provided the capital funding for fit-for-purpose community-based facilities.³¹ With that support, closing the psychiatric institutions provided an opportunity to reduce the costs of inpatient care and to redirect funding towards community-based services.

The plan also sought to support smoother transitions of people from hospital back into community living following treatment.³² To achieve this, the framework defined the roles and functions of area mental health services, aged persons' mental health services and child and adolescent mental health services, each covering a specific geographic area and linked to a general hospital.

The pace of change was rapid. By 2000, 14 psychiatric institutions had been closed and the savings targeted for reinvestment in new services such as inpatient facilities, residential units, community treatment teams and support services.³³

The significance and scale of the changes surrounding deinstitutionalisation cannot be overestimated. As Dr Neil Coventry, Chief Psychiatrist, Department of Health and Human Services, told the Commission:

Victoria has reason to be very proud of leading the nation in the major reform of the specialist mental health system which brought people out of institutions and into the community.³⁴

4.1.4 An unrealised vision

Despite many examples of good practice, there is now a vast gulf between the aspirations of deinstitutionalisation and the current state of Victoria's mental health system. People are no longer held in the institutions of the past, but the system functions in a state of crisis, and the principles intended to reflect the foundations of the earlier reforms are compromised by the pressures of resourcing and demand.³⁵ And while institutions no longer exist in name, there is increasing concern that many people living with mental illness are disproportionately represented within similarly restrictive internments such as prisons.

Broad trends have affected community needs across Victoria. These include a burgeoning population, emerging and growing needs of different demographics resulting in increased demand, homelessness and lack of public housing, the 'ice epidemic', cost-of-living increases and growing social isolation.³⁶

In this context—and in the absence of enough investment to provide the capacity required within the system—it is unsurprising that the objectives of the 1990s' reforms have not been realised and that the system has not evolved sufficiently to keep pace with the changing needs of the Victorian community.

The Hon. Robert Knowles AO told the Commission that:

*The mental health system has never been adequately funded. Often mental health seems to receive just the standard incremental funding increase each year, rather than getting the resources it actually needs.*³⁷

Victoria's trajectory is not unique. Despite the scale of the reforms and the optimism of the 1990s, subsequent independent reviews have continued to point to shortcomings in mental health services throughout Australia.³⁸

Poor access to services, a lack of continuity of care and concerns about human rights have been consistent findings³⁹ and still remain ubiquitous today.

A recurring theme in the evidence the Commission has received is that the principles reflected in the reforms of the 1980s and 1990s remain sound, but that in some important respects the current system is no longer faithful to the original plan.⁴⁰

The current system has not achieved the benefits hoped for, particularly in developing stronger community-based services.

Community-based care

The 1994 Victorian mental health framework positioned community-based care as the first treatment option.⁴¹ Community-based services were expected to help stabilise acute illness, help people prevent or manage relapse, and support recovery by connecting individuals to health, community, education and vocational services.

Now, however, two central components of the community-based system are provided inconsistently: crisis assessment and treatment teams, which provide short-term early intervention and early discharge management; and assertive community treatment teams, which were intended to provide longer term intensive mobile support and outreach to people with urgent and complex needs.

In many area mental health services, these two types of teams have been merged with continuing care teams to provide a more 'generic' service. The principal motivation has been budgetary pressure, and the result has been a dilution of the system's capacity to provide intensive treatment to people with complex needs outside of a hospital setting.⁴² As a result, people in crisis often get an emergency service response instead of a therapeutic, holistic, community-based one.

Associate Professor Dean Stevenson, the Clinical Services Director at Mercy Mental Health, told the Commission:

There has been a shift from community care to acute inpatient based care. The original community care focused model had a solid basis with assertive outreach, acute assessment in community and case management. We have lost the opportunity to further develop this model, instead dismantling it and pivoting towards a blended model in community teams with mixed functions.⁴³

This has been accompanied by a focus on medication and risk management⁴⁴ and a loss of support to the primary health care sector, in part through dismantling primary mental health teams within services.⁴⁵ Ultimately, people living with mental illness, their families and carers, are not receiving the right type of support where and when they need or want it.

Mainstreaming

In conjunction with a move to community-based care, the 1994 framework also aimed to mainstream mental health services. Its implementation, however, has been inconsistent and in some instances has led to adverse outcomes.

The concept of mainstreaming embraced the desire to 'reduce the relative isolation of mental health services and thereby reduce consequential stigma and neglect that applied to those services and the people using them'.⁴⁶ The intention was to incorporate the 'overall management of mental health services in the same framework as the general health and welfare system'.⁴⁷ In general, mainstreaming involved co-locating services while retaining some level of internal segregation, therefore retaining a distinct specialist service.⁴⁸

Mainstreaming has resulted in some benefits. Barwon Health submitted that it has helped reduce the stigma associated with mental illness and, among other things, enabled mental health to be part of a larger health service—for example, in initiatives in workforce development, research, infrastructure development and clinical and corporate governance. Mainstreaming also fundamentally recognises mental health as a crucial component of health.⁴⁹

Many leaders in the Victorian mental health system, however, consider that the key benefits of mainstreaming have not been achieved. In short, integration has been patchy and incomplete. It has been described in the following terms:

There was hope that, with mainstreaming of services many years ago now, that we'd have much greater integration of physical and mental health support, but I guess that hasn't really happened and that's been a little disappointing.⁵⁰

Mental health services and non-mental health (physical health) services within the general hospital, however, remain very separate and the potential benefits of more close working relations have not yet been realised.⁵¹

Even though our mental health acute and aged program is located within the same building as the other acute physical health services, the mental health service is not sufficiently integrated with the rest of the health service [...] For some reason, mental health services remain distant and are not well integrated within the public health system.⁵²

With mainstreaming, general hospitals increased their focus on treating people living with severe mental illness, in the process giving less priority to providing treatment and care for people with high prevalence disorders. Dr Coventry described this change:

Prior to mainstreaming of gazetted beds in stand-alone mental health institutions into general hospitals in the 1990s, large general hospitals across the state also had small in-patient and community psychiatry services [...] Those units developed particular expertise in high prevalence disorders and offered a variety of psychological treatments and were rich training and education grounds for the multi-disciplinary workforce. With mainstreaming and the amalgamation and integration of gazetted and non-gazetted beds and services from the large mental health institutions, the service focus shifted to treating consumers under compulsory orders. Consumers with higher prevalence disorders who required psychological treatments were gradually forced out of the system.⁵³

While mainstreaming may be a valuable objective, system leaders point to how mainstreaming has been poorly implemented within the Victorian system.

Some system leaders consider that the unrealised benefits reflect governance decisions—particularly in relation to the level of integration of mental health and general health, from the ministers through to service management. Their assessments include the following:

The appointment of a separate Minister for Mental Health may have suggested an increased focus on services for mentally ill people, the separation from Health may have led to less focus by government on clinical mental health services.⁵⁴

The separate branches within [the Department of Health and Human Services] and their different approaches to system management have contributed to the lack of interaction between non-mental health and mental health services, and to the slower rate of growth funding in mental health compared to non-mental, physical health.⁵⁵

The separate governance of mental health and physical health within health services has also contributed to the limited interaction and integration [...] a closer working relationship with non-mental health services and mental health services would assist in realising the potential of mainstreaming, and improve the outcomes of the increasing number of patients with physical illness and mental health issues, as well as outcomes of patients with mental illness.⁵⁶

The Commission will need to carefully consider these varied and systemic factors, particularly regarding accountability and system leadership.



Public hearings: Melbourne Town Hall

4.2 The legal framework

Underpinning the origins of the mental health system is Victoria's legislative framework that has evolved over recent decades. Legislation has existed in Victoria for more than 150 years, primarily to enable the compulsory detention and treatment of people living with severe mental illness.⁵⁷

Legislative framing can profoundly influence a service system, as it influences and enables policy and system design. As British legal academic Dr Clive Unsworth has pointed out, 'law actually constitutes the mental health system, in the sense that it authoritatively constructs, empowers, and regulates relationships between the agents who perform mental health functions'.⁵⁸

The way the criteria for involuntary or compulsory treatment have been framed in Victoria has changed over the years. In the 1950s the criteria were broad and the focus was on whether an individual was 'mentally ill and requires care or treatment'.⁵⁹ The Victorian *Mental Health Act 1986* tightened the criteria for involuntary treatment and introduced several other criteria that needed to be met, including whether the treatment was necessary for the individual's 'health or safety' or for 'the protection of members of the public'.⁶⁰ These changes were made with the aim of detaining and treating fewer people and using compulsory treatment as a last resort. The 1986 legislation also enshrined the principles of prevention, early intervention and accessible and comprehensive treatment.⁶¹

4.2.1 Current legislation

By 2014 new legislation had been enacted, with the intention of reflecting a stronger focus on human rights and recovery from mental illness. The objectives and principles of the Victorian *Mental Health Act 2014* are outlined in ss. 10 and 11 and summarised by Victoria Legal Aid⁶² as:

- a focus on least restrictive assessment and treatment, with the least possible restrictions on human rights and dignity
- a preference for voluntary assessment and treatment
- supported decision making—that is, a principle that people 'receiving mental health services should be supported to be involved in all decisions about their assessment, treatment and recovery'⁶³ and that their views and preferences be respected
- choice and respect and promotion of the rights, dignity and autonomy of people receiving mental health services
- providing mental health services 'with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life'
- responding to people's individual needs (including their health, culture, language, age, disability, religion, sexuality and gender).

The *Mental Health Act 2014* (Vic) handbook states that the Act 'seeks to minimise the use and duration of compulsory treatment to ensure that the treatment is provided in the least restrictive and least intrusive manner possible'.⁶⁴ The legislation outlines the criteria to be met and the principles governing treatment of people who have been clinically assessed as requiring treatment without their consent, either as an inpatient or in the community.⁶⁵ These criteria include assessing whether there is a need for treatment to prevent 'serious deterioration in the person's mental or physical health; or serious harm to the person or to another person'.⁶⁶

The *Mental Health Act 2014* (Vic) contains specific provisions regulating the use of 'seclusion'⁶⁷ and 'bodily restraint'⁶⁸ (sometimes referred to as restrictive practices) as well as the use of electroconvulsive treatment⁶⁹ and 'neurosurgery for mental illness'.⁷⁰ The Act does not regulate 'chemical restraint', which is defined, for example, in Tasmania's *Mental Health Act 2013* as 'medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition'.⁷¹

An emphasis on compulsory treatment in Victoria's *Mental Health Act 2014* means that many of its provisions do not apply to all Victorians with mental illness or to all aspects of the continuum of care.⁷² This contrasts with other legislative frameworks. For example, the Victorian *Disability Act 2006* grants rights to any individual who meets the criteria for disability and directs providers on the parameters for service delivery.⁷³

In a submission to the Commission, Victoria's Office of the Public Advocate proposed 'a broadening of the Mental Health Act with the objective of ensuring that mental health services are accessible to all'.⁷⁴

Despite the legislative emphasis on 'least restrictive practice' and protection of consumer rights, the Commission has heard from many individuals who have had negative experiences of compulsory treatment and restrictive practices. The rates of compulsory treatment and restrictive practices are of concern to the Commission and will be the subject of further consideration in 2020.

4.2.2 Human rights

Human rights conventions and legislation had an influence on the policies that informed the *Mental Health Act 2014* (Vic) and its implementation.

The framework for human rights in Victoria is described in the *Charter of Human Rights and Responsibilities Act 2006*. It aims to ensure that Victoria's laws, policies and service delivery have regard to everyone's human rights, freedoms and responsibilities.⁷⁵ Human rights are inherent to all human beings, regardless of status.

In 2008 Australia ratified the United Nations Convention on the Rights of Persons with Disabilities.⁷⁶ Article 1 of the convention includes those with 'mental impairments' within the term 'persons with disabilities,' and Article 4(1) requires that 'States Parties undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind'.

All people living with a mental illness are entitled to their full range of human rights. The Commission's principles that will guide its work are based in large part on the United Nations Convention on the Rights of Persons with Disabilities (Chapter 1).

4.3 Changes in approaches to mental health and service delivery

Beyond deinstitutionalisation and legal frameworks, broader changes in the approaches to mental health and service delivery in Victoria have also shaped the current system. These approaches are intended to adhere to a more holistic perspective, with emphasis on the individual and community-based treatment, care and support. These changes have signalled a shift in mental health promotion, a focus on recovery, trauma-informed care and practice, and the introduction of a greater emphasis on individual choice and control through the National Disability Insurance Scheme.

4.3.1 Public health and mental health promotion

As discussed earlier in the report, underlying the spectrum of mental health treatment, care and support is mental health promotion. Growing awareness of the role of social and economic influences on health has led to a focus on mental health promotion and prevention, both in Victoria and internationally.

In Australia in 2000, the mental health and physical health sectors came together to endorse the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health.⁷⁷ This provided a strategic framework and plan for action to promote mental health, reduce mental health problems and reduce risk factors for mental health problems.⁷⁸

The Victorian Health Promotion Foundation (VicHealth) contributed to international work in this area. In 1999 VicHealth was one of the first bodies internationally 'to develop and implement a specific framework for the promotion of mental health and wellbeing'.⁷⁹

Despite Victoria's leadership, it can be argued that mental health promotion and prevention continues to lag behind physical health promotion, both in awareness of its role⁸⁰ and of the evidence base for their contribution to overall health and wellbeing.⁸¹

As Professor Helen Herrman AO, academic and President of the World Psychiatric Association, outlined for the Commission:

I think it's something that is growing now, but for a long time the idea that the state of mental health in a person or in a community could be changed through the things that we do as a community has not been part of the activities or part—not really been part of our clinical training, not been part of the way that governments plan and practice or manage services.⁸²

Mental health and wellbeing is broader than the individual; it is linked to a number of interrelated factors that can include varying levels of support—from personal networks, schools, workplaces and communities. Considering mental health and wellbeing in the context of a broader framework will inform the Commission's ongoing work.

4.3.2 Recovery-oriented approaches

More recently, there has been greater emphasis and wider regard for recovery-oriented practices, with national reforms promoting its value. There is still further work to do, however, to ensure it is consistently applied and respected across services and workers.

As defined in the Victorian Government's 2011 Framework for Recovery-Oriented Practice:

... the aim of a recovery-oriented approach to mental health service delivery is to support people to build and maintain a (self-defined and self-determined) meaningful and satisfying life and personal identity, regardless of whether or not there are ongoing symptoms of mental illness.⁸³

Among other things, it emphasises hope and optimism about the future⁸⁴ as well as the principles of self-determination and personalised care.⁸⁵

In mental health, 'recovery' is understood more broadly than 'clinical recovery', whereby a person no longer has symptoms of illness. In mental health, it can mean 'personal recovery', through which a person claims their right to a better life regardless of whether the symptoms of mental illness are present.⁸⁶ Personal recovery can be defined as:

... a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and **contributing life** [emphasis added] even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Recovery from mental illness involves much more than recovery from the illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being; from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-determination; from the negative side effects of unemployment; and from crushed dreams. Recovery is often a complex, time-consuming process.⁸⁷

In 2008 the National Mental Health Policy adopted a recovery-oriented approach,⁸⁸ and the National framework for recovery-oriented mental health services was released in 2013.⁸⁹ Victorian mental health services have adopted elements of this approach, which is a fundamental consideration in service design.⁹⁰

The Victorian Government's 2011 Framework for recovery-oriented practice sets out the principles, capabilities, practices and leadership that should underpin the mental health workforce.⁹¹

In 2012 the National Mental Health Commission considered the recovery-informed concept of a 'contributing life' as the fundamental perspective to inform reform in mental health:

A Contributing Life is where people living with a mental health difficulty can expect the same rights, opportunities and health as those without a mental illness. Simply put, this is about having a good home, meaningful activity, valued friendships, proper health care and opportunities for education and training, all without experiencing discrimination due to having a mental health difficulty.⁹²

The importance of recovery-oriented practices has been consistently highlighted to the Commission. The Commission understands it is a critical aspect of enabling people to live full and contributing lives.

4.3.3 Trauma-informed care and practice

In Victorian mental health services over recent years, there has been a developing emphasis on trauma-informed care and practice.⁹³ This involves acknowledging the high prevalence of traumatic experiences among people living with mental illness.

While there is no universally accepted definition of trauma-informed care,⁹⁴ the practice recognises the neurological, biological, psychological and social effects of trauma and interpersonal violence.⁹⁵ It provides a strengths-based framework for care and treatment, emphasising 'safety, trustworthiness, choice, collaboration and empowerment'.⁹⁶ Trauma-informed care and practice also aims to ensure that service provision does not result in re-traumatisation.

Achieving trauma-informed care and practice requires recognition and an understanding of all types of trauma and for this to be incorporated into all aspects of services.⁹⁷ Physical spaces need to be stabilising and reassuring, services need to be organised appropriately, and organisational cultures need to be personal, holistic, creative, open, safe and therapeutic.⁹⁸ Also required is the availability of treatment options, including psychotherapy, and recognition of the importance of therapeutic relationships.⁹⁹

The Australian Institute of Family Studies highlights that efforts to incorporate trauma theory into mental health and other service delivery have been led by institutes in the United States.¹⁰⁰ The history of trauma-informed practice can be traced back to the first introduction of post-traumatic stress disorder as a diagnosis in 1980 in response to the symptoms presented by veterans of the Vietnam War.¹⁰¹ Over following decades, recognition of trauma has expanded to include a broader range of traumatic experiences such as family violence and childhood abuse.¹⁰²

In 2013 the Victorian Government released the Framework for Reducing Restrictive Interventions.¹⁰³ The framework aimed to ensure services would avoid practices that may trigger previous experiences of trauma, particularly the use of seclusion and restraint.¹⁰⁴

Victoria is also developing the Framework for Trauma Informed Practice to build enhanced and consistent ways of working with people experiencing trauma across child and family services, including family violence services.¹⁰⁵

The Commission acknowledges that significant work is required to embed trauma-informed care throughout Victoria.

4.3.4 National Disability Insurance Scheme

A significant change in the approach to service delivery has been the introduction of the NDIS. This has had implications, for better and worse, on mental health services. The experience of people living with mental illness, their families and carers and the NDIS is explored in Chapter 8.

The scheme aims to give people with disabilities control over the design and delivery of their care and represents a fundamental change in how disability services are funded and organised.¹⁰⁶

The scheme is based on an actuarial insurance model, providing 'no fault' insurance to any Australian under the age of 65 years who is born with or acquires a physical, cognitive or psychosocial disability.¹⁰⁷ It has replaced block funding of disability services with an individualised service model in which eligible Australians are allocated a funding package according to their needs and goals. Individuals can then use the funding to purchase the services and supports that most effectively meet their needs.¹⁰⁸

The scheme supports Australia's obligations under the Convention on the Rights of Persons with Disabilities. It also seeks to provide reasonable and necessary supports to people with disabilities and allow them to be confident that they will receive the care and support they need throughout their life.¹⁰⁹ Participants' choice and control are central tenets of the scheme.¹¹⁰

Since 2012 the Commonwealth Government, with the support of and joint funding from the states and territories, has progressively rolled out the NDIS across Australia. It is intended that the scheme will provide support for about 500,000 Australians with a permanent and significant disability.¹¹¹

The case for the scheme's introduction was based on evidence that disability services were 'underfunded, inflexible, fragmented and built around the needs of the service system, rather than those of individuals'.¹¹² Previously people had little choice or control over the services they could access; rather, this was decided by professionals, by government or by what was available locally. In addition, the funding, organisation and governance of disability services was complex and inefficient.

The NDIS rollout is resulting in major changes to psychosocial supports provided in Victoria by mental health community support services. As part of the rollout, a range of NDIS-funded supports, referred to as 'psychosocial supports', are replacing direct client services for those

who are eligible for the scheme.¹¹³ Historical Victorian Government funding (about \$77 million annually) for support to these programs now forms part of Victoria's contribution to the NDIS.¹¹⁴ On 1 July 2019 Victoria formally transitioned to the NDIS,¹¹⁵ with the transition of mental health community support services continuing into 2019–20.

The impact of the NDIS on the mental health sector, both positive and negative, is important to consider in the redesign of the mental health system.

4.4 Lessons for major reforms

This Commission's mandate to effect generational change in the Victorian mental health system comes a quarter of a century after the major reform brought about through deinstitutionalisation. Victoria's vision in the early 1990s was bold and ambitious. Much was achieved in the years that followed. But the consensus is that essential parts of the system as then envisaged have been dismantled under the weight of demand pressures.

The philosophy underpinning the 1994 mental health framework remains largely relevant today, but its implementation has been greatly compromised. As outlined above, in important respects the goals of deinstitutionalisation remain unrealised.

The Commission's task is not to patch and repair gaps but to enable and lead the creation of a new system that responds to current realities and the needs of future generations.

Nevertheless, an appreciation of the historical and contemporary context in which this Commission's work sits is instructive. To inform its re-envisaging of the mental health system the Commission has sought to understand what catalysed major change in the 1990s, what strengths of the original vision are unrealised, what factors have impeded the implementation of that vision and what other major factors define the origins of the current system.

The lesson from the vision of deinstitutionalisation is that major reforms require strong leadership, investment at a commensurate scale, multi-layered cooperation between governments and services that are adaptive and responsive to the community's changing expectations.

What is developed and put in place now will only serve future Victorians if it is agile, capable of continuous improvement, made accountable to self-reflective leadership and is sustained by funding that is stable, growing and enduring.

The Commission agrees with the assessment of Associate Professor Simon Stafrace, Program Director of Alfred Mental and Addiction Health, Alfred Health, that:

The system is achieving exactly the results it was set up to achieve, every time a decision was made to take funding out, without keeping track of its impact on patients and their families. It is achieving the results it was set up for, every time decisions were made to fragment the system further by introducing elements that linked poorly with one another and that were not integrated with the broader health system of preventative primary health [...] every time we turned a blind eye to deteriorating hospitals, the sub-standard accommodation, the homelessness, the poverty and the violence that is all too common an experience for people with severe mental illness [...] We all have a hand in where we are today.¹¹⁶

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- 108 Warr and others, pp. 12–13.
- 109 *National Disability Insurance Scheme Act 2013*, ss. 3(1)(a) and (d) and (4)(3).
- 110 *National Disability Insurance Scheme Act 2013*, ss. 3(1)(e) and (4).
- 111 National Disability Insurance Agency, p. 6.
- 112 Warr and others, p. 12.
- 113 *Witness Statement of Dr Neil Coventry*, para. 65.
- 114 Victorian Government, *Submission to the RCMHS: SUB.5000.0001.0001*, July 2019, p. 8.
- 115 National Disability Insurance Agency, p. 11.
- 116 *Witness Statement of Associate Professor Simon Stafrace*, paras 146–148.



Chapter 5

System foundations in need of reform

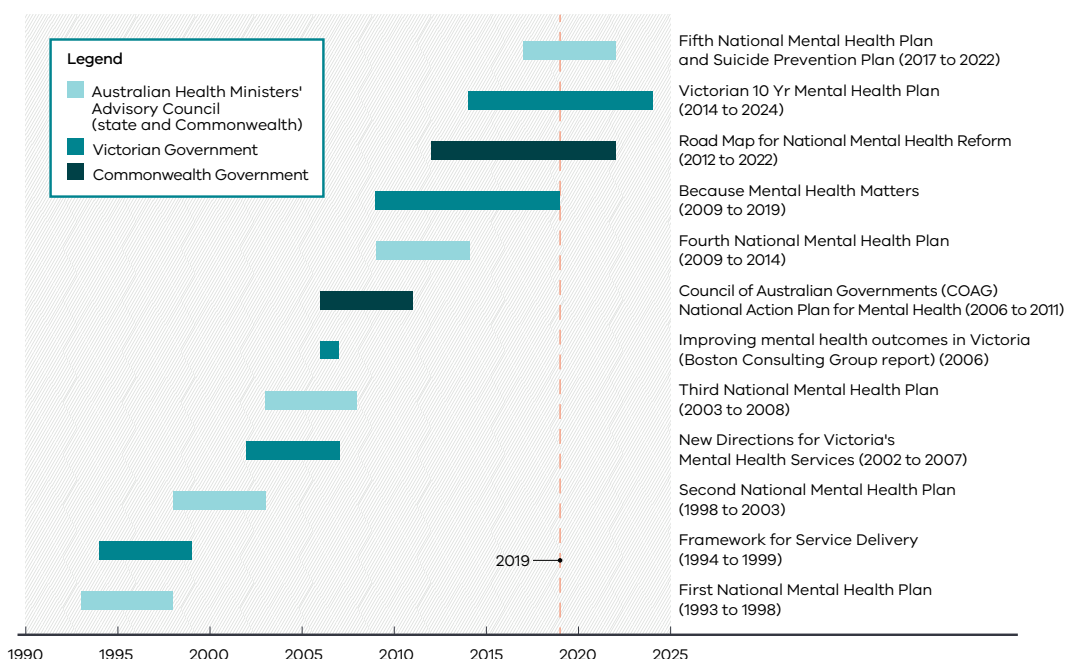
Victoria's mental health system must have strong foundations if it is to function well and keep pace with changing needs and expectations. Strong foundations create the conditions for a system to be shaped, re-shaped and sustained. They are informed by accurate data and information, with clear roles and responsibilities across the entities involved in mental health and overseen by strong system stewardship. These foundational aspects are fundamental to implementing reform and driving ongoing improvements in a way that is accountable.

While this chapter considers systemic and structural challenges, the adverse impact is always most deeply felt by people living with mental illness, families and carers. When there is a fragmented service system, people living with mental illness can fall through the cracks; when there is inadequate system monitoring, services are not shaped by the experiences of people living with mental illness; and when mental health is de-prioritised, best practice treatment, care and support is compromised.

This chapter outlines some of the major structural problems affecting the mental health system, including lack of clarity in Commonwealth and Victorian government roles and responsibilities, impeded system planning, limited system monitoring, accountability and system stewardship, and the de-prioritisation of mental health.

There has been no shortage of inquiries, reports and policies on mental health. As shown in Figure 5.1, since the early 1990s there have been at least 12 Commonwealth or Victorian government 'strategic plans' for mental health.

Figure 5.1: Plans and reports relating to Victoria's mental health system, 1990 to date



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

While these strategies have contributed to an evolution or change in some services since deinstitutionalisation, the Commission considers that many reforms—implemented as pilots or responses to specific cohorts or geography—have not delivered on wider ambitions.

Successful reforms to the structural foundations underpinning Victoria's mental health system are essential to clarify responsibilities for funding, governance and service delivery. This will ensure the service system is properly planned, monitored and regulated to achieve improved outcomes for people living with mental illness, families and carers.

The Productivity Commission's recent mental health inquiry draft report has reached similar conclusions.¹ Going forward, the Royal Commission will consider the Productivity Commission's draft recommendations as part of its own examination of the required changes to rebuild the structural foundations of Victoria's mental health system.

5.1 Commonwealth and state roles

The complexity and fragmentation of the mental health system is not a new issue; it has been discussed in the many other inquiries, reports, plans, policies and strategies on mental health mentioned above.² The consequences of this complexity negatively affect people living with mental illness, their families and carers, namely through service gaps and poorly coordinated services.

A major contributor to the system's complexity is the fact that no one entity has complete oversight or control of the mental health system. While numerous agencies deliver mental health services, such as public and private health services and non-government organisations, responsibility for funding and oversight is primarily shared between the Commonwealth and Victorian governments. These responsibilities are described below.

5.1.1 Service delivery and funding

Traditionally, the Victorian Government has been responsible for overseeing services for people experiencing severe mental illness.³ It has been described as the 'steward of the specialist mental health system',⁴ which provides clinical treatment and non-clinical support services in hospital, residential and community-based settings. Institutionally, this system-level governance is distinguished from service-level governance.⁵

The Commonwealth Government is responsible for services that cover a broad section of the population, typically catering for people experiencing mild to moderate levels of mental illness.⁶ It takes lead responsibility for commissioning primary care services and provides subsidised access to GPs and other health professionals (including psychiatrists and psychologists) via the Medicare Benefits Schedule and the related Better Access Initiative.⁷ The Commonwealth Government also subsidises mental health-related medicines via the Pharmaceutical Benefits Scheme⁸ and oversees the private health insurance sector.⁹

Other crucial parts of the mental health system have joint stewardship arrangements whereby service responsibility falls to both the Commonwealth and Victorian governments. These include prevention services, early intervention services and psychosocial services. Under the Fifth National Mental Health and Suicide Prevention Plan, the Commonwealth and state/territory governments agreed to share responsibility for improving mental health services.¹⁰

The complexity in service delivery responsibilities is matched by complicated funding arrangements (see Box 5.1).

Box 5.1

Funding of mental health services

Some parts of the mental health system are funded entirely by one level of government; for example, the Commonwealth has sole responsibility for the Medical Benefits Schedule and medications subsidised under the Pharmaceutical Benefit Scheme.¹¹

More commonly, funding for mental health services involves a pooling of resources across the Victorian and Commonwealth governments. This cooperation is governed by a series of agreements. The National Health Reform Agreement is the most significant agreement for mental health funding; as described by Mr David Martine PSM, Secretary of the Department of Treasury and Finance, this: 'enshrines that Commonwealth, State and Territory Governments are jointly responsible for funding public hospital services (including mental health services)'.¹²

Funding for community psychosocial services does not have a comparable overarching approach; it is shaped by a range of different agreements and projects delivered at each level of government primarily through non-government organisations. This, along with the significant change brought about by the National Disability Insurance Scheme (NDIS), has contributed to: 'a lack of definitive information regarding the number of [non-government organisations] receiving government funding, the amount of funding received, and the activities funded'.¹³

Nature of agreement	Mental health coverage	Size of funding commitment
National Health Reform Agreement		
The Commonwealth contributes 45 per cent of efficient growth (based on growth in volume of services provided and the national efficient price), capped at 6.5 per cent per year. The Victorian Government is responsible for service delivery and covering the final costs—this includes the remaining contribution and any increase above the growth cap.	Admitted and non-admitted mental health services—as determined by the Independent Hospital Pricing Authority. ¹⁴	In 2018–19 the Commonwealth contributed \$5 billion to all hospital services in Victoria, both mental health and general health, and the Victorian Government contributed \$6.3 billion of its own revenue. ¹⁵ This agreement is under negotiation for 2020–21 to 2024–25.
Bilateral Agreement on the National Disability Insurance Scheme		
The Victorian Government contributes a fixed annual contribution to the NDIS. The Commonwealth holds ultimate responsibility for service delivery and covering final costs. ¹⁶	Psychosocial disability supports for those eligible for the NDIS.	Victoria has a fixed annual contribution of \$2,586 million indexed at 4 per cent per annum. ¹⁷

Nature of agreement	Mental health coverage	Size of funding commitment
Bilateral Agreement on National Psychosocial Support Measure		
The Commonwealth provides funding and services through Primary Health Networks. The Victorian Government provides funding and services through the Mental Health Community Support Services Program.	Non-clinical mental health services, including for people ineligible for the NDIS. ¹⁸	The Commonwealth committed \$20.6 million over four years from 2017–18 to 2020–21. ¹⁹ The Victorian Government provides annual funding—for example, \$131.1 million in 2018–19 and \$120 million in 2017–18. ²⁰

The historical roles and responsibilities between the Commonwealth and Victorian governments have evolved and changed over time, with growing areas of overlap such as suicide and preventative mental health programs. While the Commonwealth has traditionally been responsible for strategic policy direction rather than delivering specialist services, more recently its role has expanded into different areas of service provision such as clinical mental health programs for young people via headspace.²¹ The introduction of the NDIS means that the Commonwealth Government is now responsible for administering the scheme, which provides psychosocial support services for people experiencing severe mental illness.

These changes in roles and responsibilities have unintentionally led to distorted lines of responsibility and accountability.²² As Dr Peggy Brown AO, a psychiatrist who has held a number of leadership roles in the mental health sector, told the Commission:

The mental health system is unnecessarily complicated by the fact that the differentiation between the respective responsibilities of the Commonwealth and the States has become increasingly blurred and, partially as a result of that, the system has become even more fragmented and possibly less accountable.²³

The Productivity Commission's recent draft report on mental health calls for a clearer division of responsibilities and better coordination between primary care (mainly Commonwealth-funded) and acute and specialist services (mainly state-funded). The Productivity Commission articulated: 'the lack of clarity about how both tiers of government share responsibility for mental health is an urgent issue that needs to be addressed'.²⁴ While acknowledging that some level of overlap is likely to remain, the Productivity Commission recommends that agreed roles and responsibilities of governments should form the basis of a new intergovernmental agreement on funding.²⁵

The ambiguities in oversight responsibility for the whole mental health system have contributed to the service gaps discussed in this report. These include the 'missing middle',²⁶ gaps in access and changed service arrangements for psychosocial supports as a result of many of these services transitioning to the NDIS.

The Commission has received extensive feedback on the barriers to integrated care and inefficiencies created by the current division of responsibility for mental health between the Commonwealth and state governments.

5.1.2 Service coordination and integration

Improved mental health outcomes depend on all parts of the system working well together. Within health, a person experiencing mental illness might rely on coordinated and continuous care across Victorian Government crisis and acute care services, Commonwealth-funded primary care services, and both levels of government for supports in the community.²⁷ They may require further support from a range of other services like housing or education.

Achieving integrated regional planning and service delivery was a key priority of the Fifth National Mental Health and Suicide Prevention Plan.²⁸ It is difficult to achieve, however, in a context where there is limited statewide system planning.

Dispersed funding arrangements and unclear roles and responsibilities contribute to a poorly coordinated service system. In a submission to the Commission, a group of mental health experts said that a lack of coordination between the Commonwealth and Victorian governments has contributed to an increasingly fragmented system:

Commonwealth monies [are] being expended on mental health in a manner that is not integrated with extant state-funded services: this leads to major problems in terms of dislocated care, complex care systems and lack of knowing who has responsibility for what.²⁹

Further, siloed funding and governance arrangements can lead to disorganisation and inefficiencies across the sector.³⁰ For example, the National Mental Health Commission submitted that a lack of coordination between governments has led to an uncoordinated and fragmented set of programs and policies on suicide prevention. This has resulted in a patchwork of solutions and duplication of effort.³¹

Current arrangements do not incentivise collaboration or integration between different parts of the sector.³² As South West Healthcare told the Commission:

Within the mental health sector there is prevailing confusion amongst consumers and service providers about the role and interface between state funded clinical health services and federally funded mental health packages. It is not always clear who services are targeted to, which leads to difficulty in navigating the mental health stepped care model.³³

The lack of coordination and integration was further articulated as such:

The delivery of mental health care in Victoria is a hotchpotch of numerous services, poorly co-ordinated and not staffed adequately. There are numerous services provided by the various area mental health services as well as a myriad of non-government organisations providing support roles. The services all have different names, that change from one area to another, the services change frequently and overlap one another. The referral processes are complicated and unclear. There is no or poor defining of roles and responsibilities in the care of an individual patient. There is enormous waste of scarce resources caused by this lack of organisation.³⁴

These system-level issues have harmful consequences for people living with mental illness, their families and carers, who require consistent and accessible treatment, care and support regardless of who the funder is.

5.1.3 Complexities for service providers

Having multiple layers of government involved in stewardship and funding of the mental health system has created a complex environment for service providers.

It was put to the Commission that the Commonwealth and Victorian governments fund mental health services in fundamentally different ways. The Commonwealth preferences funding based on a fee-for-service market-based system that is driven by individual need, while the Victorian Government tends to fund organisations to provide services within specified geographical areas and within capped budgets.³⁵ Associate Professor Ruth Vine, Executive Director of NorthWestern Mental Health, Melbourne Health, told the Commission:

There is a Commonwealth and state divide in relation to funding [...] These two do not sit easily together, especially when both are under pressure, such that funding is rationed to some extent.³⁶

In its submission to the Commission, Wellways concluded that different tendering, compliance and reporting arrangements across funding providers leads to administrative burden and duplication of effort.³⁷

5.1.4 Opportunities for better integration

Despite the complexities of the system, there is significant potential for governments to work effectively to improve mental health outcomes for Victorians. As Sane Australia told the Commission:

... if the Victorian Government is able to work constructively with the Commonwealth Government in a true spirit of bipartisanship, there is the very real possibility that Victorians could have access to the best mental health services in the world.³⁸

The Commission received examples of successful models of care based on integrating state and Commonwealth-funded services. For example, Alfred Health described how integration of the Commonwealth-funded headspace model of care with the state-funded specialist youth mental health service has been a positive example of collaboration, 'breaking down silos of practice'.³⁹

Similarly, Eastern Health explained how a Commonwealth-funded youth mental health service (the Youth Engagement and Treatment Team Initiative) has been a positive example of an effective partnership between both levels of government.⁴⁰

5.2 Inadequate system planning

Service planning is critical to appropriately preparing for the range of variables that influence service systems, such as changing and growing demand, particularly at the systemic and statewide levels. Effective planning builds the evidence base to demonstrate where funding and resources are required.

The mental health system has, however, not benefitted from consistent, integrated and sophisticated service planning—characterised by limited demand forecasting, fragmented planning across catchment areas, poor infrastructure planning and piecemeal approaches to previous reforms.

5.2.1 Statewide service planning

Increases of core service capacity to meet the needs of a growing and changing population will occur only if there is effective forward planning of the service system across the state. System planning involves broad considerations of population growth and of demographic, economic and technological changes, as well as associated service need analyses and demand forecasting by locality. Planning should seek to improve mental health outcomes and reduce inequalities in service access and experiences in accordance with the Victorian Government's health system design principles.⁴¹

A decade ago the Victorian Government acknowledged that:

Victoria does not systematically apply a planning model that links service responses to prevalence of mental health problems across defined areas. Nor do we currently link benchmarked levels of provision to expected benefits at a population level. This results in some unevenness in service capacity across the state, particularly for certain outer suburban and rural areas. It also results in many people falling through gaps between services.⁴²

In March 2019 the Victorian Auditor-General, in an Independent Assurance report to Parliament, found that there had been a lack of appropriate system-level planning for the mental health system over many years.⁴³ The Department of Health and Human Services did not challenge that conclusion.

In her evidence to the Commission, Ms Kym Peake, Secretary of the Department of Health and Human Services, outlined that the commissioning functions of the department begin with system-level service and infrastructure planning. Ms Peake reported that 'service planning must be adaptive to account for population growth, the fiscal environment of the time, new evidence and emerging models of practice'.⁴⁴

5.2.2 Demand forecasting

Effective service planning has also been constrained by limitations in the Department of Health and Human Services' ability to forecast demand. Mr Andrew Greaves, Victoria's Auditor-General, reported that the department's approach to *approximating* demand means that it does not adequately capture the extent of mental illness in the population and the true unmet demand for services.⁴⁵ The Auditor-General's recent report on access to mental health services states that the department lacks critical information to understand unmet demand, including information about people who contact mental health triage services but are not accepted for service provision.⁴⁶

As proposed by Mr Martine, 'forecasting demand [...] all comes down to ensuring you've got the right sort of data'.⁴⁷ The Victorian Government's submission called for a centralised capture of triage data to enable better monitoring of the 'gateway' to the specialist service system.⁴⁸

Further, the Victorian Government reported that projecting demand has been hindered by a lack of information or ineffective use of available information, which 'inhibits our ability to understand and meet demand for mental health services, with information critical to informing overall funding, capital infrastructure and service distribution'.⁴⁹ In the government's words, the 'current systems used to capture client and system performance data are no longer fit for purpose'.⁵⁰

The Commission was informed that the Department of Health and Human Services has begun work on demand analysis to identify the funding growth required to maintain service delivery, and that this work has supported recent increases in budget allocations for mental health.⁵¹

Without effective demand forecasting, unlike the wider health system, mental health has lacked the capacity to demonstrate unmet demand with system performance indicators that have political traction. For example, if a hospital's surgical capacity is consistently underfunded relative to demand growth, it quickly shows in indicators such as elective surgery waiting lists. In mental health there are no equivalent transparent waiting lists—people are not admitted to the system (registered) if their clinical need is not the most time-critical. That is, access thresholds simply notch up as the pressure on resources (beds, community team capacity and so on) grows.

5.2.3 Planning across catchments

Service planning is further constrained by geographic boundaries that inhibit systemic, statewide planning and forecasting. Public specialist clinical mental health services are responsible for providing services to people within defined 'catchment' areas. The boundaries of these catchments are not aligned with other Victorian health and human service areas, local government area boundaries or Primary Health Networks.⁵² In the metropolitan area, there are different catchments for adult, aged, and child and youth mental health services.

This causes access and navigation problems for people living with mental illness, families and carers, and makes it more difficult for governments and service providers to plan 'whole of life', integrated services for communities across the state. Currently the mental health services responsible for each catchment do their own planning and forecasting. The Department of Health and Human Services aggregates these plans, but there is no statewide plan to identify the type and distribution of services needed across Victoria.

Despite the department having received advice through several reviews on the need to reconceptualise or reconfigure the current approach to catchment areas for clinical mental health services,⁵³ they have remained unchanged.

5.2.4 Facilities planning

The Commission is concerned that there is no capital management plan for mental health services in Victoria. As discussed elsewhere in this report, consumers are often treated in mental health facilities that are in poor condition and unsuitable for delivering best practice treatment, care and support. Further, Victoria faces serious shortages of mental health inpatient beds in some areas.

The absence of a statewide capital management plan has undermined individual asset proposals. As noted by Mr Martine 'asset investment is considered in the context of overall service delivery objectives'.⁵⁴ Indeed, robust characterisation of service need is required at all stages of asset development, including at 'conceptualisation' and through the government's 'gateway review' processes.⁵⁵

The Commission received evidence that inadequate planning has led to marked underinvestment in the physical infrastructure for public mental health services.⁵⁶ The Victorian Government accepts that 'infrastructure for the mental health system has failed to respond to demand, emerging best practice and changing demographics'.⁵⁷

Few new facilities have been developed over the last 10 years when compared to medical facilities and several site-specific assessments have identified buildings accommodating mental health services to be in poor or very poor condition.⁵⁸

While there are some recently developed and very well regarded facilities built to new design standards for mental health inpatient facilities,⁵⁹ such as Mercy Mental Health's Clare Moore inpatient unit, many facilities were designed some decades ago and are no longer fit for purpose. These older facilities do not provide the therapeutic environments necessary to support mental health recovery.

5.3 System monitoring and accountability weaknesses

Measurement and monitoring of consumer outcomes and service performance are critical functions of system oversight. System planning and ongoing improvement must be based on what is working, or not working, to achieve the best outcomes for people living with mental illness, families and carers.

The Commission has received extensive evidence on current weaknesses in monitoring and measurement functions, as outlined below.

5.3.1 Measuring of consumer outcomes

Measuring treatment outcomes for people living with mental illness is critical for improving individual health and wellbeing and assessing the effectiveness of interventions. In Victoria, clinicians and individuals use a range of tools for this purpose, with different measurement scales used for children and adolescents, adults and older people.

For many years, Victoria has collected data on clinical outcomes for consumers of specialist mental health services using the Health of the Nation Outcome Scale.⁶⁰ While there has been an increase in completion rates (the percentage of acute adult 'cases' with completed HoNOS measurement increased from 64 per cent in 2017–18 to 84 per cent in 2018–19),⁶¹ there remains concerns about its effectiveness. Primarily, HoNOS is a clinician-rated tool rooted in a medical model; while it is important for planning purposes, it is limited in its ability to capture specific outcomes that matter to consumers, families and carers.

The Commission notes that a relatively new survey, the Your Experience of Service survey used to collect consumer, family and carer experiences of care in specialist mental health services, is being expanded to include questions about physical health⁶² and adapted for implementation in Primary Health Networks.⁶³

While measuring outcomes is a relatively straightforward process for one-off physical illnesses, it requires more sophistication to measure and monitor potentially chronic and episodic mental illnesses: this requires understanding consumers' longer term mental health and wellbeing, as well as psychosocial and general health improvements.

5.3.2 Measures of service performance

Mental health performance monitoring focuses too heavily on service 'outputs' such as activity, processes and program expenditure rather than service performance relevant to the community—that is, whether people can get the right services at the right time.⁶⁴

Overall, the Commission considers that current service performance measures do not effectively capture consumer outcomes. This information is vital to ensuring services are meeting the needs of people living with mental illness, families and carers while evolving to meet changing needs and expectations.

As Ms Georgie Harman, CEO of Beyond Blue, told the Commission:

... we're collecting lots of activity data [...] the rates of re-admission and the lengths of stay in hospital for example [...] But that actually doesn't tell us [...] the outcomes for those people who have been through that system, and indeed, whether or not someone is alive or dead 12 months [...] those are the kinds of things that we actually don't measure because we have the inability to track people in real-time and to know whether or not an intervention actually worked: whether or not we put the social and the health supports around a person to enable them to cope and to recover and to live well and thrive in their community or not.⁶⁵

Ms Felicity Topp, CEO of Peninsula Health, informed the Commission that key performance indicators for state-funded mental health services provide little meaningful information about service deliverables, including quality of care and consumer outcomes,⁶⁶ or the ability of a service to meet demand or provide a full range of community-based services.⁶⁷ The usefulness of current performance monitoring is further diminished by the fact that there is little benchmarking between mental health services.⁶⁸

Similarly, the Hon. Robert Knowles AO, a former Victorian minister whose responsibilities included the health and aged care portfolios, told the Commission that the Department of Health and Human Services' performance measures do not measure outcomes, and that the Royal Children's Hospital has chosen to develop its own internal performance measures to do this.⁶⁹

The Commission also heard about the narrow focus of health services' Statement of Priorities, which is another key mechanism through which the Department of Health and Human Services monitors service performance. A Statement of Priorities gives the board and executive management of a health service an understanding of what the Victorian Government's priorities are for the upcoming 12 months.⁷⁰ Ms Topp proposed that the Statement of Priorities narrows the focus of the board on those specific priorities, such as acute physical health care, and does not adequately address, prioritise or measure the performance of mental health services.⁷¹ Adjunct Professor David Plunkett, CEO of Eastern Health, told the Commission that, until recently, Statements of Priorities have not consistently included specific objectives for mental health.⁷²

5.3.3 System performance

Mr Martine informed the Commission that the Victorian Government was working to improve its ability to link and analyse data collected across different government services to improve understanding of people's whole-of-life outcomes.⁷³

The Victorian Government has indicated its intention to shift its focus to measuring outcomes rather than outputs. It accepts that 'good public policy and service delivery must demonstrate its value to the community', including by measuring what it achieves and what impact it has, not just what it does.⁷⁴ In 2016 the Department of Health and Human Services developed an outcomes framework covering all its responsibilities.⁷⁵ A small suite of outcome measures for the mental health portfolio is now reported each year in the mental health annual report.⁷⁶

The Commission acknowledges the department's progress and notes that the challenge of capturing meaningful information about service delivery, system performance and outcomes extends beyond the Victorian Government. Writing in the *Medical Journal of Australia*, Dr Sebastian Rosenberg and Professor Ian Hickie point out that major Commonwealth Government investments in mental health, specifically the Better Access Scheme, operate with:

... little or no accountability at the practitioner or national policy level [...] A more intelligent response to mental illness means taking a broader view about how best to arrange quality care and then properly assessing the impact of that care on a person's life.⁷⁷

The Productivity Commission reached a similar conclusion in its draft report on mental health:

First, while there is strong clinical evidence that individual psychological therapy can be effective, there is little evidence on the overall effectiveness of the current MBS-rebated psychological therapy program (the Better Access program). The Better Access program should be rigorously evaluated as soon as practical to ensure that it is delivering cost-effective benefits for those who need it. Second, Better Access is poorly targeted.⁷⁸

5.3.4 Data and information

Inadequacies in information gathering and data collection across all levels of the mental health system also constrain system accountability and monitoring.

The National Mental Health Commission reported that Australia's ability to identify key challenges and pursue emerging opportunities in mental health is limited by poor information design and management. Across the system, information and data are incomplete, inconsistent and often inaccessible, and lacking a nationally consistent approach to outcomes measurement, collection and use.⁷⁹ The Commission also heard from the University of Melbourne that the data that are available and routinely collected may not be best utilised.⁸⁰

The Victorian Government informed the Commission that a redesigned client data management system, including a new centralised live information system, could support more active statewide monitoring, stronger forecasting of service needs and a reduction in the burden of documentation.⁸¹

An example of where data has been shared effectively is recent collaboration between the Coroners Prevention Unit and the Department of Health and Human Services.⁸² The Commission understands that the two agencies are working together to provide more timely and relevant information, including to health services, to assist in suicide prevention efforts.⁸³

Improved data sharing is important to understand consumers' needs and improving service coordination to meet those needs.

5.4 Underinvestment and poorly allocated funding

Past investment in the mental health system has been insufficient to provide enough treatment, care and support to meet the needs of people living with mental illness. The system has also been increasingly unable to meet its stated objectives for access and effectiveness—and so is providing many people living with mental illness, their families and carers with poor experiences.

The difference between the Victorian Government's investment in mental health relative to the level of demand for services has contributed to these issues. This challenge has been known for at least 10 years; a decade ago, in a mental health strategy for 2009–2019, the Department of Health and Human Services acknowledged that 'Demand pressures on specialist public mental health services are considerable [... and] the rate of involuntary admissions, bed occupancy levels and emergency department waits remain a cause for concern'.⁸⁴ The strategy document was also clear about the implications of population growth:

Action is needed, not only to address the current needs of the Victorian population but to plan for the projected numbers of people likely to be seeking help for mental health problems in 10 years' time.⁸⁵

Successive reviews have since clearly identified funding gaps.⁸⁶ In evidence before the Commission, Ms Peake said that while considerable growth funding had been allocated to mental health services in the 2017–18 and subsequent budgets, this had followed a period of zero growth funding over the preceding three years.⁸⁷ Ms Peake also acknowledged that until recently 'new funding has often been allocated to smaller initiatives to "patch up" service gaps, rather than to core service capacity'.⁸⁸

Part Four of this report details the extent of Victoria's underfunding of mental health relative to other Australian jurisdictions, the broader health sector and other service areas. The remainder of this section examines problems in allocating the available funding for Victoria's clinical mental health services.

5.4.1 Funding models

In addition to being significantly under-resourced, available resources are not being used in a way that offers the best value for money or that achieves the best outcomes for people living with mental illness. The Auditor-General told the Commission:

Victoria's public mental health services are subject to an input-based funding model, which is not sensitive to unmet demand, the needs and complexity of the mental health services' client cohort, contemporary population data, nor demographic changes.

The introduction of activity-based funding in mental health services has been on the agenda in Victoria for over five years and, although some reform has been proposed, without an adequate quantum of funding (and the staff and infrastructure required to deliver those services) there is a risk that the intended outcomes will not be achieved.⁸⁹

The Auditor-General was referring to the fact that the Victorian Government funds clinical mental health services to deliver a targeted number of 'bed days' and 'community hours', with levels of funding determined mainly by historical allocations. Unlike in other areas of health, activity-based funding has not been introduced and funding is not adjusted for

wide disparities in demand or the varying needs of consumers.⁹⁰ The current mental health funding arrangements are unresponsive to changes in the population and inflexible to the needs of different groups or individuals.⁹¹

In information provided to the Commission, a project plan from March 2019 regarding clinical mental health funding reform from the Department of Health and Human Services notes:

These funding arrangements do not promote efficient use of available budgets, nor do they support new investment by government on the basis of demonstrable volumes of demand for demonstrable volumes and types of service delivered.⁹²

One consequence of the current funding model is growing inequity in levels of funding between different areas of the state. Some services have experienced substantial growth in demand, including as a result of population growth, without equivalent growth in funding. For example, the population served by NorthWestern Mental Health has, in the past decade, increased to the extent that 'on a per capita basis, our funding, bed stock and equivalent full-time positions have declined. We have failed to keep up with demand or to provide services of equal quality'.⁹³

The current funding model (as well as activity-based funding) provide no financial incentives for services to improve outcomes for consumers. Rather than simply adopting activity-based funding, the Commission received submissions arguing that the mental health funding model could be linked to services' success in improving consumer outcomes, as well as the level of activity they deliver.⁹⁴ However, in his evidence to the Commission, Mr Martine reflected on the difficulty of linking funding to outcome measures:

The measurement of outcomes remains complex. This is partly because the output model is focussed on the activities and services delivered, with reporting on agreed performance measures generally framed around a financial year. Outcomes are often measurable only over a longer timeframe, particularly to test the impact and sustainability of gains over time.⁹⁵

While the mental health funding model in Victoria has remained essentially unchanged since deinstitutionalisation,⁹⁶ recently the Department of Health and Human Services has undertaken work on funding reform.⁹⁷ The Commission understands that activity-based funding models for adult community mental health services are being considered⁹⁸ and that, over time, funding design may take account of consumer outcomes.⁹⁹

The Commission will consider funding models in 2020.

5.4.2 Cross-subsidisation

Due to a lack of transparency inherent in the current funding model, the funding allocated to public mental health care in Victoria has not always found its way from health services' budgets to services for people living with mental illness;¹⁰⁰ it has, at times, been co-opted for other purposes.¹⁰¹ Reflecting on his role as Minister for Health in the mid-to-late 1990s, Mr Knowles informed the Commission:

One of the suggestions which we (unfortunately) accepted was to roll funding for mental health into the overall funding of health generally. We ultimately found that this meant mental health services were starved of funding as the funding was swallowed up by physical health services.¹⁰²

Within mental health services, there has been significant cross-subsidisation from funds intended for community-based services to acute inpatient services. This is because the 'bed day' price that government pays health services for inpatient beds has been well below what it costs health services to deliver those services.

The Auditor-General noted that the Department of Health and Human Services only funds 62 per cent of the full bed day costs of a mental health acute bed compared with general health, where a general acute hospital bed is funded for 82 per cent of the full cost.¹⁰³ This estimate was endorsed by the Royal Australian and New Zealand College of Psychiatrists.¹⁰⁴

The Commission notes that recent price increases have improved the bed day price.¹⁰⁵ The adequacy of current bed day funding, however, requires further analysis.

The cross-subsidisation to inpatient services has contributed to the diminishing capacity of services in the community, which in turn has led to increased emergency presentations and a need for more inpatient treatment.¹⁰⁶ As Associate Professor Dean Stevenson, Clinical Services Director at Mercy Mental Health, explained in relation to Mercy Mental Health:

There's been a slow shift of resources within mental health services from the community to acute services which has left community services in a very difficult position of not having sufficient staff to provide or meet the case management needs of the people that we treat in our catchment area.¹⁰⁷

Similarly, Associate Professor Ruth Vine explained the position at NorthWestern Health:

Another driver of unmet need is that the under-funding of inpatient units is cross-subsidised by community teams. This means that community teams are much 'skinnier' than intended and that, for every clinician position that is lost from a community team to fund inpatient units, there is a loss of service availability to approximately 25 patients at any one time.¹⁰⁸

5.5 System stewardship and oversight

Whole-of-system stewardship is essential to the proper functioning of the mental health system. The Commission acknowledges that significant efforts appear to have been applied to mental health stewardship in recent times, stressing that the following examination is structural, not personal.

Ms Peake outlined in her evidence that the Department of Health and Human Services is responsible for supporting the foundations of the system.¹⁰⁹

We don't simply have a purchaser/provider relationship with the entities that are co-producing outcomes for people who have mental illness [...] we have a responsibility and a very significant role in working with consumer groups and with the providers of service to look at what are the best evidence and data to improve models of care, then to link that work on the design of models of care to the funding models that support those models to be delivered [...] but also that those service models are being appropriately delivered, right the way through ...¹¹⁰

It is the system steward's role to understand how the values and objectives of the system, as reflected in policy settings, are understood and are cascaded down throughout the entire system.¹¹¹ The department accepts that the functions of planning, resourcing and performance monitoring are critical to its role.¹¹²

The department, however, has historically struggled to move beyond the role of a commissioner of services in a payer–provider relationship to system steward.

The Auditor-General told the Commission that, in his view, the role of the department in a devolved service delivery environment warrants consideration. Reviews since 2005 point to a longstanding debate about the department's role, including whether it should be the systems steward or system owner in relation to service delivery.¹¹³

The Auditor-General's conclusion was that the findings of past reviews speak to:

... an ingrained culture, developed and reinforced over two decades, of not fulfilling the responsibilities that properly pertain to a system manager—either understood and accepted but not acted upon, or there remains debate and uncertainty as to what is the proper role of the department vis a vis health services.¹¹⁴

That conclusion is consistent with the entrenched nature of the problems discussed in this report. The department did not challenge this.

Where services are operating in crisis mode, it is even more difficult to find a balance in governance. As the Auditor-General said:

I [...] wonder how you can properly hold the health services to account, knowing that you haven't fully funded them to deliver the services you've asked them to deliver [...] While it is appropriate to say that the hospital is best placed to manage access [...] if they have to rob Peter to pay Paul to actually pay for that in a sense they are not best placed to manage access so that the system owner must take some accountability and responsibility for that.¹¹⁵

The Commission considers that the mental health system has struggled with the balance between system and local governance. As Ms Peake outlined, 'the relationship, or balance, between system and local governance ... is fundamental to achieving outcomes for clients and the community'.¹¹⁶

The Commission was told that the department is progressing work on its stewardship responsibilities and has made structural and resourcing changes to improve its capabilities in leading service and system improvements.¹¹⁷

Further, regulatory and oversight arrangements for the mental health system, including the Chief Psychiatrist, the Mental Health Tribunal and the Mental Health Complaints Commission, are fragmented.¹¹⁸ System reform presents an opportunity to reconsider the monitoring of service quality and safety and whether services are meeting the needs of consumers.

The Mental Health Legal Centre submitted that:

At present the mental health system operates under a disconnected web of oversight that does not allow for systemic issues to be identified and escalated or for statewide planning to take place.¹¹⁹

The centre called for changes to system-level governance to support monitoring, reviewing and driving improvements across the system.¹²⁰

5.5.1 Cross-government coordination

Another layer of complexity exists in the interactions within and between departments that have different responsibilities that relate and contribute to mental health. Interactions across sectors are also critical.

Several responsibilities are dispersed across the Department of Health and Human Services. Responsibility for mental health service stewardship and management, as well as legislative, funding and strategic policy development and implementation, is managed in one area of the department. Associated functions including relationships with regulatory agencies, capital planning and health promotion, which are delivered by other parts of the department.

The Commission heard that at times this creates confusion for executives in health services, and there have been calls for greater coordination. For example, Ms Topp told the Commission that a lack of coordination between different parts of the department makes it difficult to know who to discuss risk issues with and impedes decision making on mental health funding.¹²¹ Similarly, Mr Plunkett told the Commission that seeking funding from government requires communication with multiple areas.¹²²

Similarly, the Commission has heard of the need for greater cross-program coordination.

We found this program that was operating internationally, and we wanted to bring it here. So, we went to Health and we said, 'Hey look, we can bring this program to you and it's going to save you money and it's going to be effective.' 'No, no, go away, that's Housing.' So, we went to housing, and housing said to us, 'No, no, no, no, no, go away, go to mental health.' And that is exactly the same story over, and over, and over again.¹²³

Interdepartmental coordination is also critical, with opportunity to extend the collaboration into local government and other sectors. In presenting evidence to the Commission, Ms Emma King, CEO of the Victorian Council of Social Services, advocated for an approach to mental health that involves a range of government departments, local government and the private sector.¹²⁴ This desire for whole-of-government stewardship was reiterated in submissions and statements from across the sector, in acknowledgement that reform will not be achieved through the mental health system alone. For example:¹²⁵

Integrated [...] all of government response which recognises mental health needs to be managed across multiple platforms and departments. It is essential that government recognises the intersections between poor mental health and the punitive and discriminatory practices and policies of other government departments.¹²⁶

The Commission recognises the importance of strong and focused leadership for reform.¹²⁷ Therefore, institutional system stewardship, regulatory oversight and coordination will be a focus for the Commission's continuing program of work.

5.6 De-prioritisation of mental health

Shortfalls in mental health investment, and many of the structural problems highlighted in the preceding sections, have been identified in previous reviews over many years.¹²⁸ Nonetheless, increased funding and fundamental reforms addressing infrastructure planning, catchments, funding models and data collection have only just begun in Victoria, or not yet begun.¹²⁹

Mr Martine told the Commission that in a constrained resource environment it is difficult for governments because there are many competing demands.¹³⁰ He explained that:

The funding allocated to deliver services to the Victorian community reflects decisions that are made by Government, generally as part of the annual budget process, to implement the government of the day's objectives and priorities.¹³¹

Although government was clear that its expectations of timely access to care are no less for those living with mental illness than they are for people with other illnesses, Ms Peake acknowledged that general health services are much better placed to meet demand than mental health services.¹³²

The Commission sought the opinions of experienced system leaders, within and outside the mental health system, about why mental health has in the past been overlooked when government resources are allocated compared with other areas of health and many social services.

Ms Peake identified strong political leadership, community acceptability and the ability to quickly implement a service the community values as factors that help investments to be prioritised by government. In contrast, the perceived public value of services that are understood to be stigmatised tends to be discounted.¹³³ It was proposed that there is a lack of 'parity of esteem' between mental and physical health.¹³⁴ In her hearing evidence, Ms Peake accepted that stigma and discrimination are 'at the heart' of this imbalance.¹³⁵

Recent significant increases in funding for Victoria's mental health system have been attributed to the priorities set by government,¹³⁶ facilitated by strong political leadership and 'recognition within the community about the pressure the mental health system is under'.¹³⁷

Ms Peake's evidence raises several themes, outlined below, that were expounded by other experts and examined in the research literature.

5.6.1 The role of stigma

Evidence presented to the Commission suggests that the community's attitudes towards people experiencing mental illness deter people from wanting to pay for their care and reduces the willingness of policymakers to invest in mental health. For example, one submission noted:

Services and research funding are not fairly distributed based on need—I see 'physical' health conditions such as cancer receiving disproportionately larger funding and world-class health services, when the need is much greater for mental health. The stigma is top-down and until the Government leads by showing parity and fairness, the people with mental illness will feel stigmatized. Until the message that mental health IS health, then we are never going to reduce stigma.¹³⁸

Dr Chris Groot, a lecturer in the Melbourne School of Psychological Sciences at the University of Melbourne, informed the Commission that the distribution of government funding across the Australian and Victorian mental health systems was a result of 'unintentional structural stigma'.¹³⁹ Dr Michelle Blanchard, Deputy CEO of SANE Australia and Founding Director of the Anne Deveson Research Centre, outlined that structural stigma refers to the 'societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources and wellbeing for stigmatised populations'.¹⁴⁰

While funding decisions are not based on community attitudes alone, Mr Knowles noted that 'politics is influenced by public perception'.¹⁴¹ As Mr Gerry Naughtin, a leader across the mental health and community sectors, told the Commission:

There are not as many votes in mental health reform as there are in reforms in areas such as cancer and heart disease and mental health at times struggles against other competing demands for government resources.¹⁴²

Associate Professor Ruth Vine put forward a similar view:

Mental health is not high on the agenda for community concern (at least for severe mental illness), and there is still stigma about severe mental illness, poor understanding of the links with violence, and other negative social connotations.¹⁴³

The Commission received feedback that institutional stigma also exists at the health service level. For example, Associate Professor Ruth Vine explained that stigma has contributed to poor standards of mental health facilities compared with physical health facilities. She told the Commission:

I think that stigma and discrimination has been a focus for this Commission already and I do think that the amenity in which people receive care absolutely needs urgent attention [...] It's a very different experience coming to a bright, warm, safe, welcoming environment than it is coming to a place that's poorly looked after, poorly maintained ...¹⁴⁴

5.6.2 Advocacy

Strong advocacy is important to generate and propel reform, and to ensure it is sustained. Examples of effective advocacy can be observed in adjacent sectors, such as the disability sector, which has seen significant change in recent years through the introduction of the NDIS. This reform and its underlying principles represent a major achievement towards greater participation and inclusion for people with disability. The Every Australian Counts grassroots campaign, involving people with disability, families, carers and those who work to support them, was a key driver.¹⁴⁵ The Commission was told, however, that strong examples of advocacy are not so apparent in the mental health sector.

The Commission was also told of the difficulties of generating political interest in mental health reform. Reflecting on his experience as a parliamentarian, the Hon. Andrew Robb AO, a former federal member of parliament, told the Commission that there is relatively weak public advocacy and pressure for investment in mental health:

Mental health has not received the attention it needs. For example, from 2004–2016, during my time as a parliamentarian with a local constituency in Melbourne of 150,000 people, every 3 or 4 weeks I would get a representation from some health groups who were justifiably making their case for more public money, for example for cancer research or diabetes research. For the first 7 years I did not get one representation for mental health.¹⁴⁶

It is relevant, too, that people with severe mental illness tend to be highly disadvantaged—socially and economically. Although recent years have seen a strong increase in the level of public and political interest in mental health, the Commission notes that the discourse has been dominated by more privileged individuals who tend to have higher prevalence disorders. Therefore, any shift in public awareness is not evenly experienced across the mental health continuum.

Mental health professionals have also struggled to achieve unified activism and sustained pressure on government for a well-defined reform direction.¹⁴⁷ The mental health sector in Victoria has had high-profile and effective leaders but, from the Commission's perspective, professional groups have at times advocated for strategies that appear contradictory. Advocacy at times advances seemingly false dichotomies—for example, arguing for or against prioritising investment in prevention and early intervention, specifically at the expense of investment in services to treat established mental illness, or vice versa.

As the Hon. Julia Gillard AC, Chair of Beyond Blue, has noted: 'decision-makers get let off the hook if advocates compete and criticise, rather than cohere'.¹⁴⁸

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Chapter 6

The mental health workforce

An adequately resourced, skilled and motivated workforce is an essential part of a mental health system: it plays a vital role in delivering safe, high-quality support to people living with mental illness, their families and carers. Structural problems do, however, adversely affect the workforce's ability to work effectively and efficiently. In large part these problems are associated with workforce shortages and the recruitment and retention constraints that underpin them, along with poor job satisfaction.

This chapter looks at the history and profile of the mental health workforce including lived experience workforces, workforce shortages and the experiences workers have described to the Commission. This provides important background for understanding the workforce's current role and challenges.

Chapter 18 explores lived experience workforces in more detail and puts forward proposals for better supporting and expanding these workforces. Chapter 19 considers what is required to develop the workforce of the future and proposes a set of actions to redress immediate workforce needs, including increasing the entry-level workforce, improving data collection and nurturing leaders.

In 2020 the Commission will continue to examine the role of the mental health workforce. This will include the composition of the workforce and the skills and values that will be required for a contemporary mental health system.

A skilled, competent and engaged workforce is critical to delivering high-quality services, across any sector. In health services, the workforce is the most valuable resource—underpinning the effective functioning of the health system. Whenever workers are required to work directly with individuals, it is critically important that these interactions are empathetic, respectful and responsive to individuals and their unique needs. This is particularly true for mental health services, where a person-focused and compassionate workforce is foundational to enabling people to begin and lead their own recoveries.

A more progressive mental health system will require people to work better in partnership with consumers, families and carers, along with strengthened models of multidisciplinary care. The workforce must have the values and skills to provide consumer-focused, recovery-oriented and safe services in a collaborative, accountable and transparent way.

As societal and digital landscapes change, the way people use and engage with services will also vary. A contemporary workforce will be required to work in a diverse range of settings, with a greater emphasis on online services. The Productivity Commission's Draft Report on Mental Health places significant importance on expanding and integrating supported online treatment options.¹

Fundamentally, in moving forward, the workforce must be helped to thrive in a culture that supports and promotes thoughtfulness and best practice in an engaging and rewarding environment.

6.1 The workforce's role in recovery and healing

Positive outcomes for people living with mental illness, their families and carers are strongly linked to the composition, skills and values of the mental health workforce and their capacity to deliver evidence-based, safe and responsive services. Members of the current workforce often find themselves trying to do their best in a system that constrains them.

Many people have spoken to the Commission about the vital role workers played in their recovery, along with workers' passion and commitment:

I am yet to come across a worker who is not in the role for the right reason. Everyone bands together to get the job done, and you have trust in your team.²

There are individual heroes that we have met throughout our journey with mental health. You have to be lucky to meet one. These people think they are just doing their job, but they change the lives of families.³

People working in mental health are on the whole kind and driven by a desire to relieve others of their suffering.⁴

Therapeutic relationships with mental health workers can be powerful and, at times, life changing. Trust and personal connection are among the foundations of healing:

When you break your arm if you present to the emergency department and somebody is rude to you, but they still fix your arm, you probably still have a better arm. But if you have a mental illness and somebody isn't kind to you or you aren't regarded with empathy, your illness gets worse, so the way people treat you can directly impact the course of illness.⁵

It comes down to individual clinicians—some are outstanding, and what makes them outstanding is being able to connect to people with a mental illness on a personal level. That ability to make a connection is at the core of all treatment.⁶

Workers themselves told the Commission about their dedication to their vocation:

What is working well within our mental health services, is our frontline mental health personnel. Their resilience, adaptability and dedication to their roles, despite some of the most demoralising and traumatic circumstances is in my opinion awe inspiring.⁷

The only positive thing is, is the staff themselves and the collective desire to do the right thing.⁸

The Commission has also observed that there are particular services (government and non-government) in which workers feel highly engaged and valued and feel that they are achieving positive outcomes for people living with mental illness, their families and carers.

Concern is also evident, however, about the attitudes and competencies of some members of the mental health workforce. The Mental Health Complaints Commissioner reported that complaints about staff behaviour, competence and professional conduct constituted one of the most common complaints raised in 2017–18 (22 per cent of complaints), along with treatment (55 per cent), communication, consultation and information (41 per cent) and medication (19 per cent).⁹

The values, skills and conduct of staff are extremely important in the context of providing best practice treatment, care and support to people living with mental illness, their families and carers. They are critically important for safeguarding human rights—particularly in environments where individuals' human rights have been breached. It appears, however, that in many cases systemic pressures such as under-resourcing and outdated infrastructure make it difficult for committed staff to provide responsive and safe care.¹⁰

A definition of lived experience workforces is provided in Box 6.1.

Box 6.1

Lived experience workforces—a definition

The Commission has learnt of the deep respect within the sector for consumer and family—carer lived experience work, particularly in relation to peer support workers. Largely this relates to the hope, empathy and common experiences peer support workers apply to their work.

In this interim report the Commission uses 'lived experience workforces' as a broad term to represent two distinct disciplines—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 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.

6.2 Workforce profile and distribution

Many professions make up the mental health workforce, including the consumer and family—carer lived experience workforces. Some professions specialise in mental health; others support a wider range of people but still retain a critical role in providing treatment and support to people living with mental illness, their families and carers. The Commission is hindered, however, in its ability to quantify a detailed profile of the mental health workforce. This is due to the absence of a centralised and dynamic approach to workforce data collection and analysis, as considered in Chapter 19.

The Commission uses the term 'mental health workforce' to refer to individuals who have a direct and paid role in the diagnosis, treatment and support of people living with mental illness. This includes consumer and family—carer lived experience workforces, nurses, psychiatrists, psychologists, GPs, social workers, occupational therapists, pharmacists and counsellors working in clinical and non-clinical settings, as well as psychosocial, community and residential support workers and people offering 'alternative' supports such as music and art therapy. For all these professions, there are different registration, regulation and industrial arrangements, along with a range of training and educational pathways.

Of course, other professions also play an important part in identifying and supporting people living with mental illness and referring them on to other experts. The Commission will examine these workforces as part of its task; among them are paramedics, police and people who work in adjacent settings such as education, child protection, family violence, corrections and aged care.

Each profession brings with it a unique skill set, and the Commission sees value in creating opportunities for regularly reflecting on what is common to all professions and what each profession contributes—setting the foundation for a new kind of collaboration that also incorporates lived experience workforces.

While this chapter considers the paid mental health workforce, the Commission acknowledges the substantial work of families, carers and volunteers in providing invaluable care and support for people living with mental illness.

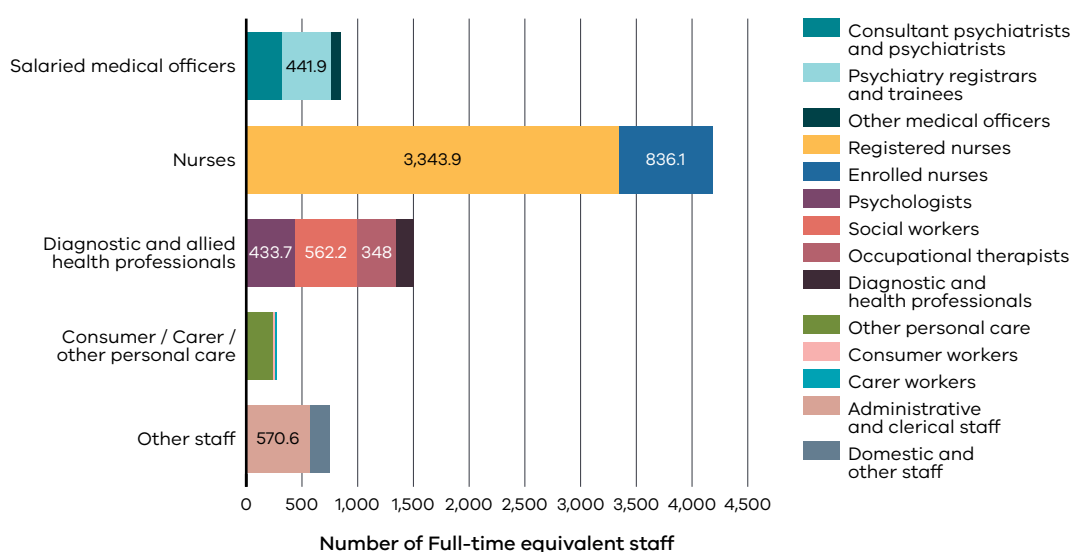
6.2.1 Workforce profile

It is difficult to comprehensively describe the profile of the mental health workforce, largely because there is no consolidated source of data held by the state or Commonwealth governments or in public or private repositories, and no data are collected at a sufficiently detailed level.

At an aggregated level, however, the Australian Institute of Health and Welfare collects data on full-time equivalent staff working in state and territory specialised mental health care facilities. These facilities are defined as public psychiatric hospitals, psychiatric units, wards in public acute hospitals, community mental health care services, and government-operated and non-government-operated residential mental health services.

As Figure 6.1 shows, in 2016–17 there were 7,547 full-time equivalent staff working in Victoria's specialised mental health care facilities—among them 4,180 nurses (55 per cent); 1,500 psychologists, social workers, occupational therapists and diagnostic professionals (20 per cent); 848 salaried medical officers (psychiatrists, at 11 per cent); 745 administrative and other staff (10 per cent); and 275 consumer and family—carer workers (4 per cent).¹¹

Figure 6.1: Full-time equivalent staff in Victoria's specialised mental health care facilities, by staffing category, 2016–17



Source: Australian Institute of Health and Welfare. Mental Health Services in Australia. Specialised mental health care facilities 2016–17. Table FAC.34. <<https://www.aihw.gov.au/reports/mental-health-services/mental-healthservices-in-australia/report-contents/summary-of-mental-health-services-in-australia>> [accessed 9 October 2019].

In 2019 there were 6,468 GPs in Victoria.¹² There are between 125 and 220 full-time equivalent psychiatrists working exclusively in the private sector and approximately 3,900 full-time equivalent psychologists working outside Victoria's public specialist mental health system.¹³

Table 6.1 shows the rate of full-time equivalent staff working in mental health care facilities per 100,000 people in the states and territories in 2016–17.¹⁴ Victoria is below the national average for almost all the professions. For example, it had a rate of 13.6 psychiatrists per 100,000 population compared with a national average of 14.3 per 100,000.¹⁵

Table 6.1 also shows the different workforce compositions for the states and territories. The Northern Territory and Tasmania have high rates of personal care employees (31.8 and 30.4 per 100,000 respectively) compared with 3.8 per 100,000 in Victoria.¹⁶

Table 6.1: Full-time equivalent staff working in state and territory specialised mental health care facilities, per 100,000 population, 2016–17

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Salaried medical officers ^a	13.6	13.6	14.9	15.1	16.2	9.5	19.1	16.7	14.3
Nurses (registered and enrolled)	70.9	67.0	63.3	68.7	74.4	65.0	60.9	74.0	68.1
Diagnostic and allied health professionals ^b	24.6	24.0	28.3	29.7	28.1	18.3	28.0	24.9	25.9
Other personal care ^c	1.0	3.8	3.2	8.5	6.7	30.4	10.1	31.8	4.5
Consumer workers	0.4	0.3	1.1	0.2	0.9	0.1	0.5	0.4	0.5
Carer workers	0.1	0.3	0.2	—	0.3	0.1	0.1	0.0	0.2
Other staff ^d	27.0	11.9	19.3	27.6	15.8	19.6	11.0	5.4	20.2
Total	137.6	120.9	130.3	149.7	142.5	143.1	129.7	153.2	133.6

Source: Australian Institute of Health and Welfare, Mental Health Services in Australia. Specialised Mental Health Care Facilities 2016–17, Table FAC.36 <<https://www.aihw.gov.au/reports/mental-health-services/mental-healthservices-in-australia/report-content/summary-of-mental-health-services-in-australia>> [accessed 9 October 2019].

a. Consultant psychiatrists and psychiatrists, psychiatrist registrars and trainees, other medical officers.

b. Psychologists, social workers, occupational therapists, diagnostic and health professionals.

c. Attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants engaged primarily in providing personal care to patients or residents but who are not formally qualified or undergoing training in nursing or allied health professions.

d. Administrative and clerical staff, domestic and other staff.

6.2.2 Workforce distribution

The mental health workforce appears to be unevenly distributed across Victoria, and workforce shortages for some professions are more pronounced in rural and regional areas.¹⁷ For example, in 2017 there were 13.9 psychiatrists per 100,000 people in metropolitan Melbourne; falling to 5.2 in inner regional areas of Victoria and just 1.2 in outer regional areas.¹⁸

Workforce shortages in rural and regional areas are exacerbated by recruitment and retention difficulties that are unique to these areas—for example, education and training opportunities being largely based in Melbourne, personal factors such as living away from family, and limited incentives. Rural and regional Victoria is explored in detail in Chapter 10.

6.3 Evolution of the workforce

Deinstitutionalisation in the 1990s brought with it a reshaping of the mental health workforce,¹⁹ particularly a move towards integrated and community-based care²⁰ provided by multidisciplinary teams.

Between 1993 and 2002 the mental health workforce in Australia increased by 25 per cent—primarily prompted by the expansion of community and non-hospital residential services.²¹ During this time there was a change in the staffing mix, with allied health workers showing the greatest percentage increase and staff shortages most notable in nursing and psychiatry.²² In Victoria the proportion of allied health workers (psychologists, social workers, occupational therapists and diagnostic health professionals) working in mental health care facilities increased from 13.1 per cent to 19.9 per cent between 1994–95 and 2016–17.²³

The vision for the workforce has been compromised, though, as the ambition of the post-institutionalisation era has struggled to consistently materialise and structural challenges have impeded the workforce's expansion and development. Over this period there have been multiple reviews highlighting workforce challenges and shortages, both nationally and in Victoria.

The second National Mental Health Plan (1997–98 to 2002–03) emphasised developing a skilled workforce in response to workforce shortages (particularly nursing), poor distribution of all disciplines (particularly psychiatrists outside metropolitan areas) and outmoded delivery models that included psychologists assuming case management roles that limited specialist delivery of expert psychological therapies.²⁴

As a result, 12 national practice standards were introduced defining the attitudes, knowledge and skills that all mental health professionals should have; these were to be implemented during the life of the Third National Mental Health Plan (2003–2008).²⁵ The intention was to include workforce attraction and retention programs, standardisation of training models with core competencies, financial incentives for private psychiatry, and innovations to enhance psychosocial roles and improve funding models.²⁶

In Victoria the New Directions for Victoria's Mental Health Services: the next five years 2002–2007 report outlined policy directions based on expanding service capacity and building a skilled workforce.²⁷ Immediate priorities were a comprehensive workforce plan for clinical services and mental health nursing and access to expert clinical advice and supervision for rural staff. Other initiatives covered attraction, preparing new entrants and developing and retaining skilled workers in the public mental health system.²⁸

By 2016 the Victorian Government had released the Mental Health Workforce Strategy as part of Victoria's 10-Year Mental Health Plan, setting out a range of actions aimed at developing the workforce.²⁹ In 2019 the Victorian Auditor-General found, however:

It is not clear what [the Department of Health and Human Services] aims to achieve through its workforce strategy and initiatives, as it has not set quantifiable performance indicators or targets, and there are no plans for a formal evaluation.³⁰

The Commission has been told that, despite the intention to move towards multidisciplinary models of care and the subsequent reviews highlighting workforce shortages, staff feel they are being deskilled and constrained by working environments that do not support their practice while services continue to struggle to recruit staff.

Increased service demand, insufficient resourcing and funding pressures have challenged the multidisciplinary approach. It was submitted that a pressured environment and increased generic case management have undermined the specialist skill sets of multidisciplinary teams such as those offered by social workers and psychologists.³¹ Dr Ravi Bhat, the Divisional Clinical Director, Goulburn Valley Area Mental Health Service, Goulburn Valley Health, told the Commission:

In these institutions there were clear roles of not just doctors and nurses but also for allied health staff such as psychologists and occupational therapists and social workers [...] I think one of the effects [of deinstitutionalisation] is that the focus became on providing what's known as case management, which is mostly coordination of care. This, in my opinion, left out a highly specific discipline skill set, such as psychology and occupational therapy and so on, which has affected Victoria-wide in my view, but has affected rural services even more ...

... it's being divided into work that is much more than what was anticipated at the time of the institutionalisation, and the type of work that was anticipated at the institutionalisation.³²

During the same period Victoria has seen a rapid expansion of lived experience workforces, particularly consumer and family—carer peer support workers. This has accompanied a growing evidence base on the effectiveness and value of lived experience workers in achieving positive outcomes for people living with mental illness, their families and carers.

Lived experience work had its origins in self-help and mutual support movements, but in the mid-1990s such positions began to evolve into more formal paid positions. People with lived experience were first employed in Victorian area mental health services in 1996, when four consumer consultant roles were created.³³ After that, lived experience workforces emerged slowly until there was a rapid increase in 2016, when the Expanding Post Discharge Support Initiative was introduced.³⁴

In 2017 the Victorian Government conducted a survey to determine the number of paid lived experience positions in Victorian publicly funded mental health services.³⁵ In that year there were 341 occupied lived experience positions, amounting to 187 full-time equivalent positions, in Victoria's public mental health services.³⁶ More than two-thirds operated from a consumer perspective (239 positions) and the remainder from a family—carer perspective (102 positions).³⁷ Of the 341 occupied positions, 238 (69 per cent) were in clinical mental health services and 103 were in mental health community support service settings.³⁸

As is apparent, lived experience workforces have evolved and markedly expanded over time, but structural supports, such as training, career pathways and remuneration, are still being established.

In the Commission's view, lived experience work will be a central pillar of the future mental health system, with new roles spanning service design and delivery, service and system leadership, research and evaluation, and system accountability and oversight.

6.4 Workforce shortages

The Victorian Government submitted that health services experience difficulties in recruiting and retaining skilled mental health professionals in nursing, psychiatry, social work and psychology.³⁹ Workforce shortages are more pronounced in rural and regional areas and in particular settings, disciplines and sub-specialties.⁴⁰

Funding for mental health in Victoria has not kept pace with funding for the remainder of the health sector, and the result is that the mental health workforce has been compromised. As discussed in Chapter 20, if Victoria's funding for mental health services had been aligned with the national average per capita funding, it would have had an additional \$1.44 billion in 2016–17.⁴¹ The Commission estimates this would have amounted to 1,500 additional medical officers (including psychiatrists), 8,000 additional mental health nurses, 2,700 additional diagnostic and allied health professionals, and 70 additional consumer or family-carer workers.⁴²

In February 2017 the Department of Health and Human Services reported an average mental health nurse vacancy rate of 10 per cent in Victoria, although some services reported a 20–30 per cent vacancy rate.⁴³ To the extent possible, some services have reported that vacancies are filled with agency staff⁴⁴ and overtime in inpatient units.⁴⁵ In 2014 the Future Health Workforce report on nurses projected a shortfall of 123,000 nurses by 2030 in Australia, and it was predicted that mental health nurses would account for the greatest nursing workforce shortfall (about 18,500).⁴⁶

Nationally, there is a shortage of psychiatrists, which is forecast to increase to about 350 by 2030.⁴⁷ In comparison, there is an oversupply of emergency medicine specialists, forecast to increase to more than 2,000 by 2030.⁴⁸

The Royal Australian and New Zealand College of Psychiatrists reports that psychiatry shortages are particularly pronounced in specific settings (inpatient units and emergency departments),⁴⁹ sub-specialties (addiction psychiatrists, child and adolescent psychiatrists and psychotherapists)⁵⁰ and in rural and regional areas.⁵¹

It has been reported that the public mental health system relies on an international workforce to fill the gaps; this is seemingly more pronounced in some specialities such as consultant psychiatry.⁵² At the Commission's roundtable comprising doctors and other experts, it was proposed that the public mental health system would not function without international recruitment.⁵³ A number of mental health services reported that they recruit internationally to redress workforce shortages.⁵⁴

In 2016–17 psychologists, occupational therapists and social workers accounted for approximately 18 per cent of people working in Victoria's specialised mental health care facilities.⁵⁵ This figure remained relatively static in the 10 years between 2006–07 and 2016–17, at an average of 18 per cent.⁵⁶ This is despite these health professionals playing a central role in the assessment, support and treatment of people living with mental illness, particularly in multidisciplinary teams.⁵⁷

The Commission received evidence that there is not a shortage of psychologists working in Victoria at an aggregated level but that public mental health services have difficulty retaining experienced psychologists—partly because of the attraction of private practice.⁵⁸ A number of area mental health services reported that they have difficulty recruiting psychologists.⁵⁹

These challenges are compounded by the fact that the workforce is ageing. In 2017 in Australia, 74 per cent of psychiatrists, 58 per cent of mental health nurses and 51 per cent of psychologists were aged 45 years or older.⁶⁰ In 2015 in comparison, 37 per cent of all employed nurses and midwives in Victoria were aged 50 years or older.⁶¹

6.5 Challenges for the workforce

Although the mental health workforce is made up of committed individuals, many find themselves struggling to work effectively because of systemic and structural challenges.

6.5.1 Education, training and practice supports

The skills of the workforce are compromised by variable early training and practice supports such as supervision and professional development. The Commission has been told that this contributes to workers feeling undervalued in the workplace and adversely affects treatment, care and support.

Education and training

Before prospective workers reach the workplace, they need to be equipped with the skills and competencies to work effectively. Failing to adequately prepare students for a career in mental health can compromise their readiness to enter the workforce and deliver high-quality, safe services.

The Commission has been told how undergraduate courses, such as nursing and medicine, are not equipping people with enough general knowledge about mental health and wellbeing and are discouraging them to specialise in mental health disciplines. This was raised in the Commission's roundtable discussions with nursing, medical and educational experts, where there was agreement about the limitations of the mental health curriculum.⁶² Mental health was described as being 'slotted into the current curriculum as the last card in the pack'.⁶³

More broadly, concerns were also expressed about education and early career training for GPs. Dr Gerard Ingham, a GP, said that undergraduate and early career training 'hasn't necessarily prepared people well for the nature of general practice and the mental health care that we provide there'.⁶⁴

Further, positive first experiences in the workplace are important for encouraging people to pursue a career in mental health.⁶⁵ A workforce under pressure, however, can compromise a workplace's ability to effectively support students and interns in doing positive rotations. The Commission was told that some people find psychiatry rotations difficult because they often do not receive suitable support as a result of overstretched workplaces.⁶⁶ This was also reflected in the Commission's roundtable discussion with doctors and education providers.⁶⁷

Practice supports

Limited access to practice supports such as supervision and professional development can constrain skill development among workers and the dissemination of best practice care for people living with mental illness and their families and carers.

Supervision is important for facilitating reflective practice and continuous development including improved risk management and service quality.⁶⁸ It also helps workers feel positive about, and engaged in, their workplaces. Although supervision varies according to the discipline and is accounted for differently in various industrial instruments, overstretched workplaces can compromise access and quality.

A survey by the Centre for Mental Health Learning found that lack of access to supervision was a constant concern, particularly among allied health professionals and mental health nurses.⁶⁹ The Australian Psychological Society reported that insufficient internal supervision or time to attend external supervision resulted in a lack of professional guidance and development.⁷⁰ One service emphasised that lack of access to supervision was a major shortcoming to be dealt with, and many staff raised supervision as a central theme for improving workforce attraction and retention.⁷¹ Lack of supervision is also noted as a particular concern among lived experience workers, as discussed in Chapter 18.

While the Office of the Chief Mental Health Nurse's Clinical Supervision for Mental Health Nurses is well regarded, there have been calls for further investment in statewide training, implementation and evaluation⁷² and ongoing work to ensure that mental health nurses can have access to the advice in practice.⁷³

In conjunction with supervision, ongoing professional development provides opportunities for workers to expand their skills and knowledge, helping them keep pace with best practice treatment. Professional development is important to maintain and augment skills for specific areas, such as concurrent mental health and substance disorders, along with broader skills such as cultural awareness/safety⁷⁴ and leadership. The Australian College of Mental Health Nurses reported:

A multi-pronged approach is required including (but not limited to) significant focus on recruitment and retention efforts, education, professional development, mentoring and clinical supervision—all essential components of efforts to sustain and build the mental health nursing workforce, to cope with the current and projected demand of mental ill-health now, and into the future.⁷⁵

It was submitted to the Commission that the extent of access to professional development is inconsistent for the various professions and services. This is a consequence of the devolved nature of the mental health learning and development landscape—there being no clear, collective approach to how organisations make decisions about workforce development priorities.⁷⁶ The Centre for Mental Health Learning has, however, taken steps to connect and share information between organisations.⁷⁷

In turn, workforce shortages make it difficult to access professional development opportunities—organisations report difficulties in back-filling and funding positions on a short-term basis.⁷⁸

Training and staff supervision are essential to ensure they are capable and have the competencies to deliver evidence-based treatment and care.⁷⁹ One submitter summarised the importance of professional development particularly well:

Having protected time for professional development is not just about learning new information. It is about helping clinicians feel more capable of working with uncertain ideas. It is about introducing and reinforcing directions the workforce should be headed in and which lead to greater understanding, respect and sense of accomplishment for both worker and the people we work with. Examples of this are recovery oriented practice, trauma-informed care, motivational interviewing—professional development that keeps the humanity in the work which we do and rekindles the clinician's passion by helping them connect to the people they work with in a deeper, richer partnership and work towards common goals.⁸⁰

6.5.2 Deskillling and low morale

Structural failures—such as major supply and demand problems and an increasingly crisis-driven model of care—have had adverse effects on the capabilities and skills of the workforce. This situation is made worse by other factors such as a lack of leave cover⁸¹ and administrative pressures.⁸²

The existence of an under-resourced system, increasing demand and associated pressures such as expediting patient throughput have contributed to a culture of risk aversion. In some cases this has led to a diminution of workers' skills in the therapeutic and relational aspects of their work that inspired them to join the workforce at the outset.

For example, it has been reported that it is difficult for psychiatrists and psychologists in the public mental health system to practise psychotherapy because of limited resourcing, growing numbers of people experiencing acute psychological distress and pressure to reduce lengths of stay.⁸³ There has also been increased employment of more generic professions to manage workload and administrative pressures. This has diluted multidisciplinary approaches, which aim to optimise a range of specialist skill sets such as those of psychologists, occupational therapists and social workers.⁸⁴

The Commission has heard how demand pressures affect the amount of time mental health professionals spend with consumers:

... when caseloads are too high, clients get [...] short appointments, they get less frequent appointments, there's more work that's done on the telephone. The families may never see a case manager under those circumstances.⁸⁵

The current practice of episodic treatment (usually just case management) rather than ongoing treatment is forced by a situation of too few clinicians to meet community need, rather than by best-practice principles. In short, the very high workloads of clinicians preclude best practice.⁸⁶

This is also illustrated in Box 6.2, in regard to a psychologist's experience working in mental health services. While this compromises the quality and safety of treatment, care and support for people living with mental illness, their families and carers, the Commission has also heard how the workforce is experiencing low morale, burnout and disengagement:

I feel exhausted and burnt out. The workload is much too big and too high risk, and we are so under resourced it just feels like you need to keep working all the time. Everyone is off sick and is unwell. It feels unhealthy to work here.⁸⁷

This is exacerbated by workforce members feeling they are constrained by the system to deliver best practice treatment:

Consumers, carers and those working in the mental health system, including psychiatrists, are being traumatised by an under-resourced system. Psychiatrists and other mental health workers are facing moral distress: a desire and knowledge to do the right thing, but system constraints make it impossible to do so.⁸⁸

There is increasing risk of exposure to occupational violence and a general lack of work satisfaction. Due to insufficient capacity to provide treatment for the appropriate duration and frequency for lasting recovery, staff are unable to see the impact of the work they are doing. This contributes to burnout and loss of staff.⁸⁹

In part, excessive demand pressures and an under-resourced public sector contribute to a move away from the public sector to the private sector.⁹⁰ For example, between 2011 and 2014 the proportion of psychiatrists working solely in private practice increased from 34 per cent to 45 per cent.⁹¹

Reforming the mental health system will require careful consideration of the renewed and new skills required to deliver best practice treatment and care and, in turn, sustain the engagement and commitment of the workforce.

Box 6.2

Angela: frontline worker⁹²

Angela* is a registered psychologist working as a case manager in a community mental health team in the public sector.

She provides care to adults aged 18–64 years who are living with severe mental illnesses such as schizophrenia, psychotic depression, bipolar affective disorder and borderline personality disorder.

Having worked in the public and the private sectors, she has witnessed the challenges experienced by both consumers and clinicians.

The clinician to patient ratio in community teams is too high to enable good quality and effective care. Depending on the organisation and team, one case manager may be looking after up to 20–50 plus patients, while psychiatry registrars and consultant psychiatrists may have 60–90 plus patients at any one time.

The clinician to patient ratios are unsustainable to provide effective care, leaving clinicians burnt out and disillusioned, with patients negatively impacted as a result.

Another pressure on the system that Angela has found difficult to counter is the number and availability of psychiatric units and beds.

Despite clinicians' best intentions, this often leads to people being turned away from emergency departments and inpatients being discharged due to bed pressure demands before they are fully recovered.

This means that vulnerable people are discharged into the community when they may put their own safety/wellbeing and that of others at risk.

**Not her real name*

6.5.3 Occupational violence

Occupational violence is caused by a confluence of systemic factors—for example, under-resourcing, sub-optimal system design, poor infrastructure, environmental causes, risk-averse cultures, insufficient opportunity for de-escalation strategies, communication and relational workforce skills, and leadership shortcomings—that warrant careful examination during the Commission's work.

Safety concerns have negative effects on people living with mental illness and their families and carers, as well as the workforce. Lack of workplace safety has consistently been reported as a primary reason for the recruitment and retention difficulties experienced throughout the mental health workforce, contributing to low morale and high turnover.⁹³

Many area mental health services reported that, in staff survey findings such as 'people matter' results, staff have highlighted concerns about occupational violence,⁹⁴ particularly when compared with non-mental health staff.⁹⁵

Occupational violence is a daily event, which has significant impact on morale, recruitment and staff retention. Understandably, it impacts on the capacity of staff to engage therapeutically with consumers when they feel that their personal safety is under threat.⁹⁶

Eastern Health reported that at any one time there are multiple members of its mental health team who are on long-term personal leave directly related to safety and harm in the workplace.⁹⁷ Experts at the Commission's roundtables with nurses and doctors stressed that occupational violence poses a major problem for attracting, retaining and sustaining the wellbeing of the workforce.⁹⁸

In 2019 the Health and Community Services Union conducted a survey involving 464 people in the mental health workforce, most of whom worked in a public setting (92.5 per cent) and over half of whom were nurses (51.9 per cent).⁹⁹ Of the survey respondents, 87.5 per cent said they put their health and safety at risk some of the time, 30.8 per cent said they had been physically attacked in the workplace in the 12 months preceding the survey, and 63.8 per cent said they had witnessed physical violence in the workplace.¹⁰⁰

The Commission has been told about the value of Safewards in reducing conflict and increasing a sense of safety and mutual support for staff and consumers.¹⁰¹ The initiative was introduced in 2014 as a trial in inpatient units in seven services in Victoria and was evaluated by the Centre for Psychiatric Nursing at the University of Melbourne. The evaluation was largely positive, finding, among other things, that Safewards showed potential to reduce restrictive practices, decrease conflict and improve communication and relationships among consumers and staff.¹⁰²

It was highlighted, however, that there needs to be an expansion of and further investment in Safewards,¹⁰³ along with a statewide rollout of occupational violence prevention and management training.¹⁰⁴

It is evident that safety remains a major concern for the workforce. The web of factors that contribute to occupational violence will be considered carefully throughout the Commission's term.

6.5.4 Perceptions of the workplace

Collectively, the experiences outlined above can compromise positive workplace cultures—those that are supportive, engaging, reflective and consumer-focused—and contribute to problems with attraction and retention. The Health and Community Services Union emphasised the importance of reforming workplace culture:

While additional funding and more workers will alleviate this pressure, the long-term neglect of the Victorian mental health system by policymakers has resulted in a toxic workplace culture taking root. Reforming this culture will require more than simply dollars and bodies, it will require sustained and sophisticated strategies and is something the Commission must have front-of-mind when considering its recommendations.¹⁰⁵

Such a culture contributes to mental health professions being regarded as less prestigious career choices than other health professions.¹⁰⁶ The Commission was informed that there is a contrast between public appointments in physical health disciplines, which carry a measure of prestige, and positions in the public mental health system, which are considered stressful and poorly resourced.¹⁰⁷ Academic studies¹⁰⁸ and Victorian reviews¹⁰⁹ have found that mental health nursing is one of the least popular career options for nursing students. One person submitted, 'Psychiatry is viewed as a non-stimulating environment by young graduate nurses as they are unable to see career advancement and have misperceptions about mental health settings'.¹¹⁰

Further, as discussed throughout this report, stigma remains an insidious problem, adversely affecting people living with mental illness and their families and carers. Stigmatising and discriminatory attitudes can manifest in structural stigma (such as discriminatory policies),¹¹¹ public stigma (attitudes towards people living with mental illness)¹¹² and self-stigma (internalising stigmatising attitudes, whereby a person can come to agree with stigmatising views and apply them to themselves).¹¹³

The workforce is not immune from these pervasive attitudes, which can deter people from choosing a career in mental health and perpetuate the stigma directed at consumers and their families and carers. The Australian College of Mental Health Nurses observed:

Research on the attitudes of undergraduate nursing students towards [mental health] nursing has consistently shown that negative attitudes towards people with mental illness are common in nurses and other health professionals.¹¹⁴

Dealing with mental health stigma is an important part of promoting the value of the mental health workforce. Efforts are underway to attract people to mental health professions; for example, in July 2017 the Victorian Government launched 'Hello Open Minds', a targeted mental health recruitment campaign,¹¹⁵ which has now been funded for a second phase.

6.5.5 Pay and conditions

Much of the information the Commission has received about the workforce's experiences has been primarily linked to structural challenges such as those just outlined. There has, however, been some reference to comparatively low pay and conditions for the mental health workforce, notwithstanding the extreme range of pay and conditions applying to the professions that make up this workforce.

For example, the Health and Community Services Union reported that, compared with mental health professionals, 'all health professionals' are more than twice as likely to strongly agree with the statement 'I get paid fairly for the things I do in my job' (3.9 per cent compared with 10.9 per cent).¹¹⁶

It has also been reported that Victoria competes with other states that offer better pay and conditions.¹¹⁷ At the Commission's roundtable with representatives of the medical workforce it was reported that psychiatrists in Victoria are the lowest paid in Australia; at the award rate they are also the lowest paid specialist doctors in the Victorian public health system.¹¹⁸ Different pay rates and conditions are also observed across public and private mental health services, forming another point of difference in the attraction and retention challenges experienced in public mental health services.

Representatives of lived experience workforces have also expressed concern about inadequate remuneration and about the expectation that the contributions of lived experience workers should be voluntary. One worker described the feeling of not being remunerated as 'demoralising' and detracting from 'self-worth'.¹¹⁹ Another person told the Commission, 'Peer workers need to be paid and awarded for their work. They shouldn't be treated as tokenism'.¹²⁰

In relation to attracting and retaining the workforce, people and organisations proposed better pay and conditions:

Creating more employment incentives and addressing current disincentives, including ... job insecurity and poor pay and conditions.¹²¹

Mentoring, better pay and conditions. Wellbeing benefits. These people are on the front line. They need help to do their jobs well.¹²²

Along with many other factors—such as low morale, burnout and disengagement—pay and conditions can influence how workers feel engaged and valued in the workplace.

6.5.6 Experiences of lived experience workforces

As emerging workforces lived experience workers face a number of unique structural barriers that constrain their ability to work as effectively as possible.

Organisational support and leadership are crucial in influencing workplace culture and cultivating inclusive environments that accept and value lived experience workers.¹²³

The Commission has been told, however, that organisational support and leadership are inconsistent throughout the system.¹²⁴ Too often this responsibility falls on the shoulders of lone workers who feel the personal burden of demonstrating their value. Feelings of professional isolation and burnout are common in such workforces. One person said of her

role as a manager, 'I am like a one-man band. It is so exhausting to be the one consumer voice. It grinds you down'.¹²⁵

In the absence of a consistent, systemic approach to the emergence of lived experience workforces, roles and responsibilities have evolved in unique ways—largely dependent on how individual services are managed and the individuals performing the roles.¹²⁶ This has led to a lack of role clarity at both the systemic and organisational levels.¹²⁷ Role ambiguity and uncertainty can result in what has been described as 'peer drift'¹²⁸ or 'role creep',¹²⁹ whereby lived experience workers are asked to do work that is not relevant to their role and does not make best use of their skills. One lived experience worker told the Commission:

There isn't clear understanding of what [...] peer support workers do, their roles are not always clarified, how they can enhance and complement the work of other health professionals in case managing an unwell person? How are peer workers to be accepted and integrated into services? Programs?¹³⁰

As with any discipline, in order to work optimally members of lived experience workforces need ongoing learning and development opportunities. The Commission has heard, however, that there are limited opportunities for professional development, training and supervision. For example, while access to supervision is a problem for all mental health workforces, the difficulties are compounded for lived experience workers, partly because of the smaller size of their workforce and a lack of understanding about lived experience work.¹³¹

In connection with training, although the Expanded Post Discharge Support Initiative required that peer support workers undertake intentional peer support training, the Commission understands that this requirement was not uniformly applied and 'some workers were in the role for months or years before having access to training'.¹³²

New roles for lived experience workers—such as consumer policy advisers and consumer team leaders—are emerging, but they are rare¹³³ and there are limited leadership opportunities and career pathways. Ms Vrinda Edan, acting CEO of the Victorian Mental Illness Awareness Council, told the Commission:

So, you come into a role and that's it basically. We need to be thinking about this as a discipline, we need to be developing senior roles with appropriate remuneration and developing them into leaders and managers of those services.¹³⁴

This might be motivated to some extent by discriminatory cultures and attitudes that remain embedded in the current system. Stigma and discrimination can result in workers being passed over for promotion as a result of misguided concerns about their capability or assumptions that they, as lived experience workers, cannot 'cope' with full-time work.¹³⁵ One lived experience worker said, 'There is a fallacy that peer workers can't do full time work which I believe to be quite discriminatory'.¹³⁶

The end result of these challenges means that members of the consumer and family—carer lived experience workforce are not valued, understood or recognised. In the short term, the Commission makes a number of proposals aimed at resolving this problem and elevating the influence of the lived experience workforce in all aspects of the mental health system in Victoria.

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Part Three

Areas of focus for the Commission to date

Areas of focus for the Commission to date

This Commission is conducting the first comprehensive re-examination of Victoria's mental health system for over a quarter of a century. Previous inquiries have looked at some aspects of Victoria's mental health system. Other bodies have examined mental health on a national scale.

This is the first time that an attempt has been made to take a comprehensive and person-centred approach. It is also the first time that the Victorian community has been able to contribute its views on mental health directly to a commission of inquiry with independence and a broad remit.

Many Victorians have put their trust in the Commission by sharing their own experiences. It is important that these voices are not just used to inform the Commission's internal deliberations. The Commission believes that it is also important to share a selection of evidence publicly, to help Victorians understand current challenges of the mental health system, the impact it can have on individuals and families, and the complexity of the Commission's ongoing work.

In the following chapters, the Commission has chosen to share specific concerns that have been raised about the mental health system. Their selection does not mean that the Commission has failed to consider other matters. A range of additional topics will form part of deliberations ahead of the Commission's final report.

In this part of the report, the Commission examines five areas that have been highlighted in the evidence, submissions and materials presented to the Commission so far. These are:

- access and navigation of services
- consumers' experiences of care, treatment and support
- the experiences of families and carers
- mental health in rural and regional Victoria
- the impacts of suicide, suicide attempts and self-harm.

The Commission has chosen to focus largely on the experiences of the mental health system, from the perspectives of consumers, families and carers. Many other people have been consulted, but when the system is seen through the prism of lived experience, the picture is revealing. Many of the stories told are intensely personal and deeply painful.

One theme that connected almost every account was access. People find it hard to gain access to mental health services at a time when it would make the greatest difference. Not only is gaining access hard; people then struggle to find their way through a

fragmented system. Many people perceive the system to be unresponsive and unable to provide suitable services.

People's experiences of care, treatment and support are highly variable. While many individuals told the Commission of positive interactions, the overwhelming majority spoke or wrote of poor experiences of the system. A lack of dignity, respect and fairness was commonly cited. People described wanting treatment that was responsive to their individual needs, rather than based on medication alone, and treatment oriented towards recovery, rather than just managing risk.

It is acknowledged that access to services, the quality of those services, and some of the determinants of poor mental health differ between metropolitan and rural and regional Victoria, where one quarter of the state's population lives. It is not just about distance, although this is important when it comes to the proximity of even primary care and the expense involved in getting to it.

Finally, this part describes the impact of suicide, suicide attempts and self-harm. Suicide is often the ultimate expression of failure of the Victorian mental health system. Its impact on families, friends and communities are profound and enduring.

The Commission will continue its inquiries into the current state of the mental health system in Victoria.



Chapter 7

Access to services

Access to appropriate and high-quality mental health services can make a big difference to people's recovery and their ability to move forward with their lives. As with many other illnesses, timing is crucial; the results are better if people receive treatment early, before they reach crisis point.

The Commission has received extensive evidence that Victorians experiencing poor mental health are often unable to access services at a time when treatment and support would make the greatest difference. It has also found a serious and often detrimental mismatch between what individuals seek and what the system offers.

This chapter discusses the accessibility of mental health services. It begins by examining two related themes that were raised repeatedly in consultations, hearings and submissions: people experiencing poor mental health are waiting longer and becoming sicker before they can access services; and there are significant gaps in the services that are available.

The first section explores some of the main gaps in Victoria's mental health system. This includes shortfalls in services for people whose illness is too complex to be treated by primary care services alone but who are 'not sick enough' for specialist clinical mental health services—the so-called 'missing middle'.

Subsequent sections of the chapter explore some of the factors contributing to the problems facing people experiencing poor mental health and their families and carers, among them the following:

- The system is difficult to navigate for people experiencing poor mental health, families, carers and workers alike.
- The complexity and fragmentation of the system contribute to delays in obtaining care and mean that people often receive limited and disjointed care.
- Underinvestment in public specialist clinical mental health services, at a time of strongly growing demand, has led to people being turned away from community-based and inpatient services and receiving less care. There is also considerable variability in their availability across the state.
- Although the Commonwealth Government has invested in Medicare-subsidised services and in headspace services for young people, such services are not equitably available to all people across the state.
- Services might be insensitive to an individual's cultural or social needs, or simply unable to provide the right kind of treatment, care and support.
- Crisis presentations to emergency departments have increased, as has the involvement of ambulance and police services due to the flow-on effects of system failures.

The Commission continues to explore the problems people experiencing poor mental health and their families and carers face when trying to access mental health services. It has, however, concluded that fundamental problems with access are undoubtedly contributing to prolonged distress and worse outcomes. At present Victorians do not have a mental health system on which they can rely.

The Commission envisages a mental health system that provides treatment, care and support when it will make the greatest positive difference. Such a system would offer services that respond earlier and in a way that recognises an individual's clinical, social and cultural needs. It should support people in finding and gaining access to the most suitable services and help them transition between services as their needs change.

7.1 Missing out when it would make the most difference

In its submission, the Victorian Government acknowledged that a high-quality mental health system is one that is person-centred and targets the needs of individuals at all stages of illness, offering a continuum of care that starts even before a person becomes unwell.¹ The Victorian Government also confirmed that, although the current mental health system might have some features of such a model, Victoria has 'not been able to achieve a true model of stepped care'² as originally intended.

7.1.1 'Not sick enough'

A prevailing theme throughout the Commission's community consultations, formal hearings and written submissions concerns people experiencing poor mental health being turned away from services. Despite requests for help, people are becoming sicker before they can obtain services, and they are receiving care much later than when it would have made the greatest positive difference.

Too commonly, not being 'sick enough' and not being 'suicidal enough' were features of stories told to the Commission by people experiencing poor mental health, their families and carers. People living with mental illness often said that when they sought care for a physical health condition treatment options and timely responses were provided. In contrast, many people felt that they had been turned away from the mental health system until their symptoms and distress became worse. One person reflected:

It is unbelievable that someone can be open to getting support, asking for help, be a risk to themselves, and their family is asking for help, and yet they are still turned away [...] This doesn't happen to anywhere near as many people who present to services with physical health issues.³

Repeatedly, people spoke of the long wait times to access services:

I managed to get an appointment within four months, but I know people who have been waiting longer.⁴

I wanted to take him back to the PARC [prevention and recovery care centre], but they told me that once someone has been released [...] you have to go back to the bottom of the waiting list. I don't know how long the wait would have been, but they said it wasn't very good. So, because he'd already been through all the process, the [crisis assessment team], the PARC stay, they said it would be at least a couple of weeks and he would be at the bottom of the list.⁵

As a result, people seeking help for themselves or a loved one spoke of giving up, experiencing increased anxiety, or symptoms deteriorating to the point of crisis.⁶ The Commission has heard accounts of people who took their own lives when treatment, care and support may have helped them recover:

A lot can happen in three months [while waiting for services].⁷

There's so much waiting until eventually there is no more waiting because your loved one is dead.⁸

For Mrs Chris Thomas, a witness before the Commission, having to fight to have her husband admitted to hospital when he was suicidal left her with little faith that a 'broken system' would keep her husband safe. She recalled:

... we got to the hospital, we waited for a long time in the public section, people coming and going. Then they moved us into a small room, and eventually a psychiatric nurse came across. She spoke with Trevor, and me, and he was highly suicidal at this time; he really wanted to die. He knew how he was going to do it, he just needed to get away from me to do it. And she said, 'Yeah, he needs a bed, he's highly suicidal, yep, he needs a bed. But we don't have a bed, so take him home and bring him back tomorrow'. And I looked at her and I said, 'You have admitted a duty of care to him. I'm leaving now', and I got up and I walked out of that room, and he'd been my husband for 20-plus years, we're pretty close. Nobody should ever, ever have to do that to someone they love, and he shouldn't have to have that done to him. And I walked out. But this worker told me, 'When you walk out, don't leave the car park, because they're probably going to put him in a taxi and send him home' [...] so I hid in the bushes. Then the phone rings, 'Oh, we've found him a bed. Could you bring his clothes in please?'⁹

... I think I was so disillusioned last time: you know, things have not improved, and I just didn't have the strength or the fight, to fight with a broken system, and this time it's been different and worse, his breakdown, and I didn't think the system would keep him safe.¹⁰

Many people told the Commission that gaining access to mental health services was impossible until their symptoms deteriorated, and they were, for example, in crisis:

I tried to connect with a community mental health service, but until a crisis occurred, I got nothing.¹¹

I received no meaningful, helpful preventative care. Numerous times actually I've been turned away by practitioners or services that either deemed my symptoms to not be serious enough or the service lacked the resources to respond [...] All three of my psychotic episodes were preventable.¹²

The Commission also heard of the extreme lengths to which some people have gone to get care. For instance, one person said:

I know of someone who got themselves arrested just so they could get into acute mental health care. For some reason there was not a single bed in the state for this person, and the person had to sit in the [emergency department] with two police officers for 36 hours.¹³

7.1.2 High thresholds for specialist care

Extensive feedback from people living with mental illness, families and carers about the high bar that people must meet to receive public specialist clinical mental health services led the Commission to explore the thresholds and criteria for access to these services.

The Commission was informed that increasing demand, coupled with limitations in service capacity, have increased the threshold for accessing these services.¹⁴ In the view of Victoria's Chief Psychiatrist, Dr Neil Coventry:

Demand pressures have increased the threshold for access to specialist mental health services so that only the most unwell consumers are seen [...] It can therefore be more difficult for consumers to access appropriate treatment at the right time.¹⁵

A number of factors are considered before a person can access public specialist clinical mental health services. Associate Professor Simon Stafrace, Program Director of Alfred Health Mental and Addiction Health, stated that the people who receive services from the Alfred are those who:

... have experienced a clinical deterioration, with or without evidence of self-harm or attempted suicide; or [is] at imminent risk of clinical deterioration and hospitalisation and/or harm to self or others; or [is] recovering from an episode of mental illness or mental distress characterised by these features and [is] at short-term risk of relapse.¹⁶

Further, the bar for being considered 'in crisis' is high. Ms Tracey Morgan, the Mental Health Community Services Manager, at Casey Area Mental Health Service, Monash Health, said: 'Most of our patients present in crisis. Some who feel they are in a crisis do not satisfy the objective criteria for access to crisis support services.'¹⁷

The Victorian Government submitted that it primarily funds public specialist clinical mental health services for 'the most unwell'.¹⁸ Mental health service providers are increasingly focusing on the most acute and severely unwell consumers in response to demand pressures:¹⁹ the 'very urgent and critically ill are prioritised for treatment.'²⁰

7.1.3 The 'missing middle'

There is a large service gap for people whose mental health needs are too complex and enduring for primary care services alone but whose mental illness is not considered severe enough to meet the high access threshold for treatment in public specialist clinical mental health services.²¹ These people are often referred to as the 'missing middle'.

Professor Patrick McGorry, Professor of Youth Mental Health at the University of Melbourne and Executive Director of Orygen, said the missing middle constitutes 'a huge blind spot'.²² He told the Commission there are many Victorians who fall into the missing middle:

Although the capacity of the primary care system to provide access to people with milder mental health conditions, such as anxiety and depression, has strengthened somewhat, and stigma has been reduced for these conditions, this is not the case for those people with moderate to severe mental health conditions.

This group of people, which I call the ‘missing middle’, is characterised by the nearly two million Australians and several hundred thousand Victorians, both young people and older adults, whose illnesses are too complex, too severe and/or too enduring for primary care alone to be sufficient.²³

The people Professor McGorry describes do sometimes receive limited assessment and treatment from specialist clinical mental health services—for example, if they present with suicidal thoughts or self-harm to emergency departments or sometimes through offending behaviour to the criminal justice system.²⁴ But they slip through the cracks when their engagement with the treating service comes to an end.²⁵

Ms Kym Peake, Secretary of the Department of Health and Human Services, submitted that the treatment gap for the missing middle exists because the specialist clinical mental health system lacks appropriate levels of ‘step-up’ and ‘step-down’ service capacity as people’s needs change.²⁶

In Victoria, prevention and recovery care units (PARCs) were introduced to help bridge this gap. PARCs were intended to provide beds that people could ‘step up’ to from the community if they needed a period of intensive support (but not an acute inpatient admission) and a ‘step-down’ facility to help people being discharged from inpatient units to recover more completely before returning home. PARCs offer short-term multidisciplinary, recovery-focused care delivered mainly by non-government organisations, with clinical support from an area mental health service.

PARCs are not equitably distributed across Victoria, and Commission analysis indicates that proportionally there are fewer PARC beds available in Victoria’s major growth corridors.²⁷ This restricts access for some people. The Commission also received evidence suggesting that many PARCs do not have sufficient clinical resources to treat people who are very unwell or to provide evidence-based psychological interventions that assist with recovery.²⁸ At the North Fitzroy PARC, in Melbourne, people looking to ‘step down’ from hospital to the PARC need to be well enough to participate effectively in the PARC’s less intensive program because the PARC is not set up to support people experiencing crises.²⁹ In 2018 the Victorian Government announced funding to boost the clinical capacity of a number of PARCs,³⁰ but the Commission is not yet aware of the outcomes of this initiative.

The Commission was also told that some PARCs can no longer receive referrals directly from the community because their beds are fully occupied by people discharged from acute inpatient units.³¹ The experience of Peter Ruzyla, CEO of Eastern Access Community Health, is that PARCs are now functioning as ‘discharge half-way houses’, with a sole focus on step-down care.³² This experience differs, however, between PARCs. A 2016 Department of Health and Human Services review found considerable variation in referral pathways to PARCs.³³ Although PARCs have been generally well received, their use is still episodic in nature. In the absence of more flexible and accessible community-based treatments, many people will continue to experience worsening outcomes.

The Victorian Government also submitted that the current limitations of primary care mean that many people living with mental illness receive inadequate support. As discussed later, the level of support provided by Medicare-subsidised services is not always adequate to affect a person’s recovery, and there are a range of other factors that lead to inequitable or restricted access to services.³⁴ Fragmentation between the primary and specialist systems creates a complicated pathway for people who need help, the onus being on the individual to find their way to a service that meets their needs.³⁵

St Vincent's Hospital Melbourne pointed out the disconnect between parts of the mental health system:

There remains a significant disconnect between primary health care and public mental health services where there is a gap in service delivery. Many people seek help from the [area mental health services] when they are unable to access services in primary health care, often due to a lack of free or affordable services (including where there is a gap payment), or where interventions are time limited and of insufficient quantity. The [area mental health services] are unable to assist as their capacity and focus of care do not align with the person's needs. This leads to dissatisfaction with the service and potentially poor outcomes for the person, with GPs struggling to provide effective treatment.³⁶

Ms Peake confirmed there are 'few options' for some people living with mental illness:

For people whose illnesses (or episodes of illness) are too complex or enduring to be treated in primary care—but who are not considered severe enough to meet the high threshold for specialist mental health services—there are few options for accessing support. This can often mean that they are left without help until their illness gets worse.³⁷

People experiencing poor mental health often feel a sense of hopelessness when they ask for help and are turned away. Ms Amelia Morris, a witness before the Commission, explained what it felt like to take the difficult step of asking for help and finding there was nothing there:

When I took that really, really difficult step, that really heartbreaking step of trying to ask for help, there was really nothing there for me. I was kind of greeted with silence in return. So, that's just really distressing when you take that very difficult step of asking for help, and there is just nothing there; it makes you feel very hopeless and like you're really never gonna get better.³⁸

Someone with both personal and professional experience of the mental health system explained the impact on many people living with mental illness when there is little support available:

I am scared at the current state of the mental health system. I have been in it from an emergency department bed, as a person on either end of a suicide call, as a desperate loved one and as a professional deciding treatment plans with and sometimes without clients present. I am scared at the lack of services to fill the ever-growing gaps of people that don't fit in the severe box, or don't fit in any box. I have been lucky enough to see some people benefit from good workers, in good programs, and keep their heads above water through recovery, but I've also been to too many funerals [...] and wondering if I was going to make it to 30. I honestly believe these experiences are preventable. I want to see this fixed before more people die.³⁹

7.1.4 Undersupply of forensic services

People living with mental illness are over-represented in the criminal justice system. An Australian study of adults in their 20s and 30s found that one in three of those with a 'psychiatric illness' had been arrested during a 10-year period and that the first arrest often occurred before their initial contact with mental health services.⁴⁰ People living with 'mental health conditions' (particularly severe conditions) are also over-represented in the prison population. Evidence shows that people in prison are 10–15 times more likely to have a 'psychotic disorder' than people in the general community.⁴¹

The Commission was told about a vulnerable group of people living with mental illness who are involved with the criminal justice system on remand, on a custodial sentence (security patients) or in prison waiting to be placed under Victoria's *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) (forensic patients). Because of the lack of forensic mental health services, these people often wait long periods to access services.

Under the *Mental Health Act 2014* (Vic), prisoners must be transferred to Forensicare, which operates the Thomas Embling Hospital, if compulsory mental health treatment is required. Compulsory treatment cannot be provided in prisons or custodial mental health facilities, and Thomas Embling Hospital is the only hospital that provides compulsory forensic mental health care.⁴²

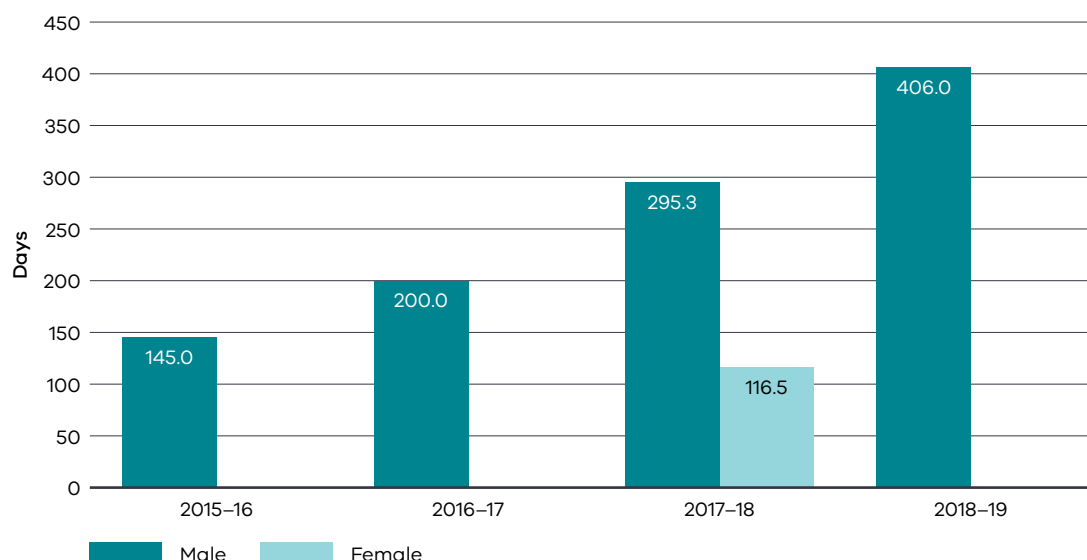
For several reasons, the demand for beds at Thomas Embling Hospital has increased. First, the prison population has grown significantly in recent years: Dr Coventry told the Commission the prison population grew by 81 per cent between 2008 and 2018, from 4,224 to 7,666.⁴³ Recent changes to bail laws in Victoria have also led to an increase in the number of accused people being held on remand. Second, the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) replaced the former 'Governor's pleasure' system, providing a new system of treatment and supervision for people found not guilty of a crime by reason of mental impairment.⁴⁴ Since the Act's introduction, many more people have received supervision orders than before, and this has added to the demand for beds at Thomas Embling Hospital.⁴⁵

Strong growth in demand has resulted in long waits for beds at Thomas Embling Hospital. In 2018–19 the average wait time for a bed for male security patients was 38.8 days; for females the average wait was nine days.⁴⁶

In 2018–19 the average wait time for forensic patients in prison to be admitted to a bed in Thomas Embling Hospital following recommendation for a custodial supervision order was 319 days.⁴⁷ For males, this waiting period has increased significantly since 2015–16. Among the 11 patients who received a custodial supervision order in 2018–19, the wait time for a bed following a court finding that the person be supervised under the Act, and subsequent determination that the person be placed at Thomas Embling Hospital, ranged from 375 to 481 days (an average of 406 days) (see Figure 7.1).⁴⁸

These big increases in demand for forensic mental health services have not, however, been accompanied by adequate increased investment to expand service capacity, with consequent restrictions on access and poorer quality of care.⁴⁹ A number of reviews have highlighted the service capacity challenges at Thomas Embling Hospital and the risks of not providing enough mental health services to acutely unwell prisoners.⁵⁰ In its submission to the Commission the Victorian Government acknowledged the inadequacy of services for prisoners living with severe mental illness who require compulsory treatment is leading to long waiting periods before treatment is obtained.⁵¹

Figure 7.1: Average wait time (days) for forensic patients in prison to be admitted to Thomas Embling Hospital, 2015–16 to 2018–19



Source: Forensicare. Yanith Bilang Quality Account 2017–18, p.49; Forensicare. Annual Report 2018–19, p.39.

There were no female prisoners in 2015–16, 2016–17 and 2018–19

Wait time on average is for forensic patients in prison to be admitted to a bed at Thomas Embling Hospital following a recommendation to the court for a custodial supervision order.

This situation has led to many people with untreated mental health needs being at risk of harming themselves or others.⁵² In its submission Forensicare referred to human rights concerns relating to prisoners who are not receiving adequate mental health treatment because of a lack of forensic mental health beds. Among these concerns are adverse effects on the prisoners' health and wellbeing and their ability to reintegrate into the community when they are released from prison.⁵³

Further, people who are acutely unwell are being held in prison for long periods even though they have not been found guilty of a crime. Because of limited bed availability, the courts routinely adjourn cases for several months.

The Law Institute of Victoria detailed a case study that demonstrates the impact of bed shortages on individuals:

Dan (a pseudonym), was an indigenous man who came to Melbourne from Western Australia and had no family or friends in the area. Whilst experiencing a psychotic episode, he entered an apartment and was found sleeping on a couch by one of the residents. He was arrested and found unfit to be interviewed. He was charged with burglary, but the police conceded that they could not prove that he had intended to steal anything. He was remanded in custody. His lawyer saw him at [Melbourne Assessment Prison] and was unable to obtain instructions due to Dan's apparent delusional state. The lawyer spoke to his family in [Western Australia] who advised that he suffered from schizophrenia.

Dan refused treatment and was held in [Melbourne Assessment Prison] for three months, without bail, waiting to be transferred to the Thomas Embling Hospital. He was not a candidate for bail as he had no accommodation and no area mental health service would accept him as he did not have a fixed address in the community and did not fit within their catchment. Once he eventually arrived at Thomas Embling Hospital, he was treated with antipsychotic medication and his condition promptly stabilised. He pleaded guilty to one charge of trespass and was sentenced to two weeks imprisonment. He had served seven months on remand.⁵⁴

Because of the limited availability of beds at Thomas Embling Hospital and the long wait times, acutely unwell prisoners who refuse voluntary treatment have to be managed within the prison system. These prisoners can be subject to lengthy lockdowns, restraint and deprivation of movement, which can contribute to symptoms escalating.⁵⁵ When they are finally admitted to hospital the acuity of their illness is higher, which means it generally takes longer for them to respond to treatment.

Prisoners who are unable to gain access to Thomas Embling Hospital and who refuse treatment in prisons remain untreated or without adequate treatment until their release. On release, they are often transferred from prison directly to the closest hospital emergency department. Eastern Health and NorthWestern Health have told the Commission that some former prisoners present with additional complexity and risk as a result of not having received adequate treatment while in prison.⁵⁶ This can lead to more instances of aggression and violence in inpatient units.⁵⁷ Limited capacity in the specialist clinical mental health system and the workforce's reduced ability to treat these people mean they often receive shorter, sub-optimal levels of care. Shorter episodes of care for people with a forensic history can result in a person bouncing between acute settings and prison.⁵⁸

7.2 Navigating a complex and fragmented system

For those seeking help for poor mental health, it is often not easy to know or find out where to go for help, the eligibility criteria that might apply, or which service might be best suited to their needs. Some of the reasons for this are explained below.

7.2.1 A difficult system to understand

The Commission has been told on countless occasions about the frustration and distress people have felt when trying to identify the right mental health services for themselves, a loved one or someone else. For example:

I am an intelligent and educated person but I have absolutely no idea how and am not well enough to find, negotiate and access mental health support services and I have no idea how any of it links.⁵⁹

No-one hands you a guidebook that shows what services there are, let alone how they link up. You just follow the bouncing ball and hope that someone will eventually refer you to a service that can actually help.⁶⁰

I am a nurse and my husband is in the medical profession, and yet we didn't know where to get help and had to shout and scream to get help. I am in the health field and I don't know what people not in the field do.⁶¹

A family member of a person who attempted suicide relayed that, in their experience, it was not uncommon for families and carers to have little understanding of what services are available:

I didn't even know about [child and adolescent mental health services] until my son was actually in hospital after a suicide attempt and the [crisis assessment and treatment team] saw him and referred him [...] I did not make any progress with finding quality treatment and support for my son [until I was put in contact with] a 'friend of a friend' who already had experience in finding help for her son [...] [When I attended carer support sessions] I was also shocked to realise how few of the carers in the group were able to access regular and effective treatment for their children/relatives with mental illness.⁶²

Consistent with these observations, Community Information and Support Victoria, the peak body representing local community information and support services, advised that people are often unaware of the available services.⁶³ Many people seen in public emergency departments report being unsure about how and where to seek out alternative, and more appropriate, supports.⁶⁴

People experiencing poor mental health often rely on service providers such as GPs, teachers, housing support workers and social workers to refer them to mental health services. But the mental health service system is so complex that many service providers—even those within the mental health system—are unaware of the full range of services available and how to connect people to them:

I think from a practical sense, as a manager I don't know what services are out there; we don't really know across Victoria what other services are doing and what we can refer into, what we can't and what we can access, so from that point of view it would be very good to have some kind of coordinated database and resources to be able to draw upon, which we don't have at the moment.⁶⁵

It is difficult for clinicians to find services for patients in our own catchment, so we can empathise the difficulty for patients to navigate the system.⁶⁶

7.2.2 Unclear online pathways

People's attempts to find mental health services often start with an online search. There are some online tools and resources available to help people navigate the system, but they are not easy to find or understand. Submissions from people living with mental illness, families and carers highlighted the need for better information about available services. For example, people called for a single source of online information:

There should be a single, easily accessible website that someone can go to, to find out where their local mental health provider is. With information on who they are, what they supply. There should also be a listing of private sources on there as well. Their specialities, their pricing, where they are located. All this information should be a few clicks or swipes away.⁶⁷

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.⁶⁸

7.2.3 Overburdened telephone services

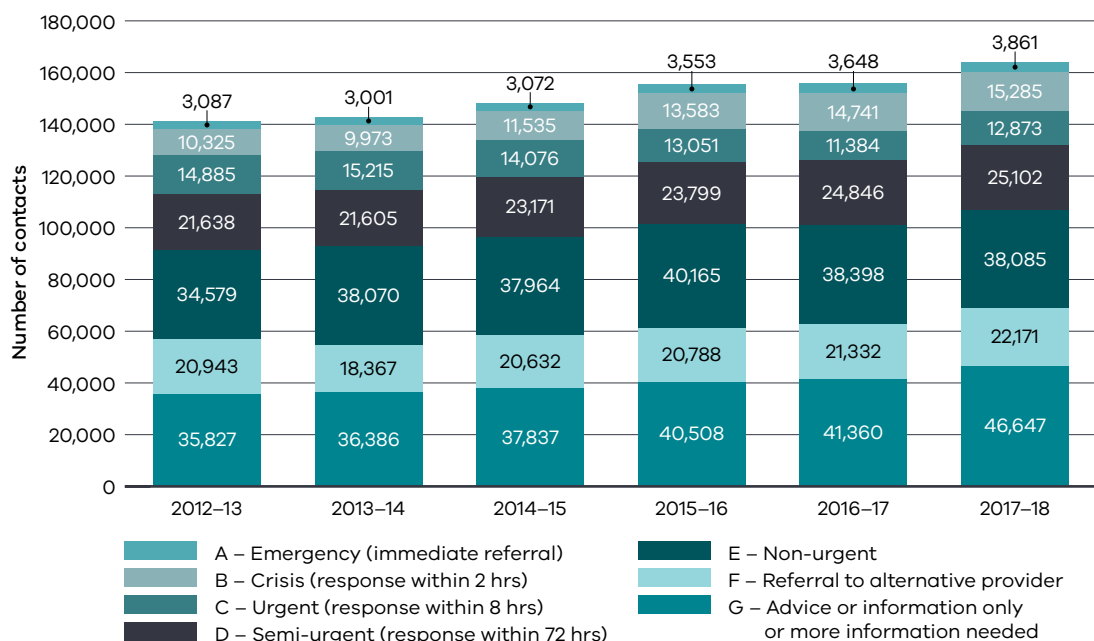
Each year many thousands of Victorians call telephone services that are meant to provide immediate advice, information and referral to appropriate mental health services. The evidence put forward to the Commission, however, is that these services are unable to respond to demand.

Specialist clinical mental health triage services

All area-based specialist clinical mental health services in Victoria are required to have a telephone number that provides access to a triage clinician 24 hours a day, seven days a week. On receipt of a call these services provide a clinical assessment of the person's needs, determine the urgency of the response required by mental health or other services, and facilitate that response.⁶⁹

Figure 7.2 shows data on the growth in triage calls between 2012–13 and 2017–18. Importantly, it shows only triage calls that were answered—it does not include unanswered calls. The strongest growth was in calls triage clinicians rated (using the statewide mental health triage scale)⁷⁰ as 'Emergency—immediate referral' and 'Crisis—response within 2 hours'.

Figure 7.2: Number of triage contacts, by triage category, Victoria, 2012–13 to 2017–18



Source: Department of Health and Human Services. Triage minimum dataset 2012–13 to 2017–18

Service providers told the Commission that triage systems are experiencing huge demand⁷¹ and that services have inadequate resources to answer all calls. Eastern Health's Child and Youth Mental Health Service and the NorthWestern Mental Health Triage Service and Youth Access Team serve as two examples. Eastern Health reported that the Child and Youth Mental Health Service received more than 10,000 calls in a 12-month period and said they do not have enough resources to respond to this level of demand.⁷² Of the 10,000 calls, 3,000 were abandoned by the caller, which Eastern Health attributed to long wait times.⁷³ The NorthWestern Mental Health Triage Service and Youth Access Team reported that wait times for an assessment can be several hours.⁷⁴

Where the triage assessment results in a determination that specialist clinical mental health services are not required at that time, Department of Health and Human Services guidelines require that triage clinicians proactively help the person to find alternative services where necessary.⁷⁵ Dr Coventry acknowledged, however, that the overburdened triage clinicians do not always provide this assistance:

For the triage system to work effectively, individuals, families and carers need to be referred to the right services, which may be within or outside the specialist system. However, feedback from services suggests that people who do not access clinical mental health services may not always be directed to other appropriate treatment or support pathways (for example, the [National Disability Insurance Scheme] or primary care pathways).⁷⁶

It appears to the Commission that the triage response from area mental health services—when it occurs—is under-resourced for assessing people's overall needs and that services are not proactively referring them to other services when specialist clinical mental health services are not appropriate or cannot be offered. The Commission is concerned that a triage system so overburdened that callers wait for hours to receive a minimalist response—or hang up before they speak with a clinician—potentially fails to avert a wide range of harmful consequences, including self-harm and suicide.

Helplines

A range of non-government and peer-led organisations have 'helplines' that provide information, advice and referral to face-to-face mental health services. Numerous different helplines are listed online, among them Lifeline, Kids Helpline, SANE Australia Helpline, Beyond Blue, Support After Suicide and Perinatal Anxiety and Depression Australia (PANDA).

There is high demand for helpline services. The data available to the Commission are limited, but the available information suggests that many calls to helplines go unanswered. For example, a recent consultation paper for a planned National Suicide Prevention Implementation Strategy stated that more than a third of calls received by the Suicide Call Back Service in 2017–18 could not be answered.⁷⁷ The paper noted that callers tend to call multiple helplines in the hope of a response, which can be frustrating and creates a risk of the caller giving up on trying to get help.⁷⁸ One person described their experience trying to call a helpline:

I remember once my mental health was very bad and I had thoughts of suicide when I decided to call one of these popular help lines, I was put on hold for 30–40 minutes to the point where I hung up. Lucky, I had a friend who helped me that night. But I never really called one of those lines again.⁷⁹

Although the resourcing of individual helplines might be inadequate, there are obvious inefficiencies in having so many different helplines with overlapping functions. The Commission also agrees with the Productivity Commission's finding, expressed in its recent draft report on mental health, that these services require clearer referral pathways to mental health and related services, including the capacity for 'warm transfer'⁸⁰—that is, the helpline operator making the connection with the service while the caller is still on the telephone.

7.2.4 Difficult transitions between services

To manage and recover, some people will need services from a range of organisations and sectors that consider all aspects of their health and wellbeing, in partnership with the individual and their families and carers.⁸¹

Victoria's mental health services are not well-connected with each other,⁸² with other health and treatment services, or with other vital support systems and services. People who attended the Commission's community consultations said they are 'handballed' between services, with no information sharing, resulting in them having to repeat their story multiple times and delaying care.⁸³ As Ms Natasza Purser submitted:

I've had repeated experiences of my referrals not being received, getting lost, not being done or not being acted upon. All contributed to delaying my recovery and gaining access to services. On many occasions I have had to chase up my own referrals, look for my own psychiatrist [...] I've also had to remain in charge of providing information across my providers as they seem incapable of actually communicating themselves. Extra strain on someone recovering from a full nervous breakdown and suicidal mindset. I found the system impossible to actually navigate whilst I was suicidal.⁸⁴

This lack of connectivity means that GPs and health care teams need to work through a complex range of supports to match someone with the care they need; this includes services provided through Medicare, Better Access, state health organisations, Access to Allied Psychological Services and headspace. Most of these supports work in isolation from one another and are relatively narrow in their focus, limiting the effectiveness of shared-care arrangements.⁸⁵ Dr Coventry concurred, informing the Commission that service gaps exist for consumers transitioning between services and that information sharing is problematic.⁸⁶

Dr Caroline Johnson, a GP, outlined some of the impacts of a complex and fragmented service system:

Unfortunately, the pathways to better mental health care are overly complex and poorly connected, particularly in the situation where a patient has already accessed some care but has not improved or when there are financial barriers and long waiting times to accessing more expert care. One example of this is that psychologists often move into private practice as they become more experienced, and some people can't afford this type of care. Or sometimes a patient in crisis agrees to get help, but by the time the appointment comes through the crisis has subsided and the patient is no longer willing to follow through with help-seeking (until the next crisis appears and the cycle starts again). Or a service is funded for a while, but then the referral rules or type of service changes just as the service is starting to be known.⁸⁷

Community Information and Support Victoria submitted that there is a lack of services for people who need assistance with navigating the system.⁸⁸ In the past many clinical and psychosocial support services had roles dedicated to helping people obtain the various services they needed. The Commission was told these roles have diminished as demand and cost pressures on services have increased, leaving many people to fend for themselves in finding the right service.⁸⁹

7.3 Rationing of public specialist services

As discussed earlier, Victoria's public specialist clinical mental health services have high thresholds for who they can see. This section examines the underlying reason for this, which is strong growth in demand in the context of limited investment in extra services. It then outlines how the resultant service 'rationing' has created serious unmet need for these services and depleted the overall service offering available to consumers.

7.3.1 Strong growth in demand

Along with the system's structural challenges discussed in Chapter 5, the failure of supply to keep up with demand is the primary reason people miss out on or wait longer for services. Although there are potentially other factors that affect demand, such as increased community awareness of mental illness, flow-on effects from changes to other systems, including education and justice and increased help seeking, population growth is the key driver. Changing patterns of drug use also warrant consideration as a factor that has created additional need for mental health services.⁹⁰

Population-driven demand

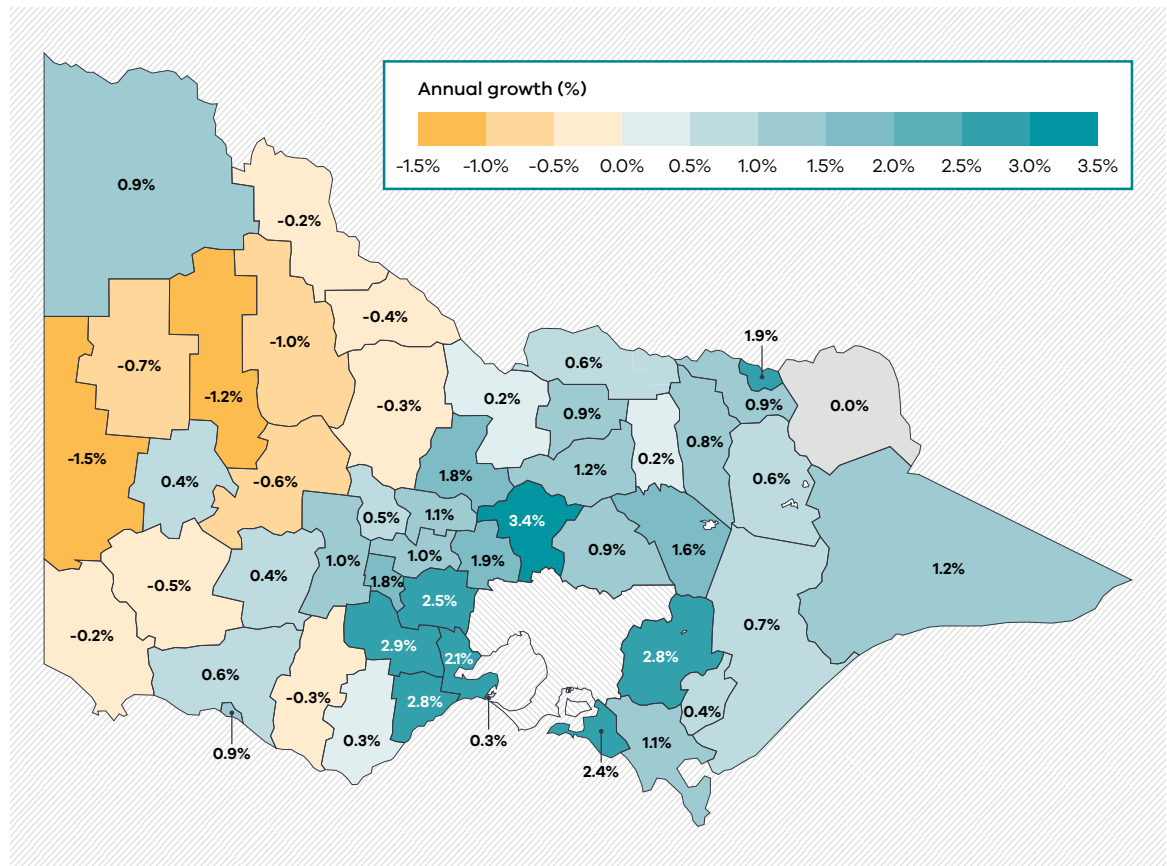
In the past 30 years Victoria's population has grown considerably and its needs have changed. The population has increased from 4.6 million in 1999 to an estimated 6.5 million in 2019.⁹¹ The 2019 figure represents an increase of 2.1 per cent on the preceding year, making Victoria the fastest growing Australian state or territory.⁹² Almost half of Victorians (49.1 per cent) were born overseas or have a parent born overseas. More than 15 per cent are 65 years of age or older, a proportion that is expected to increase in the coming decade.⁹³

The Commission was advised that general population growth in recent years has greatly exceeded government forecasts.⁹⁴ An additional challenge for those responsible for providing services is that population growth has not been even across the state. Figures 7.3 and 7.4 show population growth in regional Victoria and metropolitan areas, by local government area between 2009 and 2018.⁹⁵ This has put strong pressure on services in growth corridors.⁹⁶

Population growth has resulted in big increases in the estimated number of Victorians requiring mental health services. Table 7.1 shows the number of people who required mental health services in 1999 compared with the number who required mental health services in 2019 (see also Figure 7.5). The Commission's calculations are based on the National Mental Health Services Planning Framework which recommend that individually tailored mental health services are required for everyone living with severe mental illness, 80 per cent of people living with moderate mental illness, and 50 per cent of people living with mild mental illness.⁹⁷

The Victorian Government's official population projections foreshadow continued strong growth in the state's population, estimating that the state's population will be more than 11 million by 2056.⁹⁹ This underscores the need for sophisticated planning of mental health services and sustained investment to ensure service supply keeps pace with demand.

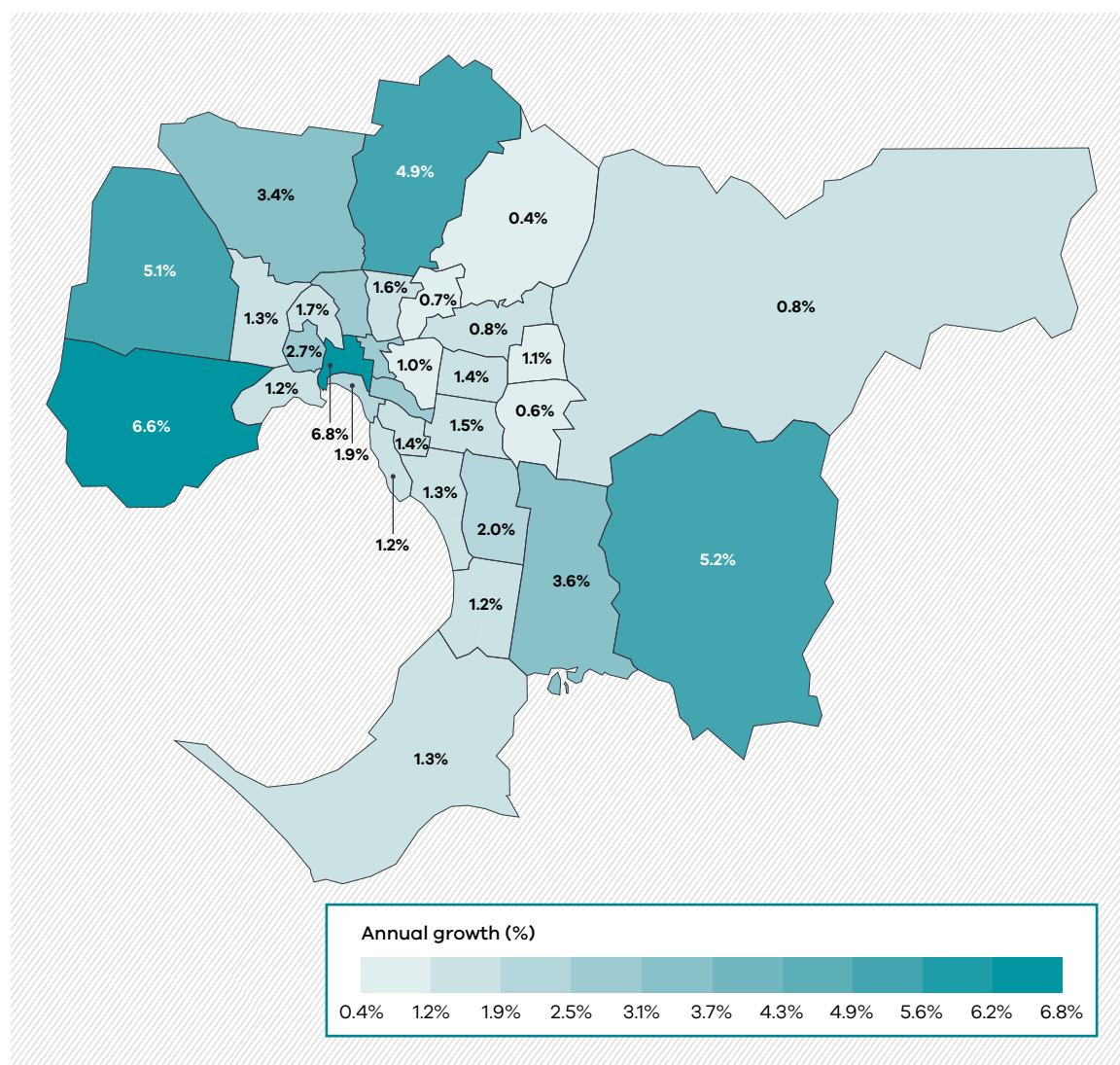
Figure 7.3: Annual population growth by rural and regional local government area, Victoria, 2009 to 2018



Source: Australia Bureau of Statistics. Regional Population Growth, Australia, 2017-18, Population Estimates by Local Government Area (ASGS 2018), 2001 to 2018 <http://stat.data.abs.gov.au/Index.aspx?DataSetCode=ABS_ERP_LGA2018> [Accessed 28 October 2019].

Annual growth represented in this figure is compound annual growth. Compound annual growth is the smoothed annual change over the specified period (as if the growth had happened steadily each year over that time period).

Figure 7.4: Annual population growth by metropolitan local government area, Victoria 2009 to 2018



Source: Australia Bureau of Statistics. Regional Population Growth, Australia, 2017-18, Population Estimates by Local Government Area (ASGS 2018), 2001 to 2018 <http://stat.data.abs.gov.au/Index.aspx?DataSetCode=ABS_ERP_LGA2018> [Accessed 28 October 2019].

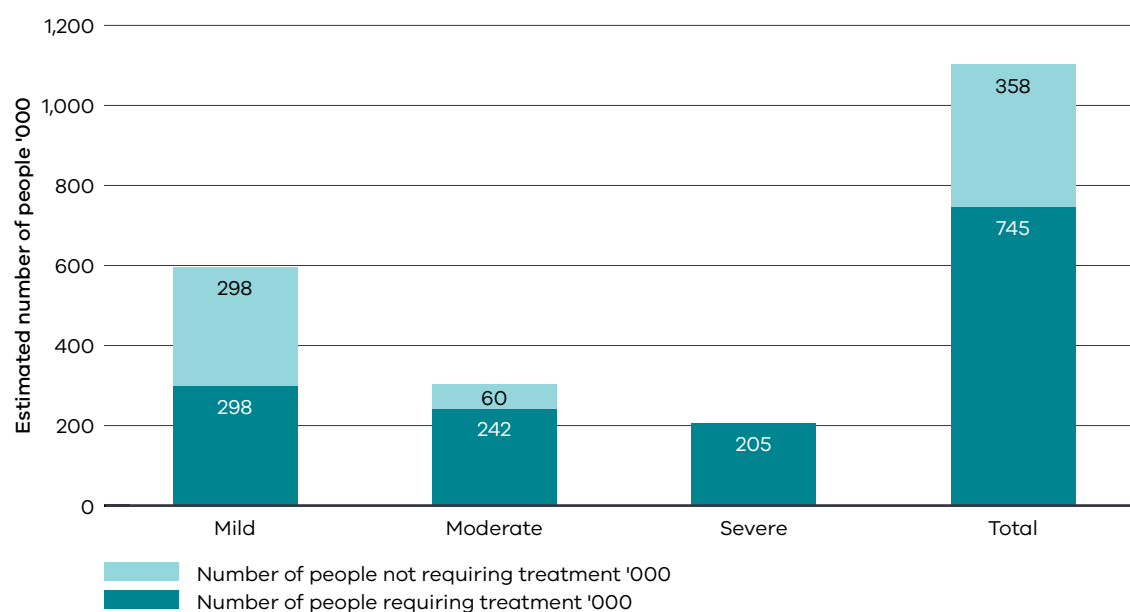
Annual growth represented in this figure is compound annual growth. Compound annual growth is the smoothed annual change over the specified period (as if the growth had happened steadily each year over that time period).

Table 7.1: Estimated prevalence of mental illness by severity and proportion requiring individually tailored mental health services, Victoria, 1999 and 2019

Severity of illness	Estimated prevalence	Estimated percentage requiring treatment	Estimated number of people in 1999	Estimated number of people requiring treatment in 1999	Estimated number of people in 2019	Estimated number of people requiring treatment in 2019
Mild	9.0%	50%	421,000	211,000	596,000	298,000
Moderate	4.6%	80%	214,000	171,000	302,000	242,000
Severe	3.1%	100%	143,000	143,000	205,000	205,000
Total	16.8%		778,000	525,000	1,103,000	745,000

Source: Commission calculations based on the National Mental Health Service Planning Framework and population data from Department of Environment, Land, Water and Planning, Victoria in the Future 2019; Australian Bureau of Statistics, Australian Demographic Statistics, June 1999, cat. no. 3101.0, Canberra.

People living with a mental illness that do not require individually tailored mental health care may be accessing other forms of support including from self-help materials, or from family or friends.

Figure 7.5: Estimated number of people living with a mental illness and proportion requiring mental health services, Victoria, 2019

Source: Commission analysis of the National Mental Health Service Planning Framework and population data from the Department of Environment, Land, Water and Planning, Victorian in the Future 2019.

People living with mental illness that do not require individually tailored mental health care may be accessing other forms of support including from self-help materials, or from family or friends.

Increasing methamphetamine use

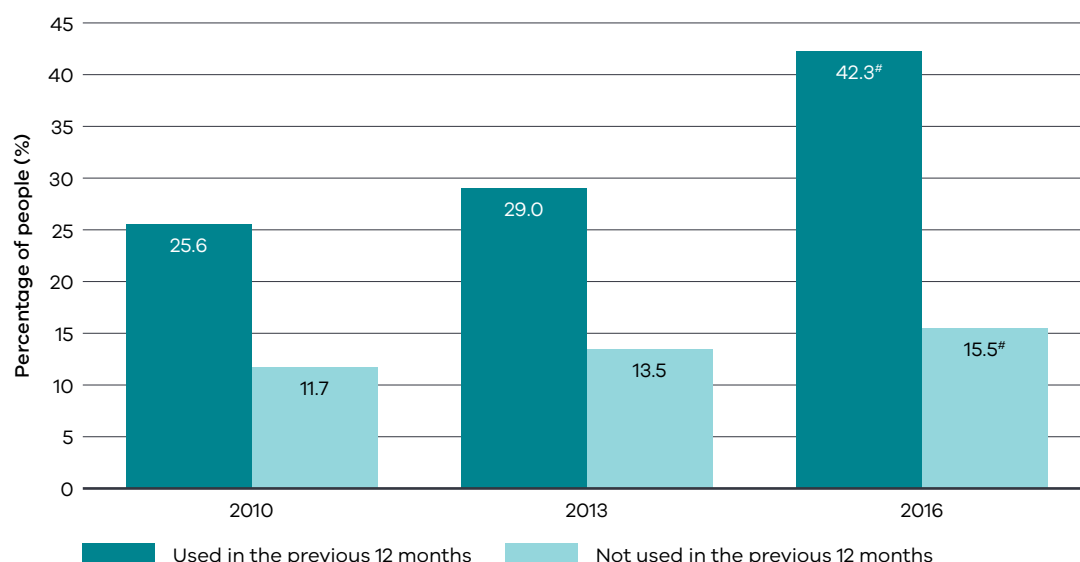
One factor consistently identified as contributing to the demand for mental health services, and the higher acuity and complexity of consumers' needs, is the community's changing patterns of alcohol and drug use,¹⁰⁰ especially increasing methamphetamine use.¹⁰¹ Dr Ravi Bhat, Divisional Clinical Director of Goulburn Valley Area Mental Health Service, Goulburn Valley Health, told the Commission that Australia has one of the highest per capita rates of methamphetamine use in the world.¹⁰²

The 2016 National Drug Strategy Household Survey found that while the use of methamphetamines in the previous 12 months declined nationally, 'ice' (also known as 'crystal meth') increased from 22 per cent of recent methamphetamine users in 2010 to 57 per cent in 2016.¹⁰³ The overall use of ice across the population doubled between 2010 and 2016 (from 0.4 per cent to 0.8 per cent).¹⁰⁴

According to the 2016 survey, 15.9 per cent of those aged 14 years or older who had used methamphetamines had been diagnosed with or treated for a mental illness in the previous 12 months, increasing from 13.9 per cent in 2013.¹⁰⁵ While the proportion of people being diagnosed with, or treated for, a mental illness who also had a drug dependency increased across all drugs, the second most noticeable increase was among recent users of methamphetamines (up 46 per cent).¹⁰⁶ People using methamphetamines in the past 12 months were also more likely than any other drug users to report being diagnosed with or treated for a mental illness (three times as high as the non-illicit drug using population).¹⁰⁷

The proportion of people aged 18 years or older who live with a mental illness and are using methamphetamines increased between 2013 and 2016 at the national level (see Figure 7.6).

Figure 7.6: Proportion of people aged 18 or older diagnosed or treated for a mental illness, that are also using methamphetamine, Australia, 2010 to 2016



Source: Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016. Specific population groups Chapter 8 Supplementary data tables. Table 8.12. <<https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed/data>> [Accessed 12 November 2019].

Mental illness includes depression, anxiety disorder, schizophrenia, bipolar disorder, an eating disorder and other form of psychosis.

Inclusions is based on non-medical use.

Statistically significant change between 2013 and 2016.

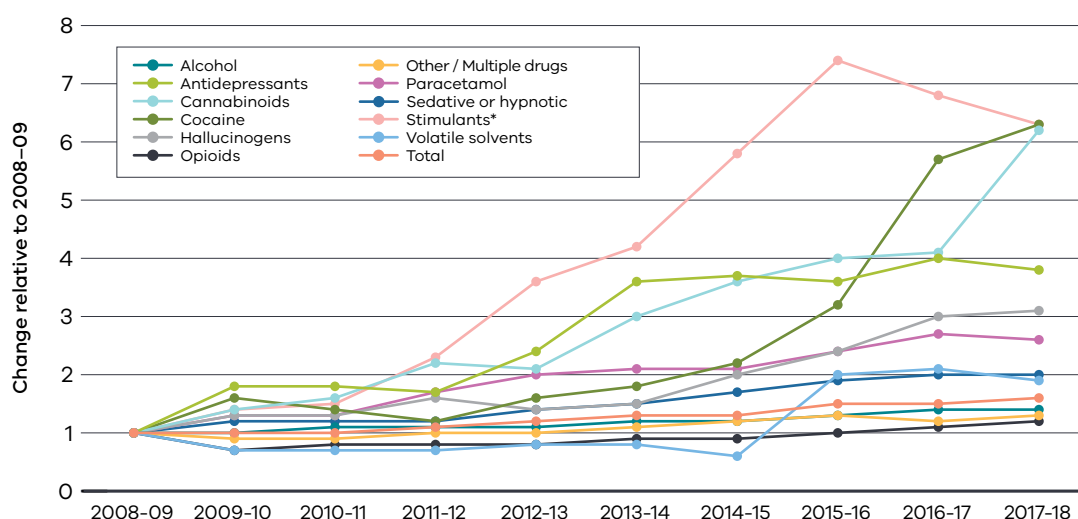
The Commission was told that Victorian emergency departments and area mental health services are seeing more people with concurrent poor mental health and methamphetamine exposure. Dr Bhat referred the Commission to Management of Mental Health Patients in Victorian Emergency Departments: a 10-year Follow-up Study,¹⁰⁸ which reported that mental health-related emergency department presentations with concurrent methamphetamine exposure doubled between 2004 and 2013, from 2.2 per cent to 4.3 per cent.¹⁰⁹

Alfred Health reported that at least 47 per cent of 'bed days' in its mental health inpatient unit are occupied by people who have a substance use disorder.¹¹⁰ Area mental health services reported 'a greater proportion of mixed and methamphetamine drug use [...] [has led] to a rise in drug-induced psychosis and aggressive behaviour by patients towards staff and other patients'.¹¹¹

Figure 7.7 shows the change in the number of people presenting to Victorian emergency departments with both mental health-related needs and an alcohol or other drug-related diagnosis between 2008–09 and 2017–18. This data indicates that among these presentations, the number of presentations involving cannabinoids, cocaine and stimulants (which includes methamphetamine) have grown the most.

The relationship between alcohol and other drugs and mental illness is something the Commission continues to explore. It does, however, accept the advice of area mental health services that drug use is contributing to a more complex client group, creating more demands on mental health services and challenges for the workforce because of the skillset and intensity of care required.

Figure 7.7: Change in the number of mental health-related emergency department presentations with an alcohol or other drug-related diagnoses, by primary drug type. Victoria. 2008–09 to 2017–18



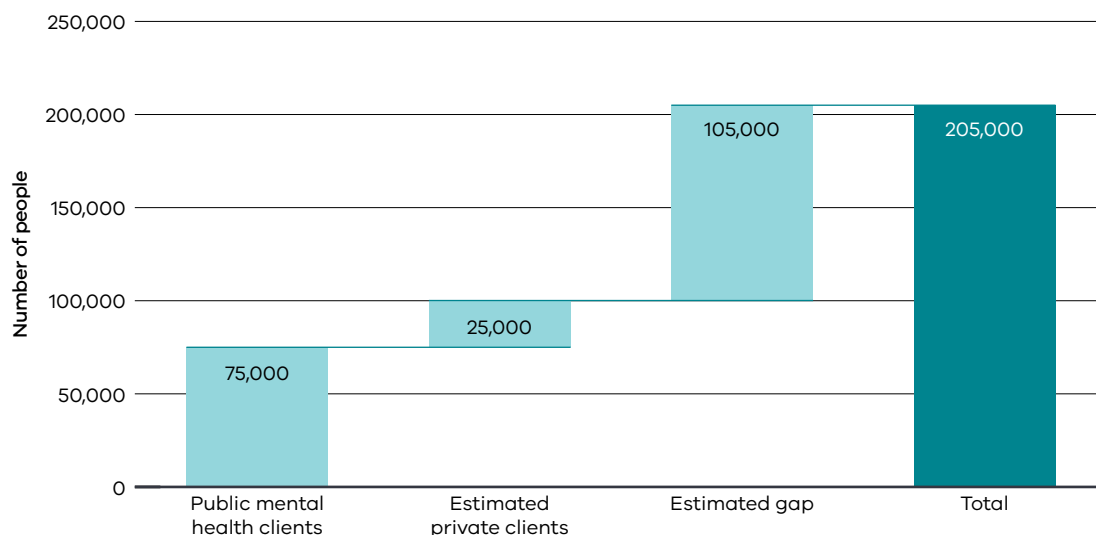
Source: Department of Health and Human Services. Integrated Data Resource, Victorian Emergency Minimum Dataset 2008–09 to 2017–18.

Mental health-related emergency department presentation defined as a) the presentation resulted in an admission to a mental health bed (inpatient or residential), OR b) the presentation received a mental health related diagnosis ('F' codes, or selected 'R' & 'Z' codes R410, R418, R443, R455, R4581, Z046, Z590, Z609, Z630, Z658, Z765), OR c) the presentation was defined to be 'Intentional self-harm', OR d) the presentation involved interaction with a mental health practitioner.

*Stimulants category includes methamphetamine.

Change expressed relative to the reported number of relevant emergency department presentations in 2008–09. e.g. 3 represents a tripling of presentations.

Figure 7.8: Estimated number of people requiring but not receiving specialist clinical mental health services, Victoria, 2019



Source: Calculation by the Commission based on National Mental Health Service Planning Framework; Department of Environment, Land, Water and Planning. Victoria in the Future 2019; Department of Health and Human Services, Victoria's Mental Health Services Annual Report 2018–19, 2019, p. 82; Australian Institute of Health and Welfare. Mental Health Services in Australia. Overnight Admitted Mental Health-Related Care 2017–18. Table ON.4 and Same day admitted mental health-related care 2017–18. Table SD.4 and SD.12 <<https://www.aihw.gov.au/reports/mental-health-services/mentalhealth-services-in-australia/report-contents/summary-of-mental-health-services-in-australia>> [accessed 9 October 2019].

The estimated number of private clients using the private system is based on the statewide proportion of overall mental health admissions in Victoria that occur in private hospitals. Utilisation of private mental health services in rural and regional areas may differ from the state average. There may also be clients receiving care 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.

7.3.2 Unmet demand

As a result of the high demand, limited investment and hence high entry thresholds, many people living with severe mental illness are unable to gain access to Victoria's specialist clinical mental health services.

There is a significant shortfall in appropriate services for the estimated 3.1 per cent of Victorians who are living with severe mental illness¹¹² and require specialist clinical mental health services.¹¹³ This 3.1 per cent equates to approximately 205,000 Victorians needing treatment for a mental illness each year. This level of need could be experienced by people living with a range of illnesses, such as schizophrenia, major depressive or anxiety disorders, severe eating disorders and bipolar disorder.¹¹⁴ In 2018–19, only 1.16 per cent of Victorians (74,794 people) living with severe mental illness were registered with the state's public specialist clinical mental health services.¹¹⁵

Private psychiatry is an alternative treatment option, but people must be able to afford these services, which can be a significant barrier for many.¹¹⁶ Further, under the *Mental Health Act 2014* (Vic) private mental health services, that are not designated mental health services, cannot accept compulsory patients.¹¹⁷ Approximately half of all admissions to public mental health inpatient units are made on a compulsory basis under the Act.¹¹⁸

Although there is limited information available on the number of people living with severe mental illness who use private mental health services, private specialist clinical mental health services treat an estimated 25,000 people living with severe mental illness.¹¹⁹ It is likely that the remaining people (approximately 105,000) are not receiving specialist mental health services (Figure 7.8).¹²⁰

More than 40 per cent of triage assessments conducted by area mental health services in 2017–18 resulted in the person being given information only or being referred to other services, suggesting a high level of unmet demand for public specialist clinical mental health care.¹²¹ Dr Coventry highlighted that in 2019 the Victorian Auditor-General found that ‘over a four-year period [to 2016–17], the number of people seeking access to but not accepted by area mental health services increased by 63 per cent’.¹²²

7.3.3 Unknown need

Notwithstanding the indications of unmet demand just outlined, much of the unmet demand for mental health services cannot be quantified and is therefore unknown. One reason for this is that, in contrast with many other illnesses, some people living with mental illness do not seek out treatment on their own, particularly as symptoms become worse.¹²³ Associate Professor Dean Stevenson, Clinical Services Director at Mercy Mental Health, noted that some people living with severe mental illness do not access services for a range of reasons:

This is a very vulnerable group of people with higher psycho-social problems, lower quality of life and poor motivation for treatment. It is difficult to capture the extent of this unmet demand.¹²⁴

Another factor that impedes understanding of unmet demand is the absence of information. The Department of Health and Human Services does not collate data from area mental health services to identify the number of people who contact triage but do not gain access to services.¹²⁵ The National Mental Health Commission submitted:

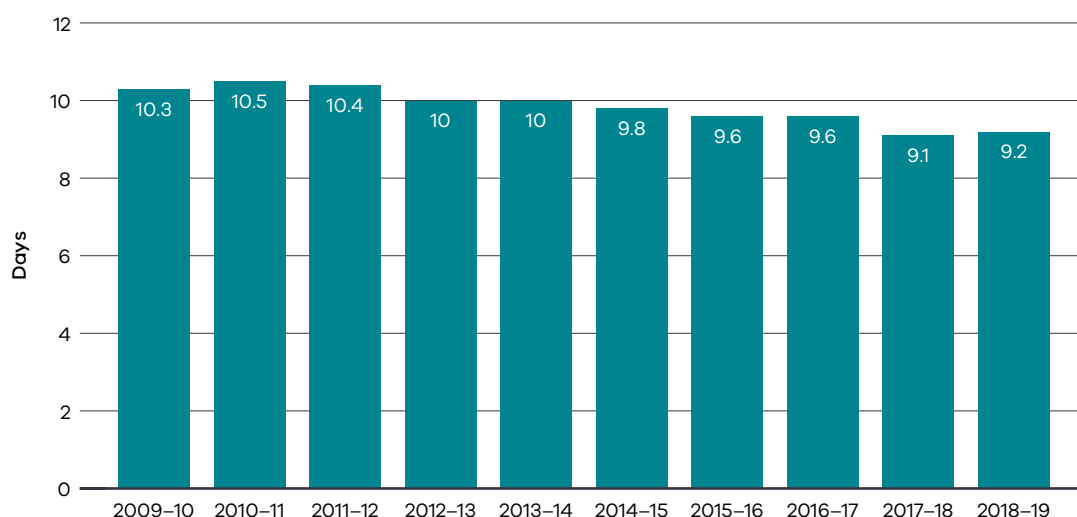
While the use of clinical mental health services is increasing, it is difficult to measure the amount of unmet need, as the available data does not quantify people who are turned away from services or how long people are waiting to access services.¹²⁶

7.3.4 Rationing of inpatient services

The Commission heard evidence that ‘unrelenting demand’¹²⁷ on adult inpatient mental health services has caused area mental health services to ‘ration’ inpatient treatment because of a shortage of acute inpatient beds.¹²⁸

The Commission’s analysis of data on mental health inpatient services confirms this. As the number of admissions to acute inpatient units has increased, the average length of stay for adults has trended downward and remains low. As shown in Figure 7.9, the average trimmed¹²⁹ adult acute length of stay declined from 10.3 days in 2009–10 to 9.2 days in 2018–19.¹³⁰

Figure 7.9: Average length of stay in public adult acute mental health inpatient units (trimmed), Victoria, 2009–10 to 2018–19



Source: Department of Health and Human Services. Client Management Interface / Operational Data Store 2009–10 to 2018–19
Trimmed length of stay excludes same day stays and discharges with length of stay greater than 35 days.
Excludes Orygen beds.

When there is insufficient bed capacity in a unit, people ‘can be discharged on the basis of an assessment of who is least likely to experience a significant negative outcome (to self or others)’.¹³¹ Service providers have told the Commission that stays in acute inpatient units are now often too short to allow for proper assessment, treatment and support to assist recovery from an acute episode.¹³²

This view is shared by many consumers and carers. Ms Erica Williams, a witness before the Commission, stated that her discharge home was premature and put strain on her family and friends:

Eventually I was discharged home, but we weren’t ready—nobody was ready for that to happen, and I think that the hospital, or Orygen as a service, kind of acknowledged that. But there was a real lack of middle ground being intensive hospital and being at home, and we just kind of had to test the waters and see if things would get better, and they didn’t. I had my partner with me most of the time. If he wasn’t there, my friends would be with me. Basically, I was on 24-hour watch while at home.¹³³

Rationing treatment with shorter durations of stay for people in inpatient units also leads to inpatient units being occupied mainly by people with high levels of clinical acuity.¹³⁴ This creates additional challenges for staff and contributes to more stressful experiences for consumers, their families and carers.

Despite overall declines in the length of acute inpatient unit stays, the Commission was told about a group of people whose stay in an inpatient bed is unduly prolonged because of a lack of discharge options. These people generally do not have the highest levels of clinical acuity but might experience complexities related to intellectual disability, severe autism, an acquired brain injury or homelessness. In 2017–18, six per cent of people discharged from adult acute mental health units had a length of stay more than 35 days,¹³⁵ occupying more than 10 per cent of total bed hours that area mental health services are funded to deliver.¹³⁶

7.3.5 Rationing of community-based services

People who are discharged prematurely from inpatient services are likely to return to clinical community-based services with higher complexity and acuity than these services are intended to treat.¹³⁷ The critical need to treat these people means that the bar is raised for everyone who is trying to gain access to community-based specialist mental health services. As discussed previously, entry thresholds are now so high that people are seen only in the acute stages of mental illness and when experiencing a serious crisis.¹³⁸

Illustrating this point, the Youth Support and Advocacy Service told the Commission:

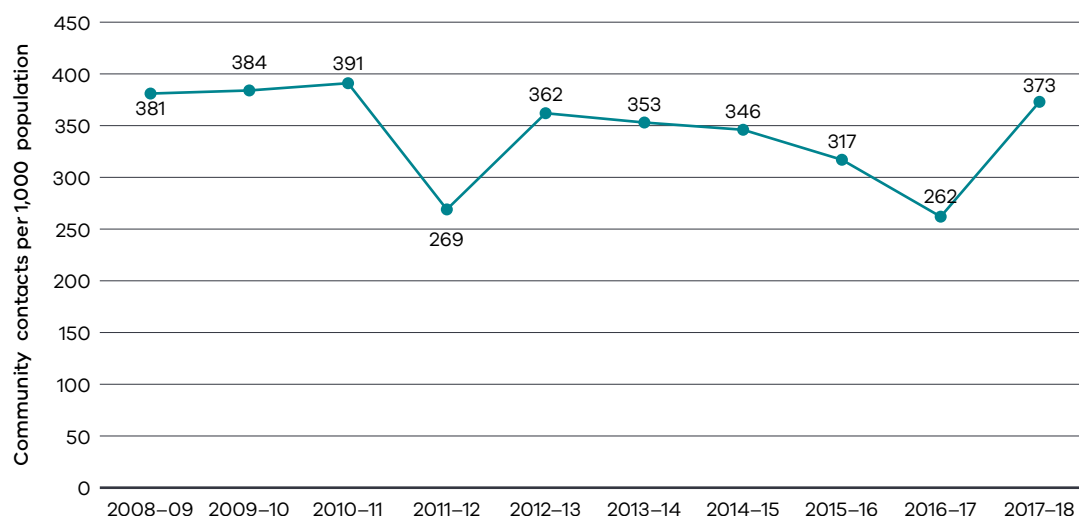
The increasing acuity of patients seeking support in the hospital system has had flow on affects for the complexity of patients being pushed out to community settings and consequently, the client profile supported by the community health sector has evolved to become increasingly complex with higher risk, broader change readiness and more diverse care needs than ever before.¹³⁹

Health services told the Commission they are not resourced to properly manage a consumer group with such high levels of clinical acuity and complexity. Eastern Health explained the challenges:

The current case management model utilised in community clinical services is under pressure as a result of increasing complexities and acuity of mental health consumers. The current workforce is inadequate, from a knowledge, skill mix, resource and funding perspective, to work effectively with this higher risk cohort. Case managers are recruited with a clinical background (nursing or allied health) however there is no specific training for case management for the highly complex consumers managed in the community.¹⁴⁰

Figure 7.10 shows a downward trend over time in the number of 'community contacts' provided for every 1,000 adults; however, recent Victorian Government investment has resulted in the number of contacts increasing back to 2008–09 levels.

Figure 7.10: Community mental health contacts per 1,000 population for registered adult mental health clients (18–64 years of age), Victoria, 2008–09 to 2017–18



Source: Department of Health and Human Services, Integrated Data Resource, Client Management Interface / Operational Data Store 2008–09 to 2017–18; Australian Bureau of Statistics, Australian Demographic Statistics, June 2009 to June 2018, cat. no. 3101.0, Canberra. Table 52

Data represents contacts for registered adult clients only, (18 to 64 years of age).

2011–12, 2012–13, 2015–16 and 2016–17 data collection was affected by protected industrial action. The collection of non-clinical and administrative data was affected, with impacts on the recording of community mental health service activity and client outcome measures.

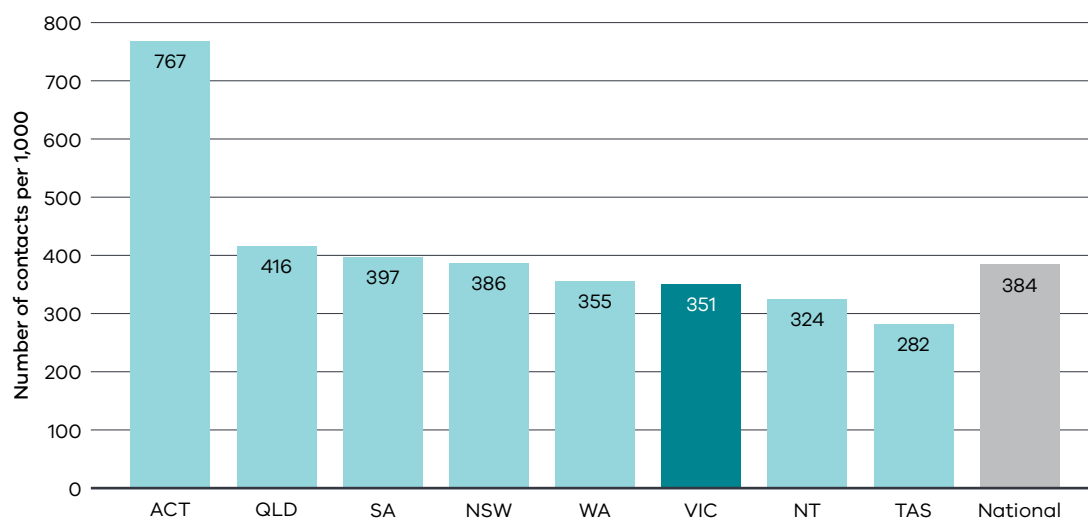
The minimalist level of service in community-based specialist mental health services was acknowledged in the Victorian Government's submission, which notes that consumers of Victoria's community-based mental health services receive a less intense service offering than most of their counterparts in other Australian states and territories:

The average rate of client contacts in Victoria is 252.9 contacts per 1,000 population, while the national average is 365.2 contacts per 1,000 population. Consequently, the rate of improvement at discharge from care has declined over the last decade.¹⁴¹

With additional investment, the Commission notes that Victoria's annual community contacts have improved but are still lower than the national average and most other states (Figure 7.11)

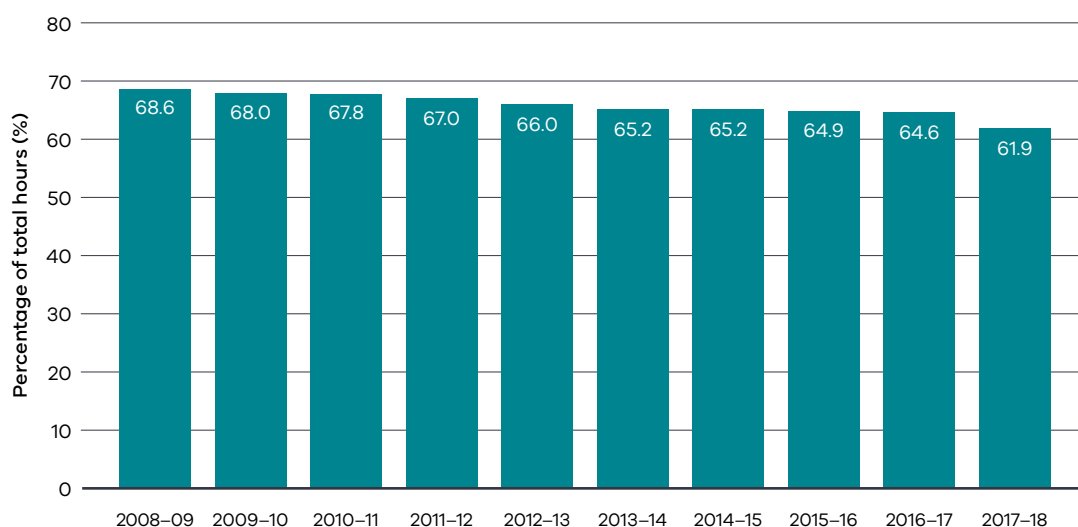
Although the 2017–18 rates of community contacts have nearly returned to 2008–09 levels, the level of direct care (face-to-face contact hours) consumers receive during a community contact has continued to deteriorate between 2008–09 to 2017–18 (Figure 7.12). This means it is unlikely that consumers are experiencing better outcomes despite the increased number of contacts.

Less intensive service offerings in the community means that people whose illness is relapsing, or those facing a situational crisis, are less likely to get the treatment, care and support they require. People who are less likely to have their needs met in the community, become sicker and are more likely to come through emergency departments.¹⁴²

Figure 7.11: Community mental health care service contacts, states and territories, 2017–18

Source: Australian Institute of Health and Welfare. Mental Health Services in Australia. State and Territory Community Mental Health Care Services 2017–18. Table CMHC.1. <<https://www.aihw.gov.au/reports/mental-health-services/mentalhealth-services-in-australia/report-contents/summary-of-mental-health-services-in-australia>> [accessed 9 October 2019].

Collections and counting rules may have changed over the reporting period.

Figure 7.12: Direct community hours (face-to-face contact) as a proportion of total community contact hours for registered adult clients (aged 18–64), Victoria, 2008–09 to 2017–18

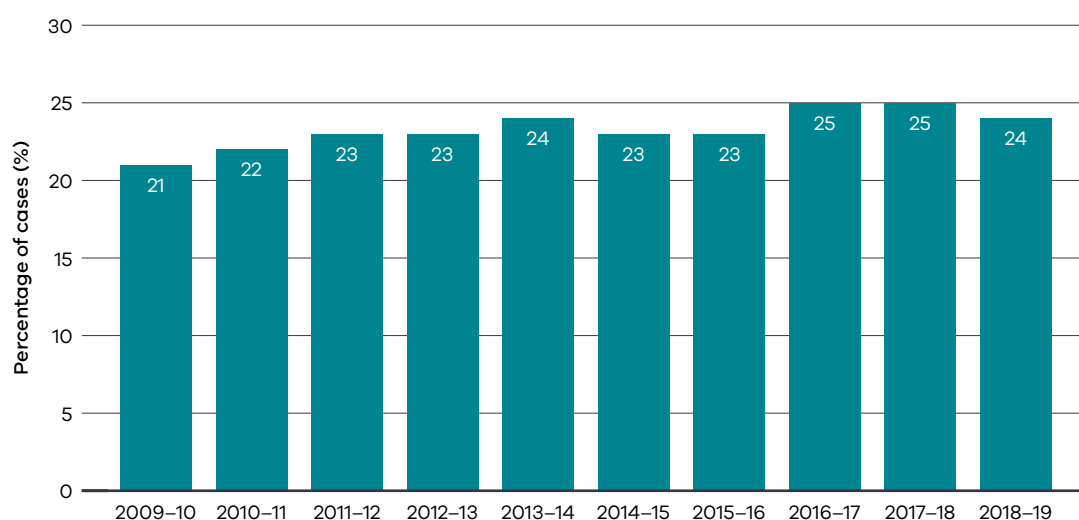
Source: Department of Health and Human Services, Integrated Data Resource, Client Management Interface / Operational Data Store 2008–09 to 2017–18

Note: 2011–12, 2012–13, 2015–16 and 2016–17 data collection was affected by protected industrial action. The collection of non-clinical and administrative data was affected, with impacts on the recording of community mental health service activity and client outcome measures.

Episodic, crisis-driven care

Sometimes area mental health services are only able to offer consumers limited assessment and treatment before referring them to other service providers.¹⁴³ However, Associate Professor Ruth Vine, Executive Director of NorthWestern Mental Health, Melbourne Health, told the Commission that the available service options for people living with severe mental illness are very limited.¹⁴⁴ Therefore, consumers tend to relapse and return to the area mental health service for another episode of care.¹⁴⁵ Figure 7.13 shows that an increasing proportion of consumers are returning to clinical community-based mental health services within six months of being discharged from the service.

Figure 7.13: Percentage of adult cases reopened (returning to clinical community-based mental health services) within six months, Victoria, 2008–09 to 2017–18



Source: Department of Health and Human Services. Client Management Interface / Operational Data Store, 2009–10 to 2018–19.

This figure describes the proportion of adult cases closed where a new case for the same person was opened within six months of case closure.

Excludes cases that were opened on the same day or the day after the previous case closure.

Excludes Orygen.

A consequence of the limited service availability is that people living with mental illness often now only receive care in times of crisis. Mental health services try to treat the crisis but they are often unable to provide services of the type and intensity needed,¹⁴⁶ resulting in people cycling back through services.¹⁴⁷ The Royal Australian and New Zealand College of Psychiatrists highlighted the impact of the ‘revolving door’ on people living with mental illness:

The [Victorian public psychiatric and mental health system] has changed over time. Historically, psychiatrists worked across both the public and private mental health systems, providing holistic and psychotherapeutically-informed continuity of patient care. Within the last two decades, the [Victorian public psychiatric and mental health system] has become unsafe as a result of increasing pressures; limited resources for psychiatrist staffing, subsequent high psychiatrist caseloads of high acuity (unwell and at risk) patients, and with constant pressures to reduce lengths of patient stay. As a result, the [Victorian public psychiatric and mental health system] has become a system that provides a revolving door of brief, crisis-focused, often restrictive and generally biomedical (medication) interventions that fail to address patients’ underlying conditions, which are often trauma-related.¹⁴⁸

Another consequence is that families and carers have increasingly become the providers of care.¹⁴⁹ As Tandem, Victoria’s peak organisation for mental health carers, pointed out, the Commission has received many stories of a ‘catch 22’ and heard about the detrimental impact on the consumer’s health and that of their families:

As commissioners you have witnessed many testimonies around the state. You will have heard stories of a Catch 22, when the only option available to people exacerbates the issues it is seeking to address. Families experience chaos as they try to find the right door, in fact any door, which will lead to support. They then report challenges in dealing with police, ambulance and other service providers who are clearly under resourced and struggling to deal with the impact of our broken mental health system. People spend hours waiting in over crowded and stressful emergency departments, only to be discharged, sometimes without the knowledge of their family, on powerful medication. Often, the process repeats over and over, with the person’s condition continuing to deteriorate.¹⁵⁰

Disintegration of community models of care

The episodic care being delivered by Victoria’s specialist mental health system is unsuitable for people living with severe mental illness,¹⁵¹ and the situation is exacerbated by the fact that services are increasingly unable to deliver the evidence-based models of care envisaged in the post-institutionalisation ‘frameworks’ for community-based services (see section Box 7.1).

In the 1990s when Victoria deinstitutionalised mental health care, it was intended that the ‘backbone’ of the new system would be recovery-oriented services in the community.¹⁵² The functions of these services were to stabilise acute illness, help people prevent or manage relapses, and support their recovery by connecting them to health, community, educational and vocational services.

Box 7.1

Post-deinstitutionalisation model of community-based specialist mental health care

The community-based model of care prescribed by the (then) Victorian Department of Health and Community Services recognised that although some people recover well after a brief episode of mental illness, others experience repeated episodes or chronic symptoms of mental illness that require engagement with mental health services for lengthy periods. The department's 1994 Framework for Service Delivery required each adult area mental health service to establish (in addition to bed-based services) three functionally separate community-based clinical teams targeted to different types and level of need:

- crisis assessment and treatment services—a 24-hour, seven-day-a-week mobile service to assess people in the community experiencing mental health crises and determine whether they require admission to an inpatient unit
- mobile treatment and support services—providing intensive long-term community support to people living with severe mental illness and associated disability (one of the intended purposes of this service was to avoid or minimise the need for repeated and lengthy hospital admissions)
- continuing care, clinical and consultancy services—clinic-based assessment, treatment, case management and consultancy services.

Demand and funding pressures have led to most area mental health services moving away from the service models specified in the 1990s service delivery frameworks. Services have evolved differently, but there has been a marked shift away from mobile crisis assessment and outreach services towards services delivered in community-based clinics and emergency departments.¹⁵³

These developments were referred to repeatedly in evidence presented to the Commission. For example:

Initially dynamic mobile assertive community outreach, and home treatment teams, began to falter and retreat into the hospital. Many were dismantled and merged with case management, which enabled further cuts to be made. Good money was thrown after bad, resourcing non-evidence-based care in emergency departments with poor results [...] The experience of patients who were treated in this system became increasingly negative. The system focused increasingly on risk management rather than the delivery of evidence-based treatment. The threshold in mental health triage teams for entry to the system became impossibly high, and many clinicians and police refused to invoke the Mental Health Act even in clear-cut cases, when care should have been assured through this route.¹⁵⁴

There is reduced capacity for assertive community treatment. This means more people drop out of treatment, fail to engage or become unwell again [...] Even those with severe mental illness who do receive a service do not necessarily receive a service that is as assertive, targeted or of the duration that is indicated [...] The outreach program was previously focused on treatment and rehabilitation but its focus is now on medication supervision.¹⁵⁵

In addition, outreach capacity (that is, the capacity to visit consumers in their homes) has diminished significantly ...¹⁵⁶

... with time, that assertive outreach component of services has also dwindled and doesn't exist anymore.¹⁵⁷

When a system is under pressure, staff tend to put up barriers and give reasons for not accepting a person for care, rather than keeping an open-door policy. Historically, one of the problems we encountered was that the Crisis Assessment and Treatment (CAT) and Mobile Support and Treatment (MST) teams set a limit on their caseloads and then declined to accept new people, with the result that the clinic-based Continuing Care Team (CCT) had to absorb more and more of the demand. This was one of the reasons we moved to integrated teams. So when a system is under pressure, people find it harder to get through to triage, to get to the right place of care and to get that care in a timely way [...] The loss of fidelity to the model is in part a result of imposed savings requirements, but it is also related to industrial requirements, safety concerns and workforce constraints. The population growth in outer and inner metropolitan areas, and population decline in some country areas, also made fidelity to the Framework model more difficult.¹⁵⁸

Difficulties reported by service providers in attracting and retaining experienced clinicians¹⁵⁹ (who have skills in responding to behavioural problems) might also have played a role in services' reluctance to employ workers in outreach roles.

The lack of assertive outreach service capacity particularly affects people living with severe mental illness who, because of the nature of their illness, homelessness or other forms of social marginalisation, are unable to attend clinic appointments and are difficult to engage in treatment, care and support.

This gap in the system exists despite extensive research showing that assertive outreach models of care can be effective in improving both individual and system outcomes.¹⁶⁰ In presenting evidence to the Commission, Professor Malcolm Hopwood, Director of the Professional Psychiatry Unit at Albert Road Clinic, said that assertive community outreach became a 'key plank of the deinstitutionalisation movement', on the basis of research showing that it helped people living with severe mental illness function better in the community by reducing admission rates.¹⁶¹ Professor Hopwood also noted that 'many people feel much safer receiving care in home [...] they feel I think a greater sense of control'.¹⁶²

One carer commented on a positive experience with one of the remaining assertive outreach services but also noted that it was a time-limited program:

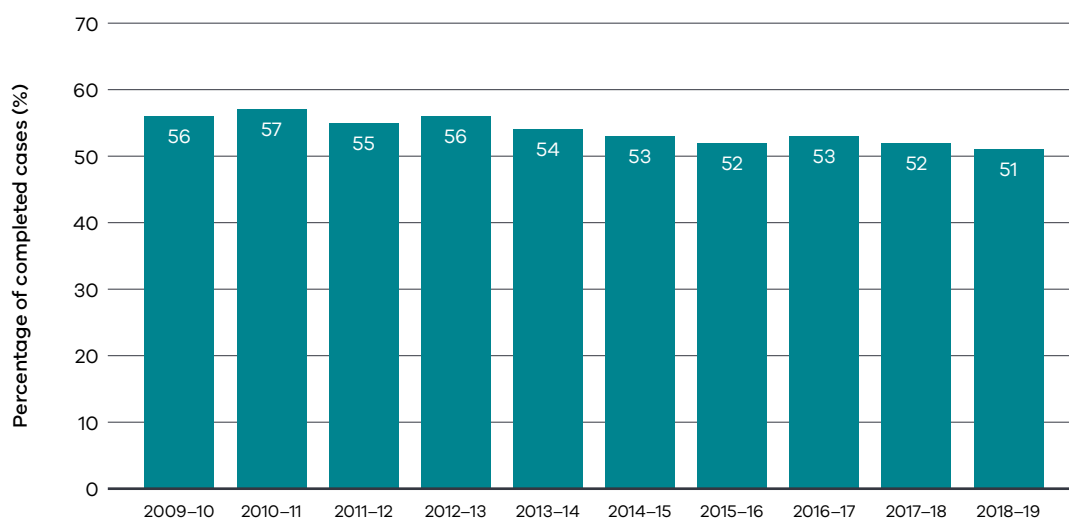
Staff come to our home. This is working really well, and we are seeing improvements in our mum. They come and check on her and make sure she is taking her medications. They come to talk and have a coffee with her. But there needs to be more of it. It is also only a 12-week program.¹⁶³

The diminished service offering provided by community-based mental health services has undoubtedly contributed to a trend towards fewer people experiencing significant improvement in their clinical outcomes after periods of treatment from these services. As indicated in Figure 7.14, the proportion of adult consumers who experience a significant improvement in their mental health has declined in the past decade (as measured by clinicians using the Health of the Nation Outcome Scales).¹⁶⁴

Attempts to manage demand by raising the bar for service access and providing fewer, less expensive community based services to more unwell consumers creates more demand for high-cost services in emergency departments and inpatient settings. The Victorian Government acknowledged that inadequate treatment of consumers in the community was contributing to:

... a cycle that drives people experiencing mental illness to return to emergency departments and acute inpatient care. Without appropriate community-based care dedicated to meeting the needs of each individual, the system risks increased inpatient readmissions, generating more demand on our hospitals and people becoming entrenched in the justice system.¹⁶⁵

Figure 7.14: Percentage of adult consumers with a significant positive change in their mental health following a period of community-based treatment, Victoria, 2009–10 to 2018–19



Source: Department of Health and Human Services.
Client Management Interface / Operational Data Store 2009–10 and 2018–19

2011–12, 2012–13, 2015–16 and 2016–17 data collection was affected by protected industrial action. The collection of non-clinical and administrative data was affected, with impacts on the recording of community mental health service activity and client outcome measures.

7.3.6 The postcode lottery

Unless they require a specialist service that is not provided or available in their catchment area, consumers of specialist clinical mental health services must attend the service corresponding to their catchment.¹⁶⁶ In metropolitan areas different catchments apply to services for adults, older people and children and young people. Because of these boundaries, a consumer's place of residence and age affect the types of interventions available to them.¹⁶⁷

As discussed in Chapter 5, the catchment boundaries have not changed since they were introduced in the 1990s, and they do not reflect demographic changes such as population growth and ageing. The Victorian Government acknowledges that there is now misalignment between service levels and service types compared to the size and needs of the population in catchments. As a result, there is inequity in service access.¹⁶⁸ It has also contributed to the great variability in access to community-based and inpatient services. One community consultation participant told the Commission:

There are huge funding disparities for mental health services—there are differences between metro and regional areas, and differences region to region. If your lottery of birth wasn't enough, what services you get is also a lottery.¹⁶⁹

In the Access to Mental Health Services report, the Victorian Auditor-General found that catchments also cause practical problems that hinder service access:

- The catchment areas are not aligned with other health and human service areas or local government area boundaries, which makes it difficult to coordinate services.
- The misalignment of age-based service groupings (child and youth, adults and older people) means that people may have to transition to different health services, where they are unknown, as they become older.
- There is a lack of coordination when consumers need access to services across catchment borders.¹⁷⁰

Rigid boundaries also mean that when a person moves outside a catchment, they need to find new services. Melbourne City Mission told the Commission this is particularly problematic for people who are experiencing homelessness:

Young people who are experiencing homelessness are regularly required to move across metropolitan Melbourne for temporary accommodation—forcing them to move between the area-based zones of clinical mental health services. The responsibility falls on homelessness services to coordinate area mental health supports for young people across different catchment areas.¹⁷¹

St Vincent's Hospital explained that for an area mental health service that has a prison or forensic hospital located in their catchment area, there are additional challenges. This is because people being discharged from these facilities:

... will be transferred to the relevant area mental health service within the facility's catchment area regardless of whether it is the most appropriate place for that consumer to attend (that is, they may need access to a secure extended care unit (SECU) bed).¹⁷²

The misalignment of age-based service groups and catchments can also be disruptive for young people. Some young people access or transition into public adult clinical mental health services at a relatively young age. Depending on the young person's place of residence, this can occur from the age of 16 years. This experience can be disruptive, as explained by Ms Nicole Juniper, a witness before the Commission, who aged 21 started going to an adult clinic:

Not what I—I guess, not what I was expecting, but at the same time I'd heard other people's experiences, and I—I'll admit, I wasn't the most hopeful going to an adult service. You know, family and friends of mine have tried to get support and sometimes you just—you just hit a wall and nothing happens. I was very lucky to get into the service that I did. Again, I've always felt like, you know, my problems are—they're not severe enough to be—I'm not severe enough to be in hospital, but quite often I am struggling. It's—I need support. I can function, I can work, I can volunteer, I can study, but I still need support. And going to this adult service, I felt like they weren't really prepared for somebody that can function like I do, and they weren't able to give me what I needed ...¹⁷³

7.4 Barriers to primary care and private services

Primary care services are often the first point of contact for people seeking help with their mental health. Primary care services, however, are not equitably accessible, restricting access for some people experiencing poor mental health.

7.4.1 Affordability

The cost of services can be a major barrier to people accessing primary mental health care.¹⁷⁴ The Commission was told there are too few bulk-billing mental health service providers, including GPs, psychologists and psychiatrists. For many people living with mental illness, the gap between the Medicare rebate and the fee charged by mental health practitioners is daunting. Consumers, families and carers told the Commission that carrying this financial burden imposed further distress and acted as a deterrent to making use of services:

I'm on the Medicare subsidised psychologist visits and I'm still out of pocket \$87 a visit. That is an astronomical cost! To walk into a doctor, say 'I contemplated suicide last night and I need help' and then have to tee up a time with a heavily booked psych during work hours at that cost. It's hard.¹⁷⁵

Finances, along with long waiting times for appointments to see psychologists, are often the hurdles. There is a dire lack of bulk-billing psychologists and the out-of-pocket expense for the 10 [mental health care plan] visits is often simply too much for many to warrant placing counselling as a priority.¹⁷⁶

Financial stress is a main cause of anxiety and depression and I feel that the struggle of wanting to remain within your support community but knowing that you'll never be able to afford a house, knowing that childcare and education will always be taking the bulk of your finances makes it hard to prioritise mental health treatment. Going to a doctor and getting a referral to mental health support that you can't afford is a terrifying prospect.¹⁷⁷

A disproportionate number of people living with mental illness live on low incomes, cannot afford co-payments and do not hold private health insurance.¹⁷⁸ As Emma King, CEO of the Victorian Council of Social Service, explained, people who live with poverty and disadvantage cannot easily get to appointments, might be difficult to reach by phone (or they may not have a phone) and might be unable to afford the out-of-pocket costs associated with certain services.¹⁷⁹

Although private health insurance can ease some of the financial burden for individuals, the high cost of private health insurance means this option is not available for people living with mental illness who are also experiencing social and financial disadvantage.¹⁸⁰

The Commission was told that private health insurance is not available to fund Medicare Benefits Schedule services outside of hospitals and where they are already available in the public sector. Private hospitals noted that private health insurance is available only for treating people in the 'acute phase' of mental illness in a hospital setting, and restrictions are a significant obstacle to treating people as outpatients in the community.¹⁸¹

7.4.2 Inequitable service distribution

A further barrier to accessing care is the inequitable distribution of primary care services.

The Medicare Benefits Schedule payment model allows providers to choose where they are located and to charge consumers with out-of-pocket expenses. This encourages providers to work in locations where they can charge more and can discourage providers from basing themselves in rural or regional areas.¹⁸² People in higher socioeconomic areas tend to have access to more services, which partly reflects the mismatch between the service providers and where people live.¹⁸³ People in outer metropolitan areas and regional and rural areas face significantly more challenges in finding a primary care provider, and there can be long wait times to access these services.

For the quarter of Victorians who live in rural and regional Victoria, the challenges that impact on accessing mental health services are multifaceted. They include: a lack of services that are available locally or otherwise accessible; less availability of specialist staff at all tiers of the health system; limited referral options between services as people's needs change; a lack of infrastructure, including public transport and accessible internet; poor health literacy; distance to services (and associated travel costs); and privacy and stigma in small communities.¹⁸⁴ Challenges in accessing mental health services as experienced by rural and regional Victorians is discussed in more detail in Chapter 10.

One example the Commission was told about was the distribution of headspace centres, the Commonwealth Government-funded 'one-stop shop' for young people who need help with mental health, physical health, alcohol and other drug problems, or work and study support.¹⁸⁵ In its submission, headspace told the Commission that the extent to which services are available and accessible in each centre varies and is affected by funding availability, staff profile and infrastructure.¹⁸⁶ Participants at the Commission's Whittlesea community consultation advised that mental health services are not distributed equitably, which limits access, especially when people have to travel long distances. The lack of a headspace centre in Whittlesea was cited as one example.¹⁸⁷

Further, many people told the Commission they had to travel long distances to obtain the services they need and noted the additional burden that the time and cost of travel creates for them and people who support them:

People are vulnerable and then you add the complexity of them having to travel to get access to a service [...] this is removing people from an environment familiar to them and away from family and friends and what they know.¹⁸⁸

I don't know how anyone in a state of mental ill-health can be expected to jump on a train to go and get help.¹⁸⁹

In terms of access, I should also mention the distances from home to the services we attended regularly during my son's treatment period: Headspace clinic: 39 kilometres; [child and adolescent mental health services] (case managers): 44 kilometres; [child and adolescent mental health services] (psychiatrist): 124 kilometres; Clinical Psychologist (private): 33 kilometres. No effective public transport for any of these either.¹⁹⁰

Louise Glanville, CEO of Victoria Legal Aid, emphasised that the need for people to travel extensively to obtain support services is incompatible with their being able to focus on their own recovery.¹⁹¹

7.4.3 Waiting times

Variable availability of services coupled with high demand contributes to long wait times for access to services. Long wait times were reported for initial assessment appointments and follow-up treatment appointments among a range of services, such as psychologists, psychiatrists, headspace, counselling and services supporting parents, families and young people.¹⁹²

During community consultations the Commission was told that there are long wait times to access psychologists and psychiatrists in the community. For example:

Wait times for public psychiatry are too high. You will only be referred in absolute crisis and then you will still have to wait 2 months to see somebody.¹⁹³

I had to wait six weeks between psychiatrist appointments [...] it's just too long.¹⁹⁴

Long waiting lists and other delays mean that opportunities are missed when people are ready and willing to engage.¹⁹⁵

Individuals are resorting to emergency departments for support due to high costs or lengthy waiting times associated with other forms of mental health support.¹⁹⁶

The Commission's community consultations and submissions also highlighted long wait times to access services provided by headspace for young people.¹⁹⁷ For its part, headspace told the Commission:

In Victoria we know that at headspace young people wait on average 10.5 days for their intake session, 27.8 days for their first therapy session and 11.8 days for subsequent therapy sessions.¹⁹⁸

Box 7.2

Jo Farmer²⁰⁴



Jo, aged 29 years, has lived experience of mental illness and of caring for others experiencing poor mental health.

First having experienced depression and anxiety as a pre-teen in Scotland, Jo has received numerous diagnoses, among them depression, anxiety, bipolar disorder II and binge eating disorder. Jo describes herself as currently well enough to function in her everyday life, although her mental health conditions remain ever-present.

Now living in suburban Melbourne, Jo has witnessed services being overstretched and ill-equipped to cope with the continually growing demand. The result is that only those who are most unwell are seen. At present the system has insufficient capacity for prevention and early intervention services.

Low capacity within the public system results in people experiencing an exacerbation of their condition whilst waiting for treatment. In rural areas, I have heard of people in acute distress who were required to be sedated for extended periods, to be safely transported to a hospital hundreds of kilometres away.

This is problematic for those who do require treatment away from home, since community and social connection are vital for recovery.

Jo notes that living in a rural part of Victoria is not the only obstacle to service accessibility and thinks the area mental health service model creates a 'postcode lottery' for access to care. She has noted responses she has received while trying to obtain a consultation with a treating psychiatrist:

'I'm sorry but you do not fit our service eligibility requirements.'

'Unfortunately, I am not currently taking new clients.'

'My next available appointment is in three months.'

She believes her doctor was only half joking when she said:

'Your binge eating disorder cannot be treated under our current eating disorder trial as we are only accepting clients with a diagnosis of bulimia. So, I guess that means you have two options: try being sick after bingeing. Or we wait until you develop diabetes and then you can get help.'

The Commission also heard from service providers, young people and carers that demands on headspace had resulted in higher thresholds and long wait times.

At my headspace, many young people are far too hard for GPs and private psychologists—but the waiting time for our services is huge.¹⁹⁹

Our experience is they (headspace and [child and youth mental health services]) handball from one to another. The bar is really high, but we don't even know what the bar is. They have suicidal ideation, but they are still not sick enough to get help.²⁰⁰

In the end we went to headspace and I had to wait six weeks for someone to see her and then she could only have 10 sessions.²⁰¹

I was too complex for headspace—even Orygen didn't really want to take me.²⁰²

According to headspace, wait lists are preventing young people from getting the help they need when they need it:

[As] more young people with complex mental health and social problems and/or moderate to severe mental health conditions are seeking help at headspace [...] these young people are often prioritised due to their high-risk profile, which extends the waiting list for young people with more mild to moderate mental health problems.²⁰³

7.4.4 Capped services

The Commonwealth's Better Access scheme offers a person up to 10 government-subsidised sessions with a psychologist, psychiatrist, GP or eligible social worker or occupational therapist each year.²⁰⁵

Although the scheme has improved services for some, such as people experiencing mild to moderate depression and anxiety, the Commission was repeatedly told that the maximum length of treatment available (the 10 sessions) is inadequate for many people.

The cap of 10 sessions [under a mental health care plan] is stupid. There is no logic behind this—some people need less; some people need more. There is no clinical logic behind this—it is just a funding cap; a number plucked out of the air. You can't structure mental health this way.²⁰⁶

[A] mental health care plan gets people into care, but 10 sessions aren't enough to unlearn a lifetime of issues.²⁰⁷

Ten sessions for psychology is not even touching the surface.²⁰⁸

People wishing to continue beyond 10 sessions are required to pay the full cost, which not everyone can afford.²⁰⁹ Dr Sebastian Rosenberg, from the Australian National University's Centre for Mental Health Research, considers that out-of-pocket costs are a major barrier for many people seeking access to the scheme.²¹⁰

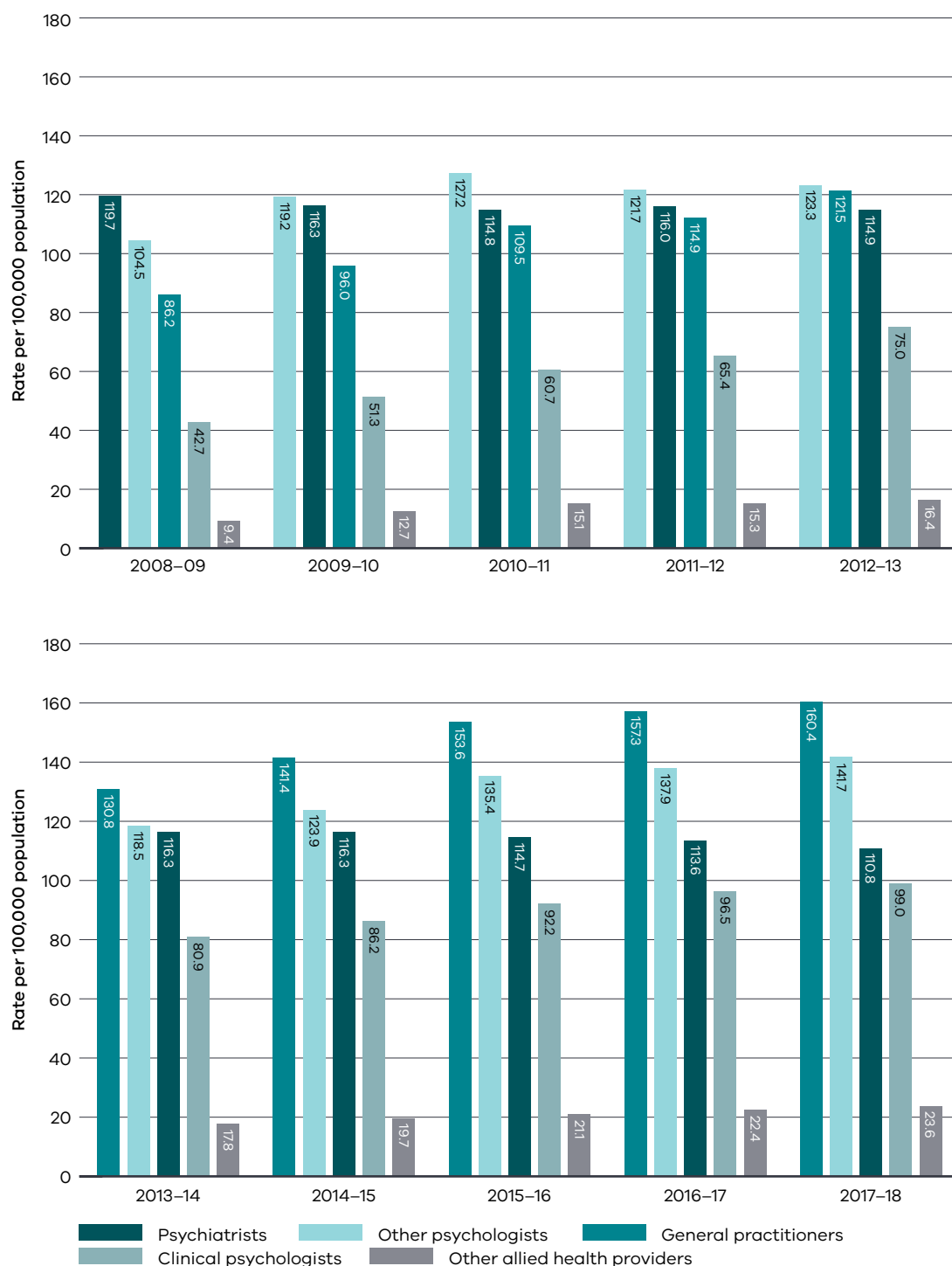
In 2018 the Commonwealth Government announced changes to Medicare to provide comprehensive access to subsidised treatment for people with eating disorders. From November 2019 people can access up to 40 psychological sessions and 20 dietetic sessions each year.²¹¹ This access has not, however, been extended to other types of mental illness. The Commission notes that the Productivity Commission recently recommended improving the flexibility of the Better Access scheme (up to 20 sessions), recognising that there is a proportion of users who would benefit from more sessions.²¹²

It was reported to the Commission that the support provided under the Commonwealth's Better Access initiative is poorly targeted.²¹³ It estimated that up to a third of people accessing individual psychological therapy through the scheme could have their treatment needs equally well met through lower intensity services.²¹⁴ The Productivity Commission's draft report recommended that targeting be improved to ensure the right people are receiving the right treatment.²¹⁵ In particular, it noted that the scheme should be better directed to people living with moderate to severe mental illness who would stand to gain the most from face-to-face psychological therapy.²¹⁶

Despite the limitations of Better Access, the Commission recognises that there are now more Victorians making use of Medicare-subsidised mental health services such as GPs, clinical psychologists, other psychologists and other allied health care providers.²¹⁷ As Figure 7.15 shows, the rate of people receiving Medicare-subsidised mental health services increased for every type of provider except psychiatrists between 2008–09 and 2017–18.²¹⁸ The Commission does not have evidence to allow it to comment on the reasons for the decline in psychiatrist services.

The Commission will continue to consider the role of the Better Access initiative and primary care services more broadly.

Figure 7.15: Change in the rate of Medicare-subsidised mental health services, by provider type, Victoria, 2008–09 to 2017–18



Source: Australian Institute of Health and Welfare. Mental Health Services in Australia. Medicare Subsidised Mental Health-Related Services 2017–18. Table MBS.12. <<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia>> [accessed 9 October 2019].

7.5 Crisis responses and services as an entry point

Systemic complexity, navigation difficulties and a lack of accessible, appropriate services can mean that people are unable to obtain the right support when it would make the most positive difference. This can result in missed opportunities to intervene early and increase the likelihood that poor mental health will lead to a crisis (for example, intentional or accidental self-harm) or escalation of symptoms.

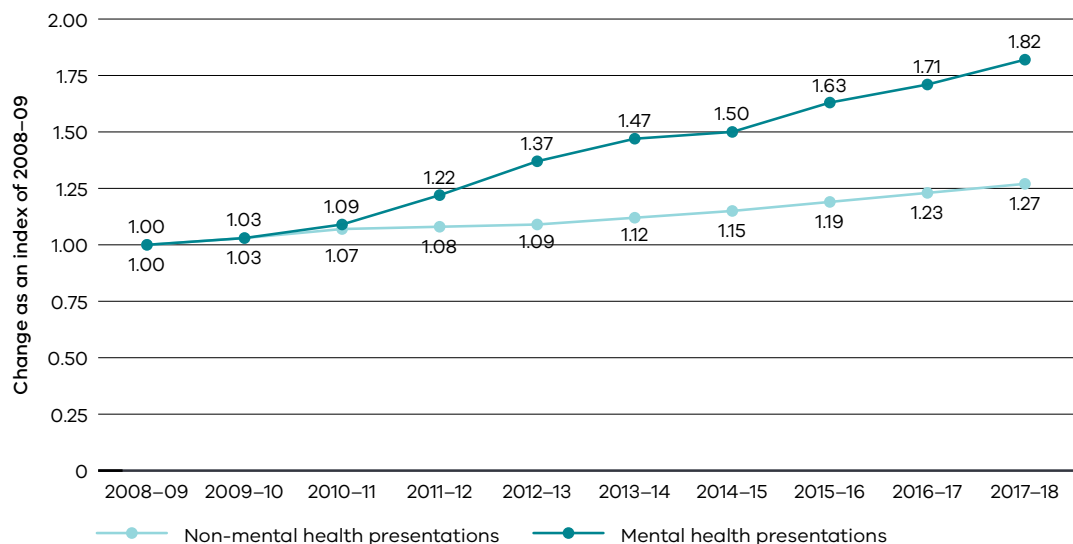
Professional groups told the Commission that the lack of appropriate community-based mental health services has led to disproportionate growth in mental health presentations to emergency departments,²¹⁹ with public hospital emergency departments becoming the default entry point for accessing treatment and care when people are experiencing poor mental health.²²⁰

Related to this, the Commission heard that police and ambulance services are increasingly responding to mental health crises.²²¹

7.5.1 Growing emergency department presentations

Figure 7.16 shows there was strong growth in the number of mental health-related presentations to emergency departments between 2008–09 and 2017–18. During that period, mental health-related presentations almost doubled (an 82 per cent increase), while non-mental health-related presentations increased by only 27 per cent. In 2017–18 there were over 100,000 mental health-related presentations to an emergency department.²²² Figure 7.17 demonstrates that the increase in mental health-related presentations outstrips both population growth and the growth in emergency departments generally.

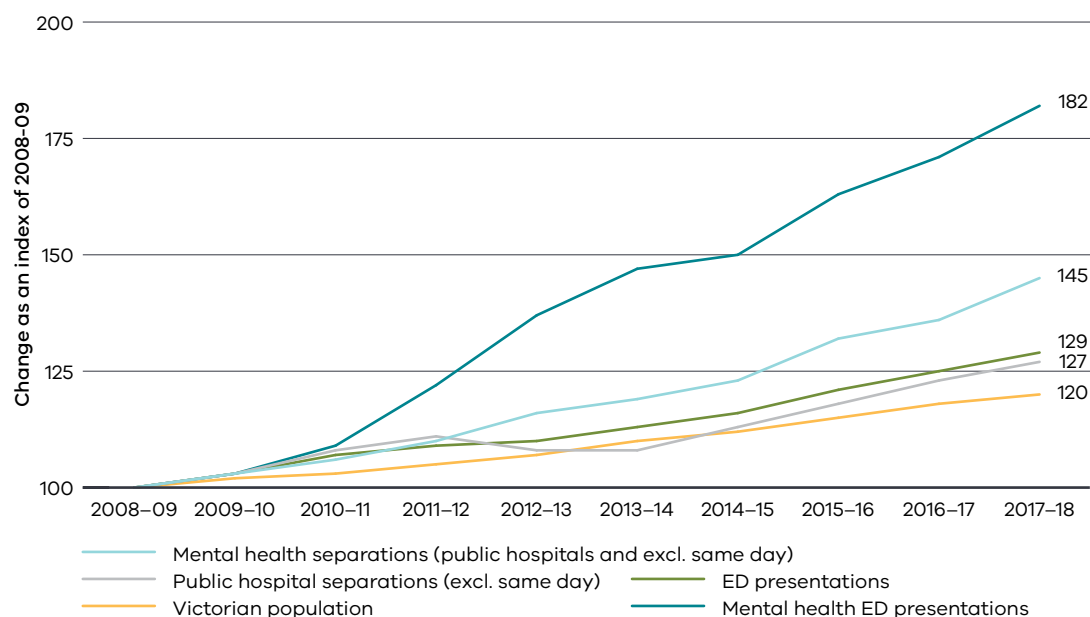
Figure 7.16: Change in the number of emergency department presentations, by mental health status, Victoria, 2008–09 to 2017–18



Source: Department of Health and Human Services, Integrated Data Resource, Victorian Emergency Minimum Dataset 2008–09 to 2017–18.

Mental health-related emergency department presentation defined as: a) the presentation resulted in an admission to a mental health bed (inpatient or residential), OR b) the presentation received a mental health-related diagnosis ('F' codes, or selected 'R' & 'Z' codes R410, R418, R443, R455, R4581, Z046, Z590, Z609, Z630, Z658, Z765), OR c) the presentation was defined to be 'Intentional self-harm', OR d) the presentation involved interaction with a mental health practitioner.

Figure 7.17: Growth in Victorian health service-related activity, indexed, 2008-09 to 2017-18



Source: Department of Health and Human Services, Integrated Data Resource, Victorian Admitted Episodes Dataset, Victorian Emergency Minimum Dataset 2008-09 to 2017-18; Australian Bureau of Statistics, Australian Demographic Statistics, June 2009 to June 2018, cat. no. 3101.0, Canberra.

Between 2011-12 and 2012-13 the negative growth in public hospital separations was due to a change in admissions policies (consumers accommodated in the emergency department only were no longer counted as admitted). Once hospitals reconfigured their emergency department/inpatient interface, growth in separations has consistently increased.

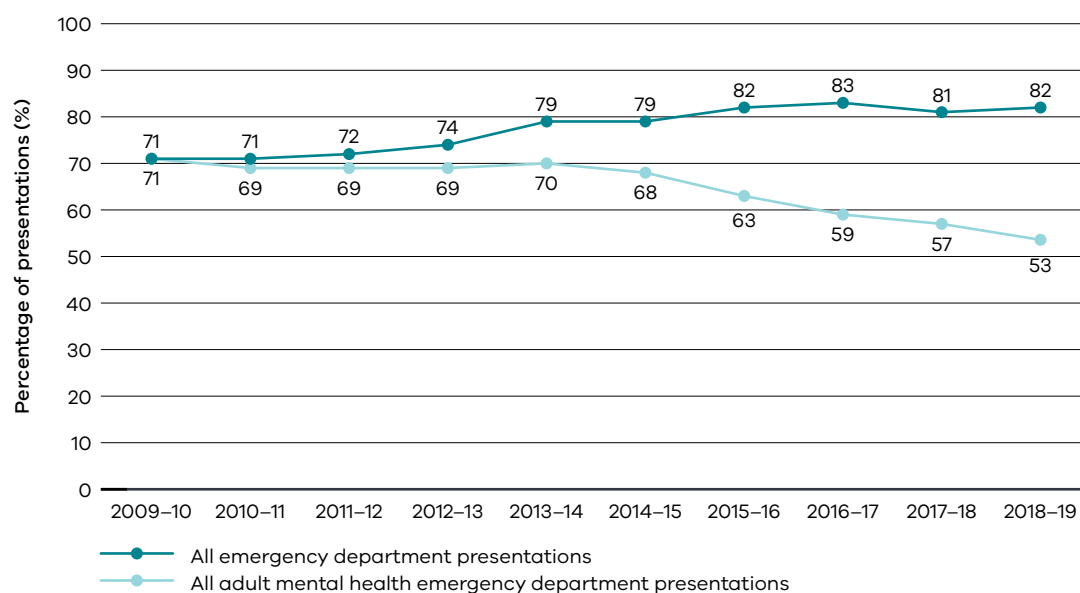
7.5.2 Longer waits in public emergency departments

Because of the increasing rate of mental health-related presentations to emergency departments, as well as the pressures on acute inpatient beds, people experiencing poor mental health are waiting longer before being assessed and treated in emergency departments.

Between 2015 and 2017 the average wait time in emergency departments increased from 7.6 hours to 9.5 hours.²²³ Under the National Emergency Access Target, the states and territories have agreed that 90 per cent of people attending an emergency department should be admitted, referred or discharged within four hours.²²⁴ The Commission was told that for mental health consumers in Victoria the state target is eight hours.²²⁵ The state target is 80 per cent of people admitted, where required, within this timeframe.²²⁶ Between 2009-10 and 2018-19 the proportion of adults admitted to a mental health bed within eight hours declined from 71 per cent to 53 per cent—well below the state target (see Figure 7.18).

Comparatively, significant overall improvements in the promptness of admissions from emergency departments have been achieved for all general emergency department presentations. Between 2009-10 and 2018-19 the proportion of total emergency department presentations admitted within eight hours rose from 71 per cent to 82 per cent (see Figure 7.18). These figures attest to a glaring difference in wait times experienced by people with mental health-related needs (who are waiting much longer in public emergency departments) compared with people who present with other needs.

Figure 7.18: Percentage of adult emergency department presentations admitted to a bed within eight hours of arrival, Victoria, 2009–10 to 2018–19



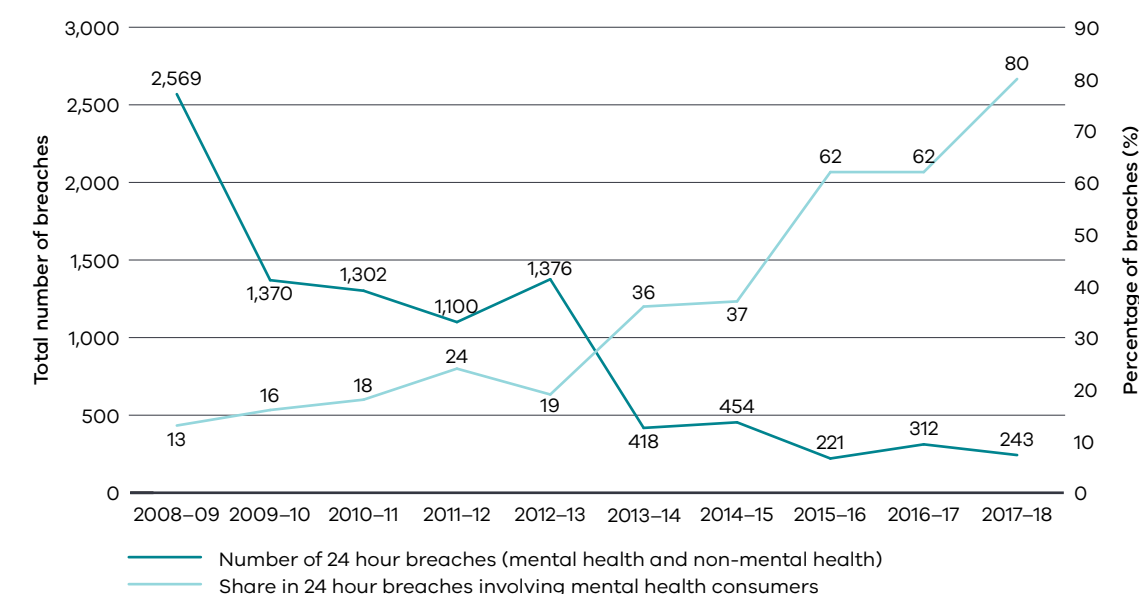
Source: Department of Health and Human Services, Integrated Data Resource, Victorian Emergency Minimum Dataset 2009–10 to 2017–18.

Mental health bed access indicator, although affected by local admission practices, such as direct admissions. Activity in all non-specialty emergency departments is included.

A breach occurs when a person waits longer than 24 hours in an emergency department.²²⁷ Dr Ainslie Senz, the Director of Emergency Medicine at Footscray Hospital, Western Health told the Commission it was not uncommon for mental health consumers to wait longer than 24 hours for a mental health bed—in some cases 48 or 72 hours.²²⁸ She also said the longest stay was five days, which is 'completely unacceptable'.²²⁹

People with mental health-related needs are over-represented when wait times in emergency departments exceed 24 hours. Although the total number of people with mental health-related needs waiting longer than 24 hours in emergency departments has decreased over time, their proportion has increased. Among people who waited more than 24 hours in 2017–18, four out of five (80 per cent) had mental health-related needs (see Figure 7.19).

Figure 7.19: Total number of emergency department 24-hour breaches, Victoria, 2008–09 to 2017–18



Financial Year	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17	2017–18
Number of mental health 24-hour breaches	333	224	239	262	267	151	166	136	194	194

Source: Department of Health and Human Services, Integrated Data Resource, Victorian Emergency Minimum Dataset 2008–09 to 2017–18.

Mental health-related emergency department presentation defined as: a) the presentation resulted in an admission to a mental health bed (inpatient or residential), OR b) the presentation received a mental health-related diagnosis ('F' codes, or selected 'R' & 'Z' codes R410, R418, R443, R455, R4581, Z046, Z590, Z609, Z630, Z658, Z765), OR c) the presentation was defined to be 'Intentional self-harm', OR d) the presentation involved interaction with a mental health practitioner.

Emergency department staff are tasked with providing care, often in very difficult circumstances, for many hours while a person waits for a bed to become available.²³⁰ People do not receive therapeutic treatment in emergency departments, so they generally do not improve and potentially get worse.²³¹ The Commission was informed that when a consumer's condition deteriorates, staff often have to manage complex behaviours without input from psychiatry staff, which can result in the person being subject to chemical or physical restraint.²³² This is an unpleasant, upsetting and stigmatising experience.²³³

One person told the Commission:

... waiting in a clinical cubicle in an emergency department for extended periods of time took me back to memories of seclusion and being held captive. The white walls, bright lights and staff member observing but not communicating led to my delusions and paranoia spiralling into fear. I soon began yelling and as a result two large security guards in uniforms approached the cubicle, further scaring me resulting in me reacting by throwing my mobile phone. The next thing that I remembered I was gaining consciousness to discover that I was lying on a bed in different area of the hospital with my hands tied to rails and not being able to move at all or speak. Still delusional I became more scared. I did not know where I was and believed wholeheartedly that I was dying.²³⁴

Such events are distressing and upsetting for staff in emergency departments. Dr Senz told the Commission how it felt to have someone restrained as their behaviour deteriorated during long wait times.

... it's just awful. It's especially awful because we can't do anything about it. We feel powerless as well, but it's a trend that patients do get to—and most patients I'm going to say, most patients would get frustrated, but the behavioural crisis is a reality for this particular group of patients with respect to waiting.²³⁵

Even without these forms of intervention, waiting long periods in emergency departments can be highly distressing for consumers and their families and carers as a result of the busy, stressful environment and high levels of competing demands on staff.²³⁶ A witness before the Commission described her experience of long waiting periods in emergency departments with her daughter:

When Natasha has reached out for help, I have seen that she has been rejected, or that she has to wait ridiculous amounts of time to get help that is usually too little, too late. Access to acute mental health services through emergency departments [is] traumatic and lengthy. They discourage people from accessing help due to the stigma and how we are treated in those moments.²³⁷

Long waiting periods can also result in people experiencing poor mental health leaving the emergency department before they have been seen or treated. If this occurs, the opportunity to intervene and provide treatment is lost, and the result might be they do not seek treatment again and their condition deteriorates.²³⁸

In 2018 the Victorian Government announced funding to establish six emergency department crisis hubs to provide specialist, dedicated care for people presenting with urgent mental health or alcohol or drug problems (see Box 7.3).²³⁹ Although the introduction of the hubs has been generally welcomed by people living with mental illness and by mental health workers, the Commission notes that the hubs do not solve the problem of the critical need for more community-based services that reduce people's likelihood of reaching crisis point and going to an emergency department in the first place.

Box 7.3

Mental health and alcohol and drug service hubs in emergency departments

The six mental health and alcohol and drug service hubs announced in 2018 will provide specialist, dedicated care for people presenting to emergency departments with urgent mental health or alcohol and drug problems. Consumers will be assessed and treated by an integrated emergency department and mental health team (including psychiatrists, mental health nurses and social workers) and referred to other services as required. Consumers are treated in a separate, quiet, purpose-built area in the emergency department. The six hubs are being established at the Royal Melbourne Hospital, Barwon Health, Monash Medical Centre, St Vincent's Hospital, Sunshine Hospital and Frankston Hospital.²⁴⁰

The crisis hubs are expected to deliver full assessments, therapeutic interventions, referrals to community-based services and assertive outreach for consumers after they have been discharged, where necessary.²⁴¹ They will operate 24 hours a day, seven days a week. The service will include:

- providing multidisciplinary care in a dedicated area
- a co-located short stay unit for people who do not need admission to an inpatient unit but who require a short period of stabilisation and crisis support
- follow up care for people discharged from the mental health emergency department hub.

7.5.3 Police and ambulance services as a default

Constraints on access to mental health services have led to Victoria Police and Ambulance Victoria becoming the default first responders for many people living with severe mental illness and others experiencing poor mental health.²⁴² For example, the Commission was told that:

Over time the [crisis assessment and treatment teams] became staffed with people who had more limited experience and police have progressively resumed their role as the frontline response.²⁴³

Police divvy vans fill the same function for mental health patients as ambulances do for physically ill people. That is a crime in itself.²⁴⁴

In the past, dynamic mobile assertive community outreach, crisis assessment and comprehensive home treatment was provided to people experiencing a mental health crisis in the community, through crisis assessment and treatment teams and mobile treatment and support teams.²⁴⁵ As clinical community-based mental health service capacity decreased, this acute treatment in the community has largely disappeared.²⁴⁶

The Commission has been told there is an increasing number of people who are calling triple zero with mental health-related requests. Mr Simon Thompson, Regional Director for Ambulance Victoria, said that, although the proportion of people calling triple zero with mental health-related needs remains relatively unchanged, the number of emergency calls continues to rise.²⁴⁷

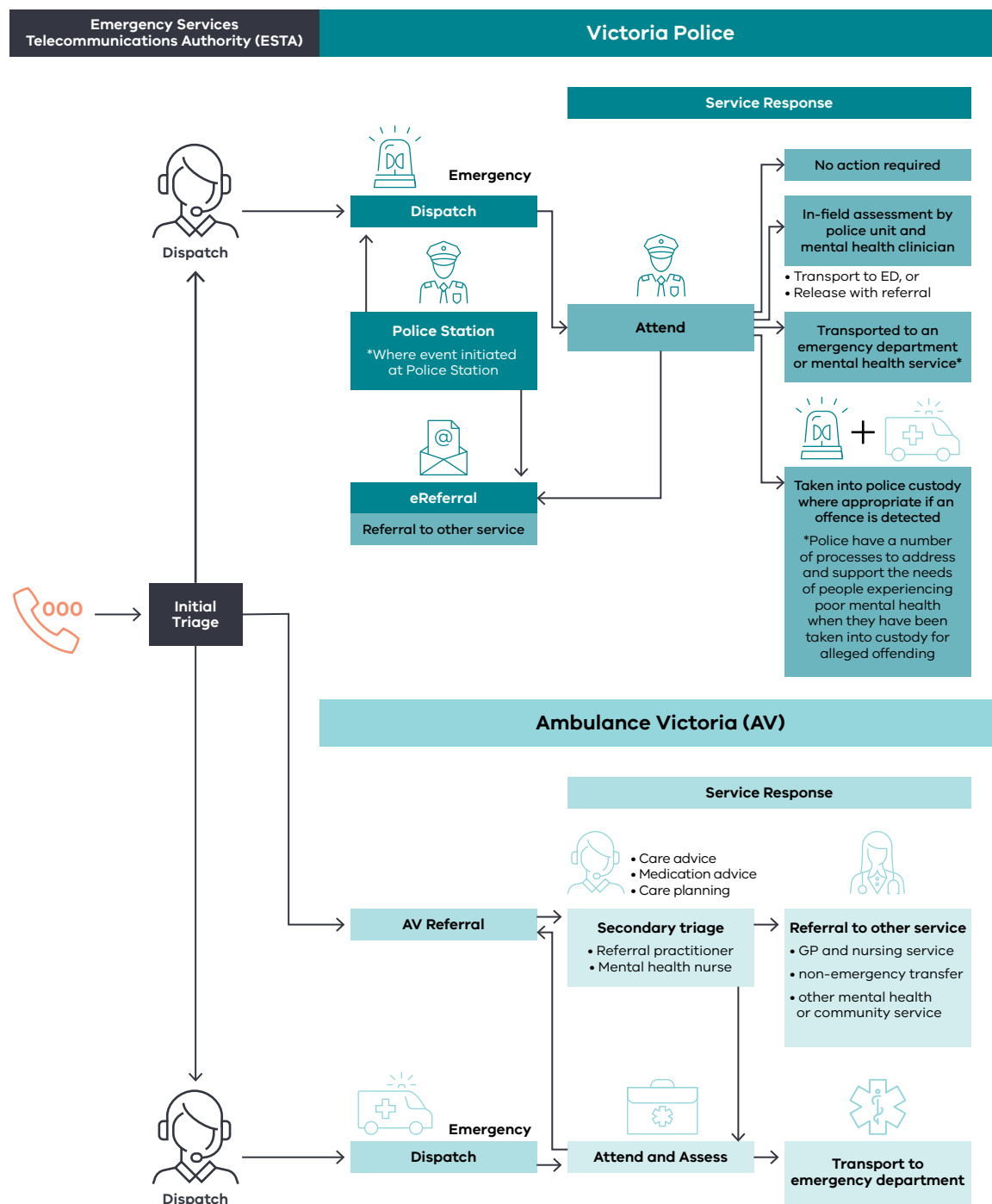
In response to growing demand, both Victoria Police and Ambulance Victoria have introduced their own referral services for non-urgent calls, with the aim of referring and connecting people to alternative services, including mental health services. The Ambulance Victoria Referral Service is staffed by paramedics and registered nurses and helps people with non-emergency needs by providing advice and referral to other clinically appropriate services or self-care advice. The referral service can also result in emergency ambulance attendance or non-emergency patient transport if required.²⁴⁸

The Ambulance Victoria Referral Service has responded to an increasing number of mental health-related calls. Since 2017, Ambulance Victoria advised the Commission of a steady increase of approximately 13 per cent in the management of mental health-related calls through its referral service. This increase is higher than the overall increase in people being managed through its referral service, which is up by about 9.0 per cent overall.²⁴⁹

Mr Thompson noted that, with the right staffing, the referral service is providing a way to link people to mental health services:

What we have seen since the introduction of that mental health nurse in 2017 and that service is a considerable reduction in the amount of times that we're sending ambulances out to see those patients because we've been able to better network them back into those responsible for their care, which might be back into GP services, it might be back into area mental health services or into community mental health services, so that the reason for their call can be dealt with on that day by somebody else who's better equipped to do that.²⁵⁰

Figure 7.20: Overview of the triple zero ambulance and police callout process



Source: Prepared by the Commission based on information from the Emergency Services Telecommunications Authority, Victoria Police and Ambulance Victoria.

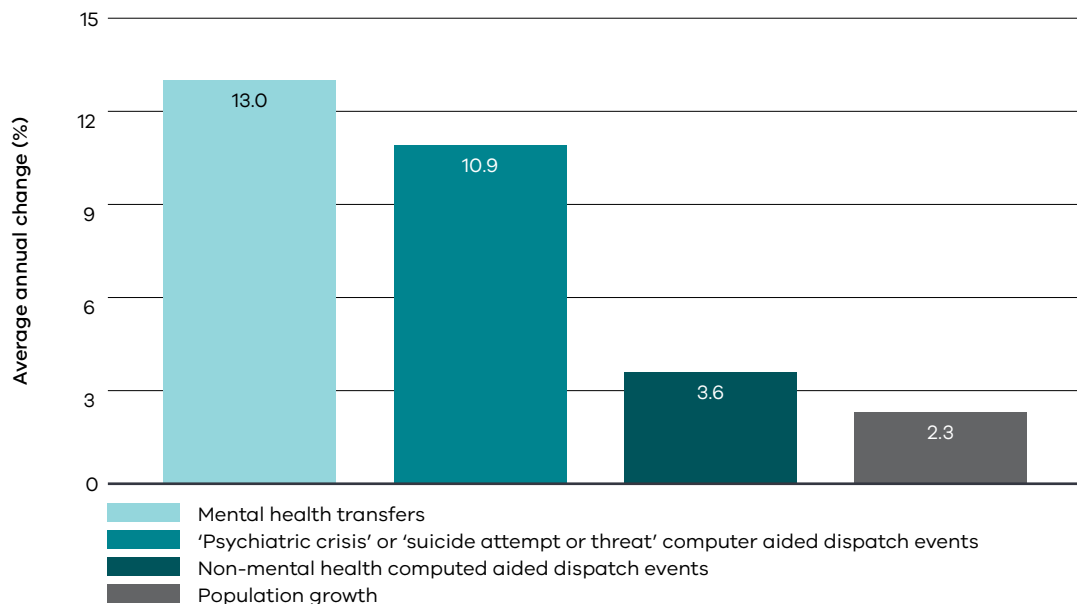
Victoria Police has also introduced its eReferral program, which aims to connect people to external supports and services as required.

When a triple zero call warrants an emergency response, a person might receive a response from Ambulance Victoria or Victoria Police or a response from both. The type of response provided depends on several factors, among them an individual's needs and risk. Figure 7.20 summarises the triple zero callout process.

Ambulance Victoria and Victoria Police data show that people experiencing a mental health crisis or poor mental health are increasingly relying on these services. Figure 7.21 shows the growth in the proportion of mental health–related attendances and transfers by Victoria Police from 2014 to 2018. It indicates that the average annual increase in mental health attendances have grown significantly (10.9 per cent) compared with non-mental health attendances (3.6 per cent) and general population growth (2.3 per cent). Mental health transfers to hospitals have grown by 13 per cent.

Victoria's *Mental Health Act 2014* gives police the power to apprehend and transport a person who appears to have a mental illness if that person needs to be apprehended to prevent serious and imminent harm to the person or any other person.²⁵¹ Police may request an ambulance to transport the person to a health service designated to provide specialist mental health services, although police are to maintain custody of the person, so they might travel together.²⁵²

Figure 7.21: Annual growth in the number of police attendances for mental health–related events and transfers to hospital, Victoria 2014–2018



Source: Victoria Police, Law Enforcement Assistance Program and Computer Aided Dispatch system, 2014 to 2018; Australian Bureau of Statistics. Australian Demographic Statistics, June 2014 to June 2018, cat. no. 3101.0, Canberra. TABLE 52. Estimated Resident Population By Single Year of Age, Victoria. <<https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3101.0Jun%202018?OpenDocument>> [Accessed 28 October 2019].

Annual growth presented in the report is the compound annual growth rate. Compound annual growth rate is the smoothed annual change over the specified period (as if the growth had happened steadily each year over that time period).

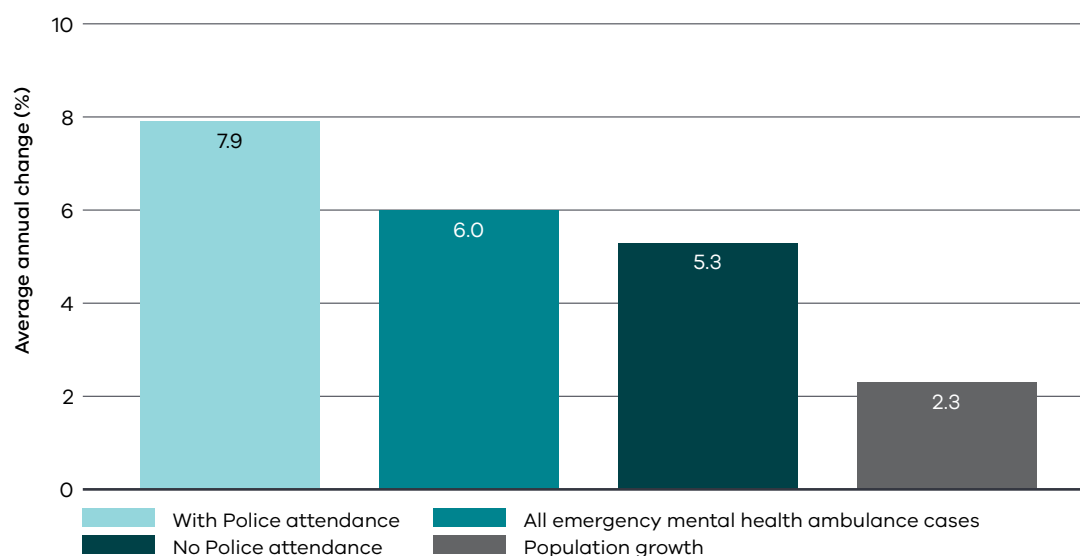
The Commission noted that ambulance attendances with a police escort increased by nearly 26 per cent between 2015 and 2018.²⁵³ Joint responses are common when there is a likelihood of threat or harm, or where police powers under the Act to apprehend and transport a person are applied.

In 2017–18 Victoria Police attended about 43,000 events relating to a 'psychiatric crisis' or 'suicide attempt or threat', amounting to a mental health callout about every 12 minutes.²⁵⁴

Missed opportunities for the mental health system to provide early treatment and support also contribute to people turning to Ambulance Victoria for care or to gain access to services. For some people an emergency ambulance response is appropriate, but for many others a better and more effective response would entail earlier mental health treatment, care and support.

Figure 7.22 shows that between 2015 to 2018 the annual growth in mental health–related emergency ambulance attendances also grew at a much higher rate (6 per cent) than population growth (2.3 per cent). Overall emergency ambulance attendances not related to mental health grew by 0.5 per cent per year on average over the same period.²⁵⁵

Figure 7.22: Annual growth in mental health–related emergency ambulance attendances, Victoria, 2015–2018



Source: Ambulance Victoria, Victorian Ambulance Clinical Information System, 2015 to 2018; Australian Bureau of Statistics, Australian Demographic Statistics, June 2014 to June 2018, cat. no. 3101.0, Canberra. TABLE 52. Estimated Resident Population By Single Year of Age, Victoria. <<https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3101.0Jun%202018?OpenDocument>> [Accessed 28 October 2019].

Annual growth presented in the report is the compound annual growth rate. Compound annual growth rate is the smoothed annual change over the specified period (as if the growth had happened steadily each year over that time period).

This data does not include cases which have gone through secondary triage and are referred away from an ambulance dispatch.

The police attendance field within the patient care record is not a mandatory field and as a result may be underreported. 2014 data was not included in this analysis as it was impacted by industrial action.

Victoria Police and Ambulance Victoria have told the Commission they are not necessarily the most appropriate response for many people experiencing poor mental health. Victoria Police emphasised that a police response will always be provided to critical incidents. In its view, however, for many of these callouts and subsequent transfers—a health-based intervention rather than a law enforcement one—would probably have been the most beneficial response.²⁵⁶ Glenn Weir, Assistant Commissioner of Victoria Police, emphasised:

Unnecessary contact between police and people experiencing mental health issues should be minimised as this can compound stigma and add to the person's trauma, leading to suboptimal outcomes.²⁵⁷

The Commission heard of people's distress and humiliation after being apprehended or transported by police when they had not committed a criminal offence. For example, in her testimony, Ms Julie Dempsey, a witness before the Commission, said:

I was in a hospital emergency department needing transport to hospital, a psychiatric hospital. There were no ambulances available, so they decided to use a [divvy] van. I wasn't agitated or aggressive, why they couldn't take me—you see these mass murderers and things being escorted with dignity in between two police officers in the back of a police car; I've never committed a crime in my life and I'm thrown in the back of this divvy van in front of a waiting room full of people at the emergency department; it was so degrading.²⁵⁸

Nevertheless, the Commission also heard examples of kindness and skill displayed by individual police officers. One of the themes of the Commission's community consultations was that police understanding of mental health has improved in recent years, especially where police have had the opportunity to work alongside mental health clinicians.²⁵⁹

Assistant Commissioner Weir told the Commission that there are now a few joint initiatives between Victoria Police, Ambulance Victoria, mental health service providers and other relevant service providers to respond to people experiencing poor mental health (see Box 7.4).²⁶⁰ These initiatives can offer many benefits compared with usual service,²⁶¹ but they are not a substitute for intensive community-based assessment and treatment.

Box 7.4

PACER: An Example of a joined-up emergency response

An example of a 'joined-up' emergency response is the Police, Ambulance and Clinical Early Response (PACER) (also known as the Mental Health and Police (MHaP) Response Initiative). It is a local mental health crisis intervention operating as a joint initiative between some adult area mental health services and Victoria Police.²⁶²

PACER/MHaP's purpose is to provide a targeted and timely response to individuals who have come to the attention of Victoria Police and are experiencing, or appear to be experiencing, an acute mental health issue requiring an urgent mental health response.²⁶³

The initiative operates on the basic premise of a secondary response which is activated on request by the police. It is delivered by a joint team comprising a police officer and a mental health clinician. Telephone advice and support can also be provided through PACER. Guidance for police officers on when to contact PACER is provided in a statewide protocol and in each local area's PACER operating guidelines and practices.²⁶⁴

PACER is not available 24 hours a day. PACER shifts generally operate from 2pm to 10pm, seven days per week, with some variation across locations.²⁶⁵ There is also a lack of available mental health clinicians to support shifts on some occasions, and misaligned service areas between police and area mental health services can affect collaboration.²⁶⁶

Police and ambulances often transport people in crisis to emergency departments because there are few alternative services available. People experiencing an acute mental or behavioural crisis are up to 16 times more likely than other people to arrive at emergency departments via police or correctional services vehicles, and almost twice as likely to arrive via ambulance.²⁶⁷

Mr Thompson told the Commission that the ambulance service does not have priority telephone access to mental health triage services. As a result of the long wait times and inability to get through to triage services, Ambulance Victoria often bypasses mental health triage and goes directly to an emergency department. Similarly, Victoria Police and primary care providers, such as GPs, do not always have priority access to mental health triage lines.

At emergency departments, paramedics and police are required to wait with the person until they can transfer them into the care of a clinician. Given the long wait times in emergency departments, this can mean they are waiting for hours. Assistant Commissioner Weir told the Commission there are circumstances when police are involved for more than six hours before they can be released for other duties.²⁶⁸ Paramedics are also put under pressure and can become frustrated because they must wait in emergency departments until the person they are with is seen.²⁶⁹

7.5.4 Discharges without a bed

While not every individual seen in an emergency department requires an acute mental health inpatient stay, the high rate of discharge without admission reflects both the lack of beds and the lack of community-based services to help people before they reach crisis.

More than 700 people with a mental health–related need presented to an emergency department on four or more occasions in one week but were never admitted, in 2017-18. These totalled approximately 14,700.²⁷⁰

Of these presentations, 50 per cent were transported by ambulance or police.²⁷¹ Victoria Police told the Commission that police frequently apprehend people they believe are at risk of harm to themselves or others, arrange for their assessment by a mental health practitioner, and then are advised that the person does not meet treatment criteria and should be released, or the person receives only some treatment and is released a short time later.²⁷² In some cases, this results in Victoria Police responding to the same person multiple times. The following example casts light on this problem:

Police are called by Person X who is concerned about the threatening behaviour of Person Y, who is in possession of a lighter and can of petrol and threatening to harm themselves. Upon arrival and assessment of the individual police apprehend Person Y under section 351 of the [Mental Health] Act and call [Ambulance Victoria] to transfer Person Y to hospital for a mental health assessment. Person Y is subsequently released by the hospital. Police are called two days later in response to another call from Person X about the behaviour of Person Y. In this case, the behaviour also required involvement of the Critical Incident Response Team (CIRT). Person Y is again taken to hospital under section 351 of the [Mental Health] Act where they are subsequently released by the hospital. Two days later, Person X called police again because Person Y was threatening suicide. Following the call, attending police observed Person Y harming himself. Person Y was subsequently apprehended by police and taken back to hospital for the third time within one week.²⁷³

7.6 Services that lack inclusiveness

Many individuals and communities in Victoria are disproportionately affected by poor mental health and suicide. Among them are Aboriginal people, people with co-occurring health conditions, people living with a disability, LGBTIQ+ people, rural and regional Victorians, people from culturally and linguistically diverse backgrounds, refugees and asylum seekers, survivors of abuse and trauma, and people in contact with the justice system.

The inequities in mental health outcomes that many people experience are partly attributable to a range of barriers to obtaining care. Some of these stem from a system that can be unfair and unresponsive to an individual's circumstances, as well as their social and cultural needs. This section is not wholly representative of the diversity of needs, experiences and identities that exist between and within communities throughout Victoria. Rather, the concepts explored here illustrate the additional barriers some people and communities face when seeking access to mental health services, as highlighted to the Commission in its work so far.

7.6.1 Discrimination

Disturbingly, a number of inquiry participants spoke of experiencing discrimination when seeking access to mental health services and how fear of discrimination deterred people from seeking help.

For example, Ro Allen, Victorian Commissioner for Gender and Sexuality, explained that 'fear of discrimination prevents [LGBTIQ+] people from seeking help when they want or need it, yet people also experience discrimination when they seek help'.²⁷⁴ This discrimination can take the form of misgendering, heteronormativity (where it is assumed that everyone is, or should be, heterosexual and cisgender) and use of derogatory terminology.²⁷⁵ In the Private Lives 2 survey, nearly 34 per cent of LGBTIQ+ Australians reported 'usually or occasionally' hiding their sexual orientation or gender identity when approaching services in order to avoid possible discrimination and abuse.²⁷⁶

As a result, the anticipation or fear of discrimination is a major barrier to accessing services.²⁷⁷ Recent research found that more than 71 per cent of LGBTIQ+ people chose not to use a crisis support during their most recent fluctuation in mental health, and many said this was because they expected to experience discrimination, based on their sexuality, gender identity or another stigmatised or minority identity.²⁷⁸ Another reported reason for not using a service was the fear of being 'outed'—a fear that the disclosure of their identity could threaten their personal safety or their professional life.

Aboriginal people can also be reluctant to seek help because of fear of discrimination. Mr Andrew Jackomos PSM, a Yorta Yorta/Gunditjmara man and the Executive Director, Aboriginal Economic Development, Department of Jobs, Precincts and Regions, explained, 'Aboriginal people, to the detriment of their health and wellbeing, would rather not attend a service than be victims of racism and discriminatory practices'.²⁷⁹

Aboriginal organisations stress that, for Aboriginal young people, fear of shaming oneself or family, racism and a lack of awareness of available mental health services are important barriers to accessing mental health services.²⁸⁰ One Aboriginal person told the Commission, 'People don't realise how hard it is to go to a GP and ask for help'.²⁸¹

7.6.2 Stigma can deter help seeking

While stigma associated with poor mental health persists throughout Victoria, in some communities the shame is so great that mental illness is ‘very much a hidden phenomenon’.²⁸²

People’s beliefs about other people’s attitudes—particularly a fear that they will be viewed negatively—are part of the reason people do not seek help.²⁸³ Ms Adriana Mendoza, Manager, Victorian Transcultural Mental Health, observed, ‘The experience of stigma, structural inequity and discrimination in society impacts on whether [culturally and linguistically diverse] people engage or disengage with the mental health system.’²⁸⁴

Mr George Yengi, a witness before the Commission, described his experiences and the challenges faced by others in the South Sudanese community:

Although I did get help from a psychologist, mental health is stigmatised in our community. Mental health is a white people/Australian thing which they make a fuss about. For our community, it doesn’t exist. You’re either strong or weak ...²⁸⁵

In describing the significant negative effects of stigma on help-seeking among refugees, Ms Kylie Scoullar, General Manager, Direct Services, Foundation House, reiterated this view, noting that ‘if the words “mental health” are in the name of a service provider, a person of refugee background will often be reluctant to use that service’.²⁸⁶ Ms Scoullar added that often families seeking asylum will not want young children to engage with mental health services because of the perception of shame—‘as the parents blame themselves for their child’s problems’.²⁸⁷

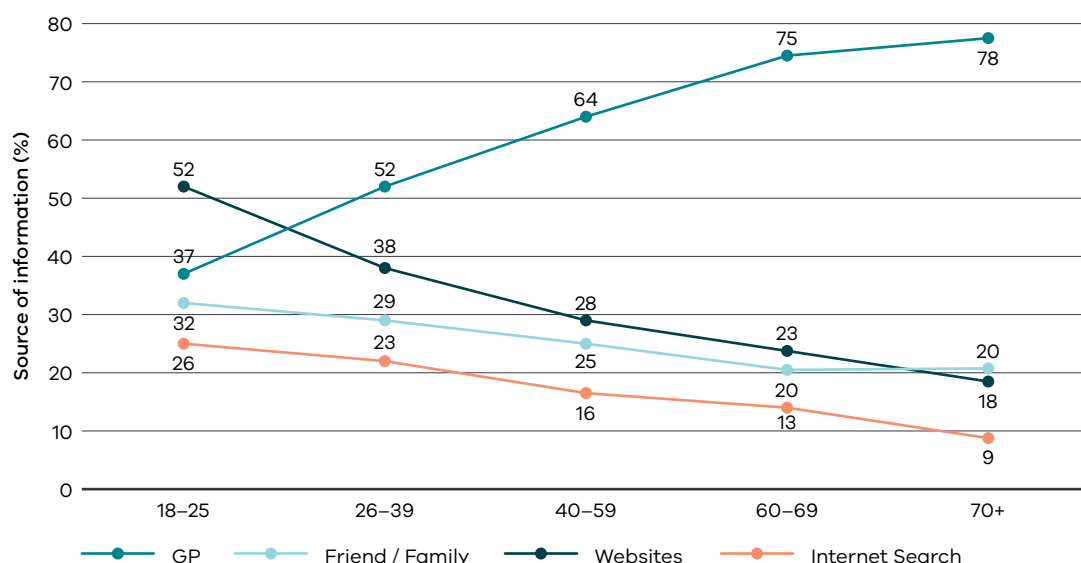
inTouch Multicultural Centre against Family Violence described how many of its clients do not easily recognise poor mental health or come from cultural backgrounds that attach stigma to mental illness. inTouch characterises these factors as ‘significant barriers faced by migrant and refugee women in the prevention and treatment of mental health conditions’.²⁸⁸

Stigma can also deter people living with disability from obtaining access to appropriate treatment, care and support. A community consultation survey of people living with autism, their families and carers found that there was significant stigma associated with autism and separately with mental illness. Amaze submitted that, of participants who found it hard or very hard to obtain access to the right services to support their mental health, 19 per cent attributed this difficulty to stigma.²⁸⁹

One family member described how labels and misconceptions have led to difficulties in accessing mental health services for her children:

When seeking a mental health plan for our child, one GP provided feedback that our child ‘did not look like they had [attention deficit hyperactivity disorder] and to be wary of labels [...] It has been difficult to find a suitable mental health practitioner and for now we have conceded defeat ... It has been our experience that many mental health practitioners still have a poor understanding of [attention deficit hyperactivity disorder] and are exposed to the same misconceptions as the general public, which ultimately leads to minimal to no treatment for our children.’²⁹⁰

Figure 7.23: Likely sources of information approach when facing a 'mental health challenge', by age group Victoria



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

7.6.3 Lack of accessible information

A lack of accessible information can also impede efforts to find services and make one's way through the mental health system. Ms Mendoza said that 'difficulties in navigating or engaging with the mental health system are exacerbated by the lack of accessible information relevant to the experiences of [culturally and linguistically diverse] people'.²⁹¹

In its submission the Ethnic Communities Council of Victoria expressed a similar view, saying that the council's consultation with member organisations revealed:

... the need for more mental health literature and documentation to be translated into community languages, especially those of new and emerging communities, who are generally most in need of support with their health literacy and understanding of the Victorian mental health system.²⁹²

The lack of translators on offer from the system was also recognised as an impediment to engaging with mental health services, with many people from culturally and linguistically diverse backgrounds being unable to fully engage with health professionals.²⁹³

Lack of accessible information is also a barrier to access for people living with disability. Deaf Victoria described the mental health system as 'inaccessible' for people who are deaf and hard of hearing. This is a particular problem for people who use Auslan as their preferred language.²⁹⁴ One person, who sought the assistance of an Auslan interpreter, described their experience trying to obtain access to the mental health system:

I requested several times for an interpreter. Every time they said an interpreter would come, but it never happened once. [My wife] had to continue interpreting for me and the stress on her was enormous.²⁹⁵

Children and young people can be reluctant to seek help in person, and many prefer to access support and information online. A survey conducted for the Commission found that, while older people are more likely to visit their GP about mental health concerns, young people are more likely to use the websites of specific mental health support services (see Figure 7.23).²⁹⁶ A survey cited by Lifeline reported that ‘over 59 per cent of young people prefer to contact crisis services via short-form messaging such as text (25.3 per cent), online chat (18.7 per cent) and social networking (15 per cent)’.²⁹⁷

7.6.4 Little confidence in safety and inclusivity

For some, past experiences with a range of services in Australia and abroad—that may or may not be related to the delivery of mental health treatment, care and support—have led to distrust and a lack of confidence that mental health services will be inclusive of their needs.

Ms Helen Kennedy, Chief Operations Officer of the Victorian Aboriginal Community Controlled Health Organisation, noted, ‘Many Aboriginal people in Victoria have profound distrust in mainstream health services, pointing to the need for trauma-informed and healing-based care models.’²⁹⁸ The Victorian Aboriginal Health Service concurred with this:

Our experience indicates that many clients are unaware of the mental health supports that do exist, or if they are aware they are fearful of using them without Aboriginal workers being available to walk them through the processes as they experience misinformed assumptions, negative judgement, overt and covert racism and a total lack of cultural understanding from mainstream services that are available. This contributes to additional distress being experienced by individuals and families to self-manage conditions that need therapeutic responses. It can mean that people do not access supports until a crisis occurs.²⁹⁹

Previous experiences that have led to mistrust of services and deterred individuals from seeking help in the future were also mentioned by some culturally and linguistically diverse communities. For example, Ms Scoullar, from Foundation House, described how past experiences of trauma can lead to distrust:

Another barrier is that in some cases persons with refugee backgrounds are afraid of doctors and authority figures and do not trust them. In some cases, doctors have been a part of the trauma perpetrated upon the person in their country of origin.³⁰⁰

Similarly, the African Australian Communities Leadership Forum said:

We have reached a point in the relationship between the African Australian communities and mental health services where there are truly Circles of Fear. Some of the African Australians mistrust and often fear services. While in the inpatient services or prison services, staff are often wary of the Black community, fearing criticism and not knowing how to respond, and fearful of young Black men. The cycle is fuelled by prejudice, misunderstanding, misconceptions and sometimes racism.³⁰¹

Another person described how the current system does not fully acknowledge the past traumatic experiences of migrants and those seeking asylum: ‘Trauma experienced by migrants is never fully acknowledged, particularly those that have arrived here seeking asylum from conflict, tyranny and persecution.’³⁰²

Similarly, one person who has worked as a clinical psychologist for more than 30 years told the Commission that the current system is not responsive to the circumstances of asylum seekers or refugees:

While asylum seekers and refugees suffer from the same range of mental disorders as the general population, their presentations are often shaped by posttraumatic symptoms and reactions to current stressors; service staff are often not well-equipped to meet their needs.³⁰³

Access to inclusive mental health services was also a commonly cited concern among LGBTIQ+ people. The Understanding LGBTIQ+ Lives in Crisis report found that negative experiences when seeking access to mental health services were predominately related to the practitioner's lack of awareness of the issues pertaining to sexual and/or gender identities.³⁰⁴ In the report, one person described their previous experiences with psychologists and how this experience was a deterrent to seeking mainstream services in the future:

I don't feel safe in using mainstream services as a queer person. I've experienced judgement, and done disproportionate educating to psychologists in the past—I can't do that during a time of crisis. That's not safe for my mental health.³⁰⁵

Dr Ruth McNair, a GP and witness before the Commission, spoke of the many people who travelled from rural Victoria or outer urban areas of Melbourne to her clinic in Fitzroy North in the hope of finding more responsive care. She said that when people were asked why they were travelling for care, they explained:

'I just don't know who to go to in my local area', or 'I have tried a local counsellor or local GP and found that they, firstly, have no understanding of my specific issues; secondly, they felt they were homophobic or transphobic; thirdly, they didn't know who to refer me to', so the default was to come to our clinic.³⁰⁶

Access to inclusive services is also a challenge for people living with disability. One person spoke about difficulties obtaining access to mental health services that would accept her diagnosis as an adult with attention deficit hyperactivity disorder:

[It] has taken me time to find a new GP who was accepting of the idea adults could have [attention deficit hyperactivity disorder] and require treatment. This attitude of [attention deficit hyperactivity disorder] being a 'kids problem' or a 'disruptive school boy problem' is also prevalent among psychologists and other mental health workers.³⁰⁷

It is clear that people living with mental illness and their families and carers do not have a mental health system they can rely on. Access difficulties are widespread, touching every part of the system. These challenges are experienced by individuals and communities throughout Victoria, with sometimes devastating impacts contributing to prolonged distress and harmful outcomes for people.

Greater consideration of how people gain access to and find their way around the mental health system will be fundamental to the Commission's ongoing work. The Commission envisages a mental health system that provides treatment, care and support when they offer the greatest benefit. This necessitates services that act earlier and in ways that respond to an individual's clinical, social and cultural needs.

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Chapter 8

Experiences of treatment, care and support

Chapter 7 describes how difficult it is to obtain mental health services. Finding and accessing services, however, is just one part of what matters. Of equal importance are people's experiences of the mental health system.

Experiences of treatment, care and support vary greatly. They are influenced by the type of service accessed, an individual's symptoms and, in some cases, others' stigmatised perceptions of mental illness. The experiences of treatment, care and support across people's lives are wide-ranging and can have a profound and enduring impact.

This chapter focuses on the voices of consumers, and their families and carers. It begins by acknowledging some of the positive and affirming experiences of treatment, care and support that people have shared with the Commission. This includes displays of compassion by many mental health workers and how particular services helped individuals to manage their recovery on their own terms.

Troublingly, reports to the Commission of positive experiences of the system have been few and far between. Too often, experiences of the system have been characterised as being poor and lacking in dignity, empathy, choice and equity. In some cases, the system that was meant to provide support has had the opposite effect.

This chapter provides an overview of the various factors that people have identified as contributing to poor experiences including a lack of consumer autonomy and influence in decisions around their own treatment, care and support. It then describes concerns about consumer safety including violence and sexual assault in acute mental health inpatient units.

Subsequent sections of the chapter discuss the current focus on risk management and medication, which the Commission has heard has come at the expense of effective practices that are valued and preferred by consumers, and the lack of individualised and responsive services that are inclusive of people's needs and experiences. The final section describes how ageing and unsuitable infrastructure in the current system is impacting on people's experiences.

The hardships and difficulties described by inquiry participants are certainly not universal, but their number is so great that the Commission is gravely concerned that parts of the system are failing to meet people's needs and, in some circumstances, they are causing further harm.

The Commission holds firm that the treatment, care and support that is provided in the mental health system should respect an individual's dignity, be integrated, multidisciplinary, and have a focus on recovery. These principles underpin the Commission's ongoing work to redesign a mental health system that can, and must, do better to meet the needs of Victorians.

8.1 Affirming experiences

Some people have had positive, affirming experiences of Victoria's mental health system, ranging across service settings from GPs to specialist clinical mental health services, and involving a variety of mental health workers in a range of disciplines.

Central to many of the positive experiences told to the Commission were services that recognise and respond to individual needs, services provided in therapeutic homelike settings and services delivered by the same individual or team of workers.

A common theme throughout the Commission's community consultations, evidence presented and submissions received concerned the value of prevention and recovery care centres. These centres offer short-term, multidisciplinary, recovery-focused care that is delivered mainly by non-government organisations, with clinical support from an area mental health service.

Many people described how prevention and recovery care centres promoted independence and provided a safe space in which to recover:

[The prevention and recovery care centre] is the sole reason I'm still here. It's incredible—you have freedom, they focus on your optimal health; there are support workers who take care of you while you're there. I felt safe and a feeling of community.¹

I liked [The prevention and recovery care centre]. It was [...] self-contained, cook your own meals and everything [...] everyone was caring. They'd come and walk around all day and make stuff for me to do. I think I made their vegie garden for them for the spring [...] They'd come fishing with you if you wanted to go down the river fishing [...] It was good, just nice, relaxed ...²

Consumers, families and carers also provided positive feedback on some models of care for young people. For example, headspace was raised as an example of a service that was working well to support consumers by providing a range of services and supports from across different parts of the system.³

Some young consumers also reported valuing headspace centres because they felt it was a less clinical environment.⁴ In this regard, Ms Erica Williams, a witness before the Commission, described her positive experience of a youth service:

I have a GP, a psychologist, a psychiatrist, and a case manager—all in the one place. I still have the same case manager from when I first started [...] She has worked very hard to understand my trauma history and my [borderline personality disorder], and together we have developed ways of understanding my illness that make sense to me. Without my case manager and doctors [...] persisting with me even when things were very severe, I would not be alive.⁵

Many people also spoke of the value of peer support workers who were able to draw on their own lived experience to provide support. One person described their interaction with a peer support worker: 'It felt like talking to a friend who wasn't judgmental'.⁶ Another individual spoke of the importance of peer groups in creating safe spaces to share stories:

Peer groups are a really fantastic way for participants to communicate with each other. You get to talk to a spectrum of people—there are shared stories; the groups do different things such as cooking [...] gym [...] Within those groups, I'm able to do things I wouldn't feel confident to do in any ordinary community setting. People understand what you're going through. It's a safe space.⁷

Others spoke of the valuable connection they had formed with a trusted worker who understood what they were going through. One person described their relationship with their GP: 'She has time, patience and understanding and I find myself incredibly lucky to have found her'.⁸ Another person spoke about how their GP was central to their recovery and their ability to maintain hope:

Having regular and ongoing access to my GP has sat at the cornerstone of my care. There have been times when this access has made the difference that has enabled me to maintain hope and persist rather than continue to crumble towards what can feel like the inevitable conclusion of taking my own life.⁹

The importance of forming trusted relationships with mental health workers was also expressed to the Commission:

It's important to have support that can change along the way—one-on-ones that helped me build the courage to go to a group, that led to me going to activities and meeting other people in a non-judgemental and safe environment.¹⁰

More broadly, the value of the mental health workforce has also been made clear to the Commission. Consumers saw empathy, connection and understanding as crucial to having positive experiences:

What makes them outstanding is being able to connect to people with a mental illness on a personal level. The ability to make a connection is at the core of all treatment.¹¹

The staff were so understanding of me having an eating disorder [...] I felt understood and I know they really helped me unpack why I used certain behaviours, and helped me explore different avenues for coping when, you know, the alternative for me would have been using the behaviours. Yeah, I felt really understood and was well supported there.¹²

Consumers also highly valued mental health workers who understood their individual identity and culture. Mr Daniel Bolger, a witness before the Commission, spoke of the benefits he felt from receiving support from a worker who understood and connected with his culture:

I got an Aboriginal worker, connected back with my culture, found some identity, and just talking about life, what I was gonna do in the future, talking about footy, talking about issues that was going on with me, and just that connection was unbelievable in there.¹³

Similar experiences are reflected in the results from the 2018 Your Experience of Service survey, which is conducted on behalf of the Department of Health and Human Services. Among those who accessed public specialist clinical mental health services in the preceding three months, one in three people who completed the survey (noting that almost two-thirds of respondents received treatment and care at three services only) rated their experience as 'excellent' and about 25 per cent rated their experience as 'very good'.¹⁴

This survey, however, is not representative of the experiences of many with the system, nor does it reflect the weight of the sentiment expressed to the Commission about poor experiences. Among the diverse group of people who contributed and shared their insights with the Commission, positive stories were the exception. As one individual said, there are 'pockets of brilliance against a sea of mess'.¹⁵

8.2 Autonomy and influence

This section describes how many consumers feel that their experience of mental health services has been marred by a lack of autonomy and influence in decisions about their own treatment, care and support. It also looks at the often demoralising effects of compulsory treatment and restrictive practices, as well as the experiences of consumers who interact with police.

The role of compulsory treatment and use of restrictive practices features in the Commission's ongoing work to redesign the mental health system. The complexity of these matters requires deep consideration, and the Commission needs to undertake further work before drawing conclusions and making any recommendations.

Nevertheless, given the prevalence of discussion in the Commission's community consultations, as well as in the submissions and documents that have been presented, the Commission felt it was necessary to include the experiences of consumers, and their families and carers, on the use of compulsory treatment and restrictive practices, as conveyed to the Commission to date.

8.2.1 Involvement in decision making and care

Victoria's *Mental Health Act 2014* states that consumers 'should be involved in all decisions about their assessment, treatment and recovery, and be supported to make, or participate in, those decisions, and their views and preferences should be respected'.¹⁶

Similarly, the Victorian Government's overarching plan for mental health, Victoria's 10-Year Mental Health Plan, identifies the importance of putting individuals, families and carers at the centre of the design and delivery of services.¹⁷

Ensuring consumers are at the centre of decision making—and that mental health services are delivered in accordance with human rights in a way that promotes individual autonomy, respect and dignity—has been impressed on the Commission.¹⁸ The system, however, is not currently functioning sufficiently, with adequate safeguards, to consistently give this assurance. The Commission was told that, too often, the voices of consumers were not heard, resulting in limited choice and control over their treatment, care and support:

Sense of agency makes a big difference. Myself and others feel as though there is no real choice. Even when something is presented as a choice, they say come voluntarily but you don't really have the choice.¹⁹

Under the medical model, you are 'difficult' if you refuse medication. There is a lack of talking to patients and giving choice. It has to be a consultative process.²⁰

Ms Janet Meagher AM, an advocate for people with lived experience of mental illness, submitted to the Commission that many people feel a lack of dignity and respect, particularly when they are understood purely in terms of their mental illness:

Many people who experience mental health issues are labelled impersonally as, 'a patient', 'a client' or 'the consumer', or have a diagnosis that represents only what is seen as their 'sick' or 'broken' parts. People see them not so much as a person, but more so as a diagnosis (e.g. 'a depressive', 'a schizo', 'a crazy one' etc. etc.) and frequently as inherently dangerous and not to be trusted.²¹

A witness before the Commission, Teresa, put forward a similar perspective, recalling an experience of being 'not treated as a human' in an inpatient unit:

... Being an inpatient—like, you're—you're not treated as a human, as a person, you're treated as a, kind of someone whose behaviour needs to be managed and controlled, and everything that you do has to be—you have to seek someone else's permission to do it, and yeah, there was no kind of—I think my voice just wasn't heard.²²

The impact of poor treatment, care and support on the lives of consumers can be devastating. One consumer said: 'When the system doesn't treat you with compassion, it traumatises you more.'²³ A worker in a mental health service also reflected on experiences when consumers had been treated with a lack of dignity and respect:

In the mental health hospital, the treatment is horrific. Patients have no choices. They are held against their will and given treatment they don't want. There are no psychologists; it's medication or nothing. Their trauma is not considered. It's just medicating the symptoms. Working as an art therapist, there was not enough time for people to talk.²⁴

8.2.2 Compulsory treatment and restrictive practices

Under Victoria's *Mental Health Act 2014*, compulsory treatment provided by designated mental health services should be delivered in the least restrictive way possible.²⁶

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'.²⁷

Alarming, about half of people admitted to public acute mental health inpatient units in Victoria are done so on a compulsory basis.²⁸ This raises a question about whether compulsory treatment is being used as a measure of last resort. For some people, fear of compulsory treatment can affect the way in which they choose to engage with services. In some circumstances, this fear can deter people from seeking treatment altogether:

I am not currently on any treatment orders under the Mental Health Act 2014 and am considered a voluntary patient. I would like to be treated at home however I have been told that if I try and leave or do not comply with my treatment, the treatment team will take action under the Mental Health Act 2014.²⁹



Box 8.1

Georgina McLaren²⁵

Georgina started self-harming as a 12-year-old while completing Year 8.

Her parents arranged a school counsellor. The school counsellor told her she should be ashamed of her scars. Georgina said the school counsellor did not suggest she seek psychological help but instead tried to talk to her about how she felt. Georgina was not ready to be helped at that time but feels now that if she had been offered some early intervention, she would not have become as unwell as she did.

At the age of 18, after years of self-harming, hospitalisations, various diagnoses and extensive contact with the mental health system, Georgina was diagnosed with borderline personality disorder.

Today, Georgina says she has been irreparably harmed by the mental health system. She felt disempowered and lost, and the only way to get the attention she felt she needed was to self-harm.

I have been made to feel that I am just an illness—that I will never be anything more than that.

Except that I'm not even worth the diagnosis of an illness—I'm just a broken personality so I can't be fixed. I have been passed from practitioner to practitioner. I have lost all my trust in the system that has not been there for me. I will never ever lose the scars that the system has given me.

When Georgina was hospitalised again last year after a relapse, her lack of trust in the system had led to her not reaching out for help:

This system has tried to tear my life apart for the crime of having [borderline personality disorder] with no history of trauma in my life. Many practitioners have suggested that I am faking my illness. To have it suggested that you are faking something that is as horrific as [borderline personality disorder] because you weren't abused or assaulted as a child just eats away at the part of my brain that has been told many times over, you're not sick, you just want attention.

Georgina explains that her experience made her feel that she is unworthy of help or beyond help. She has had to fight all the way to receive the help she so desperately needed to help her manage her complex mental health challenges.

Staff reported a client who had had negative experiences of mental health treatment, including unwanted side effects from medications and involuntary treatment, and that this perpetuated a fear of further engaging with mental health services, which in turn resulted in further involuntary treatment.³⁰

The consequences of the over-use of compulsory treatment and lack of adherence to a recovery focused approach include that consumers are less likely to seek assistance from mental health services and past experiences of trauma may be compounded. We often see consumers who have presented to mental health services voluntarily and have subsequently been made compulsory patients and subject to unwanted and restrictive treatment. These consumers report to us that this experience makes them less likely to seek out support from mental health services in the future.³¹

Compulsory treatment can result in significant trauma and have enduring negative effects on people's lives. One person described how the use of compulsory treatment had made them feel as if their human rights were denied, 'The compulsory treatment order made it hard for me to experience good mental health. I felt as if my basic human rights were taken away from me'.³²

Victoria Legal Aid's submission described a person who was ordered by the Victorian Civil and Administrative Appeals Tribunal to receive electroconvulsive therapy. Describing to them the trauma experienced, he had said:

It was one of the most traumatic days of my life, when I was taken into the [electroconvulsive therapy] room and held down on the bed. I didn't know I was going to have [electroconvulsive therapy] [...] The most terrifying aspect of having [electroconvulsive therapy] is that I didn't know what state I would be in after.³³

The Commission was told, however, of some families and carers who have at times taken comfort in the availability of compulsory treatment. One parent observed that 'an involuntary treatment order meant that my daughter had to attend appointments and engage with services'.³⁴

Despite the profound consequences of compulsory treatment, the Mental Health Complaints Commissioner considers that:

... the gravity of compulsory treatment and the restrictions it places on people's human rights are not well understood or routinely considered in mental health services when making decisions about compulsory treatment.³⁵

Victoria Legal Aid also observed that, despite the conditions set out in legislation, compulsory treatment should only be used 'where absolutely necessary and as a last resort [...] this is not currently the case in Victoria'.³⁶

Like compulsory treatment, the use of seclusion and restraint was also identified as having a profound and dehumanising impact on people. One consumer described seclusion in an inpatient unit as 'worse than prison'.³⁷ Another person told the Commission how the use of seclusion exacerbated their feelings of distress: 'As soon as I saw them putting me in a white padded room I completely flipped out again; I just didn't want to be in that room alone'.³⁸

Among the terms consumers used to describe their experiences of physical restraint were 'triggering', 'disempowering', 'traumatising' and 'controlled':

Shouldn't be held down and forced medication at an inpatient unit. Very triggering for someone with sexual abuse history.³⁹

Chemical restraints and forcing people into beds is not the way for people to get better; this is just a way for people to be controlled. This is the last thing people want. You need to empower them and respect their intelligence.⁴⁰

I was in the mental health system but was diagnosed with an eating disorder only two years later. I was only taken seriously when I absconded from a ward in order to end my life. I was traumatised because every day my treatment consisted of security, restraints and a nasogastric tube.⁴¹

Figure 8.1 indicates that the rates of seclusion in public acute clinical mental health services in Victoria have improved in the past decade. Yet, the trend in more recent years has been worsening for the three years from 2015–16 to 2017–18. Rates of seclusion in Victoria also remain worse than the national average, being 9.1 per 1,000 bed days in Victoria compared with 6.9 per 1,000 bed days nationally in 2017–18.⁴²

Rates of physical restraint in public acute clinical mental health services in Victoria are also significantly worse than the national average. In 2017–18 the rate of physical restraint was 22.0 per cent in Victoria compared with the national average of 10.3 per cent.⁴³

The seclusion rate in child and adolescent acute mental health inpatient units in Victoria is equally concerning. As highlighted by the Victorian Auditor-General, 'the rates of seclusion in [child and youth mental health services] continues to exceed [the Department of Health and Human Services'] target of 15 seclusions per 1,000 beds and the national rate in 2017-18 of 8.1 seclusions per 1,000 bed days'—noting that the Department of Health and Human Services considers this is due to Victoria adopting a stricter definition of seclusion.⁴⁴

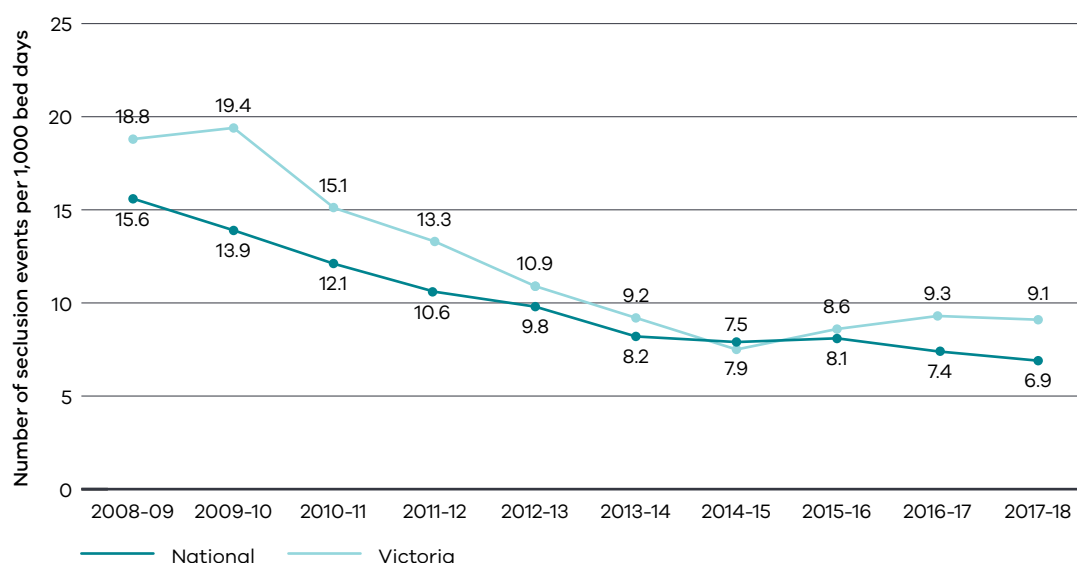
The Commission notes that this has occurred even though there have been efforts to reduce the use of restrictive practices in public adult acute mental health inpatient units.

The use of seclusion and restraint can have long-lasting consequences for people. The Commission has heard that, for many people, the use of these practices has stayed with them, affecting their lives even years after the event itself:

I continued to have nightmares about being locked in that room for over 7 years afterwards. I felt like an animal. I do not feel that at any point I was treated with dignity, like a child (which I was) or even as a human being.⁴⁵

I feel like my spirit broke over those years. I cannot count the amount of times I have been shackled to trolleys or beds, I often wake up at night feeling like I am back there. I never once received any kind of debriefing for the trauma I have endured in the inpatient facilities.⁴⁶

Figure 8.1: Rates of seclusion events for public acute clinical mental health services, states and territories, 2008–09 to 2017–18



Source: Australian Institute of Health and Welfare, Mental Health Services in Australia. Restrictive Practices 2017–18. Table RP.2. <<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia>> [accessed 9 October 2019].

Victoria's service delivery model produces a higher threshold for acute admission and the seclusion and restraint metrics may be inflated compared to other jurisdictions. See the AIHW's data quality statement for more information.

The Office of the Public Advocate submitted that in Victoria, 'at a systems level, no explicit commitment is made to reduce and eliminate the use of restraints and seclusion within the sector'.⁴⁷ This stands in sharp contrast to the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.⁴⁸

A number of people and organisations, among them the Victorian Mental Illness Awareness Council and the Office of the Public Advocate, have called for the elimination of restrictive interventions.⁴⁹ Similarly, the National Mental Health Commission has previously recommended a reduction in the use of involuntary practices and the elimination of seclusion and restraint, and notes that seclusion and restraint are 'often an early sign of a system under pressure'.⁵⁰

The Mental Health Complaints Commissioner stated that significant work is needed to change this culture, identifying that this will require 'the input and leadership of people with lived experience, who have experienced the impacts of having their human rights limited by the provision of compulsory mental health treatment'.⁵¹

Box 8.2

Julie Dempsey⁵²

Julie Dempsey has more than three decades of experience with the mental health system and says she is here today despite the system, not because of it.

Illness is only ever a few serious stresses and sleepless nights away. You never get back to where you came from, but I have defiantly and gratefully moved forward in my life to a new positive place.

Her experiences have included extensive electroconvulsive therapy, which she says was conducted primarily against her will. At the time, she was 'certified' and in a locked ward.

I'd come out of [electroconvulsive therapy] with a splitting headache, confusion, not sure where I was [...] your mind becomes quite battered [...] you start to submit because you've just lost your fight and you're so confused. You don't even know your personal self any more [...] it takes away your essential sense of being and soul ...

Julie describes one of the lowest points of her life, which came when she was put in the back of a police van:

I had been certified by the staff at a hospital emergency department and needed to be transported to a psychiatric unit. As there were no ambulances available, the police van was used instead.



Photo by Zalika Rizmal supplied by ABC News

I was not violent or agitated and I still don't understand why I had to suffer the indignity of being put in the police van, in front of a packed waiting room full of people in the emergency department when I had not done anything wrong, I just needed treatment. At that moment, I lost my sense of citizenship. If I see police out on the street, I don't feel protected, I feel vulnerable.

She also talked about the 'cold and alienating' nature of the support systems and the negative impact compulsory treatment had on her:

They weren't like the warmth you'd get from a family member or a friend supporting you through a crisis. They were much more clinical and directed.

I don't want to be too critical of psychiatrists, they've helped keep me alive, they have to make some tough decisions to keep people here and living, but they can make quite unilateral decisions at times, and without much consultation with the rest of the treating team ...

The seclusions during my hospital stays occurred because I refused medication. I wasn't violent or aggressive to start with. However, staff would surround me with blue gloves and a needle in a kidney dish, which made me feel cornered and threatened. I believed the medication was turning my brain into concrete. No one listened to or reassured me. This would go on for weeks until they broke my spirit. Getting out of hospital for me means completely submitting and surrendering to the system, even if I don't feel any better within myself, I feel that I must sacrifice my own self-respect and principles. I give in.

Julie has worked hard to rebuild a meaningful life, and the hope of friends and family has helped her:

For many years I felt so degraded by the system and the illness and I felt quite sub-human.

[The hope], somehow in all that despair, connected enough to keep me alive [...] Then when I was ready to re-emerge, if you like, and batter my way back up to the surface, I had that to pull on and to cling to and never underestimate how much a friendly word or a bit of compassion can mean to someone when they're desperate.

Julie works as a senior consumer consultant and works to promote and preserve justice and human rights for patients of Forensicare services. She has received numerous awards for her contribution, including the 2019 Meritorious Service Award by the Victorian branch of the Royal Australian and New Zealand College of Psychiatry.

8.2.3 Police involvement

In situations where police are satisfied that a person appears to have a mental illness and is at risk of harming themselves or another person, the person can be apprehended, as specified under s. 351 of the *Mental Health Act 2014* (Vic).⁵³ Victoria Police can then arrange referrals for further assistance.⁵⁴

For many people, apprehension by police can be a confronting and upsetting experience. One person described their experience as degrading and demoralising:

On two occasions, staff from the Hospital turned up on my doorstep out of the blue, informing me that they needed to admit me to hospital, involuntary. On both occasions I refused to go, kicking and screaming. One of the young men tackled me to the ground. He was twice my size and I was in a great deal of pain as I had fallen a few days before and had bruised my ribs. I was cuffed and thrown into the back of a [police] van and taken to the hospital. These experiences were demoralising and degrading. I have checked that this is lawful and I am told it is, as on both occasions I was experiencing mania.⁵⁵

Similarly, families and carers spoke of the distressing impact of watching their loved ones being apprehended by police:

It is heartbreaking seeing your child being forcibly taken for treatment. Whilst the police do the best they can, there should be other options before it becomes life threatening for either the consumer or the family member.⁵⁶

On the night [my son] was picked up by the police, he lost his human dignity. It was a very long way back and we aren't there yet.⁵⁷

This is not a universal experience, though. Throughout the Commission's community consultations, many people spoke of how members of Victoria Police were in some instances, the only services that responded when they asked for help. For example, a mother spoke of her positive experience with Victoria Police: 'The police were caring and compassionate towards my son and even more caring and compassionate towards me'.⁵⁸

8.3 Feeling unsafe

Consumers, families, carers, workers, advocates and others commonly raised concerns with the Commission about the safety of people in adult acute mental health inpatient units.

These concerns are consistent with the findings of the 2016 Review of Hospital Safety and Quality Assurance, which noted that in-hospital assaults and self-harm are much more common for 'mental health patients'.⁵⁹ It also noted that 'mental health patients' are at risk of a range of safety incidents that are often associated with mental health settings:

These include self-harm and suicide, assault (including sexual violence) from other patients, along with trauma or physical harm arising from seclusion and restraint. Further, mental health patients may have lower capacity for self-advocacy and so be less able to protect themselves from harm.⁶⁰

A number of area mental health services have also described the safety risks to both consumers and workers arising from aggression and violence in inpatient units. Some providers noted that aggression and violence have been exacerbated by the lack of early access to services:

Over recent years, the adult inpatient mental health units have been admitting more acutely unwell consumers with a corresponding increase in occupational violence and aggression. This is partly due to the limited bed capacity, as only the most unstable and acutely unwell consumers can access a hospital bed; with others being managed in the Community, also resulting in increased risk to those consumers and staff working in the Community.⁶¹

Increasing levels of violence, especially in inpatient settings, exacerbated by poor early access to services, poor access to intensive supports, and poor infrastructure planning [...] In addition, a lack of appropriate early intervention and community treatment capacity means consumers are entering hospitals sicker than ever before, which increases the potential for violence and aggression.⁶²

Many people, predominantly women, have also told the Commission about their experiences of sexual assault and harassment in the mental health system:

I have had three compulsory admissions, and during three of these admissions I have been sexually assaulted by male patients.⁶³

My three compulsory admissions for psychotic episodes were actively harmful, caused intense suicidal ideation related to being assaulted by male patients during the admissions, and in significant ways, were more challenging to recover from than my mental health conditions. Currently sexual harassment and assault is a live risk and daily reality in mental health services across Victoria.⁶⁴

The Right to be Safe, a 2018 report from the Victorian Mental Health Complaints Commissioner about sexual safety in acute inpatient units, reported that 80 per cent of complaints about sexual safety breaches, including harassment and alleged sexual assaults, in inpatient units were reported by women. Men were described as the perpetrators in 83 per cent of all complaints, and more than three-quarters of alleged perpetrators were identified as other consumers obtaining inpatient treatment.⁶⁵

Among other factors, the report identified the sharing of bathrooms as posing a particular risk for women in inpatient units where the infrastructure is no longer fit for purpose.⁶⁶ Mrs Williams, commented on this:

I was one of two women in the unit. The rest of the patients were older men. I was 22. There was no segregation of men's and women's bathrooms. Men would come in to the bathrooms unannounced. (There were no locks on the bathrooms, which I understand, however there was also no attempt to stop men going in the bathroom while I was in there).⁶⁷

Notwithstanding the range of laws, protocols and reporting requirements around breaches of sexual safety, families and carers also raised concerns about their loved ones being vulnerable and unsafe while in inpatient units. One mother said: 'My daughter was 18 and had lots of drugs to sedate her. She was vulnerable. We ended up taking shifts and staying with her in the hospital to keep her safe'.⁶⁸ Another family member expressed disappointment at the lack of action taken to address the sexual assault of their partner:

Whilst my wife was in the inpatient ward she was sexually assaulted by a male mental health nurse, and when we complained, nothing happened. Even the patient advocates told us not to complain because that has happened to them before.⁶⁹

In response to concerns about the safety of women, the Commission has heard calls for separate treatment spaces for women, as well as greater visibility of staff to promote safe environments.⁷⁰ Similarly, the 2018 report from the Mental Health Complaints Commissioner made a number of recommendations aimed at supporting sexual safety; among them were ensuring that unit planning, design and maintenance support sexual safety, including exploring opportunities for single-gender inpatient units.⁷¹

The Commission notes that in response to such experiences and concerns, the Victorian Government has developed guidelines and new reporting mechanisms to encourage area mental health services to strengthen their focus on sexual safety in inpatient units.⁷²

Nevertheless, Victoria's Chief Psychiatrist, Dr Neil Coventry, acknowledges that this is an area of continuing concern:

I struggle with our issue of sexual safety in inpatient units and having areas that are designated safe areas for predominantly vulnerable females, and hearing that at times that capacity goes because of the pressure on beds and males will be admitted to that area, which is totally against the whole philosophy and approach.⁷³

The Mental Health Complaints Commissioner also submitted that despite improvements designed to protect and respond to sexual safety breaches, there is still significant work to be done to ensure the safety of people in inpatient units:

... despite significant improvements in the approach of some services to preventing and responding to sexual safety breaches, we note that people continue to make complaints about experiencing sexual harassment or alleged assault, or other sexual safety breaches to our office, indicating that there is still significant work to do to ensure people's safety.⁷⁴

Ensuring the safety and dignity of consumers, families, carers and workers in Victoria's mental health system is central to the Commission's ongoing work to redesign the system.

8.4 System trade-offs

Many people have expressed concern that the current system is overly focused on managing risk and the prescription of medication, in the absence of consideration of broader needs. For example, many people have told the Commission that there is limited service capacity to offer effective psychosocial supports, approaches that are responsive to experiences of trauma, coordinated services and continuity of care.

8.4.1 A focus on risk and medication

In some cases, the system's current focus on risk management has been reported to result in people not getting the type of care that would offer the greatest benefit, or people missing out on treatment altogether.

As Dr Sika Turner, Discipline Senior, of Adult Mental Health at Monash Health, explained:

We use risk assessments as the main access point to services and as a system [...] The cost of this is that we do not provide mental health services to some people who have a lot of distress, because they do not express the right type of risk or enough of it. Another cost is that by focusing on risk, we often do not spend enough time on understanding the person and providing them with appropriate treatment. [...] There is a lot of activity in the system focused on risk, but sometimes the amount of activity can obfuscate an absence of genuine evidence-based treatment.⁷⁵

For many people, medication is a critical element of their treatment and care — helping them to manage symptoms of mental illness and stay well. Often, people also need access to a broader range of treatment, care and support services. The availability of a variety of options and alternatives is not, however, the common experience.

The Commission has been told that in some cases service providers and mental health workers are only able to offer medication for managing symptoms, with minimal provision of psychosocial supports.⁷⁶ The Victorian Mental Illness Awareness Council urged that the system give consideration to a person's individual needs and circumstances:

It is indisputable that mental 'illness' is linked to social determinants—trauma, isolation, adversity, socioeconomic disadvantage, violence, racism, homophobia, bullying, family violence, sexual assault, and other forms of harm. An effective mental health system must respond to these factors, it must be a whole-of-government response (not just the health system), and it must move beyond current approaches that attempt to 'fix' human distress with simplistic responses like providing (or forcing) medication.⁷⁷

Similarly, many consumers, and their families and carers, said the treatment they or their loved ones received was overly focused on medication without enough consideration of the person's broader needs. One person described how inpatient units were used to 'contain' people until their medication took effect:

Many mental health units currently offer primarily a 'pillow and pills' service. That is, mental health units are mainly used to contain a person until their medication takes effect. This does nothing to support medium or long-term mental wellbeing in consumers, or their carers.⁷⁸

Sole reliance on medication was raised as a particular concern for older people. For example, one person who attended a consumer and carer workshop held by the Commissioner for Senior Victorians, observed that 'GPs focus too much on medication rather than general health and wellbeing. They are [too] time poor to help patients with mental illness'.⁷⁹

While medications provide a range of benefits to people living with mental illness, people have described experiencing a number of adverse consequences as a result of medications offered to manage symptoms:

Medication inevitably has dramatic side effects. Over the years, I have suffered eye sight disturbance, sedation, weight gain, increased appetite, high cholesterol, confusion, akathisia, dry mouth, dental issues, constipation, diabetes, low blood pressure, low motivation resulting in lack of exercise, incontinence, asthma complications, clashing with other medications, urinary retention, sex drive impairment, stomach reflux, cognitive impairment, Parkinsonian-type tremors, nausea and a stomach ulcer.⁸⁰

That treatment made me feel worse, suffer damaging side-effects, and rendered me incapacitated of my full potential.⁸¹

Many consumers are advocating for more information about medication and treatment so they can inform themselves and be aware of the potential side effects.⁸²

Box 8.3

Dave Peters⁸³

It was after Dave's initial contact with area mental health services that he discovered the extent and history of mental illness and distress in his family. He believes that stigma has prevented an open dialogue about the various experiences of different family members. He wishes he had known about his family history when he was growing up:

Prior to the age of the internet and Google, I was reliant on what was available at school. Given my parents both taught at the school, I felt I was unlikely to have any sort of confidentiality or privacy should I attend the school counsellor, so I suffered the effects of my illness without knowing what was happening to me or why.

Dave would like a better quality of care, where information about medication and treatment is provided so people are aware of the potential side effects such as weight gain, nausea, stimulated appetite, fluid retention, metabolic syndrome, shortened life span, early mortality from cardiovascular disease, diabetes and stroke:

Even if a person is on a treatment order, they should still be informed of the risks involved with their treatment and it is a breach of their human rights to deny this.

Having experienced both mental and physical health problems, Dave would like to see better access and navigation options for the physical health needs of people living with chronic and acute mental health conditions:

I would like to be able to access and navigate services that have a 'no wrong door' policy. Being able to walk into any service at any time and be able to access support, even if the service can't provide long term support, and ultimately needs to find a service that can help you.

Dave would like to see stigma and discrimination addressed and believes the best way to approach this is through public education and awareness, particularly in primary schools, allowing distress to be normalised as a part of life:

I would like to see people with a lived experience sharing their stories of hope and recovery and believe this is the only strategy that can assist with the stigma surrounding mental illness and the barrier it imposes against help-seeking. To me, self-stigma was the biggest barrier to getting the help that I needed.

I was scared and ashamed, fearful of what I was going through and feeling alone and desperate, but nothing could have compelled me to ask for help for fear that my worst nightmare would come true—being diagnosed with a mental illness.

8.4.2 Under-use of effective practices

Despite the existence of effective practices, many are not routinely applied or systemically embedded in the current system.⁸⁴ This may be partly explained by the current system's focus on risk management and crisis response.⁸⁵ There may also be limitations in the way people with lived experience are engaged with determining and influencing evidence-informed approaches.

Professor Patrick McGorry AO, Professor of Youth Mental Health at The University of Melbourne and Executive Director of Orygen, explained: 'We have not actually built a system that delivers what we already know.'⁸⁶ That is, many consumers do not have access to treatment, care and support that is proven to be effective in supporting their recovery.

This sentiment has been echoed by many. Ms Gail Bradley, the Interim Operations Director of NorthWestern Mental Health Service, which is part of Melbourne Health, said that, despite the evidence that psychosocial interventions (supports focused on recovery, rehabilitation, wellbeing and community participation) reduce relapse rates and improve quality of life for people with schizophrenia, there has been minimal uptake in the current system.⁸⁷

While there is a strong evidence base for psychotherapy—a form of treatment based on establishing therapeutic relationships with clinicians—the Royal Australian and New Zealand College of Psychiatrists submitted that there is limited capacity in the current system for consumers to access this kind of treatment.⁸⁸

Similarly, while the benefits of recovery-oriented approaches are well documented, the transition to practice has been limited. A recovery-oriented approach to mental health focuses on supporting people in building and maintaining meaningful and satisfying lives.⁸⁹

While the importance of a recovery-oriented approach is acknowledged⁹⁰ and the approach is adopted in some parts of the mental health system, its use is not widespread. Many people feel that recovery is mere rhetoric rather than a practice that has been accepted and embedded in the current system.⁹¹

These assertions are further supported by findings from the Second Australian National Survey of Psychosis. The survey found that fewer than one-quarter of participants with diagnosed psychotic disorders had received any of the six evidence-based psychosocial interventions identified in the research literature as being effective in improving recovery outcomes for people living with these forms of mental illness.⁹² Another Australian study on the quality of mental health treatments found that, of people with mood or anxiety disorder who sought professional help, only 26 per cent received an evidence-based treatment.⁹³

A lack of effective approaches that are informed by evidence means that many people living with mental illness are not getting access to optimal treatment, care and support. Dr Coventry observed that a lack of evidence-based treatment can have adverse effects on the experiences of consumers, including slower recovery or relapse of symptoms:

Community-based services have insufficient resources to provide the intensive treatment and support required for consumers who are very unwell. Their resources do not allow them to provide evidence-based psychological interventions which assist with longer-term recovery. These consumers are therefore more likely to experience slower recovery or a relapse of very acute symptoms.⁹⁴

Going forward, the Commission will consider the range of challenges that are constraining the dissemination of effective practices, particularly recovery-focused practices.

8.4.3 Changes to psychosocial supports

Psychosocial supports focus on recovery, rehabilitation, wellbeing and community participation, and can play a crucial role in helping people's recovery.⁹⁵ Examples of such services are assistance with managing daily household tasks, counselling services, advocacy, group recreation and leisure activities and supported independent living services.

Many people have discussed the value of psychosocial supports in improving outcomes and experiences for consumers. They have also called for an expansion of these kinds of therapeutic supports:

We have limited psychosocial programs, we need more community houses, drop-in centres, structured day programs.⁹⁶

Ongoing therapeutic support is an absolute must. So important but mostly unaffordable. Make other treatment options available such as yoga, meditation and mindfulness.⁹⁷

There have been great youth services that allowed weekly catch ups, to participate in art, and social outings and excursions. But those are, you guessed it. Under funded. They're also for YOUTHS, so the cut off is at 24. Now at 31, I would love to be able to catch up in my town again and sit and talk and paint and enjoy some time with other people.⁹⁸

The National Disability Insurance Scheme is changing the way psychosocial supports are delivered. A range of psychosocial supports previously funded by the Victorian Government are now being funded by the NDIS for eligible participants.⁹⁹

Providing psychosocial supports through the NDIS was intended to give people living with severe mental illness access to a range of the scheme's benefits—including greater personalisation of services and more choice in relation to what supports are provided and by whom.¹⁰⁰ The National Disability Insurance Agency advises that the average NDIS annual funding per participant with psychosocial disability (the term often used to describe disabilities that may arise from poor mental health) as their primary disability was \$44,400 (as at June 2019); this compares with \$11,000 in psychosocial services before the scheme.¹⁰¹ In this regard, the NDIS represents a substantial increase in funding available to some people.

While for some people the NDIS is working well to improve choice and control, for many people living with mental illness the scheme is yet to reach its full potential. One person told the Commission, 'There are less services than ever with NDIS sucking up all the funding, and no-one is able to actually get into the NDIS'.¹⁰²

Another person commented that they are no longer able to obtain psychosocial support, meaning that 'people can't go to their usual activity like art, music, my trainer, social outings, cooking sessions and many more'.¹⁰³

For some people, transition to the NDIS has adversely affected their recovery from mental illness. Mr Peter Ruzyla, CEO of Eastern Access Community Health, described how supports through the NDIS to assist with lawn mowing and shopping had an adverse impact on a consumer's recovery:

The recovery worker was horrified because it had taken them 12 months for this agoraphobic person to get around to mowing his own lawn and doing his own shopping, so you had a perverse outcome of a plan for a person who'd actually made some great steps forward in their recovery.¹⁰⁴

While the NDIS holds considerable promise for people living with mental illness, it is not working well for everyone. In response to these challenges, the National Disability Insurance Agency has taken steps to improve the experiences and outcomes of people with psychosocial disability, with a focus on recovery.¹⁰⁵

As redesign of the mental health system continues, the Commission will give careful consideration to the NDIS, including undertaking further discussions with the National Disability Insurance Agency. This will include consideration of supports and services at the interface of the NDIS, mental health services and other community supports, as well as arrangements for people who are ineligible for the NDIS.

8.4.4 Need for trauma-informed practice

There has been a growing emphasis on trauma-informed care and practice in Victorian mental health services.¹⁰⁶ This involves recognising the high level of traumatic experiences among people living with mental illness.

Trauma-informed practice recognises the neurological, biological, psychological and social effects of trauma and interpersonal violence.¹⁰⁷ It provides a strengths-based framework for treatment and care, emphasising 'safety, trustworthiness, choice, collaboration and empowerment'.¹⁰⁸

Trauma-informed care is commonly informed by a series of principles, among them a focus on therapeutic relationships that are empowering, and an approach to treatment that is based on a person's history of trauma and careful consideration of the potential for re-traumatisation.¹⁰⁹

The use of trauma-informed practice can help people feel safe, understood and willing to engage with mental health services. Some consumers have noted the benefits of obtaining treatment, care and support embedded in trauma-informed practice. One person said, 'Trauma-focused counselling is really effective and it changed my life'.¹¹⁰ Another person submitted that, 'The most effective approaches I've encountered are trauma-informed care and open-dialogue accompanied by attitudes of humility and respect'.¹¹¹

These experiences, however, are not commonplace. While there is widespread regard for trauma-informed practices, it is not consistently embedded throughout the mental health system. One person described: 'We are a mental health system that doesn't know how to respond to trauma'.¹¹²

The Commission has been told that consumer experiences of trauma are often silenced, minimised and disregarded:

Most people, even mental health professionals treat me as if I am uneducated, unintelligent, a liar, drug and alcohol dependent and a drama queen who has no knowledge or insight into my own illness. I'm viewed as pathetic, weak and someone who just doesn't try hard enough to recover from mental illness. Most people seem to have no idea that I am a human being who is damaged because of the trauma I have experienced and statistically it could happen to any of them.¹¹³

Despite advising the [crisis assessment and treatment] team of the sexual assault, the hospital I was admitted to failed to detect my subsequent pregnancy, treated me without consideration of my pregnancy and did not provide trauma informed care which was most evident when they put me in seclusion after I reacted to being followed by a man on the ward.¹¹⁴

Ms Kylie Scoullar, the General Manager of Direct Services at Foundation House, described how failure to understand experiences of trauma can have profound and enduring consequences for individuals:

I am aware of a trauma survivor who was admitted to a public mental health facility and treated for an eating disorder. She refused to eat and was close to dying. However, it became evident that she did not have an eating disorder—she was a torture survivor and had been forced to eat terrible things as part of her torture in her country of origin. Despite the fact that it was widely known that torture was prevalent in her country of origin, no consideration was given to this in her assessment or initial treatment. In a pressured mental health system, there is not always capacity to take on other considerations and this can lead to a misdiagnosis.¹¹⁵

Similarly, Domestic Violence Victoria raised a concern that the current mental health system fails to acknowledge and appropriately respond to the impact of violence and trauma among survivors of family violence. For example, to appropriately respond to survivors of family violence and trauma, who also have poor mental health, services 'need to have a common understanding of trauma and violence-informed care and what that means for practice'.¹¹⁶

Orygen, the National Centre of Excellence in Youth Mental Health, told the Commission that, despite the prevalence of experiences of trauma and the impacts on mental health, trauma-informed care is often poorly understood and inadequately implemented in mental health services, with a notable absence of systemic and system-wide policies to inform this approach.¹¹⁷

A lack of trauma-informed practice not only compromises quality of treatment, care and support, but risks retraumatising consumers. Many people described how service and system failures can lead to further trauma and, in some cases, deter people from seeking help in the future:

When I was younger I used to have a diagnosis of [post traumatic stress disorder]. When this moved to a borderline personality disorder diagnosis the same services that supported me pushed me out. People don't understand that diagnosis is often trauma-based and it means people can be re-traumatised by being rejected by services.¹¹⁸

The whole experience has done untold damage to my state of mind [...] the hospital only succeeded in providing an experience so traumatic that I will never again go to a hospital if I have feelings of suicide.¹¹⁹

I was one of two women on the unit and the rest of the patients were men. With my trauma history, which the hospital knew about, I already found that quite frightening.¹²⁰

A lack of knowledge and support for me, a complex trauma survivor caused me to be extremely retraumatised and in turn hospitalised. Please legislate that psychologists are trauma informed and use trauma informed practice-so they do no harm.¹²¹

A prevailing theme throughout the Commission's work so far is the need to embed trauma-informed practice throughout the mental health system to ensure the system is responsive to past experiences of trauma and the potential for further re-traumatisation.¹²²

8.4.5 Need for integrated treatment, care and support

There is widespread acknowledgement that people achieve better mental health outcomes when they receive integrated, multidisciplinary care that is responsive to their needs across multiple life domains.

Many consumers, and their families and carers, have said that they value services that understand their broader needs and are more connected to their everyday lives. One person said, 'We need to think about all of the elements that make up a person's life'.¹²⁴

Many service providers, workers and advocates also echoed the need for coordinated and integrated services. Mercy Mental Health told the Commission: 'A redesigned system should be person-centred and provide a cohesive network of services that deliver holistic support to people living with a mental illness throughout their life'.¹²⁵

Despite this, Victoria's mental health and related services currently operate largely in silos. People experiencing poor mental health typically receive services delivered by separate providers. As a result, mental health services are not well coordinated or integrated with other health and social supports that people need to experience good mental health.

CoHealth, a large community health service, told the Commission that 'Without holistic, integrated services that can intervene, early mental health gains can be slower, or jeopardised'.¹²⁶ CoHealth went on to describe that this is crucial for people who live with multiple and complex needs, such as co-occurring mental illness and disability, who without support might not know of or receive suitable supports in a consistent and coordinated way.¹²⁷

Many people spoke of how current silos have compromised the quality of services they receive. A lack of coordination and integration has resulted in some people being handballed between different services, or turned away all together:

There are many consumers falling through the gaps of the mental health system, specifically to do with not meeting risk criteria and symptom criteria. This includes consumers who have [a dual diagnosis] and dual disability who experience services, including the mental health service, bouncing the consumer from one service to the other because no service is willing to take accountability to respond to their needs.¹²⁸

The people working in the disability sector are reluctant to work with someone who has a mental health issue as the needs are too complex. The people in the mental health sector are reluctant to work with people with a disability as the behaviour is seen as stemming from the intellectual disability, not the mental health issue.¹²⁹

Box 8.4

Sandra¹²³

Sandra* leads a happy and healthy life, but she reflected that it was not always that way.

Aged 24 years, she has a history of trauma and abuse, and remarked that she fought for many years to be something other than a diagnosis:

I was made to feel like the way I functioned and was surviving was 'wrong' or a 'problem' rather than as an understandable response to what I have experienced.

I first reached out for help with my mental health when I was 13, when I became actively suicidal. Despite another few attempts at getting some support (and again feeling misunderstood, patronised and dismissed), my depression continued to go untreated and undiagnosed until I was 16.

As a result of the bullying and sexual assault she had experienced, Sandra developed anorexia nervosa. She says her treatment was not effective. She describes attempting suicide within weeks of starting her treatment.

Sandra's experience with the public mental health system has included voluntary and involuntary stints in youth and adult facilities, where she believes her treatment was less than helpful:

The default response was to lock me in a cell, drug me and allow me to scream myself hoarse for over an hour until I eventually fell asleep.

Sandra credits the support and treatment obtained via private health insurance with saving her life. To support people properly, she said the system needs to go much further to understand how people's symptoms come about in the first place, and how to stop people from continually re-entering the system:

I now no longer have nightmares, flashbacks or negative beliefs about myself [...] however there will always be some long-lasting impacts of my experiences. I remain scared of small spaces and I have lost trust in doctors, nurses and other health professionals.

I am now happy to report that I am free of the impact of any mental illness and am doing everything I can to support others going through hard times. I am a highly active member of the community and advocate for young people who do not have a voice.

* Not her real name

An often raised example is where people living with mental illness also experience alcohol and other drug problems.¹³⁰ In these cases, the Commission has been told that pressures to treat co-occurring mental illness and alcohol and other drug misuse in separate systems can lead to the treatment of one at the expense of the other, gaps in treatment and the failure to address needs.¹³¹ One person spoke about their family member's experience:

There is no integration for people with mental health issues and [alcohol and other drug issues]. There's no facilities, there's no referral points and the constant refrain I got from her mental health team was that until she recognises she has a problem with alcohol, there is nothing we can do. If something had been done years ago, maybe we [wouldn't] be here at this stage.¹³²

Physical wellbeing and mental health are intrinsically linked. This means that for many people recovery from mental illness must be complemented by services and supports that address their broader physical needs. Many people who live with co-occurring mental illness and physical health conditions have described the challenges they face when receiving appropriate treatment, care and support. One person described being denied access to medication for their physical health issues:

In many of my admissions, I couldn't access my medications for my physical health issues. I was denied my insulin for over a day, which resulted in an emergency department admission. There was no justification for being denied my medication. This resulted from a lack of communication between staff and a lack of understanding of my physical health needs. The physical health of many people in psychiatric wards often deteriorates.¹³³

Another person described how their mental health needs were assigned lesser priority. They were told, 'let's get your diabetes under control first, as your anxiety won't kill you'.¹³⁴

Similarly, Victoria Legal Aid submitted the following case study that describes how a lack of integration and coordination between different services can have a detrimental impact on a person's quality of life:

Sally is 67 years old and lives in a remote regional town. She was on an inpatient treatment order for three months. Sally was treated for her mental health issues during her stay, but not her physical illnesses. Sally has various complex health conditions, including type 2 diabetes, carpal tunnel and glaucoma. During her stay, Sally had two falls because she is unsteady on her feet and vision impaired.

Sally wanted to visit an ophthalmologist to discuss her glaucoma and deteriorating sight, but was told the hospital could not facilitate an appointment and she had to wait until she was discharged from hospital. During her three-month admission, Sally was unable to access appropriate healthcare and found the focus on her mental health frustrating given her age and complex health needs. As Sally's physical health deteriorated she became increasingly stressed, which [had further effects on] her mental health.¹³⁵

8.4.6 Need for continuity of treatment, care and support

The current system is failing to provide continuity of care for many people. One person described, 'There is no continuity. There is no beginning, middle or end. There is just gaps'.¹³⁶ In part, this can be explained by the complexity and fragmentation of the mental health system, combined with a lack of coordination and integration with broader services.

Consumers typically receive treatment, care and support from multiple mental health workers at different times and stages of their lives. Dr Turner observed that this lack of continuity can inadvertently affect opportunities to form therapeutic relationships with consumers:

The other great difficulty I have with this system as a psychologist is that research reliably shows that the therapeutic relationship is one of the most powerful tools we have in the work we do with people. And yet our clients are often seen by ten or eleven different people. When we shift people around without letting them establish a therapeutic relationship with someone, we throw away one of the most valuable tools we have.¹³⁷

For some consumers, receiving services from many different workers can diminish trust and delay their journey towards recovery:

Mum's had a different psychiatrist every two weeks. She had to tell her story over and over again and they all have different approaches to treatment.¹³⁸

There's a lack of continuity of care. Every time he would get a different doctor and every time he'd have a different support person, you start again trying to build trust.¹³⁹

High staff turnover, whether because of poor pay or the emotional demands of the work, means a lack of continuity and difficulty building constructive long-term relationships that are necessary to provide real support to someone suffering poor mental health.¹⁴⁰

Moving between the different parts of a fragmented system can also disrupt continuity of treatment, care and support. Ms Anne Lyon, the Executive Director of Mental Health and Alcohol and Other Drugs at Eastern Melbourne Primary Health Network, described how understanding 'an ongoing story' is essential to ensuring responsive services:

What we know is that transitions of care for people need to improve; so, people leaving particularly acute health services, they need to have a transition into community-based support services with good information.

The continuity of care for people needs to be supported so when they move between services or practitioners, that there is an ongoing story and a pick up of what their needs are.¹⁴¹

A lack of continuity in service delivery can be distressing for consumers who might have used services at one point in their lives but then end up with compromised treatment or gaps in support later in life.

In recent years, services have become more constrained in their capacity to provide support to people in the community following discharge from public specialist clinical mental health services. Incomplete discharge summaries,¹⁴² time-pressured discharge assessments and inadequate planning can all negatively affect experiences and outcomes of treatment, care and support.¹⁴³

Data from area mental health services suggest that only one in four consumers receive face-to-face follow-up in their own home following discharge from an inpatient unit.¹⁴⁴ The Mental Health Complaints Commissioner submitted that it has received numerous complaints relating to inappropriate discharge arrangements; among them are expressions of concern about consumers being discharged into unsuitable accommodation or unsafe situations without adequate follow-up support.¹⁴⁵

Similarly, the Commission was told of people being discharged from public specialist clinical mental health services without a plan or without their family or GP being told. Some were put on a train leaving town and some had nowhere to go. One person described how it made them feel: 'It's that loneliness in between hospital and going home, having no one.'¹⁴⁶

Many people have described being 'discharged to homelessness'¹⁴⁷ simply because there is nowhere else for them to go. One person described how people are pushed from public specialist clinical mental health services to prevention and recovery care centres, 'and when those are full, people get pushed onto the street and into homelessness.'¹⁴⁸

One mental health worker spoke of the impact of having to discharge people without stable housing, saying, 'We discharge people back onto the streets, and I have to live with that.'¹⁴⁹

Box 8.5

Erica Williams¹⁵⁰

Erica Williams has a history of mental illness and complex trauma, which she says informs her experience of the mental health system.

At the age of 22, she was diagnosed with borderline personality disorder, anorexia, major depressive disorder and anxiety, and she has had multiple hospital admissions in the past five years.

The admissions have always been quite helpful. I've found them to be really supportive. My discharges were sometimes a little bit early.

She can recall one of the times she was discharged home after a long stay in a mental health facility.

Everyone was so uncertain about what to do [...] we weren't ready for that to happen. There was a lack of middle ground between intensive hospital and being at home. We had to test the water and see if things would get better.

Erica said things didn't get better and she was on a 24-hour watch while at home.

My community was asked to play the role of a hospital for about two or three weeks, things weren't getting better. I wasn't safe and it was an enormous strain on everybody around me.

Nobody is a mental health nurse [...] we don't all know what to do in these situations and a lot of the time that's what they're being asked to do when we discharge patients from a kind of really high-intensity inpatient service to a home environment.



Photo by James Bennett and ABC News

8.5 Need for tailored and responsive services

A prevalent theme throughout the Commission's work to date concerns the need for services to be tailored to, and inclusive of, people at all stages of their lives, and as their needs and symptoms change.

Some people consider that the services they have obtained were not sensitive to their specific needs and experiences. Others speak of the pervasive impact of stigma and discrimination that consumers, and their families and carers, can experience while obtaining services through the current system.

8.5.1 Responsiveness to ages and stages of life

Experiences of mental health and mental illness are both personal and varied, with poor mental health a consequence of different factors that may change throughout the ages and stages of people's lives.

The mental health system must therefore be adaptive and responsive if it is to meet the diverse needs of Victorians during the course of their lives. For many, the system often fails to provide services that are tailored and inclusive.

In acknowledgement of the different needs and experiences of children and young people, the Victorian *Mental Health Act 2014* specifies that they should receive services separate from those for adults, whenever possible.¹⁵¹ A recent report from the Victorian Auditor-General's Office found, however, that children as young as 13 years were using adult mental health services.¹⁵² The Auditor-General also observed that the Department of Health and Human Services has never analysed or monitored this, despite it being 'clinically inappropriate, inconsistent with legislation, and a potential indicator of significant demand pressures'.¹⁵³

Increased demand and cost pressures have resulted in some children and young people receiving inappropriate treatment, care and support in the adult mental health system. Children and young people described how admissions to adult inpatient units further exacerbated distress and led to feelings of isolation:

There were no beds in the youth psychiatric ward and the youth psychiatric ward was also far away [...] I was admitted to the main ward of an adult psychiatric hospital at the age of 17. Within two days of my admission, I had seen things that have scarred me for a lifetime. I saw people crying and screaming in anguish on the floors. I saw people being dragged away and restrained by medical staff.¹⁵⁴

I was initially placed in an intensive care ward. There were only curtains between beds, there was no privacy and no division between age or gender. I felt like this wasn't what being a teenager was supposed to be like. I wasn't around anyone my age, and I felt like none of the staff knew how to deal with a teenager. It felt wrong to me, and I felt abnormal. I attended group therapy but being in an adult ward, the participants were speaking of stresses that did not relate to me at all [...] This reinforced my feeling of isolation.¹⁵⁵

Transitioning from a child and adolescent service to an adult service because of age-based service requirements can also result in the needs of children and young people not being met.

Professor McGorry observed that adult mental health services often have difficulty engaging and working with young people during this transitional stage of life, explaining that this might be, in part, a result of the morale and culture of adult mental health services.¹⁵⁶

One person described how transitioning to a new mental health service because of age requirements can be 'detrimental' to a person's mental health:

... people with [borderline personality disorder] have significant trouble forming relationships at the best of times, and to force them to have to start therapy with a new therapist just because they turn 18 is detrimental to their mental health and [can] set them back in their treatment.¹⁵⁷

Families and carers also shared their concerns about the transition between services:

The transition to the adult system was awful; we were shut out of the adult system as parents. Now we have an 18 year old, very malnourished, and can't make any decisions for herself and we are shut out.¹⁵⁸

Similar concerns have been raised in regard to the other end of the age spectrum: when people in specialist clinical mental health services turn 65 and are moved from the adult system to specialist older persons services. One family member described the difficulty of transitioning between services for their loved one: 'My brother fell into that gap between adult and aged services and transiting between these services is really hard'.¹⁵⁹

The appropriateness of the current arrangements between adult and aged care specialist clinical mental health services has been questioned and is considered by some to be arbitrary.¹⁶⁰ Council on The Ageing Victoria told the Commission of the challenges regarding age limitations between adult specialist clinical mental health services and specialist older persons' services, including where a person passing the age threshold may experience even greater geographic separation from available treatment.¹⁶¹

Among the concerns often raised with the Commission are that, although people transition out of the adult specialist clinical mental health services at 65 years of age, many people are living more active lives for longer and may benefit more from the adult rather than older persons' services.¹⁶² The question of service continuity and specialist support for people with lifelong mental illness when moving into residential aged care was also raised, and people called for a more nuanced understanding of mental illness and psychological distress as people age.¹⁶³

Alongside concerns regarding transition between services, the Commission has also been told of fears that mental illness in older people can often go undiagnosed and untreated because it is attributed to ageing.¹⁶⁴ One person emphasised that 'growing old does not mean growing mentally ill'.¹⁶⁵

A family member also told the Commission:

I had a terrible time trying to manage [my grandfather's] mental health as a carer. We fell through the cracks in this system. Doctors did not know enough or understand what he was going through. Many health professionals would [write] off his condition as 'dementia' or 'old age'. This was not the case with my grandfather. He had his memory intact yet would suffer delusions, depression and extreme paranoia [...] The system let him down by not acknowledging his mental health needs earlier enough. The system let me down, as a young person trying to provide him with care. These were dark times for myself.¹⁶⁶

8.5.2 Cultural and social inclusiveness

The Commission was told that services that are inclusive and sensitive to people's cultural and social needs are crucial to personal empowerment and for delivering effective services that are valued by those who use them. Cultural safety is about creating safe spaces based on mutual respect and shared understanding. It can be defined as:

... 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 together with dignity and truly listening.¹⁶⁷

Victoria's mental health system lacks accessible, inclusive and culturally appropriate services that respond to the individual needs of consumers, families and carers. Aunty Nellie Flagg, an Elder and a Taylor-Charles, whose traditional countries are Wemba Wemba, Dja Dja Wurrung and Boonwurrung, and a witness before the Commission, described how the mental health system is not sensitive to the needs of Aboriginal people and does not understand Aboriginal spirituality:

I can walk into a building and know there is something here and feel it. It may be a good or bad spirit [...] a medical person might think talking about spirits means bad mental health. If you are not open to that, as a doctor, the bells and whistles are going to go off. Because of this, you clam up, and don't talk about it, because of a fear they will think you have mental health problems [...] in hospital psychiatric wards, I have felt that the environment was very sterile. It was not culturally sensitive. I have seen that Aboriginal people are afraid to stay or just feel uncomfortable there.¹⁶⁸

A lack of cultural understanding and cultural safety can diminish people's experiences of treatment, care and support. It can make them feel unsafe, vulnerable and misunderstood. Ms Tamara Lovett, a Gunai and Gunditjmara woman, and a witness before the Commission, spoke about why she felt uncomfortable using mainstream services:

I am not comfortable using mainstream services, because in mainstream services workers aren't able to understand cultural needs. They are just fixed on a diagnosis and also on medications, but that's not the therapy I wanted. They are also limited on time, rushed and don't listen. And you never see the same people, which means you have to keep re-telling traumatic events over and over again.¹⁶⁹

Similarly, the current system does not respond well to the needs or circumstances of people from culturally and linguistically diverse backgrounds. Mr George Yengi, a member of the South Sudanese community, and a witness before the Commission, observed that services are not culturally sensitive and suggested:

Tailor the approach to care to be more culturally sensitive: for example, rather than seek to unpack the baggage that migrants may have carried over with them, or label someone with a specific illness, in appropriate cases, take a more gentle approach and focus on culturally appropriate strategies to help the person with their problems including for example (soccer/basketball), socialising and dancing.¹⁷⁰

The Commission has been told that the current system often imposes a Western model of treatment, care and support that fails to recognise and respond to people's culture, including their language preferences and connections to family and communities:

They are applying a Western model to an Eastern ideology—clinicians can't understand why you're so integrated into the family. Also the language barrier is a problem. If you have somebody else translating then there are privacy issues. Also, how do you access the system? You think, 'Oh my god, where do I start?'¹⁷¹

The most significant barrier to service access for migrant and refugee women is a lack of availability of relevant or appropriate services. In most of Victoria there are simply no tailored or targeted services that can provide specialist expertise in perinatal mental health for migrant or refugee women.¹⁷²

At the Commission's roundtable on the needs of culturally and linguistically diverse community members, participants noted the low levels of availability and use of interpreters among mental health services. The group emphasised that the system needs to assist people in communicating their needs in order to access help.¹⁷³

Deaf Victoria raised similar concerns. It noted that people who use Auslan often do not have access to Auslan interpreters in hospitals. Deaf Victoria also advised that they know of only four mental health professionals in Victoria who are 'hearing, yet are fluent in Auslan'.¹⁷⁴ It emphasised that the 'assessments and treatments used by mental health professionals are often not 'deaf-friendly' and do not recognise the cultural and linguistic needs of these individuals'.¹⁷⁵ These communication barriers can have serious negative effects for individuals. One person in their submission observed:

The system, it failed me. I had to use my friend [...] and his networks to get access to what the hospitals should have known and provided in the first place. If it wasn't for his help, I would have been in the psych ward for weeks. This demonstrates that something needs to change.¹⁷⁶

A lack of inclusivity is also a problem for LGBTIQ+ communities. Dr Ruth McNair AM, a GP, described how some health services fail to provide inclusive care:

... failing to understand and acknowledge the possible role of discrimination, violence or marginalisation on mental health; failing to use appropriate language and therefore misgendering people or assuming they are heterosexual; referring to other health services that are not LGBT inclusive; and providing bed-based mental health services that are highly gendered.¹⁷⁷

The Commission has been told of LGBTIQ+ communities' negative experiences of the mental health system and medical professionals 'ranging from ignorance to outright prejudice'.¹⁷⁸ In some instances, LGBTIQ+ people take on the dual role of being treated by, as well as educating, the mental health workforce on LGBTIQ+ issues.¹⁷⁹ Ro Allen, Victoria's Commissioner for Gender and Sexuality said:

One of the most profoundly negative experiences for a LGBTIQ person who seeks mental health support is when the clinician, service provider or support worker assumes that the person's mental health issues are the direct result of their sexuality, gender identity or intersex status.¹⁸⁰

Ro Allen went on to describe the LGBTIQ+ communities' poor experiences of the mental health system:

Inpatient settings can pose particular problems for LGBTIQ people. In addition to experiencing discrimination from staff and services, LGBTIQ people can also experience abuse, harassment and even violence from other patients.¹⁸¹

Another LGBTIQ+ person told the Commission: 'I've also had to quit a mental health care plan and go without at some points in my life because my GP sent me to a biphobic counsellor', where this person felt they were being counselled into repression.¹⁸²

These experiences mean that others within LGBTIQ+ communities may avoid seeking help, even if they have not personally experienced this discrimination.¹⁸³

Beyond the traumatising effects of discrimination, such experiences can also compromise the quality of care by discouraging some LGBTIQ+ people from sharing information about their sexuality, gender, identity or intersex status with health professionals because they do not feel safe.¹⁸⁴

Box 8.6

Gloria¹⁸⁵

Gloria* is a transgender woman who has concerns about the lack of trans-inclusive health practices and the discrimination she has experienced while receiving inpatient care in an acute psychiatric hospital.

I voluntarily admitted myself to hospital in October 2017 as a result of the impact the marriage equality debate was having on my mental health, emotional wellbeing and suicidal ideation.

On admission, I informed staff of both my preferred name and my preferred pronouns (she/her) and was assured that the staff had undergone inclusivity training and understood the importance of respecting my wishes.

Gloria said that during her 10-day admission she was repeatedly misgendered and disrespected by staff.

This treatment continued despite multiple requests from me, formal complaints, and patient advocacy services instructing staff as to their obligations. In addition to this I was often denied care by staff unless I referred to myself by my legal name and outed myself to the other patients.

The hospital's direct discrimination and disclosure of my identity culminated in me being attacked by a male patient who had been informed of my transgender identity, despite my having raised concerns over transphobic and homophobic comments made to me by this patient, and my request to be transferred to the secure female area after receiving these threats. Despite multiple requests, I was refused access to the secure female area of the ward.

Following her stay in an acute psychiatric ward and in step-down facilities, Gloria would like to see attention directed towards addressing the situational factors that lead to admissions, such as homelessness, lack of family support, discrimination in the community and lack of community support and services.

She also has multiple recommendations for the Commission:

That the wishes and preferences of trans and gender diverse patients be respected and adhered to at all times.

That ongoing care be provided to patients who have experienced violence and discrimination in an acute hospital setting.

That all mental health staff should have appropriate training into trans-inclusive practices, and this should be developed through consultation with those who have a lived experience.

There should be clear anti-discrimination policies readily accessible.

There should be free legal support for people with legal cases against mental health institutions such as hospitals.

Gloria believes mental health support services need to listen more to the unique needs of the trans and gender-diverse community and would like to see research conducted into the intersection of the LGBTIQ+ community and mental health. Care should be aimed at early intervention strategies to address and alleviate situational factors that contribute to poor mental health and lead to suicide.

** Not her real name*

8.5.3 Experiences of stigma and discrimination

Stigmatising and negative attitudes towards mental illness, as well as discriminatory behaviours from mental health workers and the wider community, have been a constant refrain. Contributors to the Commission have spoken of the profound negative effects these attitudes and behaviours have had on their lives.

Stigma and discrimination are strongly connected, and the distinction is not always clear. Some believe that stigma is better described as discrimination. Another view is that stigmatising attitudes 'are the attitudes or beliefs held by a person, whereas discrimination is behaviour or perceived behaviour'.¹⁸⁶

Ms Meagher was even more assertive in her view of the word 'stigma':

The word 'stigma' I hate with a vengeance, I hate it, and I hate it because it's soft and deflective. It allows for forgiveness. I've reached the stage, I don't allow forgiveness. It's a weasel word. I use 'discrimination', and unapologetically ...¹⁸⁷

Stigmatising attitudes towards people living with mental illness can negatively affect their experiences and outcomes. A striking example described to the Commission relates to how people living with personality disorders, including borderline personality disorder, experience treatment, care and support.¹⁸⁸

The Commission was told of experiences of stigmatisation by the mental health workforce¹⁸⁹ including instances where clinicians have distanced themselves from people living with borderline personality disorder, making the care less helpful and less empathetic.¹⁹⁰ Longer waiting times are experienced,¹⁹¹ and inadequate resourcing is more apparent.¹⁹² One person even described a relative being turned away from services because of a diagnosis of borderline personality disorder.¹⁹³

These poor experiences of treatment, care and support might be influenced by misplaced perceptions that people living with borderline personality disorder are manipulative rather than in need of help.¹⁹⁴

The Commission was told of the great difficulty one young person living with borderline personality disorder faces. She reported finding relationship development difficult in part due to her illness but was set back in her treatment when age and catchment cut-offs forced her to change services.¹⁹⁵

Stigma can have a significant influence on poor experiences of the mental health system and the poor outcomes that often follow. People have told the Commission that, once in the health system, they were treated dismissively, judged and not listened to, particularly in relation to their personal history and treatment needs.¹⁹⁶ One person described:

I feel that the area that can benefit the most from stigma reductions is with the professionals (nurses, doctors, psychologists and psychiatrists to name a few) who deal with 'us' on a regular basis. Most of the workers I've seen as part of a care programme have been excellent, with a few exceptions, however the treatment of myself and friends who have sought crisis care has been well below my level of [expectation]. Many of us are lied to about what medications are designed to treat [...] The medical field overall has a very stigmatised view of people with mental illness, and it needs to change.¹⁹⁷

Even where people are able to receive mental health services, stigma can compound experiences of psychological distress,¹⁹⁸ including through social isolation.¹⁹⁹ Obtaining treatment is made more difficult because of fear of how friends, family or colleagues might perceive their mental illness.

Mr Wayne Schwass, a former AFL footballer and CEO of Puka Up, described his experience of eventually seeing a doctor about mental illness and his commitment to 'close the door and lock it because of fear of people seeing'.²⁰⁰ He also described telling his family of his condition 12 years on from his first diagnosis after living in fear until then, and his relief when in fact no one left his life because of it.²⁰¹ He said, 'I had invested 12 and a half years of my life into a lie to protect everything out there at the expense of myself, because of fear'.²⁰²

The loved ones, families and carers of people living with mental illness also experience the impacts of stigma and discrimination towards mental illness. One witness described the experience of families or carers returning to the workplace after caring for a loved one with mental illness and experiencing a different and lower level of support than if they had been caring for their partner, parent or child with a physical illness.²⁰³

8.6 Ageing and unsuitable infrastructure

At all levels there has been a lack of investment in mental health service infrastructure.²⁰⁴ The Commission heard that this has affected the ability of services to effectively respond to safety concerns²⁰⁵, the changing needs of consumers²⁰⁶, and provide therapeutic environments to assist consumers in their recovery.²⁰⁷

Some inpatient settings have been described as sterile and uninviting:

The service felt fairly stereotypical of a psychiatric hospital. It was a sterile environment with high ceilings and rendered concrete walls. The building sat next to the light, bright and modern, main part of the hospital. It felt like the psychiatric service was the poor cousin or the second level of the main hospital department.²⁰⁸

Many acute inpatient units were designed decades ago and are no longer fit for purpose:

[Area mental health services] are left to make the best of outdated and impractical facilities in order to safely treat and support patients with increasingly complex needs, often at significant cost. All while trying to create an environment that is welcoming, therapeutic and supportive of risk mitigation and patient recovery across all age demographics and service settings.²⁰⁹

... when you walk into a ward where water is leaking through the roof, where you're sharing a bedroom with a second person who makes you feel scared, where you're having to endure having somebody stand over you in the middle of the night, these are not—this is not good, this is not a place where you would think that healing takes place, where recovery takes place. And we see this as clinicians, and we despair about this stuff.²¹⁰

These sterile environments were often contrasted with newer and more tailored spaces that people described as safe, clean and with access to light and ample green spaces.

Poor physical infrastructure does not support the delivery of therapeutic treatment, care and support.²¹¹ One consumer told the Commission how a lack of personal space was traumatising: 'There is no personal space and people are going off around you [...] It's really traumatic in there—but the main thing is boredom'.²¹²

Similarly, another consumer spoke of their experience of an acute hospital unit:

Acute wards in hospitals are not good environments. The level of acuity has increased enormously—particularly with drug-affected patients and those with psychosis. Then there are other patients with clinical depression and other issues and they are all in the same mix. They may not be helping each other in their recovery.²¹³

In some cases, ageing infrastructure means that mental health services cannot offer gender-specific environments²¹⁴ or flexibility for services to manage their beds in optimal ways. Several services pointed out that inappropriate mixing of patients with very different needs in inpatient units can have grave consequences:

Currently the diagnostic mix and the gender mix of consumers in [inpatient units] generally, and in [intensive care areas] particularly, contribute to a significantly increased risk of sexual and physical assault. There are depressed and withdrawn consumers sharing space with elevated and disinhibited consumers or acutely drug affected consumers and consumers with predatory behaviours. The risk for inappropriate consumer to consumer physical or sexual contact to occur is perhaps not entirely preventable given the current resources and infrastructure.²¹⁵

The risk of aggression is compounded by the fact that Eastern Health mental health facilities are not purpose-built to manage the complex consumers being admitted.²¹⁶

Poor adoption of information technology also affects outcomes. One carer described that every time his father attended a new service, it was like he was starting a new treatment because files could not be transferred due to confidentiality.²¹⁷ Recognising potential privacy restrictions and diverse understandings of their application, the value of electronic medical records is increasingly apparent.²¹⁸ Administration is described as 'antiquated' without these records²¹⁹ or the required structures for effective information sharing between mental health services.²²⁰ Indeed, information sharing between the different services that people experiencing poor mental health may interact with, such as justice or social services, is also limited.²²¹

Clearly, the mental health system is failing to consistently provide high-quality treatment, care and support to consumers, their families and carers. People are experiencing the negative consequences of a failing mental health system in varied ways, shaped by their own diverse lives. The experiences shared with the Commission strengthen its resolve that the mental health system requires fundamental transformation to achieve better outcomes for people experiencing poor mental health, and their families and carers.

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2 *Evidence of Trevor Thomas*, 15 July 2019, p. 956.

3 RCMHS, *Geelong Community Consultation* – April 2019; RCMHS, *Warragul Community Consultation* – May 2019.

4 RCMHS, *Mildura Community Consultation* – May 2019.

5 *Witness Statement of Erica Williams*, 1 July 2019, para. 45.

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- 12 *Evidence of Georgia Harraway-Jones*, 10 July 2019, pp. 642–43.
- 13 *Evidence of Daniel Bolger*, 2 July 2019, p. 69.
- 14 These results are based on only those who responded to the ‘Your Experience of Service’ (YES) survey, 2018. The YES questionnaire is a nationally developed survey that seeks to understand the experience of people who use public mental health services. Sixty-one per cent of the statewide survey results are from Melbourne Health, Monash Health and Eastern Health.
Sample size: $n = 876$ (bed-based), $n = 1,563$ (community).
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- 32 Elijah-rei Onekawa, *Submission to the RCVMHS: SUB.0002.0027.0037*, 2019, p. 5.
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- 36 Victoria Legal Aid, p. 13.
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- 38 *Evidence of Daniel Bolger*, p. 62.
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- 42 Australian Institute of Health and Welfare, *Mental Health Services in Australia: Restrictive Practices 2017–18*, Table RP.3.
- 43 Australian Institute of Health and Welfare, Table RP.6.
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Chapter 9

Family and carer experiences

Families and carers play an invaluable role in providing care and support to people experiencing poor mental health.

In 2018–19 there were more than 58,000 carers of people living with mental illness in Victoria;¹ about 5,600 of these people were aged under 25 years.² A 2015 analysis found there were approximately 2.8 million informal carers in Australia and that about 240,000 of these people were caring for people living with mental illness.³

The importance of people with relationships of care and support and the need to support, respect and recognise them are acknowledged in the *Carers Recognition Act 2012* (Vic)⁴ and reiterated in the Victorian Carer Strategy 2018–2022.⁵

Families and carers have expressed great interest in the work of this Commission. More than 430 family members and carers participated in the Commission's community consultations; more than a third of the more than 3,250 submissions the Commission received related to the experiences and needs of families and carers; and a number of people who gave evidence at the Commission's 2019 hearings were motivated to do so by their experience of caring for someone living with mental illness.

This chapter describes the often profound and lifelong impacts of providing care and support for loved ones living with mental illness—impacts that are often rewarding and at times challenging.

Companionship, fulfilment, enjoyment and satisfaction are some of the many terms used to describe the positive aspects of caring.⁶ Some carers report becoming enriched by their experiences.⁷ Yet many families and carers experience challenges.

This chapter also describes: how families and carers feel when they lack information or are excluded from the treatment of their loved ones; the difficulties families and carers face in obtaining access to support (including education and information); and the financial difficulties associated with supporting loved ones living with mental illness. Finally, the importance of services that are inclusive of families and carers is discussed.

The contribution and commitment of families and carers to supporting their loved ones living with mental illness is outstanding, and the Commission recognises this. The Commission envisages a system in which families and carers are supported by the mental health system in return.

As its redesign of the system progresses, the Commission will continue to consider how the system can better respect, value and support families and carers.

9.1 Diversity and dedication

The Commission considers families in the broadest sense and recognises that relationships of care and support for people living with mental illness extend beyond traditional carer relationships. The Commission also recognises that families are not always a source of support for people living with mental illness, and that for some people, friends, colleagues, community and families of choice play an important role. This chapter is intended to be inclusive of the breadth of all these connections.

Ms Marie Piu, CEO of Tandem, Victoria's peak body representing families and carers of people experiencing mental health challenges and emotional distress, told the Commission that 'family' should be understood in its cultural context, embracing biological and non-biological relatives, intimate partners, ex-partners, people in co-habitation, friends and those with kinship responsibilities.⁸

Further, the word 'carer' does not capture the diversity of the relationships involved: carers are parents, grandparents, siblings, partners, friends, neighbours, teachers and others from extended networks. For some individuals who provide care and support, being perceived or described only as a carer is a limiting identity.⁹ One witness who has cared for two siblings, a mother and a father living with mental illness, told the Commission:

I have never felt like the word carer was appropriate to my role, what I was, was part of my mum's and my brothers' support network, along with many other people.¹⁰

For LGBTIQ+ communities in particular, support can often be drawn from relationships beyond a person's biological family. The Commission was told that lesbian, gay and bisexual Australians are twice as likely as heterosexual Australians to have no contact with their family or minimal contact, with little to no support.¹¹ It was also told of the long history of LGBTIQ+ peers and organisations in providing support and connection for their communities.¹²

There are more than 162,000 carers aged 65 years or older in Victoria, and the average age of a primary carer is estimated to be 55 years.¹³ Many older carers are very concerned about who will care for the person they care for and provide support when they can no longer do so.¹⁴ The Commission was told of a 74-year-old woman who has cared for her brother since she was 17 who wanted to know that when she was gone '... someone would be available to check on him and make sure he is okay'.¹⁵ The Commission also heard from a mother who has cared for her 45-year-old daughter living with a mental illness since the age of 13:

As her mother, I am expected to be her complete support system, which at 73 years of age is just not feasible. I am exhausted, the endless years of battling to get her help have worn me down. In order to survive I will soon be relocating [...] I simply cannot stay any longer.¹⁶

Carers and families exhibit courage and determination in the lengths to which they go to support their loved ones and to pursue treatment in the face of systemic difficulties and the increasingly wide gap between asking for and receiving services. In circumstances where the system has been unable to provide meaningful options and support, families and carers can be forced to act. In the words of one mother who was frustrated at the system's failures:

I am totally and utterly at the end of my tether, so at 79 my fervent hope is that someone is ultimately going to listen to me, and others like me.¹⁷

9.2 Taking on multiple roles

The breadth of responsibilities that carers and families assume is striking. They are advocates, primary carers, financial managers, counsellors, case workers, cleaners and friends. They are often both a first and a last resort. They are resourceful and determined to support those they love. Their roles and responsibilities are diverse, and they are sometimes the only supports available for people living with mental illness.¹⁸

The fact that the mental health system has become increasingly stretched has meant that families and carers have an ever-growing role. Victoria's Chief Psychiatrist, Dr Neil Coventry, explained that capacity constraints mean that some people who would benefit from many weeks of treatment for major symptoms can be discharged from an acute mental health inpatient unit while acutely unwell in order to free up inpatient beds.¹⁹ In these circumstances, families and carers often take on responsibilities when the system is unable to do so. Some carers provide care at home until a crisis occurs:

Our daughter desperately needs treatment, but the only way that will happen is for her to make a suicide attempt or have a breakdown. Why do matters have to get to a crisis point before any action can be taken?²⁰

Even then, one mother told the Commission of a pattern of arriving at the emergency department after a suicide attempt by her daughter only to find that, yet again, no mental health beds were available. Instead, her daughter was discharged and sent home with inadequate follow-up.²¹ The Commission was told of experiences of extended and distressing waits in emergency departments for both carers and their loved ones²² and of people being turned away from care and emergency departments in moments of crisis.²³ A private hospital told one mother that if her son became too unwell to be treated there he would be discharged. The mother said that 'if that happened, we would have our son, too unwell for the private hospital to cope with, at home'.²⁴ The Commission was told that if families and carers cannot provide the support, there is little else available.²⁵

But carers do not just help by supporting a person in managing the symptoms of mental illness or medication compliance.²⁶ Some cook, shop, clean, look after children and pay bills.²⁷ Some become de facto case managers and financial planners.²⁸ Some provide shelter and housing and manage the household for those in their care.

Finding suitable housing for a person living with mental illness is often the biggest difficulty carers face.²⁹ Many families and carers take their loved one into their own home, aware of the problems associated with doing so (including adverse effects on their own wellbeing, finances, employment, social participation and other relationships)³⁰ because they are unable to find an alternative. Families and carers conveyed their distress at the prospect that their loved one will become homeless if they can no longer provide accommodation for them. One mother said:

I don't want my daughter at 25 to be homeless, yet I cannot cope with being a full-time carer, especially on my own, any more.³¹

Carers seek out medical help for their loved ones, often in desperate circumstances. One mother described moving to New South Wales so her daughter could obtain care that had not been available in Victoria.³² A woman who had been caring for her brother told the Commission:

... I was interstate, I was recovering from a hip replacement at the time. I [called] all sorts of people to try and get him out of where he was and eventually a friend of mine agreed to drive the 120 kilometers to pick him up and drive him back to the local Emergency Department of where he normally lived in order to be admitted into that mental health unit rather than being far away from his usual supports.³³

Carers often act as advocates for their loved ones, in various ways and to various audiences. About 25 per cent of complaints and enquiries to the Mental Health Complaints Commissioner are made by family members and carers.³⁴ Families and carers enlist and coach others to assist those in their care.³⁵ At times they advocate to workplaces and call on unions to ensure their loved ones can return to work.³⁶ Much of the care and support the families of people living with mental illness and those who care for them provide, arises from bonds that are independent of any illness.

Providing emotional support is an essential part of what carers do.³⁷ As one carer said of her brother, 'I sat by his bed for many, many hours just letting him know that I was there'.³⁸

9.3 The challenges of caring

The impacts of caring on family members and carers can be profound and lifelong.³⁹ Families and carers provide care and support for their loved ones because of the bonds of family and friendship, because they believe they can provide better care than is otherwise available or than they could afford to pay for, and because comparable services are simply unavailable.⁴⁰

In some circumstances, care is provided out of fear or on the basis that the carer feels that they have no choice. For example, the Loddon Mallee Mental Health Carers Network states that without housing support:

... many carers are forced to house their loved one, regardless of the toll it takes on their wellbeing, finances, employment, social and community participation, and other relationships.⁴¹

Another parent told the Commission that a short-term detox program for their daughter was an '...unbelievable relief, to have her somewhere safe so John and I could get a few decent nights' sleep and enjoy each other's company'.⁴³ This was an experience of respite that is otherwise not available to carers in Victoria.

The social and emotional toll of caring for loved ones can be heavy.⁴⁴ One study of more than 4,000 Australians found that carers had the lowest collective wellbeing of all groups identified in the study—including people experiencing unemployment, low income earners, people living alone and people experiencing combinations of these factors.⁴⁵ According to the study, carers had an average rate of depression classified as moderate.⁴⁶ Another study found that 56 per cent of family carers whose children were experiencing a first episode of psychosis suffered a level of anxiety or depression that could meet criteria for a 'psychiatric illness'.⁴⁷ About one in four carers have high or very high levels of psychological distress.⁴⁸

Box 9.1

David and his daughter⁴²

David* first took his daughter, Simone,* to see a psychologist when she was in primary school following some developmental delays and what he describes as symptoms of obsessive-compulsive disorder. They took advantage of a mental health care plan from their GP but started paying for services when they had used up the free services provided under the plan.

Simone struggled to keep up at school, and David described the 'cracks' that she began falling into.

She was not bad enough to get funding for help, but she was not quite right either.

David said Simone's condition became worse when she started high school, and a series of hospital visits and treatments began. Simone has been diagnosed with obsessive-compulsive disorder, schizophrenia, oppositional defiant disorder, autism, bipolar disorder, generalised anxiety disorder and anorexia.

Simone took [a range of medications] [...]. Some did nothing. Some seemed to make things worse. At one stage they were considering shock therapy. And we were desperate for help so would have tried it if we thought it would work.

David described a system that failed to help Simone and took a toll on his family emotionally and financially. It left his family to make impossible choices—including leaving Simone at hospital so alternative accommodation for her would be found.

We live with that drive home from the hospital every day and will never forgive ourselves for having to make a choice in which there was no choice.

David is still trying to make sense of a long and complicated experience that has left him with no hope.

An often-repeated explanation is that the system has 'cracks' and that people will fall through them. I don't know if Simone is just unlucky to continually step on those cracks, or if the cracks are so wide that you cannot avoid them. The more time passes, the more I am convinced it is the latter.

** Not their real names*

Carers can also become less likely to participate in activities outside of home⁴⁹ and become isolated from their social networks.⁵⁰ Further, the demands of caring can affect personal relationships and give rise to high levels of stress. A mother who cares for daughters living with mental illness told the Commission: 'I am desperate and cannot adequately function in my normal life [...]' The desperation I feel has led to me having a mental health plan myself'.⁵¹ Another mother said:

Six days ago I buried my husband. He couldn't take any more stress [...] Our stress from caring for our daughter has been ongoing for 12 years [...] Sadly her dad has been overwhelmed over the years by the build-up of relentless stress. I am 63 years of age and have heart problems. I have taken the most active care of the two of us. I cannot do this anymore. I have lost my team mate.⁵²

The Commission heard that caring can place 'extreme stress' on the relationship between families, carers and their loved ones.⁵³ One mother and her daughter described to the Commission their individual experiences of the daughter's eating disorder and their varying difficulties when trying to provide and obtain mental health services.⁵⁴ Another witness told the Commission of the way her relationship with her husband changed because of her son's experience: 'Every time my husband called me at work, my opening greeting was, not hello but, "What's happened?"'.⁵⁵

Caring for a loved one can also affect carers' work or employment. The weekly median income of carers is reported to be 42 per cent lower than that of non-carers,⁵⁶ and more than one-third of carers are thought to be concerned about job loss as a consequence of their caring role.⁵⁷

9.3.1 Experiences of young carers

The caring role can adversely affect the employment and educational opportunities of young carers in particular. One study showed that 71.4 per cent of 15–24 year-old carers are studying or in paid work; this compares with 91.3 per cent of their non-carer counterparts.⁵⁸

Young carers can struggle to provide the care and support they often want to provide while also being fully engaged in their childhood and education. Young carers miss about 50 school days each year because of their role.⁵⁹ On average, adolescents and children who support someone at home for at least two hours per day may fall up to 15 months behind in maths and 18 months behind in reading by the time they are in Year 9 compared with other children.⁶⁰ Some school-age carers do not go to school at all. The available research, albeit limited, suggests that young people caring for loved ones who live with mental illness are more likely to not attend school than young people who care for people with other kinds of illness.⁶¹

The caring role can also become normalised, with young carers having to 'step up' because there is a need.⁶² The Commission heard of one young carer's experience:

As a kid growing up with a parent with a severe mental illness it is so confusing. You end up being a carer without even realising it or with anyone supporting you in your role.⁶³

It is also common for young carers to feel excluded from services during a parent's hospital admission or discharge.⁶⁴

Many carers, including younger carers, prefer to be the provider of the care and support their loved ones need. One young carer told the Commission of his caring relationship and the lengths he and his family went to in order to maintain this close relationship of care and support. He told the Commission of how he, his brother and their mother, who lives with mental illness, 'lived in a constant fear of being separated from each other'. The 'fear' described by this young carer and his family, of being separated from a relationship that includes care, sits alongside a recognition that the caring role can also reward with companionship, fulfilment, enjoyment and satisfaction.⁶⁵ But carers also often do not have, or do not consider they have, other options. There might be no one else who can care for and support their loved one.⁶⁶

9.4 Experiences of exclusion

Families and carers consistently said they often felt excluded from care and treatment decisions, that healthcare providers refuse to listen to them, and frustrated because of the lack of information they receive.

The experience of exclusion is also reflected in many complaints made to the Mental Health Complaints Commissioner about inadequate involvement of families and carers in treatment decisions and inadequate communication as well as inadequate, inappropriate and premature discharge.⁶⁸

Not to consider the voice of families and carers has been characterised as ignoring the experience of a motivated, skilled and committed part of the community in the search to improve the delivery of care.⁶⁹

9.4.1 A lack of information

Tandem told the Commission that '... families and friends almost universally report being denied basic information, which would aid them to care, build stronger relationships, or just understand what's going on'.⁷⁰

Having supported two grandparents, both parents, two brothers and an uncle, one witness summed it up: 'I had enough experience with the mental health system to know that you don't wait for phone calls'.⁷¹

One father expressed astonishment that, after repeated requests over the years that he and his wife be told about their son's hospital admissions and any movement between hospitals, they were still not told.⁷²

The Commission was told of many instances where inadequate or no information at all was provided to families and carers regarding their loved one's discharge from mental health services. Not being told about the discharge of a loved one can cause acute anxiety.⁷³

Box 9.2

Jesse Morgan and his mother⁶⁷

Twenty-five-year-old Jesse Morgan, a witness before the Commission, experienced a role reversal during his teenage years when he was 'unofficially' caring for his mother.

I helped Mum as best as I could—I did the shopping, looked after my brother, tried to keep the house clean and did the laundry as well [...] I also worked part-time six days a week at a pizza place [...] We were drowning in responsibilities as children.

He describes having no support as a young carer and said that through his mum's post-traumatic stress disorder and schizoaffective disorder her personality became unrecognisable.

She had visual and auditory hallucinations. She was dependent on me for her daily activities. She needed my help to get up from her chair, go to the toilet or take a shower.

Jesse described how caring for his mum has affected him. He would like to see real changes to the system, including education about mental health and more information being available to young men.

My caring role for Mum was always my first priority growing up, to the detriment of my own life and development [...] I feel like it has set me back in life.

Lack of supports can have an immense impact on young carers lives, including on their education and their own mental health.

Jesse also reflected on how his role as a carer has changed, and what has changed for his mother.

... I feel like my role as a carer now is less around physical help and more around emotional support and championing ... trying to keep her going and telling her she's doing a good job ...

... She's empowered herself and done a really amazing job at creating and maintaining a support network for herself that, yeah, allows her to get better and better ...

I remember the panic that I felt when I found out that he'd been discharged ...⁷⁴

On the ground this means people being discharged from hospitals in the middle of the night, sometimes hundreds of kilometres away from their only family support or any shelter, without even a phone to call that family.⁷⁵

In rural and regional areas there can be a misplaced expectation that carers are available and have the time and funds available to travel sometimes considerable distances when their loved one's discharge occurs—they might not in fact have those resources.⁷⁶

There are complex reasons why information might not be shared between clinicians and mental health services and the families and carers of people living with mental illness.

The mental health principles in the *Mental Health Act 2014* (Vic) include that carers (including children) should be involved in decisions about assessment, treatment and recovery, whenever this is possible.⁷⁷ Further, under the Act, information can be disclosed without consent when it is reasonably required to enable carers to provide care.⁷⁸ For example, mental health services are often permitted to inform carers when their loved ones are discharged from hospital.

Achieving the best possible mental health—for families, carers and people living with mental illness—requires that the right balance be struck between the agency of people living with mental illness and the rights of the families and carers supporting them. Mental health professionals strive to maintain confidentiality to align with their ethical duties⁷⁹ and sometimes with the wishes of their patients. Some circumstances might allow for confidential patient information to be disclosed, including where it is necessary to protect the safety of the patient or of other people.⁸⁰

The Commission heard that clinicians might resist asking for and using information from families and carers⁸¹ for complex reasons, even where the families and carers want to provide this further information to the treatment team.⁸² Some people specifically instruct the person providing treatment or care not to communicate with their family. The Commission was told that in some cases this can be because, in their view, it is the family who are the cause of their symptoms and their problems.⁸³

The Commission was also told that some carers consider that they are excluded from their loved one's care on the grounds of patient confidentiality or privacy and that they considered this to be only an excuse.⁸⁴ The Commission is also aware that some interpretations of the law might hinder clinicians in their ability to gain valuable information from families,⁸⁵ rather than foster better relations between clinicians, families and carers, and people living with mental illness.⁸⁶ These factors, and the legal framework that supports Victoria's mental health system, will be considered in the Commission's work in 2020.

9.4.2 Experiences of LGBTIQ+ families and carers

Relative to other carers, LGBTIQ+ carers (including those caring for LGBTIQ+ people) can experience even greater exclusion from the mental health system. A recent Victorian study reported generally positive and inclusive experiences for LGBTIQ+ carers and people caring for LGBTIQ+ people living with mental illness but also reported other experiences of inappropriate and discriminatory behaviour.⁸⁷ The Commission has been told of instances where an LGBTIQ+ carer was dismissed and also of carers feeling the need to deceive hospital staff about their relationships so they can maintain contact during hospital stays.⁸⁸ These experiences can be traumatic for a person living with mental illness and for the person providing care or support.⁸⁹ They can also lead people to stop seeking support.⁹⁰

9.4.3 Missed opportunities to use family and carers' knowledge

Families and carers often know important things that could help clinicians and care teams in their treatment and care of people living with mental illness. They might be able to relate a person's medical history, past diagnoses or current situation.

The Commission has been told of instances where loved ones who live with mental illness become less able to seek help and more fearful about doing so in crisis situations. Families and carers have described their unsuccessful attempts to provide information about the seriousness of their concerns to health services when trying to seek help for a loved one.⁹¹

Some carers referred to the difficulties of supporting loved ones who did not want to receive treatment or had simply given up on the mental health system. One mother told the Commission:

[My daughter] told me that she distrusts the system too. When [she] has reached out for help, I have seen that she has been rejected, or that she has to wait ridiculous amounts of time to get help that is usually too little, too late.⁹²

Some loved ones might not be aware or might not agree that they have a mental illness. Relationships can be damaged when people living with mental illness do not want to engage with mental health services and their carers and families believe treatment is necessary.

The Commission was told that, in some cases, if people working in mental health services have access to this information from families and carers, better outcomes might be more easily achieved. One mother lamented, 'If only there had been some sort of database, to show [her daughter's] escalating pattern of violence. If only someone in authority had noticed this and then consulted her family'.⁹³

9.4.4 Benefits of engaging with families and carers

In the context of increasing system constraints, families and carers are important supports for their loved ones in continuing the care provided by mental health services.

Family and carer involvement is important in early intervention.⁹⁴ In the assessment of Dr Paul Denborough, the Clinical Director of Alfred Child and Youth Mental Health Service, the most effective services do engage with families, and part of the failure of Victoria's mental health system to meet demand is because families are not involved:

Services that are most effective are the ones that involve families from the very beginning, collaborate with them and are flexible enough to adapt their treatment to the needs of the family.⁹⁵

Involving families and carers in treatment and care could lead to fewer relapses (with evidence to support improvements of up to 20 per cent) and a resulting reduction in hospital admissions, better adherence to medications and a reduction in symptoms.⁹⁶

Dr Coventry told the Commission that lasting improvements can be achieved by ensuring mental health services have the capacity to plan discharges and recovery in a manner that takes full account of the multiple needs of people living with mental illness and their family and carers.⁹⁷

People whose families or carers are not involved can face greater difficulty with their treatment, recovery and management. They are more likely to distance themselves from mental health services—for example, by not keeping their appointments with community mental health services after discharge from a hospital stay.⁹⁸

9.4.5 Complex reasons for exclusion

An increasingly crisis-driven mental health system has meant that families and carers must provide more and are given less support. Long-term recovery work and psychosocial interventions that could include families and carers might be elusive when staff are caught in a cycle of crisis–response.⁹⁹ Limited engagement with families and carers is one symptom of a severely under-resourced sector.¹⁰⁰

The crisis-driven experience of the workforce, and the pressures on their time, limit opportunities and organisational support for engaging families and carers.¹⁰¹ The Commission was told that members of the workforce have reported feeling ill-equipped, overstretched and not supported in their efforts to deliver the compassionate care they want to deliver.¹⁰² Systemic challenges mean that staff also lack opportunities to undertake training.¹⁰³

The culture and training of the mental health workforce that focuses only on the individual and not on their social network also contributes to limited engagement with carers and families.¹⁰⁴ This limited focus might not be appropriate. One person told the Commission that for some people, including from Aboriginal communities or multicultural homes, an approach that recognises interdependence is normal.¹⁰⁵ The focus on the individual to the exclusion of family and social networks is present in the culture of the mental health system. It is influenced by perceptions of confidentiality and the limited funding and time provided to staff to be trained and equipped for engaging with families and carers.¹⁰⁶

9.5 Lack of support for families and carers

9.5.1 Educating and empowering families and carers

The Mental Health Act, and accompanying National Standards for Mental Health Services, recognise the need to involve families and carers.¹⁰⁷ Further, it states that carers should have their role recognised, respected and supported.¹⁰⁸

The Chief Psychiatrist's guideline on working with families and carers also recognises that public specialist clinical mental health services have a responsibility to provide support and appropriate referrals to families and carers, as well as relevant information and education to ensure they can perform their caring role.¹⁰⁹

Despite the need to engage families and carers, and the value in doing so being recognised by law and regulation,¹¹⁰ the experience of families and carers has shown that this engagement often does not occur.

This education can help both the carer and the person they care for to experience good mental health. Interventions aimed at improving carers' knowledge and abilities are beneficial in reducing carer distress, providing psychological support, improving coping and crisis management skills, and improving carers' quality of life.¹¹¹ One carer described the value of education in how to practically help someone experiencing or caring for someone with mental illness as simply knowing how to listen.¹¹² Dr Margaret Leggatt AM, Founding Director of Wellways Australia, Founder and Patron of SANE Australia and Board Member of Tandem, stated that if families learn how to calm down an emotional environment and establish better communication patterns; they can assist in avoiding escalations of tense situations and reducing relapse rates and might help reduce symptoms.¹¹³

As a young carer or in the early stages of a loved one's mental illness, receiving education on how to cope effectively with the situation as a carer might be particularly important.¹¹⁴

Some carers receive only limited access to services for their own mental health. A mother caring for a daughter with mental illness described her situation to the Commission:

There are not enough supports out there for families and carers or the clients. I have been lucky that I have found a great support team at ACSO [Australian Community Support Organisation] Traralgon in the last two years, but for a long time I had no one. I would think, who else can I talk to, what can I do? I was a mess. But the team at ACSO go above and beyond. They listen to you, they come to visit and I know I can always call when things get bad. There should be supports like this for carers and clients available everywhere.¹¹⁵

Box 9.3

Cathy and her daughter¹¹⁶

Cathy* aged 73, has supported her daughter, Laura,* who lives with mental illness, for many years. She has not been able to gain access to public mental health services for Laura in the regional area where they live, and years of battling to get help have worn her down.

I first took my daughter to get psychological support when she was 13 years old, she is now 45 years old and I am at the end of my tether. She's not really my daughter anymore; I love her but I don't know her anymore.

Laura also has a substance use problem, which has intensified over the years from marijuana to ice. This has made navigating support services even more difficult.

We have tried rehabs [...] once discharged from these services the support was almost non-existent. As her mother I am expected to be her complete support system, which at my age is just not feasible.

Cathy highlights the struggles and expectations put on families. The current system depends on families doing the heavy lifting of navigating and advocating for supports, especially when individuals are unable or unwilling to do this themselves.

In Cathy's opinion, support for families that want to help their loved ones is lacking.

I know there are many people out there going through what I am, it's hard on both parties, but families need better support so that we can be there for our family member. People like me go through so much trauma, it really takes its toll on your health. We need support services specifically for families, so we have someone to talk to, to connect with, who understands what we are experiencing.

I love my daughter and I want the best for her. Before the mental illness and drugs took over, we had a good relationship. I miss that person. I have lost someone important in my life, to drugs and mental illness because the supports weren't there when we asked again and again for help.

** Not their real names*

9.5.2 Barriers to obtaining support

Even when supports are available carers might not make use of them, sometimes because of fear and a lack of information.

Some carers are afraid of seeking out support because of fears for their loved one or because they fear being separated from their loved one. Sometimes they feel forced to choose between one crisis and another. One mother told of her situation:

I rang a crisis team that we had been in touch with but was put on hold. I then rang Dr D and desperately asked her what I should do. She heard Anna screaming in the background and told me I would have to ring the police. But what if she lunges at them with the knife? They might shoot her!¹¹⁷

Young carers might avoid seeking help for fear of being separated from their parent.¹¹⁸ Parents living with mental illness can also avoid seeking help for fear of being judged as a poor or bad parent,¹¹⁹ while others know of the distress that previous experiences with the mental health system have caused their loved ones.¹²⁰

The Commission was told that, because the public mental health system lacks the capacity or funding to take on more patients, it might fail to reach out to people not currently receiving services,¹²¹ and that if already stretched services are made fully accessible, they will be 'overrun'.¹²²

Carers might not have access to essential information or might come across it only by accident. One young man, Jesse Morgan, a witness before the Commission, had been a carer since he was a teenager but did not know of the Carer Allowance (currently a \$129.80 fortnightly payment)¹²³ until years later when the allowance was mentioned to him in passing.¹²⁴

Further, the lack of information available to carers about the system in a form that is easy to access, understand and navigate imposes particular barriers for some people and those with more limited financial resources, who are less able to draw on expert professional assistance.

9.5.3 Financial support

Families and carers often face financial difficulties associated with supporting loved ones living with mental illness.

Helping loved ones with out-of-pocket expenses when obtaining treatment is one example of financial stress that families and carers can experience. One witness described relying on her family's limited financial resources to cover her \$220 a week out-of-pocket expenses to see a psychiatrist.¹²⁵ Another family gratefully noted their ability to spend about \$10,000 a year for some years (in addition to private health cover) on services they believe contributed to their loved one's recovery.¹²⁶

Some financial support is available to the carers of people living with mental illness in Victoria. One of the available supports, through the Carer Support Fund, is administered by Tandem and provides up to \$1,000 a year to carers. In 2018 it aided 3,427 people.¹²⁷ The level of this support is not sufficient to fully meet the needs of carers and those they care for. The

Commission has been told that the level of funding has not been reviewed in the 10 years of the fund's existence and that it has only recently been indexed.¹²⁸

Concerns also exist about the criteria applied when considering eligibility for the Carer Allowance and Carer Payment—including that the current means tests might not take into account criteria relevant to mental health carers¹²⁹ and might limit carers' opportunities to engage in paid work and education.¹³⁰

Mental health community support services including relevant financial supports are currently undergoing significant change because of the transition to the National Disability Insurance Scheme.¹³¹

9.6 Better outcomes through family and carer involvement

Engaging families and carers may improve outcomes for people living with mental illness as well as families and carers themselves. For example, the Commission has been told that the Alfred Child and Youth Mental Health Service is deliberately designed for families and young people.¹³² It uses single-session family consultations that involve both the person receiving treatment and their care and support network in a session with the person's clinical care team.¹³³ This treatment has been shown to improve self and parent-rated wellbeing for young people.¹³⁴

Other programs that involve a person's family in treatment have resulted in significant benefits to families, carers and people living with mental illness. Ms Gail Bradley, the Interim Operations Director at NorthWestern Mental Health Service, Melbourne Health, described to the Commission how involving families and carers in treatment had reduced relapse rates for consumers and eased the burden of stress on families and carers.¹³⁵ Another review of studies indicated that family involvement in treatment, care and support resulted in fewer hospital admissions as well as enhanced outcomes for family members through improved family functioning.¹³⁶

There is also evidence to support the cost-effectiveness of involving families and carers, with one study reporting a cost-benefit ratio of up to 1:34 when services engage with families and carers.¹³⁷

Programs that engage with families and carers also improve the lives and mental health outcomes of the families and carers themselves, including through learning coping strategies and reducing loneliness and isolation.¹³⁸ Examples are programs that aim to reduce the impact of parental mental illness on all family members, particularly children,¹³⁹ and peer support programs for young carers.¹⁴⁰

The continued availability of programs that include family and carers is, however, often subject to political and policy changes; for example, programs started by one government might not be continued by the next.¹⁴¹ Implementation can also be limited because research results associated with these programs are not widely known or disseminated by advocates.¹⁴²

The contributions and the commitment of families and carers to supporting both their loved ones living with mental illness and the mental health system are exceptional. The mental health system must support their contribution and commitment in turn. The experience of people living with mental illness and that of their families and carers is central to the Commission's ongoing work to redesign the mental health system.

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- 25 *Witness Statement of Marie Piu*, para. 15.
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Chapter 10

Mental health in rural and regional Victoria

People's experiences of mental health and of service delivery vary throughout Victoria, including in rural and regional areas.

This chapter describes some of the factors—beyond precise location—that contribute to the mental health of people living in rural and regional Victoria. It also describes the difficulties people can experience when seeking mental health services in rural and regional areas, among them the pervasive impact of stigma, limited access to local services and the 'tyranny of distance'.

Also examined are the structural problems associated with current funding arrangements and the challenges in recruiting and retaining mental health workers. The last section of this chapter looks at the potential of technology to make mental health services more accessible.

People's experiences of living in rural and regional communities differ between large regional centres, smaller country towns and dispersed rural farming communities. Recognising that each community has its own identity and culture, for the purposes of this report the Commission uses the term 'rural and regional' to refer generally to all areas in Victoria outside Melbourne.¹

The proportion of Victorians living in rural and regional Victoria is projected to decline from around one in four in 2016 to one in five by 2056.² While large regional cities are growing³, several small rural towns have an ageing and decreasing population.⁴

Wherever possible, rural and regional Victorians should be able to obtain mental health services close to home and close to their families and loved ones. The changing composition, needs and preferences of rural and regional Victoria demands the development of new models of treatment, care and support that stretch geographic boundaries and lessen the barriers to obtaining services. This will require innovative and flexible approaches to service delivery.

The preferences, needs and circumstances of rural and regional Victorians will be an important part of the Commission's considerations as it continues working to redesign the mental health system. In particular, the Commission will consider the need for community-based mental health services that are close to people's own support networks, as well as the role of new digital technologies and online services that aid service delivery.

These approaches complement the Commission's interim recommendations that respond to current inequities in the distribution of aftercare services for people following a suicide attempt, and those that begin to redress some of the challenges associated with workforce availability in rural and regional Victoria.

10.1 Prevalence of mental illness and suicide

The prevalence of mental illness and psychological distress in rural and regional areas throughout Victoria appears relatively comparable to that of people living in metropolitan areas.

The 2017 Victorian Population Health Survey found similar levels of high to very high levels of psychological distress for adults living in all metropolitan regions and all rural regions—being 15.2 per cent and 16.3 per cent respectively.⁵

There is, however, significant variation in levels of psychological distress across the state. For example, in 2017 the local government area of Swan Hill had one of the highest proportions of adults with high to very high levels of psychological distress, at 23.3 per cent.⁶ In contrast, the local government area of Southern Grampians had one of the lowest, at 8.0 per cent.⁷

The 2017–18 National Health Survey results show that the proportion of adults reporting a 'mental or behavioural condition' is relatively consistent in all areas of Victoria.⁸ The National Health Survey measures the proportion of people who reported experiencing symptoms of mental illness at the time of the survey, with those symptoms having lasted or being expected to last for at least six months.

A point of difference between rural and regional Victorians and those who live in metropolitan regions appears to relate to anxiety and depression. According to the 2017 Victorian Population Health Survey, the proportion of Victorian adults who self-report ever being diagnosed with anxiety or depression is higher in all 'rural regions' (32.7 per cent) when compared with all 'metropolitan regions' (25.8 per cent) in the state.⁹ This represents a significant widening in the gap between 'rural regions' and 'metropolitan regions' when compared with the 2016 results (see Figure 10.1).¹⁰

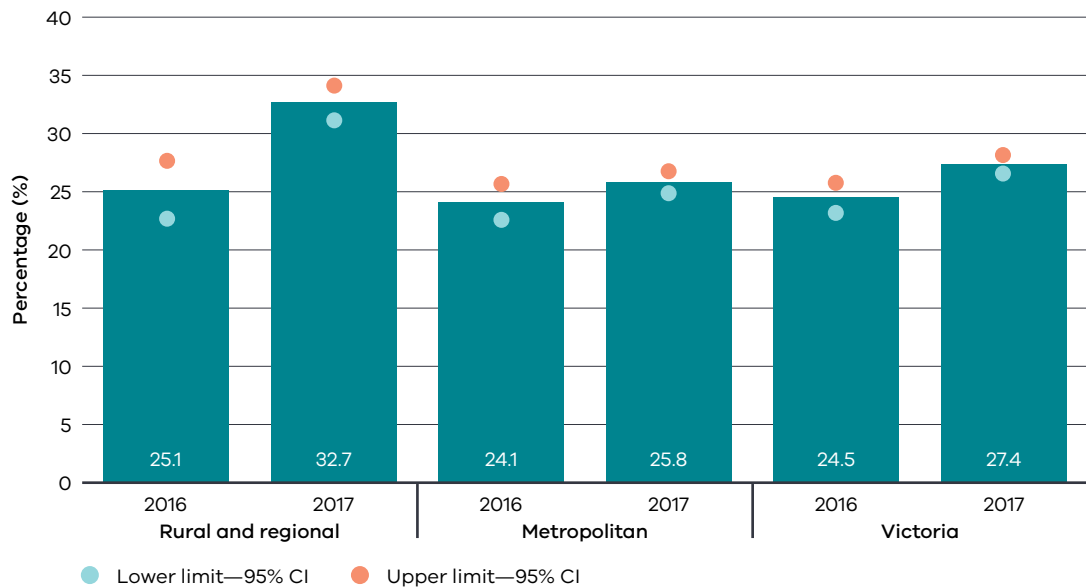
Disturbingly, rates of suicide and self-harm are higher among people living in rural and regional Victoria:

- The rate of self-harm-related emergency department presentations between 2013–14 and 2017–18 was about 30 per cent higher in rural and regional areas when compared with metropolitan areas.¹¹
- Data from the Coroners Court of Victoria indicates that between 2009 and 2018 the annual suicide rate was about 40 per cent higher in rural and regional Victoria than in metropolitan Melbourne.¹²
- The rate of suicide among men aged 35–54 years who lived in rural and regional Victoria between 2009 and 2018 is about 60 per cent higher than that for those living in Melbourne.¹³

In presenting evidence to the Commission, Dr Alison Kennedy, a Research Fellow at Deakin University in the Faculty of Health and at the National Centre for Farmer Health, noted that differences in suicide rates between rural and regional areas and metropolitan areas are at times explained by a lack of access to services.¹⁴

Suicide does not always depend on the presence of mental illness, however.¹⁵ Other factors include 'acclimatisation to risk'—particularly for people working on farms, who may have greater access to the means of suicide.¹⁶

Figure 10.1: Proportion of adults ever diagnosed with depression or anxiety, by metropolitan and rural and regional Victoria, 2016 and 2017



Source: Department of Health and Human Services. Victorian Population Health Survey 2016; Victorian Agency for Health Information. Mental Health and Wellbeing – Victorian Population Health Survey 2017 (preliminary draft and unpublished) For more information, refer to <<https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/victorian-population-health-survey>>

Proportion represented in the graph is 'ever diagnosed' with anxiety or depression.

Data is age standardised to the 2011 Victorian population.

Upper/lower limits are the 95 per cent confidence interval upper and lower limits.

10.2 Looking beyond location

Location aside, there are several factors that influence whether people living in rural and regional areas experience poor or good mental health. These factors reflect the degree to which place influences mental health. One literature review on anxiety, depression and substance use in rural and urban communities concluded:

Studies need to go beyond the 'one size fits all' terms rural and urban, which assume location is the key issue, and examine the mix of economic, physical, social, environmental and socio-cultural factors within both rural and urban settings which may be important determinants of mental illness.¹⁷

It is important to recognise that many of the factors described in the sections that follow also play a role in shaping the mental health of other communities.

10.2.1 Social connection and community participation

The sense of community spirit and social connectedness and the positive impact this has on mental health among rural and regional Victorians has been impressed upon the Commission.

The commitment in rural and regional towns to community participation and leadership, including through implementing local ideas and the work of support groups, was also noted. For example, Glenelg Shire submitted: 'There is a real strength in rural communities and a willingness to be part of the change'.¹⁸ In Hamilton, farmers introduced a phone-tree system and regular catch-ups to check on each other as a way of providing support.¹⁹ In Swan Hill, the Commission was told about the power of men's sheds in facilitating engagement with local community members.²⁰

There is a correlation between this kind of community participation and social connectedness activity and good mental health.²¹ For example, in the aftermath of the 2009 Black Saturday bushfires, involvement in community groups, relationships with family and close friends, as well as broader social connections, were all found to be important influences on resilience, recovery and good mental health.²²

A longitudinal study conducted several years after the 2009 Black Saturday bushfires found that, despite the enormous scale and devastation of the event, most people showed resilience years later. It was observed that this might be attributable in part to efforts to rebuild community connectedness following the disaster.²³

One example of a program that is increasing community connectedness and participation in rural and regional Victoria is 'Go Goldfields', operating in the Central Goldfields Shire.²⁴ Designed through a collaborative process, Go Goldfields focuses on collaborative activities and partnerships across the community to respond to social change.²⁵

Yet, although there is much to learn from the strength and resilience of these communities, such experiences are not uniform throughout rural and regional Victoria. Changing economic conditions, the movement of younger generations to urban areas and declining populations in some communities are affecting ways of life and at times risk undermining community cohesion.²⁶

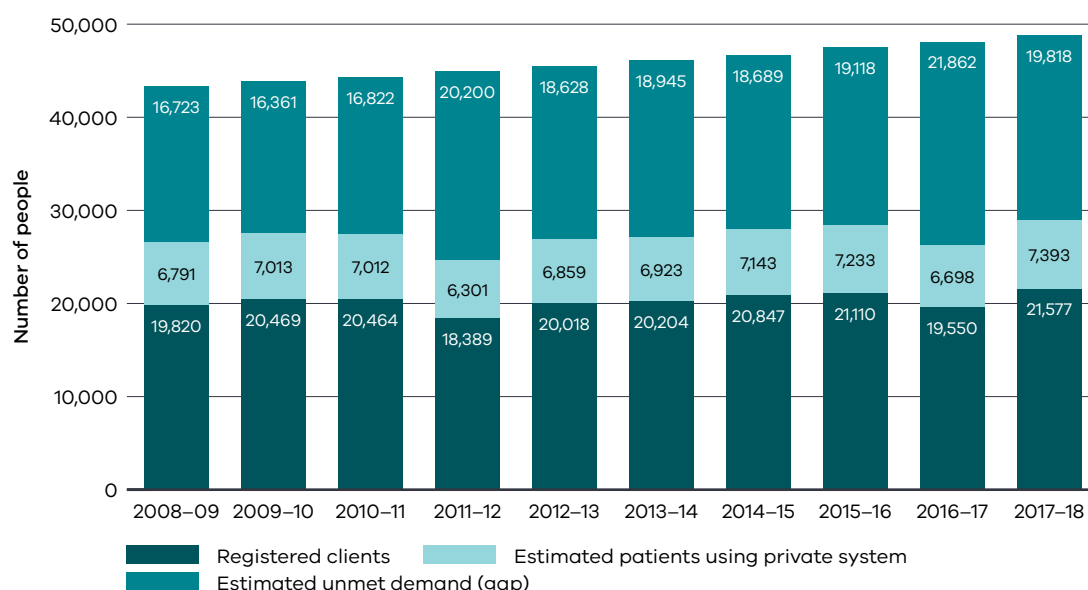
10.2.2 Unmet need for mental health services

Unmet need for mental health services is also considerable in rural and regional areas. Two in five people in rural and regional Victoria who live with severe mental illness are not accessing specialist mental health services (see Figure 10.2).

While there are limited data on the number of rural and regional people who use private specialist mental health services, Figure 10.2 indicates that, in 2017–18, 7,393 people living with severe mental illness received private services compared with 21,577 people who received treatment through public specialist mental health services. It is likely that the remaining people living with severe mental illness (19,818) are not receiving specialist mental health services.

The unmet need for mental health services for young people in rural and regional Victoria is also pronounced. For example, the 2018 Victorian Student Health and Wellbeing Survey found that about 63 per cent of young people in rural and regional Victoria reported being unable to gain access to mental health services when they needed them.²⁷ This is significantly higher than those who reported they were unable to gain access to physical health services (17 per cent).²⁸

Figure 10.2: Estimated unmet demand for specialist mental health services in rural and regional areas, Victoria, 2008–09 to 2017–18



Source: Calculation by the Commission based on Department of Health, The Fifth National Mental Health and Suicide Prevention Plan (Commonwealth of Australia, August 2017), p. 10; Australian Bureau of Statistics, Australian Demographic Statistics, June 2009 to June 2018, cat. no. 3101.0, Canberra; Department of Health and Human Services. Integrated Data Resource, Client Management Interface / Operational Data Store 2008–09 to 2017–18; Australian Institute of Health and Welfare. Mental Health Services in Australia. Overnight Admitted Mental Health-Related Care 2017–18. Table ON.4 and Same day admitted mental health-related care 2017–18. Table SD.4 and SD.12 <<https://www.aihw.gov.au/reports/mental-health-services/mentalhealth-services-in-australia/report-contents/summary-of-mental-health-services-in-australia>> [accessed 9 October 2019].

Estimated utilisation of private beds based on Australian Institute of Health and Welfare statewide data.

The estimated number of private clients using the private system is based on the statewide proportion of overall mental health admissions in Victoria that occur in private hospitals. Utilisation of private mental health services in rural and regional areas may differ from the state average. There may also be clients receiving care 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.

10.2.3 Impacts of disadvantage

Socioeconomic disadvantage plays a role in the experiences and mental health of many Victorians. This includes people living in the outer suburbs of Melbourne²⁹, people who have arrived as refugees or asylum seekers³⁰, Aboriginal people and people living with disability.³¹

Commission analysis³² shows that eight of the 10 most disadvantaged local government areas in Victoria are in rural and regional Victoria.³³

People who are socioeconomically disadvantaged—including people who are unemployed and people for whom Year 10 was their highest level of education—disproportionately experience poor mental health.³⁴

Economic impacts may also be felt more acutely in rural farming communities subject to situational stressors. The Victorian Farmers Federation submitted: ‘There can be many factors that lead to farmers encountering mental hardship; they include natural disasters, season failure, financial difficulty and relationship breakdowns’.³⁵

10.2.4 Social isolation and loneliness

Social isolation and loneliness can affect a person's mental health³⁶, and loneliness and limited social interaction have been associated with higher levels of anxiety, poorer psychological wellbeing and poorer quality of life.³⁷

Geographic and social isolation can contribute to poor mental health and are risk factors for suicide.³⁸ Isolation can also present barriers to people seeking help. For example, Mr Terry Welch, CEO of Maryborough District Health Service, told the Commission that in smaller, ageing rural communities many women face the problem of isolation following the death of a partner. Additionally, although they may be experiencing poor mental health, the additional factors of social isolation, inadequate social support networks and lack of financial means can prohibit women from seeking help.³⁹

Another factor to consider is that older people living in rural and regional areas can be particularly at risk of social isolation and loneliness because of the changing roles they have in their community, losing connections with family and friends⁴⁰, and the onset of major health problems.⁴¹

Farmers can also become socially isolated because of the demanding nature of their work and, as farms become more mechanised, farmers can have even less social contact, leading to further isolation.⁴²



Box 10.1

Al Gabb⁴³

Al Gabb is a farmer who grew up in Skipton, about 45 minutes' drive west of Ballarat.

At boarding school, he was constantly bullied and would phone his parents in tears. The lack of early intervention from the school has had a lasting impact on his life and has contributed to the poor mental health he now experiences.

After travelling the world in his 20s and 30s, Al decided to return home to his family and the farm about seven years ago. He bought a block of land for himself, but a year later he was facing serious financial difficulties and a relationship breakdown.

Living alone on the farm also made him reclusive, and it wasn't uncommon for him to go weeks without human interaction beyond going to the local store. He also shut out his family and friends.

... It really made me spiral downhill as a person [...] the walls started to cave in around me. I was making it worse for myself through my behavioural patterns.

Al realised he needed help and sought the advice of a local GP, who diagnosed him with depression, prescribed antidepressants and put him on a mental health care plan, including access to 10 sessions with a psychologist.

I was in crisis. I had made attempts on my own life. For me it was not enough. When you're in crisis as a person and your life is in the balance, 10 sessions does not fix everything. It doesn't even start to fix [it].

Al's father recommended a Melbourne private psychiatrist, who had helped other family members. Al found the support helpful but driving more than two hours each way for a session was too much.

I felt that the Melbourne psychiatrist was good, and we made some inroads. However, travel to and from these appointments was a whole day venture. I stopped seeing the Melbourne Psychiatrist because it was too inconvenient and too hard to be away from my work on the farm for that long.

After one of his attempts to end his life, Al and his brother met the ambulance at an intersection in Skipton so he could be taken to hospital:

Unbeknownst to me the volunteer (ambulance officer) was a local farmer who I know really, really well. For him to have to pick me up in my state, he was just doing what he does. There was also another neighbour who's a great friend of my family—all there helping me get in the ambulance on the side of a country road.

Using his own personal experience, Al is now taking up an advocacy role and openly talking about mental health.



10.2.5 The link between risk and suicide

Rates of suicide and self-harm are higher among people living in rural and regional Victoria.⁴⁴ This can be partly explained by exposure to risk via increased familiarity with injury, accident and pain.⁴⁵

An Australian study that investigated the suicide of 18 Australian male farmers found that, among other factors, repeated exposure to violent or painful events and ready access to (and familiarity with) firearms increased an individual's threshold of fear and pain and resulted in a perceived fearlessness of suicide.⁴⁶ Dr Kennedy explained in her evidence to the Commission:

... once somebody is in a place where they are considering taking their life, it actually makes that journey that little bit easier when people are acclimatised to risk-taking, particularly in farming communities where there is also access to means, so an accumulation of factors can lead to suicide.⁴⁷

10.2.6 Environmental impacts

Variability in environmental factors—such as climate change, extreme weather events and natural disasters—can play a role in shaping mental health, particularly for people living in rural and regional areas.⁴⁸ For example, despite the community's overall resilience, high rates of post-traumatic stress, depression and high levels of psychological distress are evident a decade on from Victoria's 2009 Black Saturday bushfires, especially in the communities most affected.⁴⁹

Environment-related anxieties can be felt more acutely in farming communities. Dr Kennedy told the Commission, 'Farmers often have a strong connection to their land and can draw solace from that connection. Where that connection is threatened it can cause real psychological distress'.⁵⁰ Unpredictable changes in environmental conditions can result in loss of resources and economic insecurity, which can lead to prolonged periods of stress and poor mental health.⁵¹ In some cases this can be a contributing factor for suicide in farming communities.⁵²

Drought has been found to have a particularly devastating impact on mental health and wellbeing. As part of the 2008 National Review of Drought Policy, the expert social panel on the social impacts of drought on Australian farm families and communities observed, 'Extended dryness has a significant negative impact on the mental health of farm families and others within rural communities'.⁵³ The expert panel also acknowledged that it had heard repeated evidence that the pressures of drought were 'leading to an increase in the incidence of depression, anxiety and stress in rural and remote areas'.⁵⁴

More recently, a 2018 study of farmers in New South Wales reported that farmers experienced significant drought-related stress, with younger farmers experiencing financial hardship and isolation being particularly at risk.⁵⁵

10.3 Stigma in rural and regional communities

The Commission has been told that stigma associated with mental illness is felt acutely in rural and regional communities and that this is a barrier to seeking help.

The reluctance of people in rural and regional communities to seek help often stems from a fear of judgement or embarrassment or a fear that their circumstances might become public knowledge.⁵⁶ For example, the Commission was told of a case in which one person who, despite wanting to seek assistance from a mental health professional, remained silent because he feared that seeking professional advice would lead to the loss of his business.⁵⁷

In some communities, mental health workers are well known to the people they support. This kind of familiarity can sometimes be an asset, but it can also result in a perceived lack of anonymity or confidentiality when seeking support. Mr Welch observed:

In regional towns, one of the challenges is that when a resident presents at the GP (which is the access point); they know the person who is at the reception desk. People are not likely to seek and engage with support in those circumstances.⁵⁸

This reluctance to seek help can be exacerbated by what has been described to the Commission as the 'tough it out' attitude among rural people, the 'we'll be right approach; the stoic rural way'.⁵⁹

Small towns built on a culture of independence and self-sufficiency can restrict frank and open discussion about mental health, leading people to shy away from asking for help. The Royal Flying Doctor Service Victoria submitted:

In rural and remote communities, stigma, in particular, self-stigma, is a key barrier to progress. There is still a strong cultural desire for independence and an attitude that aligns asking for help with failure.⁶⁰

This could be particularly the case for farmers and men in small country towns, who might feel bound by gender and cultural expectations.⁶¹ One farmer said, 'Farmers are good at helping each other, but not good at asking for help'.⁶²

10.4 Lack of local services

Access to local health services is problematic in rural and regional Victoria. This affects mental health just as it affects physical health.

In rural and regional areas it is not uncommon for one centralised area mental health service to be stretched across multiple geographic boundaries, including large regional towns, small rural communities and, in some cases, state borders.⁶³

Further, following the deinstitutionalisation of Victoria's mental health services in the 1990s some rural and regional health services did not receive all elements of the area mental health redesign.⁶⁴ For example, child and adolescent mental health service inpatient units and statewide specialist mental health services, such as eating disorder services and personality disorder services, are primarily located in Melbourne.

These services are available to people in rural and regional areas by referral pathways⁶⁵, but they are already in high demand, and geographical distance can further compound access problems for people living in rural and regional Victoria.⁶⁶ There is also a lack of after-hours services in rural and regional communities.⁶⁷

While local health services play a vital role in supporting people in rural and regional communities, the Commission has been told that some services are constrained in their ability to support people experiencing acute mental illness or psychological distress. Goulburn Valley Area Mental Health explained:

People living in areas farthest from Shepparton often first present to their local hospital (a small rural hospital) where staff may not be skilled in assessing and deescalating situations, resulting in the use of emergency services.⁶⁸

The Shire of Corangamite provided its perspective on service provision in rural and regional Victoria: 'There is often minimal access to mental health service providers on site, lack of outreach capacity as well as rigid and deficit-based service system entry points'.⁶⁹

Mr Welch told the Commission that Maryborough District Health Service does not provide specialist mental health services. Instead, people presenting for mental health care and treatment are referred to an outreach service from Bendigo.⁷⁰ This can delay service provision and sometimes can result in consumers being managed through local emergency departments, which in turn can result in escalation of need.⁷¹

Further, Victoria Legal Aid submitted that people living in rural and regional communities have limited access to the treatment, care and support of their choice and are less likely to obtain second opinions about their mental health.⁷²

For some people, access problems in rural and regional areas have led to a strong sense of injustice: 'There is a big disparity [in service access] between rural and metro in what's available—we shouldn't have a postcode lottery'.⁷³

10.5 The challenge of distance

The Commission has often been told that distance and travel times to get help contribute to low levels of help-seeking behaviour among people living in rural and regional Victoria.

In many cases people in such areas are expected to travel hundreds of kilometres from home, family, friends and support networks to gain access to mental health services.⁷⁴ This presents many problems, not least in relation to the vulnerability of consumers and deep concerns for family and carers: 'Can you imagine having a child who is in crisis and having to send them off to Melbourne?'⁷⁵ The inability to leave a town or farm easily because of work, family or caring responsibilities can also present a barrier to obtaining mental health services.⁷⁶

For rural and regional Victorians who need public specialist mental health services, multiple handovers between service providers are often necessary. For example, a person living near the South Australian border can sometimes need up to five transfers to obtain appropriate support.⁷⁷ Multiple transfers of this nature can lead to system inefficiencies and exacerbate risks to consumer outcomes and experiences of care through delayed treatment.⁷⁸

There are additional costs for consumers, families and carers associated with travel, accommodation and lost income as a result of time away from employment.⁷⁹ The Commission was told that the economic burden of travel and a severe lack of public transport for some mean that people in rural and regional areas do not gain access to services.⁸⁰

Furthermore, without access to a vehicle, it can be very difficult for people living in these areas to obtain services when and where they might offer the greatest benefit:

People living in rural Australia are particularly affected by transport disadvantage, especially the rural poor. Even those who own a car often do not have capacity to pay for fuel necessary to travel long distances to see mental health clinicians.⁸¹

10.6 Funding inequities

An audit of access to mental health services conducted by the Victorian Auditor-General's Office found that rural area mental health services face higher operating costs than metropolitan ones.⁸² Rural and regional area mental health services also conveyed this to the Commission.⁸³

In this report the Auditor-General notes that block funding—the annual grant apportioned to a rural health service by the Victorian Government—is allocated on the basis of the number of inpatient beds or the previous year's client numbers, without consideration of unmet demand, complexity of need, population data or demographic change.⁸⁴ There has also been a recent move to a single price for all beds, regardless of location.⁸⁵

These funding arrangements fail to take into account the specific needs of rural and regional communities. Grampians Area Mental Health Services told the Commission:

Population-based funding models disadvantage regional, rural and remote mental health services as the funding does not take into consideration the social, economic and geographical challenges inherent in these catchments.⁸⁶

The Commission has received evidence that current funding arrangements do not take account of factors such as:

- the higher operating costs associated with consumers, families and carers travelling long distances to access support⁸⁷
- the costs outreach services incur when travelling over large geographical areas to reach a dispersed population⁸⁸
- the lack of local mental health services in rural and regional communities and the consequently increased pressure on area mental health services to fill the gap⁸⁹
- the cost associated with area mental health services providing support and education services to small rural health services within their catchment⁹⁰
- increased staffing levels and costs as a result of delivering services in rural and regional areas.⁹¹

Funding pressures are evident throughout Victoria's mental health system, but it appears that a distinct set of concerns confront rural and regional communities.

10.7 Workforce challenges in rural and regional areas

10.7.1 Workforce shortages

It is difficult to accurately describe the distribution of Victoria's mental health workforce, largely because the state and Commonwealth governments have no centralised data source.

The National Health Workforce Dataset collects data on employed health professionals through the Australian Health Practitioner Regulation Agency. Table 10.1 shows the number of employed psychiatrists, mental health nurses and psychologists per 100,000 people in Victoria according to the Australian Statistical Geography Standard of Remoteness Areas. The number of employed psychiatrists, mental health nurses, psychologists and GPs per 100,000 people is significantly lower in inner regional and outer regional areas.

The limited number of psychiatrists in inner regional and outer regional Victoria is most pronounced—there are 13.9 psychiatrists per 100,000 people in metropolitan Melbourne,⁹² but the number falls to 5.2 in inner regional and just 1.2 in outer regional areas.

Table 10.1: Number of health workers employed, by remoteness area, Victoria, 2017

Mental health workforce	Major cities	Inner regional	Outer regional
Psychiatrists	13.9	5.2	1.2
Mental health nurses	82.4	85.3	33.4
Psychologists	78.9	39.4	25.5
GPs	78.8	67.8	69.0

Source: Department of Health. Health Workforce Data Tool. <<https://hwd.health.gov.au/datatool.html>>, [Accessed 13 November 2019]; Australian Bureau of Statistics, Australian Demographic Statistics, June 2017, cat. No. 3218.0, Canberra. Figures are for clinical full-time equivalent positions per 1,000 population.

Derived from remoteness area of main job where available; otherwise, remoteness area of principal practice is used as a proxy. If remoteness area details are unavailable, remoteness area of residence is used. Records with no information are coded to 'not stated'. Remoteness area was classified using the Australian Statistical Geography Standard.

Crude rate is based on the Victorian estimated resident population as at 30 June 2017.

Only includes psychologists employed in Australia working in registered profession.

The number for each variable may not sum to the total due to the estimation process, rounding, not stated/missing data and/or confidentialisation.

Remote Victoria has been excluded due to a small number of GPs and no clinical full-time-equivalent positions for psychiatrists, mental health nurses and psychologists.

The Victorian Branch of the Royal Australian and New Zealand College of Psychiatry noted in its 2017 report, 'Whatever the issues facing the psychiatry workforce and delivery of effective mental health services in Victoria, it is safe to say that these are exacerbated in rural areas'.⁹³

The decreasing number of GPs in rural and regional Victoria is also a concern because of the increasingly important role they play, along with local healthcare services, in responding to mental health needs. GPs report increasingly seeing consumers who have complex mental health needs and who are unable to gain access to Victoria's specialist mental health services.⁹⁴

For many people, GPs are the point of entry into the mental health system. In rural and regional areas, in the absence of other services, GPs play a more prominent role than metropolitan GPs in responding to the mental health needs of consumers. Dr Gerald Ingham, a GP, told the Commission that rural GPs are 'both the gap-fillers and the glue of the mental health system'.⁹⁵

In Mildura many people described the significant shortage of GPs, resulting in increased wait times and delayed access to other health services via referral. One person said, 'There is no [primary care] support. You can't find a doctor who will take you'.⁹⁶

Despite these workforce shortages, a recent study of access to mental health services conducted by the Victorian Auditor-General's Office reported that the Department of Health and Human Services' 2016 Mental Health Workforce Strategy 'does not set action to address the significantly greater staffing challenges that regional and rural areas face'.⁹⁷

Box 10.2

Margaret: frontline worker⁹⁸

Margaret* is a GP working in Victoria. She says very little is working well when it comes to mental health in her rural community.

I've been a GP for over 35 years and things are worse than ever. I see suicidal patients almost on a daily basis [...] If I refer patients to a public mental health service and they are dismissed because they are not in crisis, this does more harm [...] I see patients at risk daily or weekly until I feel they are less in danger of dying.

She described a health service in New South Wales where any person attending an emergency department with suicidal thoughts must be assessed by a psychiatrist using teleconference before they are allowed to leave.

This should be the bare minimum for prevention of suicide.

Margaret described knowing many patients with strong suicidal thoughts who were taken to an emergency department, sent home and told someone will follow up with them the next day and the follow-up calls never happened.

It is unacceptable. The issues behind poor mental health lie in society generally and are complex. We desperately need more psychiatrists in rural areas.

Drawing on her experiences as a GP, Margaret said services do not link well with family doctors, who end up providing the majority of mental health services in a rural area.

I don't know what it is like in the cities, but very poor access to highly trained psychiatric professionals is really impacting the poor mental health in our communities.

She described the way physical and mental health conditions are treated differently within the system, stating that if someone was to present at emergency with chest pain they would be triaged, quickly seen by a doctor then a cardiologist and potentially flown to Melbourne for an urgent angiogram.

People with severe mental illness are at most risk of dying [...] Almost every life-threatening illness I can think of gets treated as rapidly as they need and by the relevant specialist in that field. This doesn't happen in mental health with utterly tragic results. The situation is desperate.

* Not her real name

10.7.2 Workforce recruitment and retention

Although recruitment and retention difficulties are a feature of the entire mental health workforce, some of the difficulties can be more pronounced in rural and regional areas. Attraction, recruitment and retention problems in rural and regional areas encompass a range of personal, financial and professional factors.

Personal factors such as living away from extended family, friends and support networks have been identified as a major barrier to recruitment. Individual and family needs such as access to schooling for children and professional opportunities for other family members, as well as lifestyle factors, also play a role in attracting and retaining a suitably qualified workforce.⁹⁹

Although there are some incentives for the workforce to move to rural and regional areas, such as the General Practice Rural Incentives Program¹⁰⁰ and the Practice Nurse Incentive Program¹⁰¹, this is not uniform across the workforce. For example, the Victorian Government offers no relocation or accommodation supports to psychologists.¹⁰² There is also a lack of incentives under the Commonwealth's Better Access program.¹⁰³

The Commonwealth Medicare Benefits Schedule payment model can be a further disincentive to practice in rural and regional Victoria. Under the payment model the mental health workforce can choose where to locate and whether to charge consumers out-of-pocket payments. As a result, the Productivity Commission notes that mental health workers prefer locations that allow them to charge co-payments and meet their own personal preferences.¹⁰⁴ The Productivity Commission found that consumer use of Medicare Benefits Schedule -related mental health services decreases with remoteness;¹⁰⁵ the Productivity Commission has recommended funding reforms to try to achieve a more equitable geographic spread of services.¹⁰⁶

The Psychiatry Attraction, Recruitment and Retention Needs Analysis Project, undertaken by the Royal Australian and New Zealand College of Psychiatrists, reported that a major disincentive for metropolitan-based psychiatrists from the private sector contemplating moving to rural Victoria is the funding disparity: '... one psychiatrist who has moved to a rural area reported being better off economically by maintaining their metropolitan practice and commuting to Melbourne once per week'.¹⁰⁷

The Australian Psychological Society also submitted that psychology practices face financial challenges associated with smaller client numbers, the need to travel longer distances and an increased demand for bulk-billing.¹⁰⁸

Additionally, workforce recruitment and retention problems in rural and regional mental health services mean that additional system pressures such as funding cuts and workforce flow can have a greater impact on services.¹⁰⁹

The difficulties associated with attracting and recruiting the workforce means that staff might need to be replaced by less experienced workers,¹¹⁰ or via locum¹¹¹ or overseas recruitment.¹¹²

The rural and regional workforce is also adversely affected by professional isolation and limited access to professional support and networks.¹¹³ The risk of being the 'last person standing' or the 'lone worker' if one or more colleagues leave is also a deterrent.¹¹⁴

10.7.3 Education and training

Lack of professional development and training opportunities is also a consideration in rural and regional Victoria. The Commission has been told there is a distinct lack of incentives to support local training programs in rural and regional areas.¹¹⁵

Because of the unpopularity of rural placements among trainees, the Royal Australian and New Zealand College of Psychiatry has no requirement for trainees to participate in a rural placement.¹¹⁶ The Australian Psychological Society described there has been no investment to support rural psychology students '... with scholarships, rural placements and supported internships, and registrar opportunities.'¹¹⁷

Studies have shown that the location of vocational training has an impact on where medical students choose to work. One study found that 83–91 per cent of GPs who did their final training in a rural area or who came from a rural area continued to work in the same or a different rural area for their first four years after completing training.¹¹⁸

Additionally, most training and professional development opportunities are concentrated in Melbourne, which makes participation for the rural and regional mental health workforce problematic.¹¹⁹ The ability to take up training and education opportunities in Melbourne is affected by distance and the costs associated with back-filling roles and paying additional expenses associated with travel and accommodation.¹²⁰



Box 10.3

Dr Ravi Bhat¹²¹

Dr Ravi Bhat is the Divisional Clinical Director of the Goulburn Valley Area Mental Health Service, at Goulbourn Valley Health, and an Associate Professor of Psychiatry in the Department of Rural Health at the University of Melbourne.

The Goulburn Valley Area Mental Health Service provides community-based and inpatient care for children, adults and older people. On average, the service has had more than 6,000 referrals every year in the past five years.

Dr Bhat said the regional context for mental health treatment was very different from the metropolitan context, and within his catchment area there were 44 per cent more people who were registered mental health clients than the Victorian average.

One of the things I think we all have to appreciate is that the problems that mental health services face are hugely amplified in rural areas.

I think one of the best things that we can do in regional mental health services is to train locally in all disciplines.

Dr Bhat believes that in rural areas recruitment is harder, with there being fewer incentives for trained staff to move to regional towns. Some regional mental health services may not have the same staffing buffer that metropolitan services have.

Psychiatric nurses are the backbone of state-funded mental health services [...] the capacity for rural training is quite important and, as many rural clinical schools have shown, you can train medical students in rural areas [...] I think the same things can be done for [the] mental health professional workforce as well.

In the last decade we have had about 49 graduate nurses go through our program; 41 stayed on the first year [...] we have this year employed our first psychiatrist who was also a trainee at the service. So, these things are possible, but they need a lot of attention, they need localised capacity building ...

He said the demand pressures on the system in his area were such that they cannot always provide the level of care they would like post-discharge.

I think state-funded mental health services are reasonably good at providing a good assessment and managing the risks, but many people with complex problems [...] need psychotherapies for ongoing treatment and often that capacity simply doesn't exist.

Dr Bhat said that among other pressure points for demand are the capacity to provide intensive follow-up across the entire catchment area and the limitations in the number of inpatient beds available.

10.8 The potential of technology

Many people have cited technology as a way of improving access to mental health services, particularly in rural and regional communities with limited local services.

For consumers, technology can remove the burden of travel and make it easier for those who live remotely to obtain access to mental health services when and where they need them. Mr Trevor Thomas, a witness before the Commission, said:

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.¹²²

Digital technologies are breaking down geographical barriers and providing effective treatment, care and support to consumers. For example, Mindspot—a service that delivers mental health services across Australia entirely using digital technologies—has been found to improve consumer mental health outcomes and experiences, producing a reduction in mental health symptoms and an increase in economic and social participation.¹²³ It appears these kind of digital technologies are in high demand: 40 per cent of the 100,000 Australians using Mindspot are from rural and remote communities.¹²⁴

In some communities telehealth and associated technologies are being used or trialled for triaging and urgent assessment, reducing the need for consumers to be transported by ambulance to larger regional hospitals, if an inpatient admission is necessary.¹²⁵ This kind of technology has been tested in New South Wales and found to improve the accessibility and availability of emergency mental health services for people in rural and regional communities.¹²⁶ It has also increased the confidence of local emergency department clinicians in providing treatment, care and support for consumers.¹²⁷

Telehealth and digital technologies can also benefit the rural and regional mental health workforce by facilitating multidisciplinary treatment when workers are in various locations and delivering education and training.¹²⁸

In an October 2019 report the Productivity Commission pointed to the efficacy, cost-effectiveness and travel savings for consumers using digital technologies delivering mental health services in remote areas. Such services are time-effective for clinicians and so reduce costs and workforce pressures. Importantly, these services can be available on a 24-hour basis and might also reduce privacy concerns.¹²⁹

Although telehealth and digital technology have enormous potential for improving service delivery in rural and regional Victoria, they are currently not being used to their full potential.¹³⁰ Barriers include poor internet connectivity, the limited availability of suitable infrastructure and equipment,¹³¹ and the perception that telehealth is less effective than face-to-face treatment.¹³²

There is, however, an overwhelming sense of telehealth's potential to deliver effective treatment, care and support in rural and regional communities. Mr Welch told the Commission, 'I don't see one barrier that can't be overcome with telehealth'.¹³³

Telehealth and associated technologies might play an important role in delivering mental health services in rural and regional communities, but there is nevertheless widespread acknowledgement that this kind of technology does not eliminate the need for human connection and face-to-face contact in service delivery.¹³⁴ Technology might be effective for some people, but it might not be suitable for all people living with mental illness—for example, people who do not have the skills or confidence to use technology or people who are experiencing severe psychological distress or suicidal ideation.¹³⁵

Taking into account the needs, preferences and experiences of people living in rural and regional Victoria will be fundamental to the Commission's redesign of the system. The Commission envisages a system in which, wherever possible, rural and regional Victorians have access to treatment, care and support that is close to their homes and their families.

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- 1 The Australian Bureau of Statistics categorises Australia into five areas of remoteness: (1) Major cities of Australia; (2) Inner Regional Australia; (3) Outer Regional Australia; (4) Remote Australia; and (5) Very Remote Australia. The remoteness of areas is based on measurement of a road distance from a point to the nearest urban centres and localities in five separate population ranges. According to the Map of 2016 Remoteness Areas for Australia, Victoria's level of remoteness is primarily categorised as Inner Regional and Outer Regional, with two Remote areas and no Very Remote areas listed as at 2016. See: Australian Bureau of Statistics, '1270.0.55.005 - Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure: Defining Remoteness Areas', 2016 <<https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/1270.0.55.005Main%20Features15July%202016?opendocument&tabname=Summary&prodno=1270.0.55.005&issue=July%202016&num=&view>> [accessed 10 October 2019].
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 - 3 Department of Environment, Land, Water and Planning, p. 5.
 - 4 Department of Environment, Land, Water and Planning, p. 9.
 - 5 Victorian Agency for Health Information, *Mental Health and Wellbeing – Victorian Population Health Survey 2017* (preliminary draft and unpublished), p. 61.
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Note: According to the National Health Survey, mental and behavioural conditions refer to persons who reported having a condition at the time of interview and that the condition had lasted, or was expected to last, six months or more.
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 - 15 *Witness Statement of Alan Woodward*, para. 24.
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Chapter 11

Suicide

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

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

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

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

... to best understand suicide and the behaviours that flow from it, we should view a person's desire not to live as an expression of profound human suffering.¹

Throughout public hearings, during community consultations and in submissions, the Commission repeatedly heard distressing stories of people who, having experienced overwhelming suffering and feelings of despair, had attempted to or succeeded in ending their lives. These events invariably had profound effects on individuals, families and loved ones.

Compounding these tragedies, many people had attempted to receive support from the mental health system when they or a loved one experienced a suicidal crisis, only to be turned away for not being 'suicidal enough' or for 'not having a plan'.²

The Commission heard that even when people do access public specialist mental health services, the pressures on these services means they are unable to offer enough support or the right kind of services.³ The Commission was told about the devastating consequences when people are sent home after the briefest of stays in the emergency department or hospital, and with no follow-up care:

My daughter suffered mental health issues and it took 12 years for someone to talk to me but by then the damage was done. She tried to take her life in the hospital and cut herself wrist to elbow. We went to the hospital and it was taped up, and she was sent home. They told us someone would call tomorrow, and no one rang. In early December she got sent into hospital to review her medication and cut her wrists in hospital with a CD. They let her out and she suicided nine days later. Now they all want to talk to me, only once she has died.⁴

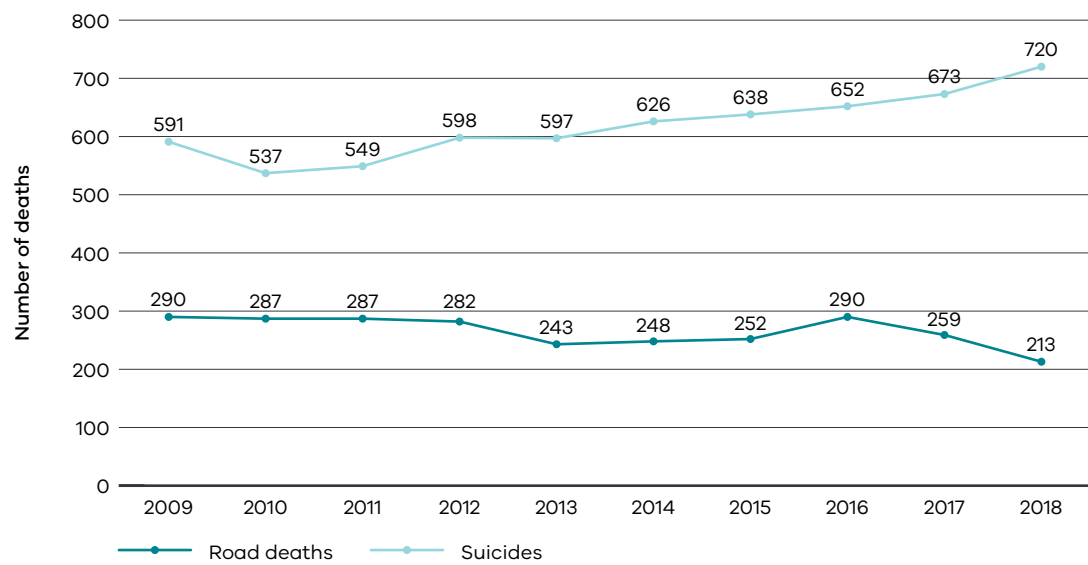
We lost our [...] son to suicide [...] this year. He felt that the mental health and private systems let him down. He cried out and reached out for help many times, only to be turned away, because he didn't fit their criteria, [and] didn't have funds to seek help in private facilities.⁵

Currently, if someone has made an attempt on their life, they are taken to an emergency department at the closest hospital, treated, maybe seen by a mental health nurse and then sent home. There is no follow-up, assistance or treatment path provided to the patient or the carers—everyone is left on their own wondering how to deal with the situation which has just happened and terrified of when and how it may next occur and what they can do to stop it.⁶

To illustrate the impact of suicide in Victoria's communities, comparisons are often made between the number of deaths by suicide each year and the annual road toll. In the past decade in Victoria 6,181 lives have been lost to suicide: this compares with 2,651 lives lost on our roads. On average, there were more than double the number of lives lost to suicide than lost on our roads between 2009 and 2018 (see Figure 11.1). In 2018 the number of suicides was more than triple the number of road accident deaths—720 lost to suicide and 213 lost on the roads.

Despite these figures, the investment in suicide prevention has not been commensurate with the investment in reducing the road toll.⁷ In 2016 the Towards Zero 2016–2020 Road Safety Strategy was announced. The goal, a worthy one, is to reduce road deaths to below 200 by 2020, and the strategy was accompanied by record investment of \$1.4 billion. In the same year the Victorian Suicide Prevention Framework 2016–2025 was released. The goal is to halve the suicide rate by 2025. This equates to a goal of saving 326 lives.⁸ A total of \$27 million was invested to implement the framework—about *one-fiftieth* of the amount invested in the Towards Zero Strategy.⁹

The Commission understands that suicide and its prevention are complex and multifaceted, and that the solutions will not be found in the mental health system alone. Evidence points to the need for an integrated approach across the Commonwealth and state government services responsible for mental health and social, economic and community wellbeing.¹⁰

Figure 11.1: Changes in the annual number of suicides and road deaths, Victoria, 2009 to 2018

Source: Coroners Court of Victoria. Suicide Data Summary, 2009 to 2018; Transport Accident Commission. Search statistics. <<http://www.tac.vic.gov.au/road-safety/statistics/online-crash-database/search-crash-data?>> [Accessed 27 October 2019].

Fortunately, the Commonwealth and state governments have committed to a 'towards zero suicides' strategy.¹¹ The Commission considers that the ambition of 'towards zero' serves as a solid basis for creating a comprehensive, multifactorial response to suicide prevention based on universal or population-based approaches, as well as interventions for people with risk factors, suicidal thoughts or suicidal behaviours.¹²

Mr Bruce Crossett, acting CEO of the Transport Accident Commission at the time of the Commission's hearings, described the central pillars of 'towards zero' as:

- a combined government approach, with all responsible agencies involved in strategy development and with clear responsibilities and key actions for each partner
- the strategy should be based on evidence that will withstand scrutiny from the community and the media
- a comprehensive communication approach, including community and stakeholder engagement, that underpins the strategy
- clear short- and long-term public targets are developed with and actions designed to meet the targets developed.¹³
- While some good progress has been made at both the Commonwealth and state levels to drive suicide prevention responses, the Commission was told that responsibilities remain unclear, leading to service duplication and gaps.¹⁴

This chapter discusses the prevalence of suicide in Victoria and the current responses being implemented to address it. It begins by examining the rates of suicide in Victoria, the risk factors associated with suicide, and the disproportionate affect suicide has on some communities and cohorts.

It then explores current approaches to suicide prevention, concluding that although some progress has been made, there is still much to do.

The remaining sections of the chapter explore the role of mental health and related services in supporting people at risk of suicide or in suicidal distress, and the supports available for those who have attempted suicide. The discussion highlights some of the major barriers and problems people at risk of suicide experience when trying to get support. For example:

- Service capacity challenges in public specialist clinical mental health services have resulted in people at risk of suicide being turned away or receiving inadequate or delayed care.
- People are increasingly having to present to emergency departments, which are unsuitable environments for supporting people experiencing suicidal distress.
- Crisis hotlines are unable to manage high levels of demand, resulting in unanswered calls.
- Mental health workers often feel ill-equipped and need training to help them to respond appropriately to potential suicidality and immediate suicidal crises.
- Despite some improvement, Victoria does not have an adequate network of bereavement services available to support people and communities after someone has died by suicide.

The chapter concludes by foreshadowing the Commission's future work in this area.

Box 11.1

Susan Trotter¹⁵

Susan's* son, Rowan,* died by suicide at the age of 33 in 2010.

Susan, a witness before the Commission, said:

This is a difficult story for me to tell. My son had attempted suicide 26 times before he died, but I still always believed he would stay with us. I was totally destroyed when he died.

Rowan was diagnosed with attention deficit syndrome at the age of 5 years and a borderline intellectual disability at the age of 10. His mental health seemed to deteriorate in his late teens, and he attempted suicide for the first time when he was 19. It took some time for him to get follow-up support.

Rowan was in the emergency department for 48 hours before he was discharged into my care. [He] was not able to see a counsellor straight after release from hospital, as there was a waiting list. Around 2 or 3 months after his first suicide attempt Rowan started counselling.

Rowan attempted suicide a further three times between the ages of 19 and 21:

Rowan seemed to become more frustrated each time he attempted suicide. It seemed to me like no one was helping him. Each time the hospitals just released Rowan and told him to keep up his medication and treatment.

In his late 20s Rowan was in a constant cycle of issues, overdoses and recovery.

So for me it was a roller coaster and hospitals after hospitals. I could not believe that after so many suicide attempts there did not seem to be any real help [...] Despite all of this, in family meetings and at the hospitals I was told that Rowan was an attention seeker who would not take his life. Rowan would always cry and say things to me like: 'Why can't anybody help me and stop this stuff inside my head?' It broke my heart.

Following a series of distressing events, Rowan overdosed on prescription medications two days before Christmas and was taken to the emergency department.

I begged them to hold on to him until Boxing Day, because that's when I could come and pick him up. I begged them, 'Please, hang on to him because he's not in a good way'. They told me they would.

Rowan was discharged from hospital on Christmas Day and called Susan telling her not to worry about him.

He said, 'Don't forget, mum: love you', and then hung up. About two hours later I started to worry, I had a horrible feeling in my stomach because I hadn't heard from him.

Susan was called that evening and told that Rowan had died by suicide.

That day absolutely destroyed me and for the rest of my life now all I think of is, why, if, but, if only. And that's why I run these support groups, to help other parents that go through the same pain and suffering that I feel every day of my life.

** Not their real names*

11.1 A public concern with far-reaching impacts

According to the Coroners Court of Victoria, there were 720 deaths by suicide in Victoria in 2018.¹⁶ Three-quarters of those who die from suicide are men. Disturbingly, in 2017 suicide was the leading cause of death among young Australians aged between 5 and 17 years.¹⁷

The rates of suicidal thoughts, suicide attempts and self-harm are significantly higher than the number of deaths by suicide. In Victoria in 2018 the number of people who were reported to have been hospitalised for self-harm was more than 10 times the number of those who died by suicide.¹⁸ The Australian Bureau of Statistics National Survey of Mental Health and Wellbeing found that 30 times as many people try to end their life each year as die by suicide, and even greater numbers experience suicidal crisis without trying to die.¹⁹ An analysis of survey data found that:

- 13.3 per cent of Australians aged 16–85 years reported experiencing suicidal ideation at some point in their life.
- 4.0 per cent reported that they had made suicide plans.
- 3.3 per cent reported having attempted suicide.²⁰

When someone dies by suicide the people affected most are those closest to that person such as family members, friends, co-workers, classmates and intimate social contacts. Up to 135 people—including family members, friends, colleagues and associates—can be exposed to each suicide death.²¹ On this basis, up to 97,200 Victorians were affected by the suicide of someone close to them last year alone.

But suicide and suicidal behaviour have far-reaching effects across the whole community.²² The impact of exposure to suicide deaths and suicidal behaviours has been characterised as being so profound as to warrant it being treated as a public health concern.²³

Understanding this ripple effect, and where trauma exists following exposure to suicide, will help in identifying opportunities for intervention, support and education.²⁴ This will continue to be an area of focus for the Commission.

11.1.1 Little improvement in the suicide rate

Despite a strong focus on suicide prevention in recent Commonwealth and state government mental health plans, data indicate that there has been no meaningful improvement in Victoria's suicide rate over the past 10 years in Victoria.²⁵

One measure for reporting on suicide is the standardised death rate, which is the number of deaths per 100,000 population. This rate enables meaningful comparisons to be made as populations change in size over time.²⁶

In Australia the national average is 12.1 deaths by suicide per 100,000.²⁷ In comparison, the global standardised suicide rate published by the World Health Organization was 11.4 per 100,000 people in 2016, and the 2012 average for high-income countries was 12.7 per 100,000.²⁸

Australian Bureau of Statistics data show that in 2018 Victoria had the lowest standardised death rate for suicide in any Australian state or territory, at 9.1 deaths per 100,000 people.²⁹ This rate has remained relatively stable between 2008 and 2018, with some minor fluctuations.³⁰

While this data indicate that Victoria is performing better than some other states and territories, the fact that Victoria has been unable to significantly reduce its suicide rate reinforces that more needs to be done. Mr Alan Woodward, a specialist in suicide prevention and mental health, told the Commission of several reasons why Victoria has been unable to reduce its suicide rate, including that:

- There is inadequate coordination of effort and insufficient resources as well as a lack of universal coverage for a range of important services such as after-care programs, workforce training, supports for people in suicidal crisis, school-based prevention programs and bereavement supports.³¹
- There is a need to ensure suicide prevention funding is provided to a broad range of services—including mental health services, housing, youth justice, family support, education and community and social services—to create a whole-of-government approach to suicide prevention.³²
- There is insufficient coordination between programs and services at the Commonwealth and state levels, leading to duplication and service gaps.³³

11.1.2 Risk and protective factors

Suicide prevention approaches need to respond to the fact that suicide is a multifaceted problem, and suicide rates are the product of a complex mix of ‘systemic, societal, community, relationship and individual’ factors.³⁴

A history of self-harm is a primary risk factor associated with suicide.³⁵ The majority of people who die by suicide have a history of self-harm, and self-harm can be viewed as a precursor to potentially lethal suicidal behaviour, particularly in adolescents.³⁶

Research suggests that people living with and without mental illness who died by suicide had multiple immediate stressors recorded as present at the time of their death. This research grouped these stressors into the following categories:³⁷

- personal—for example, sexuality, isolation and experience of abuse
- interpersonal—for example, conflicts with a partner, family members and non-family members
- physical—for example, illness, injury and pain
- situational—for example, work, financial, legal, education, bullying and substance-related
- exposure to suicide—for example, of a family member.³⁸

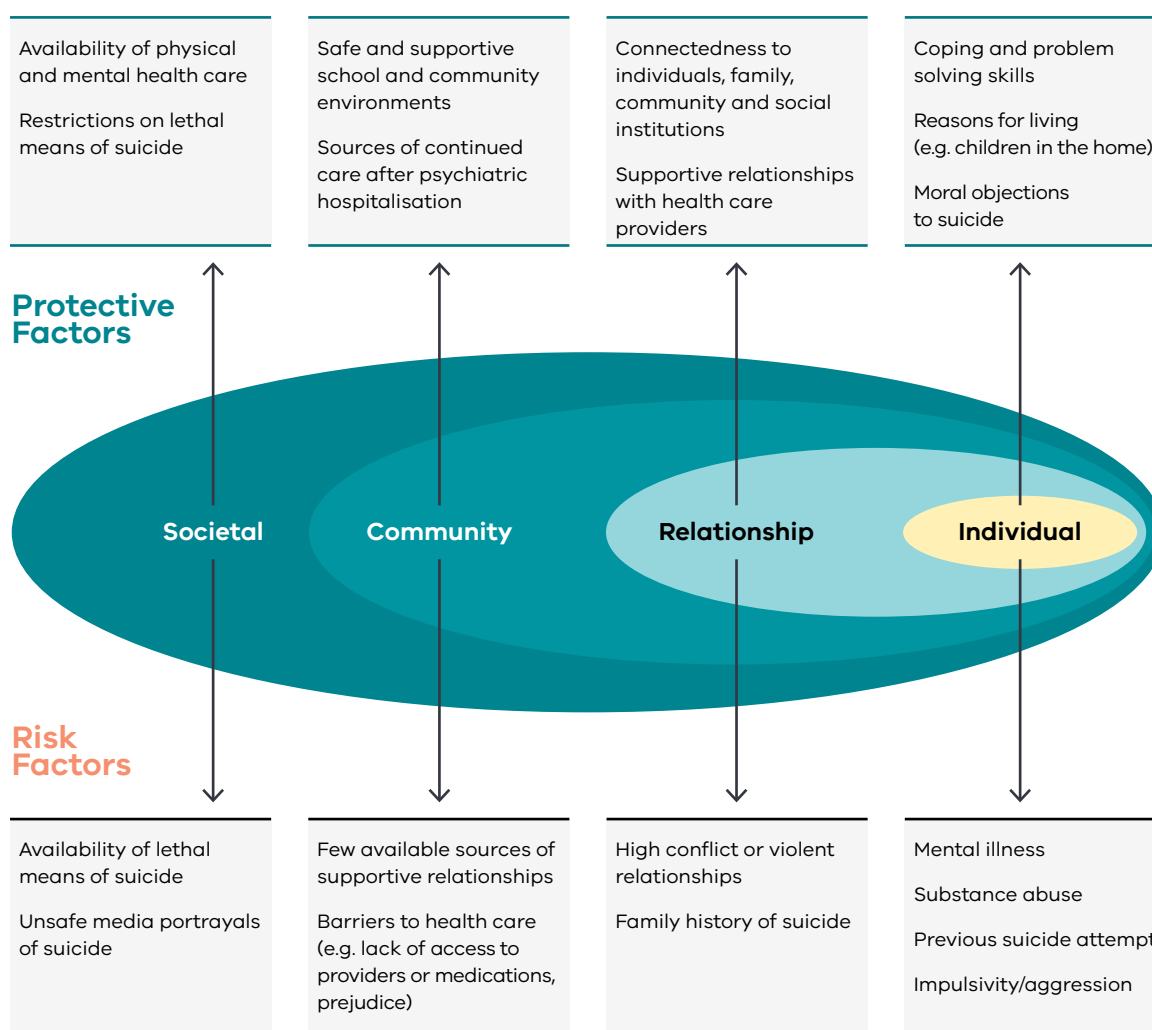
Individuals often experienced several stressors simultaneously.³⁹ Overall, mental illness, alcohol or other drug problems, physical illness, divorce/relationship separation and trouble with the police are the most commonly reported stresses.⁴⁰ Suicide is also partly influenced by the attitudes and actions of others.⁴¹

Ms Georgie Harman, the CEO of Beyond Blue, emphasised that life stressors can be the 'tipping factors' that can contribute to suicidal behaviour and suicide attempts:

[Of] people who think about suicide or attempt suicide, or indeed die by suicide, many do live with mental health conditions; but some don't, and it can be those tipping factors in life that actually cause suicidal distress [...] homelessness, losing your job, living in extreme poverty, or you're just not able to put food on the table or pay the rent; relationship breakdowns, these are the life stressors that can massively contribute to suicidal behaviour and suicide attempts.⁴²

There are also protective factors that make it less likely for an individual to consider, attempt or die by suicide.⁴³ Protective factors include: availability of physical and mental health care; safe and supportive school and community environments; and connectedness to family, community and social institutions.⁴⁴ Figure 11.2 shows some of the major risk and protective factors for suicide.

Figure 11.2: Risk and protective factors for suicide



Source: US Office of the Surgeon General. US National Action Alliance for Suicide Prevention 2012. <<https://www.ncbi.nlm.nih.gov/books/NBK109906/>> [Accessed 27 October 2017]

11.1.3 Mental illness and suicide

While it is widely recognised that mental illness is a risk factor for suicide, many people without a diagnosed mental illness die by suicide. Mental illness can be a factor in suicidal behaviour, but it is not the only factor, and it might not even be the primary factor.⁴⁵

Caution is needed in attributing a close causal link between mental illness and suicide.⁴⁶ Professor Jane Pirkis, Director of the Centre for Mental Health in the Melbourne School of Population and Global Health at the University of Melbourne, explained the relationship:

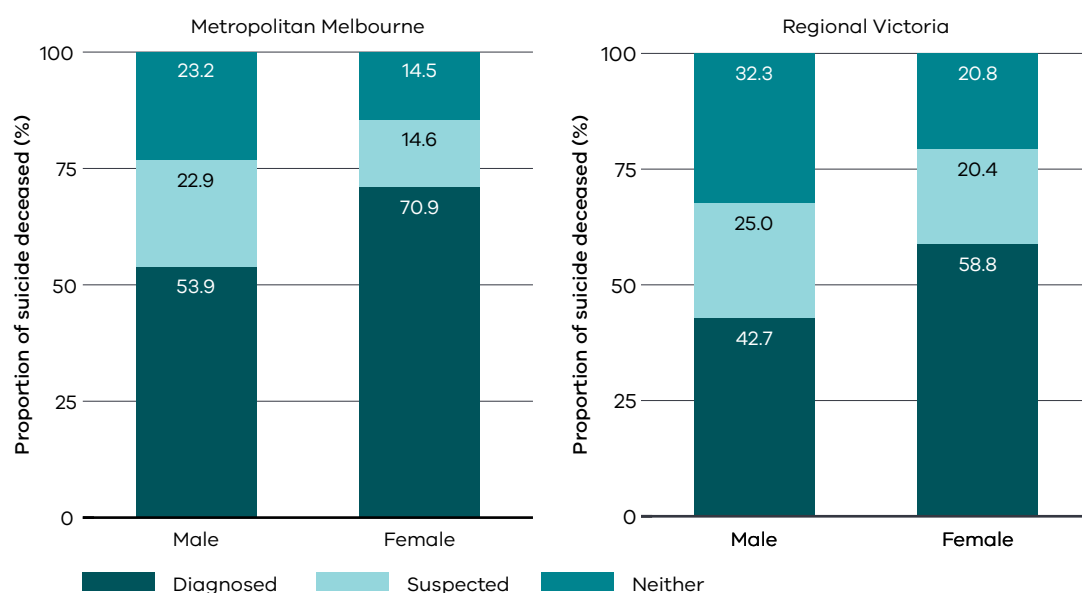
Suicidal behaviour is related to but also distinct from mental illness. Mental illness heightens the risk of dying by suicide, but there are a range of other factors that increase the risk of suicide, including immediate proximal stressors that may be present both for those who have a mental illness and those who do not.⁴⁷

But, while suicide is considered multifactorial, there is a view that the final common pathway to almost all suicide is poor mental health requiring a clinical intervention.⁴⁸

Information about Victorians who die by suicide is held in the Victorian Suicide Register. The data is used to inform suicide prevention strategies and recommendations made by the Coroner. Among the information recorded is the person's gender, their usual place of residence and whether they had a diagnosed mental illness, a suspected mental illness or neither.⁴⁹

Victorian Suicide Register data showed that between 2009 and 2015 approximately 54 per cent of Victorians who died by suicide had a diagnosed mental illness, and approximately 22 per cent had a suspected mental illness.⁵⁰ A higher proportion of females compared with males had a diagnosed mental illness, and a higher proportion of males compared with females had a suspected mental illness or no mental illness.⁵¹ A higher proportion of metropolitan Melbourne residents (both male and female) had a diagnosed mental illness compared with regional Victorians (see Figure 11.3).⁵²

Figure 11.3: Diagnosed and suspected mental illness among suicide deceased, Victoria, 2009 to 2015



Source: Coroners Court of Victoria, Suicide Data Summary, 2009 to 2015.

11.1.4 Disproportionate impacts

Some groups in the community are affected by suicide and self-harm more than others. Groups with higher rates of suicide include the following:

- *People with an alcohol or other drug use disorder.* The risk of suicidal behaviour is elevated in those diagnosed with an alcohol or other drug use disorder.⁵³ An analysis of Victorian Suicide Register data for the period 2010 to 2011, found that '32.9 per cent of all deceased were drug-dependent proximal to their deaths'.⁵⁴
- *Men.* In 2018 about 74.4 per cent of people who died by suicide in Victoria were men.⁵⁵ Nationally, in 2018, age-standardised suicide rates were highest for men aged 35–59 years.⁵⁶
- *People living in rural and remote communities.* The rates of self-harm and suicide increase with remoteness.⁵⁷ Nationally, the suicide rate in rural and regional areas is about 40 per cent higher than that in major cities, while the rate in remote areas is almost twice that in major cities.⁵⁸ The rate of suicide among men aged 35–55 years who live in rural and regional Victoria is nearly double that of Melbourne.⁵⁹
- *Aboriginal people.* The national suicide rate for Aboriginal people is estimated to be twice the general population rate,⁶⁰ and suicide among this population group generally occurs at much younger ages.⁶¹ In 2016, 30 per cent of reported suicide deaths were Aboriginal children and young people, despite this group accounting for only 3–4 per cent of the Australian population.⁶² Aboriginal people aged 15–24 years are estimated to be over five times more likely to suicide than their non-Aboriginal peers.⁶³
- *The LGBTIQ+ community.* Members of the LGBTIQ+ community are more likely to attempt suicide than members of the general population. For example, LGBTIQ+ people aged 16–27 years are estimated to be five times more likely to attempt suicide than the general population, and people with intersex variations aged 16 or older are estimated to be nearly six times more likely.⁶⁴

- *Transgender and gender-diverse young people.* Almost four in five transgender young people in Australia have engaged in self-harm, and 48 per cent of transgender young people have attempted suicide.⁶⁵
- *Children and young people.* Preventing suicide amongst children and youth is a major priority for the Commonwealth Government and Victorian Government. In 2019, the Commonwealth Government announced significant investment to develop a new national strategy to prevent suicide and promote mental wellbeing for young people. Similarly, the Victorian Suicide Prevention Framework 2016-25 includes a strong focus on supporting children and youth.⁶⁶ In 2017 the Australian Bureau of Statistics reported that, nationally, suicide accounted for 36 per cent of deaths among people aged 15–24 years, and suicide was the leading cause of death for individuals aged 15–24 years.⁶⁷ The Commission was also told that children as young as 10 are presenting to emergency departments with suicidal behaviour. On average, two to three Victorians aged 10–14 take their own lives each year.⁶⁸

Monash Health described the challenges of supporting children and young people at risk in emergency departments:

[regarding a 7-year-old primary school student] On one occasion, her [Department of Health and Human Services]-appointed carers were sitting on her to keep her calm, and on another occasion she was settled with ice-cream (in the presence of 4 security guards) [...] At the same time that the first code grey had been called on the 7 year-old, I received a notification from triage about a 12 year-old boy with suicidal ideation who had been assessed as a triage category 2 (urgent, needing to be seen within 10 minutes), as well as a 16 year old girl brought in by police and ambulance with concerns for her mental health (who was pretty agitated, but settled with oral medication).⁶⁹

A parent also described their difficulties finding support for their child:

I had a child at 4 [years old] who had suicidal thoughts; we didn't know where to go. There was no support; no one there to catch them and guide them.⁷⁰

- *Children known to child protection services and young people leaving out-of-home care.* In October 2019 the Commission for Children and Young People released findings from an inquiry into children who died by suicide and were known to child protection. It found that 83 per cent of the 35 children reviewed had a diagnosis of or suspected mental illness, and 60 per cent had shown evidence of a drug or alcohol dependence. Of these children, 89 per cent had at least one recorded contact with a mental health service,⁷¹ and 62 per cent of males and 93 per cent of females had contact with a health service in the 12 months preceding their death.⁷²

Young people leaving out-of-home care have far higher rates of suicidal ideation and selfharm than other young Australians. In comparison with the 11 per cent of 12–17-year-olds who reported selfharm in the previous 12 months in a national study of Australian youth,⁷³ a third of out-of-home care leavers reported having thought about selfharm in the previous 12 months, a quarter had hurt themselves on purpose and a quarter reported having seriously considered suicide.⁷⁴

- *Culturally diverse groups.* Research shows that immigrants and members of ethnic minorities do not receive the same level of mental health care during or after a suicide attempt and are less likely than the general population to contact mental health services when experiencing suicidal thoughts.⁷⁵ In particular, refugees and asylum seekers are at greater risk of self-harm and suicidal behaviours than the general Australian population.⁷⁶

11.2 Suicide prevention initiatives

11.2.1 The evidence-base

Despite significant investment in international, national and state/territory suicide prevention strategies, there are still gaps in the evidence on the effectiveness of interventions.⁷⁷ Part of the reason for this lack of evidence is the challenge inherent in research into suicide prevention. One of these challenges concerns the vulnerability of the population at risk of suicide: they cannot form part of a randomised controlled trial, so the effectiveness of an intervention cannot be evaluated against such a control.⁷⁸

While there is still much to learn about what works and what does not,⁷⁹ the profound effects of suicide create an imperative for governments to act. As Professor Pirkis stressed:

*We cannot wait until we have perfect evidence; we must do the best that we can based on the information available.*⁸⁰

Current global best practice in suicide prevention is described in the World Health Organization's 2014 report *Preventing Suicide: A Global Imperative*.⁸¹ The report emphasises the need for coordination and collaboration across multiple sectors of society, both health and non-health sectors, and public and private sectors: 'These efforts must be comprehensive, integrated and synergistic, as no single approach can impact alone on an issue as complex as suicide'.⁸²

The 2019 opening statement by the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, positions the protective factors for suicide prevention into a rights-based approach that the Commission supports:

*Providing holistic support for individuals and populations as a whole, particularly those who are most vulnerable, enables the attainment of the right to health by addressing the structural and psychosocial determinants of distress, such as childhood trauma and abuse, social inequality and discrimination [...] We must pursue new routes to suicide prevention that invest in fortifying healthy, respectful, and trustful relationships and community connectedness.*⁸³

Reviews of the international evidence have supported adopting a multi-component approach.⁸⁴ Initiatives generally fall into three main categories:⁸⁵

- *Universal interventions.* These target whole populations and are often designed to modify the environment (for example, restricting access to the means of suicide) or encourage responsible media reporting.

- *Selective interventions.* These target vulnerable groups of people in the population who are not actively suicidal but who have recognised risk factors for suicidal thoughts and behaviours. For example, ‘gatekeepers’ who assist the vulnerable and services such as helplines.⁸⁶ Selective interventions also work with at-risk groups to build resilience and strength in vulnerable groups—for example, children who are survivors of child abuse⁸⁷—and to promote self-help behaviours.
- *Indicated interventions.* These target individuals who are already having suicidal thoughts or engaging in suicidal behaviour—for example, services offered after a suicide attempt.

The Commission was told that one of the best examples of a comprehensive approach to suicide prevention in Australia is LifeSpan.⁸⁸ This model was developed by the Black Dog Institute and is subject to testing through state-based trials and some primary health networks.⁸⁹ The model (see Figure 11.4) consists of nine evidence-based strategies that cover the spectrum of interventions—from interventions for high-risk individuals through to interventions directed at a population level.⁹⁰

Figure 11.4: The LifeSpan model



Source: Ridani, R. et al. (2016). An evidence-based systems approach to suicide prevention: guidance on planning, commissioning, and monitoring. Sydney: Black Dog Institute

The model emphasises that a systems approach, whereby all strategies are implemented simultaneously, is central to the success of suicide prevention.⁹¹ In her evidence to the Commission, Scientia Professor Helen Christensen AO, Director and Chief Scientist, Black Dog Institute, highlighted the need to take a broad, multifactorial approach:

We cannot predict who will die by a suicide. We have to cast a large net; we can't just focus on particular people who might have risk factors. We [...] must spread this across the whole community [...] so a universal prevention [...] that requires that you engage the community and that everybody has a place and is aligned in a way for a coherent approach to it.⁹²

Universal prevention approaches and cross-government interventions beyond health are particularly important in reaching people who have no clinical risk factors but who are experiencing situational or environmental stressors.⁹³ As Mr Woodward said:

These are important areas for suicide prevention because the issues and life circumstances that they are addressing may be factors in a person's suicidality, and because they provide points of contact with persons who may be suicidal and could be approaches with the offer of help—earlier and more effectively than waiting for a suicide attempt to occur.⁹⁴

11.2.2 Commonwealth and state responses

Increasingly, Commonwealth and state and territory governments are coordinating support for suicide prevention efforts. Recognising the lack of improvement in suicide rates, suicide prevention has become a national and state priority.

Both the Commonwealth and Victorian governments have already made a commitment to multifactorial suicide prevention programs. The Council of Australian Governments Health Council endorsed the Fifth National Mental Health and Suicide Prevention Plan in August 2017. The plan outlines the Commonwealth and state and territory governments' commitment to work together in agreed priority areas—including actions to strengthen suicide prevention work in Australia, consistent with the World Health Organization's systems-based suicide prevention framework.⁹⁵ The plan is to be supported by a National Suicide Prevention Implementation Strategy for Australia's health system.

While a recent focus and investment in suicide prevention by Commonwealth and state/territory governments is welcome, the Commission was told that the responsibilities across governments remains unclear, leading to duplication and gaps for consumers. Suicide prevention services are fragmented, remain in pilot stages, or are limited in geographical coverage.⁹⁶ This is partly because suicide prevention is funded by both the Commonwealth Government and the state and territory governments, leaving no one level of government with clear responsibility for reducing suicide rates.⁹⁷ Primary Health Networks, which are Commonwealth-funded, have commissioned some services; while health services, which are state-funded, are trialling other initiatives. The National Mental Health Commission advised that 'there are currently four sets of systems-approach trials to suicide prevention occurring in 29 sites across the country, including 13 in Victoria'.⁹⁸

The Fifth National Mental Health and Suicide Prevention Plan recognises the limitations of the current approach:

... with unclear roles and responsibilities across governments [leading] to duplication and gaps in services for consumers. Where there are competing or overlapping services, there is a lack of clarity about which services are most effective or efficient.⁹⁹

In its draft report, the Productivity Commission has recommended that a National Mental Health and Suicide Prevention Agreement be developed between the Commonwealth, state and territory governments to make it clear which tier of government is responsible for funding particular services and for mental health outcomes that are attributable to those services.¹⁰⁰ The Productivity Commission also recommended that the agreement identify responsibilities for suicide prevention activities across portfolios to create a truly whole-of-government approach to suicide prevention.¹⁰¹ The Commission agrees with this approach.

The Commonwealth Government has introduced a commitment to ‘towards zero’ suicides and to bringing together Commonwealth and state and territory governments, service providers, experts and people with lived experience to create a coordinated approach to suicide prevention across Australia.¹⁰²

As part of this response, the Commonwealth Government appointed a National Suicide Prevention Advisor, Ms Christine Morgan, in July 2019 to drive a whole-of-government approach to suicide prevention.¹⁰³ In a public message, Ms Morgan outlined the importance of governments, service providers and the broader community coming together to prevent suicide, and articulated the opportunities to do things differently in a coordinated way.

In my view, there is a real opportunity for us to come together on this issue but we must think more broadly than we have been. While it is easy to say that suicide prevention is every body’s business, it is harder to really achieve the kind of cross-government, cross-jurisdiction and whole-of-community response that is required. While our health services, community organisations and funded suicide prevention programs certainly have a critical role to play, we must consider the broad range of issues impacting on people’s lives and consider all of the touchpoints where we have an opportunity to make a positive difference [...] It’s critical governments, services and the broader community come together to ensure an inclusive and proactive response to suicide. This is a big issue that requires a big response.¹⁰⁴

11.2.3 Major initiatives in Victoria

Victoria has implemented several major initiatives to address the suicide rate and better support people at risk of suicide.

Victorian Suicide Prevention Framework

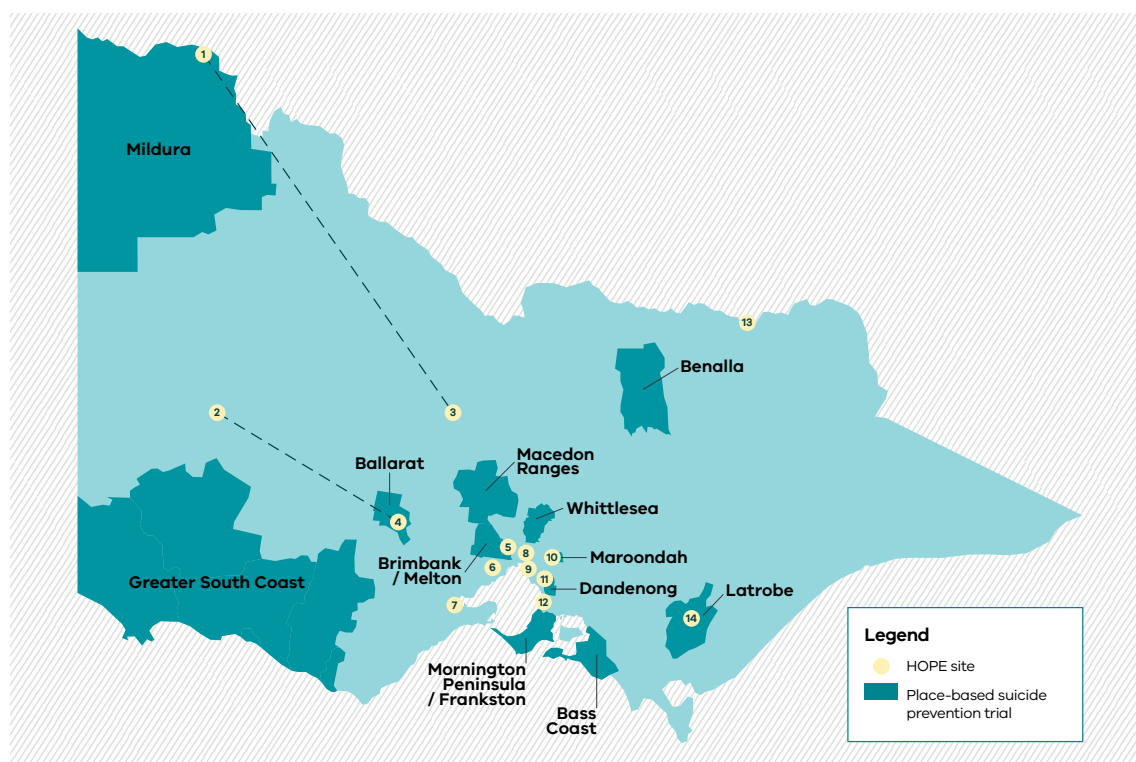
In 2016 the Victorian Government released its Suicide Prevention Framework 2016–2025, a strategy for reducing suicide and suicidal behaviour. The framework details five objectives, in keeping with a broad public health approach to suicide prevention:¹⁰⁵

- Build resilience throughout Victorian Government services—including in schools and health and emergency services.
- Support vulnerable people—those who experience higher risks of distress and suicide—for example, people in rural and regional communities, Aboriginal communities, emergency services workers, paramedics, police and LGBTIQ+ people.

- Care for the suicidal person using strengthened approaches to assertive outreach and personal care when a person who has attempted suicide leaves hospital or an emergency department.
- Learn what works best—a commitment to test and evaluate new trial initiatives and share data with local communities.
- Help local communities prevent suicide by trialling a coordinated approach to suicide prevention, implemented at the local community level.

Two key initiatives underpin the framework: place-based suicide prevention trials and Hospital Outreach Post-suicidal Engagement (HOPE) programs. Figure 11.5 shows the locations of the place-based prevention trials and the HOPE sites.

Figure 11.5: Location of place-based suicide prevention and HOPE initiatives, 2019



HOPE Sites

- | | |
|-------------------------------|-------------------------------------|
| 1 Mildura | 8 St Vincent's Hospital |
| 2 Horsham | 9 Alfred Health |
| 3 Bendigo Health Care Group | 10 Maroondah Health |
| 4 Ballarat Health Services | 11 Monash Health |
| 5 Western Health | 12 Peninsula Health |
| 6 Mercy Public Hospitals Inc. | 13 Albury Wodonga Health Wangaratta |
| 7 Barwon Health Geelong | 14 Latrobe Regional Hospital |

Source: Department of Health and Human Services. Suicide prevention in Victoria, <<https://www2.health.vic.gov.au/mental-health/prevention-and-promotion/suicide-prevention-in-victoria>> [Accessed 27 October 2019].

Place-based suicide prevention trials

The place-based suicide prevention trials are taking place as a partnership between the Victorian Government and Victorian Primary Health Networks.¹⁰⁶ Ms Anne Lyon, Executive Director of Mental Health, Alcohol and Other Drugs at the Eastern Melbourne Primary Health Network, told the Commission that the trials are designed to take a systematic, coordinated approach to suicide prevention, with each site being supported to implement evidence-based suicide prevention initiatives.¹⁰⁷ The operating model parameters, developed by the Department of Health and Human Services, require the sites to focus on local capacity building and enhancing system effectiveness to reduce suicide, rather than service expansion or new services.¹⁰⁸

The 2018–19 Mental Health Services Annual Report states that more than 300 local partnerships have been established at the 12 trial sites.¹⁰⁹ During that year more than 2,000 people were trained to identify and support people in mental distress or suicidal crisis.¹¹⁰ The trials have delivered activities consistent with the LifeSpan model of building the capacity of local communities, awareness-raising, responsible media training, other targeted training, and health and wellbeing events.¹¹¹

The Commission notes that the Productivity Commission has recommended that the 'National Mental Health Commission assess evaluations of current trials that follow a systems approach to suicide prevention' and 'consider whether the evidence shows if these approaches are likely to be successful at reducing suicide rates and behaviours in Australia'.¹¹²

Hospital Outreach Post-suicidal Engagement program

The HOPE program is designed to support people after they are discharged from hospital following a suicide attempt or people who express suicidal ideation or repeatedly intentionally self-harm but who do not meet the threshold for entry to specialist clinical mental health services.¹¹³ Each site has discretion to restrict its eligibility criteria within those parameters, although all sites must provide their target cohort with assertive, tailored 'postvention' support in the community for up to three months.¹¹⁴ After-care supports, HOPE trials and their proposed expansion are discussed in Chapter 15 in Part Five.

Way Back Support Service

Another after-care initiative in Victoria is the Way Back Support Service, operated by Beyond Blue. This is a non-clinical psychosocial support service where support coordinators provide assertive after-care and practical support for up to three months; it includes planning to help people stay safe, connected with their support network, and engaged with health and community services.¹¹⁵ There are two Way Back Support Service sites in Victoria (South East Melbourne and Geelong),¹¹⁶ but the initiative is to be expanded to a further six sites following a recent agreement between the Victorian and Commonwealth governments. This will bring the number of government-funded suicide after-care sites in Victoria to 16.¹¹⁷

Data collection and application

Reliable data are central to developing evidence-based policy, planning and implementation of suicide prevention activities.¹¹⁸

The Fifth National Mental Health and Suicide Prevention Plan states that improved data on care and outcomes following suicide attempts are a priority and will support 'better identification of suicide attempts in routine health data collections and better measurement of integrated care and follow-up after suicide attempts'.¹¹⁹

Victoria's approach to suicide data collection, through the Victorian Suicide Register, has been acknowledged as nation-leading.¹²⁰ However, the data are not linked, reported or disseminated to suicide prevention services on a regular or continuing basis. This means that suicide prevention services do not necessarily have the information they need to intervene quickly and effectively to support people and prevent (further) suicides.¹²¹

The Commission heard from several people that overcoming the current lag in the availability of information on suicides and attempted suicides would facilitate better follow-up action and prevention.

[We should have] surveillance systems that are far more real-time, that are more localised, that enable local services, communities, first responders, health services, mental health services, schools, to be identifying emerging clusters of suicide, for example, and then to wrap-around supports for a school community.¹²²

Real-time surveillance of suicide, suicide-related behaviour and self-harm would increase the capacity for the health system to prevent further deaths, provide appropriate and timely support, and allow Victoria to accurately track progress against state-wide strategies to reduce suicide rates. This should collect data from state coroners, police, ambulance and hospital emergency departments, and it should be connected to an immediate, coordinated response at the community level.¹²³

The Department of Health and Human Services has developed a memorandum of understanding with the Coroners Court and emergency services to ensure that up-to-date, consolidated and relevant information is provided to the suicide prevention place-based trial sites and to health services.¹²⁴ In 2018 the department supported a project by the Victorian Injury Surveillance Unit that retrospectively links data from the Victorian Suicide Register with Victorian emergency department and hospital admissions data in the year preceding an individual's death.¹²⁵ The Commission understands that this study has recently been expanded to include child protection, family violence and family support datasets.

The research aims to create a better understanding of the utilisation of general health and mental health services among people who subsequently suicide, as well as their health at the time of death. The Commission understands that this information will be used to identify risk factors for suicide, as evidenced from health service use patterns, and potential gaps in service provision.

Commonwealth Government agencies are also working to improve information sharing. The 2019–20 Federal Budget allocated \$15 million over three years to the Australian Institute of Health and Welfare (as part of the National Suicide Information Initiative) to create a national suicide surveillance system.¹²⁶ Among the current areas of interest are: exploring the utility of integrating ambulance data into existing datasets related to suicide, understanding the intersection between suicide data and other demographic factors, and looking at service use in the preceding 12 months for people who die by suicide.¹²⁷

These are all useful first steps, but the Commission considers that efforts should be accelerated. The collection and use of suicide data will be an important area of focus for the Commission as it continues its work.

Outcomes to date

Although the Victorian Suicide Prevention Framework is aligned with global best practice approaches,¹²⁸ Victoria's suicide rate has not significantly reduced. The Commission has been informed that this is partly because of issues with the funding and oversight of the strategies: there is a lack of coordination of effort, and the resources are inadequate.¹²⁹

Service providers mentioned the lack of cohesion and consistency in suicide prevention initiatives. Mr John McLaren, the Community Manager at St Vincent's Mental Health, St Vincent's Hospital told the Commission:

Currently, there are numerous initiatives that have been implemented, some long-term and others short-term, but they do not operate consistently across Victoria and they do not seem to operate in a cohesive manner.¹³⁰

The Commission also heard about a lack of robust evaluation of pilots and coherent, appropriately scaled implementation of models shown to be effective. For example, Mr Woodward emphasised the need for consistency across the state:

While some regions in Victoria have benefitted 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.¹³¹

11.3 Role of health and mental health services

The Commission received evidence that about 60 per cent of people who die by suicide have had contact with a public or private health service¹³² for mental health-related problems in the preceding 12 months.¹³³ Around fifty per cent had contact with a health service in the six weeks preceding their death.¹³⁴ Data provided to the Commission from the Victorian Coroners Court shows that around 30 per cent of people who die by suicide see their GP about a mental health problem in the six weeks preceding their death.¹³⁵ Figures 11.6 and 11.7 provide further information about health and mental health service contacts in the six weeks preceding suicides in Victoria between 2009 and 2015.

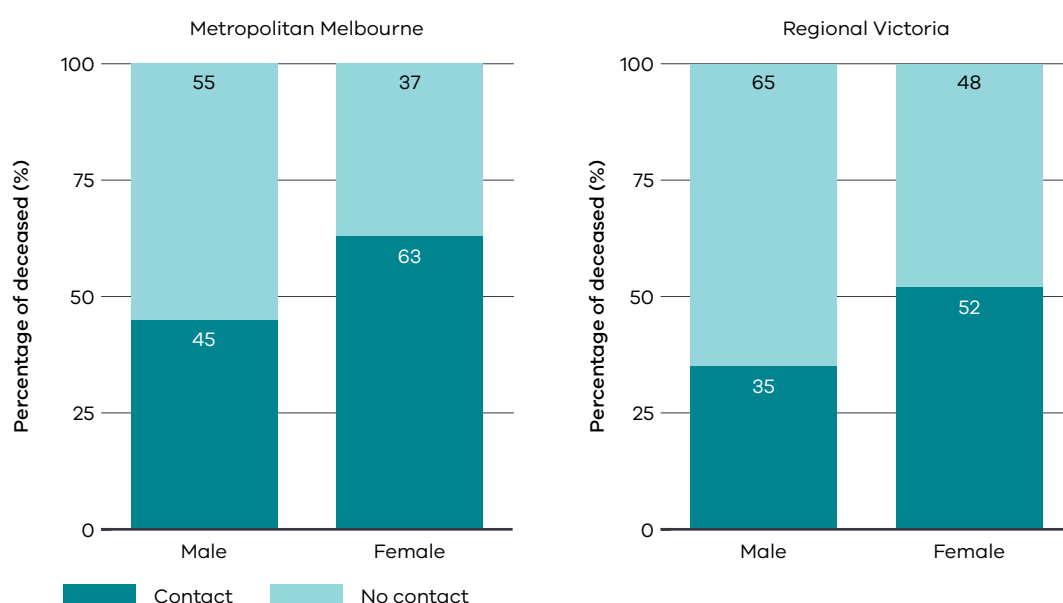
The Commission heard that timely access to mental health care services and treatments can reduce a person's vulnerability to suicide.¹³⁶ According to the Black Dog Institute, as mental illness is associated with suicide attempts, providing 'accessible and appropriate mental health care is essential to suicide prevention'.¹³⁷ Scientia Professor Christensen emphasised that 'getting people into treatment' is one of the suicide prevention strategies in Black Dog's LifeSpan model that has the greatest impact.¹³⁸

Professor Pirkis said that, because clinical prediction tools for assessing suicide risk are not reliable, there is a need for 'mental health services to provide optimal mental health care to all'. In her testimony, Professor Pirkis described this as a selective intervention in suicide prevention:

Because it's so difficult for mental health services to predict who might be at the absolute most risk, I feel like there's an onus on mental health services to provide optimal mental health care to all: it's kind of the best of the selective interventions.¹³⁹

Health and mental health services can provide interventions to people who are not actively suicidal but who have recognised risk factors for suicidal thoughts and behaviours, including people living with mental illness or showing signs of psychological distress.¹⁴⁰ Interventions may provide direct treatment, care and support for at-risk individuals or equip professionals to detect and assist people who may be at risk of suicide.¹⁴¹ Alongside mental health services, GPs, for example, are well placed to identify the potential for suicidality, even in patients not reporting distress.¹⁴²

Figure 11.6: Proportion by sex, of deceased who had contact versus no contact with health services for mental health related reasons within six weeks of suicide, Victoria, 2009 to 2015



Source: Coroners Court of Victoria, Suicide Data Summary, 2009 to 2015.

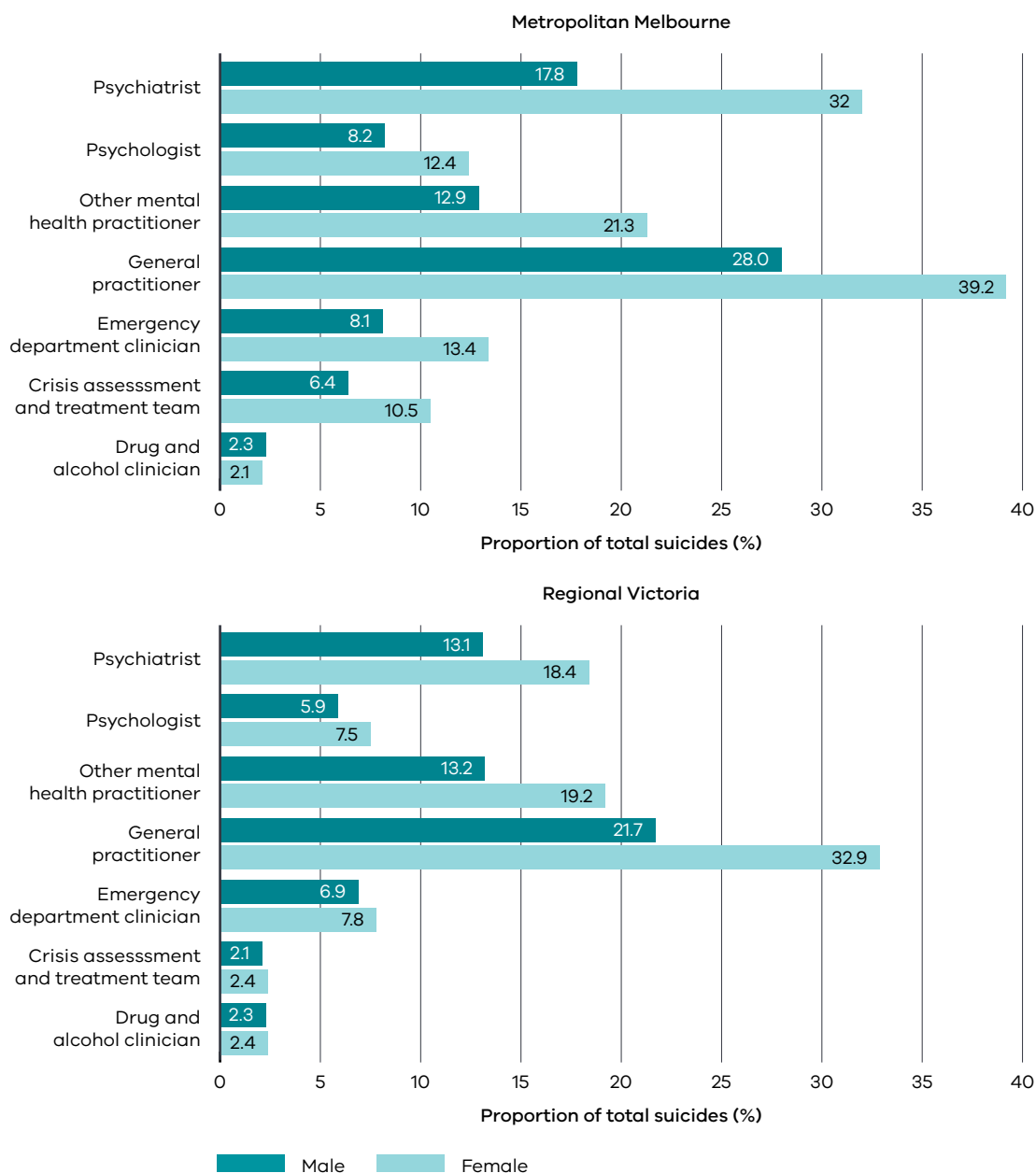
11.3.1 Inability to access care

While mental health services are a core part of preventing suicide, the Commission was told that people at risk of suicide often find it difficult to access mental health services, which sometimes leads to devastating outcomes for individuals and their families and loved ones.

A major barrier to people who are at risk of suicide receiving appropriate mental health care treatment is the lack of service capacity within the community-based mental health services.¹⁴³ For example, one person spoke of seeking help through an emergency department:

A few friends of mine and myself have all had issues with this system at some point or another. I find that emergency services are limited. When I have been in suicidal situations I find that I only know the 000 number to call, I only found out about the [crisis assessment and treatment] team through a friend later on. I have admitted myself to emergency because of self-harm with escalating thoughts and possibility of suicide and been turned away because I 'didn't have specific plans to'. This is frankly unacceptable as all it did was escalate my thoughts further.¹⁴⁴

Figure 11.7: Proportion of total suicides where the person had contact with a health service for a mental health-related concern in the six weeks preceding suicide, by sex, usual place of residence, by service provider, Victoria, 2009 to 2015



Source: Coroners Court of Victoria, Suicide Data Summary, 2009 to 2015.

As discussed in Chapter 7, demand pressures and lack of capacity have resulted in public specialist clinical mental health services raising their thresholds for service access and rationing treatment. The Commission heard many people speak of experiences of not being 'suicidal enough' to be seen by public specialist mental health services, being dismissed by health professionals, or being sent home from emergency departments without adequate follow-up.

The attitude (or maybe even policy?) is that if you don't have a plan to kill yourself today or aren't able to articulate that plan, then you really aren't that bad and you should go deal with it yourself. I was sent home with my severely suicidal friend after the hospital refused to take them in (I have two small children), they only gave 10mg of Valium and told me to 'keep an eye on them'. I was petrified that I would wake to find my friend dead on our couch [...] People need to be taken seriously and offered real support (aka care) BEFORE they get to be so desperate for help that they make an attempt on their own life or something else to this effect to be taken seriously.¹⁴⁵

Parents should not have to beg for their children, who are expressing suicide ideation, to be admitted to care because of a shortage of outpatient and inpatient treatment facilities.¹⁴⁶

Families and carers identified a gap in supports for people who seek help because they are having suicidal thoughts but who are considered 'not unwell enough' to be admitted to specialist clinical mental health services. The Commission heard that mental health services require a person to be at imminent risk—to have a clear plan for suicide—to qualify for help. One mother despaired:

When I initially rang triage on behalf of my son who was suicidal, they asked 'was he suicidal now, did he have a plan in place?' He didn't right at that moment on the phone, but the weeks or months prior he may have, and tomorrow he may have, but he obviously wasn't triaged as important enough. The responsibility has fallen back onto family to try and support and manage the system.¹⁴⁷

11.3.2 Inadequate care

As discussed in Chapter 7, pressures on acute inpatient units in hospitals have led to people being discharged while they are still very unwell.¹⁴⁸

Hospitals will keep you in until you calm down, then eject you with no medication, referrals or promise of follow up.¹⁴⁹

When a family or a young person is in crisis, the only place you can go is the emergency departments or triage if you are lucky. I have had numerous times in [emergency departments] waiting for eight hours and when a doctor finally came to see her, they told her to go home. I have had to battle so hard to get her admitted.¹⁵⁰

Discharging people from emergency departments and hospitals before they are well enough to be in the community¹⁵¹ puts pressure on community-based specialist mental health services to manage people with increasingly complex needs. This raises entry thresholds for everyone and contributes to long wait times before people that are discharged from hospital can access any care in the community.¹⁵²

Evidence presented to the Commission showed that this can have terrible outcomes. The Commission heard about a system that failed parents before the death of their children:

My lived experience of having a 19-year-old son who desperately was trying to live but had suffered 2.5 years of health intervention that offered him and us no effective support was too much. His suicide and the trauma of our lived experience and him telling me he just wanted to die, is something I will never get over. The health system must change!¹⁵³

My story of my son's journey over 16 years—he is no longer with us, all this is too late for him, but there are still thousands out there struggling, and I would hope that I could play some little part in bringing about change. Over those years there have been so many times when I felt no-one really listened, I was not heard, despite letters to a Clinic Manager, the Complaints Commissioner, the Premier, and the Minister of Health (it was nearly a year before this letter was answered). Most of the time I felt totally alone, apart from a small support group in a neighbouring town—this group was like a lifeline to me. I suffer the grief of the loss of my son, a loved family member and a person of worth. Even worse is the grief I carry at what he suffered over 16 years, not only from a terrible illness, schizophrenia, but also in the mental health system.¹⁵⁴

We have had family who come to us on their knees, desperately seeking help for their loved one and it just seems like we come up against barrier against barrier. We've had people discharged straight from the high dependency unit only to commit suicide hours later. It's just heart-breaking. We just want to make the system compassionate for families.¹⁵⁵

Relying on risk assessments to ration limited services is problematic in the case of people experiencing suicidal thoughts because there are currently no assessment tools that accurately predict the risk of suicidal behaviour in the short term.¹⁵⁶

An expansion of the range of treatment options is needed to help people at risk of suicide. Associate Professor Peter Burnett from NorthWestern Mental Health told the Commission:

There are currently options for standard hospital admissions or referrals to community care teams, however there is no appropriate treatment option for the portion of patients who do not require hospital admission but require intensive support. These patients may benefit from a more integrated treatment option.¹⁵⁷

The following comments highlighted the current lack of support for someone who has attempted suicide:

Very little is working well to prevent suicide. Currently, if someone has made an attempt on their life, they are taken to an emergency department at the closest hospital, treated, maybe seen by a mental health nurse and then sent home. There is no follow-up, assistance or treatment path provided to the patient or the carers—everyone is left on their own wondering how to deal with the situation which has just happened and terrified of when and how it may next occur and what they can do to stop it.¹⁵⁸

I have found that healthcare services possess extremely limited accountability regarding patient welfare in the immediate post discharge period. Patients readmitting to emergency departments due to suicide attempts within a few days of discharge appears to initiate no formal or informal review procedures regarding if discharge was appropriate. This results in little incentive for mental health units to act in the best interests of patients during discharge planning and promotes the prioritisation of other incentives, such as freeing up immediate resources.¹⁵⁹

While it is difficult to draw a causal link between pressures on mental health services and overall rates of suicide in Victoria,¹⁶⁰ the Commission accepts advice that mental health services must be able to respond more quickly and effectively to reduce the number of people who take their life each year.¹⁶¹

Box 11.2

Katerina Kouselas¹⁶²

Katerina Kouselas's husband, Bill, died by suicide in 2016, and she believes that the mental health system failed him: 'Bill had depression for nine to 10 years prior to his death, but we had no experience of the mental health system until the six months before he died'.

Katerina described how Bill had been receiving treatment at an adult prevention and recovery care service but that he really struggled when he was released. Before his death, Katerina took him to an emergency department:

In all our years of marriage I had never seen him like that. People who are suicidal should not be in emergency with all the people with broken legs, you should be in a specialised area.

Katerina described the loss of her husband as isolating, but she said that by contributing to the Royal Commission she hopes to make a difference for someone else in the future.

We had been married for 32 years when Bill passed away. I will never come to terms with it ...

I just hope that by talking about Bill, and by talking about suicide, it might help even just one other person. I hope that it helps to fix the system that let Bill down, a system that is letting other people down too.

11.4 Crisis responses

11.4.1 Experiences in emergency departments

With limited options in the community, many people who are in suicidal distress or who have attempted suicide present to emergency departments. However, evidence before the Commission indicates that emergency departments are not optimal environments for supporting people experiencing a mental health crisis, and the experience can be traumatic or distressing for some people.¹⁶³ One person wrote:

In order to prevent suicide, there needs to be somewhere people can go and not the emergency department. I have heard more horror stories of judgement and trauma than I can bear to admit about from friends who have fronted up to one.¹⁶⁴

An Australian study found low levels of satisfaction with healthcare services after a suicide attempt, and there was particularly low satisfaction with emergency department care.¹⁶⁵ A study by Orygen, the National Centre of Excellence in Youth Mental Health, also found that young people going to emergency departments after self-harming had negative experiences, including negative reactions from staff.¹⁶⁶

Patients, families and carers commonly report that their emotional distress was not attended to, and many thought they had been discharged too rapidly and were left to seek their own options for ongoing care.¹⁶⁷

I've been told at emergency: 'We're not going to help your daughter as we'll help others first who want help'. The staff said to me, 'If she's going to kill herself, she'll do it whether she's here or not'.¹⁶⁸

The main problem has been in emergency departments. The staff have given very little time to assessing the individual. My daughter presented four times at emergency departments over a three-day period in full psychotic states after several violent extreme episodes, both causing harm to others and threatening to kill herself [...] Upon presentation and the briefest of assessments she was turned away each time with no plan, no medication, no support, nothing. In emergency departments individuals are asked to wait a long time and this can escalate their condition.¹⁶⁹

It was the way we were treated at hospital that was the worst ever experience! Mental health guy takes hours to show up, says a few things, asks me to leave, talks some more then tells me she has issues, needs help from a psychologist but I need to find my own, they have no beds! Take your daughter home but keep her on suicide watch 24/7! Do you know how hard it is to get some help for your child that wants to kill herself, self-harm? It took days to find someone that would help us, in that time I couldn't sleep at all for fear of her doing something! It's a nightmare that continues all the time!¹⁷⁰

The high levels of demand in emergency departments and the high-intensity, high-stimulus environment of such places make it difficult to meet the needs of people in suicidal distress.¹⁷¹ For clinical staff, it can be challenging to deal adequately with complex needs in emergency departments, where consultation settings and short triage times can make building patient–clinician rapport difficult.¹⁷² The Commission recognises the challenges for emergency department staff in meeting the needs of suicidal patients, often in very difficult circumstances and without appropriate training.¹⁷³

11.4.2 Crisis helplines

Crisis helplines form an important part of the suicide prevention system in Australia. Several organisations operate mental health helplines staffed by trained professionals and volunteers who provide crisis support.¹⁷⁴ Some helplines operate 24 hours, seven days a week, while others are restricted to standard business hours. The services also vary in terms of what they provide—from general counselling to targeted crisis support for specific at-risk groups. Table 11.1 shows examples of helpline support organisations in Australia.

Table 11.1: Examples of Australian helpline support organisations

Organisation	Operating hours
Beyond Blue	24/7
Butterfly Foundation's National Helpline (eating disorders)	9am–5pm, 7 days
Eheadspace (youth aged 12–25 years and their families)	9am–1am, 7 days
Kids Helpline	24/7
Lifeline	24/7
MensLine Australia	24/7
QLife/Switchboard Vic	3pm–12am, 7 days
Perinatal Anxiety and Depression Australia	9am–7.30pm, weekdays
SANE Australia	10am–10pm, weekdays
Suicide Call Back Service	24/7
Open Arms (veterans and families)	24/7

Source: Healthdirect. Mental health helplines, <<https://www.healthdirect.gov.au/mental-health-helplines>> [Accessed 11 November 2019]

Mr Woodward told the Commission: 'Australian and international research studies suggest that around one third of callers to crisis helplines will be "actively suicidal"'.¹⁷⁵ Mr Woodward said that a benefit of these services is that they are confidential, available when other services are not open, and able to provide immediate support to people from the privacy of their home.¹⁷⁶

Many submissions to the Commission also highlighted the benefits of being able to access support through these helplines. One person said:

*Services like Lifeline, Suicide Call Back Service, SANE and others are definitely great ways in communicating to the public that there is someone willing to listen, someone who cares and someone to help you.*¹⁷⁷

In 2018 Lifeline crisis supporters helped 42,340 individuals nationally to create safety plans to prevent suicidal behaviour for 24 hours, which allowed time for follow-up. The supporters also initiated 5,840 emergency interventions by contacting emergency services and ensuring the safety of those assisted by remaining connected wherever possible until emergency services arrived to offer care.¹⁷⁸ Lifeline reported an 83 per cent call-answer rate. Lifeline noted: 'This rate is high by international crisis line standards, but, to achieve a significant reduction in the rate of suicide every call must be answered'.¹⁷⁹

In 2017–18 the Suicide Call Back Service received 37,341 calls; 55 per cent of callers spoken to had a diagnosed mental health problem. Of the 37,341 calls, however, about 36 per cent could not be answered.¹⁸⁰

The high level of demand for helpline services can lead to people who are in urgent crisis being unable to obtain support.¹⁸¹ Submissions to the Commission show this to be a common experience:

I think that Lifeline is a great service. However, when I have called they are often engaged and I can't get through. This suggests to me that services like these where people can make contact in their own time, need to be resourced better. It is the first support service listed in suicide prevention information resources, but if you can't get through you will not likely try again. This could mean life and death for someone.¹⁸²

I assume that due to lack of funding, there is just a recorded message. If you are desperate enough to ring a helpline, you want to speak to someone NOW, not leave a message and hope they will ring back at some unknown time.¹⁸³

11.4.3 Technology and digital support

The Commission was told about the increasing use of and potential for using digital technologies to help prevent suicide, particularly among younger people. Technology and online platforms are increasingly providing support for and advice to people who are unable to get help from mental health services.¹⁸⁴ Internet applications, virtual reality, social media and other forms of technology can be used in different ways and in different forums to deliver mental health training and interventions.¹⁸⁵

Scientia Professor Christensen told the Commission about mobile app initiatives the Black Dog Institute has been trialling, both as early intervention initiatives and as crisis and after-care responses to a suicide attempt. Examples included RAFT, which is a safety planning app that also offers psychological intervention for people following a suicide attempt.¹⁸⁶ Another example is the safety planning app developed by Beyond Blue to support people who are having suicidal thoughts: it takes users through a process of identifying triggers and protective factors and provides immediate access to crisis contacts.¹⁸⁷

Black Dog has also introduced SPARX-R and Ninja Sleep in New South Wales. These are early intervention apps designed to help reduce depression in young people. SPARX-R uses a video-game-like environment to teach young people to replace unhelpful thoughts with more effective coping strategies.¹⁸⁸ Ninja Sleep helps address poor sleep patterns in young people, which can be linked to depression.¹⁸⁹

The Commission will examine the role of new technologies as part of its design of a reformed mental health system.

11.5 Bereavement and postvention supports

‘Postvention’ interventions offer support and assistance to the bereaved after a suicide has occurred. The aim is to help with the grieving process and to reduce the possibility of imitative suicidal behaviour. These services include ‘school-based, family-focused or community-based postventions’ and bereavement support groups¹⁹⁰ and are an important part of a comprehensive approach to suicide prevention.

11.5.1 Bereavement by suicide

Bereavement by suicide differs from bereavement after other forms of loss because of the potential preventability of the death, possible self-blame on the part of the bereaved, and the stigma that can be associated with suicide.¹⁹¹ Ms Katerina Kouselas, a witness before the Commission, said:

No one understands it unless you have lost someone to suicide. It’s very isolating. It’s not like you’re losing a loved one to something else; it’s like you have a big sign on your back saying, people don’t know what to say to you, so what they do is they avoid you at all costs.

I’m hoping that with all the information that is put in, and some procedures, it might save someone else. I want people to know what it’s all about and hopefully how to prevent all of this. I do not know what else I can do to talk for Bill, but his death has to make it matter now.¹⁹²

The impact of loss after a suicide was reflected in submissions to the Commission:

... the ripple effect of the families—children left behind—the scars on their lives their minds, their outcomes cannot just be swept under the mat and lost within statistics.¹⁹³

We are trying to find our new normal, even though we don’t want to. We are slowly grieving, each in our own way. It’s very hard to watch your children processing such a profound loss. It’s going to be a lifelong process; this loss will never leave us. The grief of losing a loved one to suicide is in many ways the same as losing a person to any other illness. There are some extra aspects though. The sense of a missed opportunity for a different outcome. The fear, when you look at any of his belongings (or even just go into the shed for the first time) that there may be a surprise lurking. The survivor’s guilt and self-blame which is inevitable.¹⁹⁴

Mr Woodward told the Commission that young people, in particular, may be at risk following a suicide in their community, and that ‘clusters of suicidal behaviour can develop’.¹⁹⁵

A study on the effectiveness of interventions for people bereaved through suicide reported that: ‘compared with the general population, people bereaved by suicide have a higher risk of suicidal behaviour, and psychiatric problems such as depression, anxiety, post-traumatic stress disorder, and substance abuse’.¹⁹⁶ While the research literature offers limited evidence about what interventions are effective, promising interventions include ‘supportive, therapeutic and educational approaches, involve the social environment of the bereaved, and comprise a series of sessions led by trained facilitators’.¹⁹⁷

11.5.2 Services to support the bereaved

Support After Suicide offers counselling for people affected by suicide, training for health and education professionals, and online resources.¹⁹⁸ In Victoria almost half of its referrals come from Victoria Police.¹⁹⁹ The Commission was told of the benefits of Support After Suicide groups: 'Support After Suicide groups are amazing. Once you're in they are good at supporting you; however, they can be hard to access'.²⁰⁰

Dr Louise Flynn, the Manager of Jesuit Social Services' Support After Suicide Program, told the Commission that Support After Suicide does not have enough funding to respond to all the requests for support it receives and that services are restricted in regional areas.²⁰¹

StandBy is a national suicide postvention support service delivered by Life in Mind. It provides immediate face-to-face and telephone support to individuals, families, workplaces and community groups following a death by suicide and operates in 11 Primary Health Network areas in Australia. Only one of these—the Murray Primary Health Network—is in Victoria.

The Commission's view is that there is a need for more post-suicide support services so people who are affected by the loss and grief of a loved one's suicide are properly supported.

In 2020 the Commission will consider the range of interventions for people bereaved by suicide. This will include looking at existing programs as well as creating new interventions to effectively support families, carers and whole communities experiencing loss.

Box 11.3

Louise Flynn²⁰²

Louise Flynn is a psychologist and holds a Doctor of Philosophy. She has managed Jesuit Social Services' Support After Suicide program since January 2005.

The suicide 'postvention' program supports people after someone important to them has ended their life. Last year, they directly assisted 964 children, young people and adults bereaved by suicide.

Most of the team are psychologists and social workers, but they also have more than 50 peer support volunteers who are actively involved in counselling and supporting partners, parents, siblings, men, children and young people.

It's a very complex experience, losing someone to suicide, it's also very prolonged; it takes a long time for people to kind of get on their feet again, and so we're really trying to educate about those experiences.

Some of the people who we've met with have themselves experienced an earlier loss, a death by some other cause, and really felt that sense of being surrounded by people, and then when they've lost someone to suicide it's a really stark difference, and so they often can be left more alone.

Louise said one of the things she learnt is that the mental health system is not helpful to people, particularly some of those in suicidal crisis. If it was more helpful, she said, 'there would be some people who would not die'.

The Support After Suicide program has been operating since July 2004, and half the referrals come from Victoria Police. Louise said their day-to-day work is about suicide prevention and assisting people with their mental health and in their engagement in community life.

When someone has deliberately and intentionally ended their own life, it does result in a unique and difficult experience for those close to them.

... people I have worked with often say that they feel guilty, or they feel like they failed the person, or that they have let them down; they question whether they caused it or could have prevented it.

A person bereaved by suicide often has a relentless and distressing experience of trying to understand how it could have happened.

People I work with have told me that sometimes others in their social network avoid them, sometimes by crossing the street so as not to interact with them; that there is a silence around them in that people don't talk about or mention the death or speak about the person who died.

11.6 Skilling up the workforce to respond to suicidal crises

While many people told the Commission about the supportive role mental health workers played in their recovery,²⁰³ the Commission also heard from people who have experienced suicidal distress in finding some health professionals dismissive or lacking in compassion:

I saw my GP the day I tried to kill myself. I begged her for help [...] She told me to go home, run a bubble bath, have a nice glass of wine and come back and see her in a week if I still felt 'down'.²⁰⁴

I had my first contact in a public hospital after an overdose and was not believed. They ignored what I said [...] the nurses said that 'you need to look at where you are and how you got here'.²⁰⁵

Families and carers reported not being included and not being listened to by staff when they sought support for their loved ones. At times, it has been reported that people were made to feel as though they were part of the problem.²⁰⁶ Family members shared the following experiences:

My mum was discharged and sent home even though she was actively suicidal. She had to go back to hospital a few days later. She attempted suicide two to three times even after going to hospital and had to be readmitted. They didn't take us seriously because she has a history of mental illness. Staff just shoved her off.²⁰⁷

The family members and carers need to be listened to and treated with dignity and respect as do the patients [...] something which has been sadly lacking during my sixteen years of fighting to keep my son alive.²⁰⁸

Research also identifies that health and other professionals may lack skills in responding to people experiencing suicidal distress. For example, there is evidence that some emergency department staff may react negatively to young people who present with self-harm. This may be for number of reasons including 'a lack of confidence and skill when it comes to interacting with people who self-harm' and 'a lack of understanding of the association between self-harm and mental illness'.²⁰⁹

Other research examined mental health professionals' documented assessments of people who died by suicide and found that many patients may not be asked appropriate questions about their suicidal thoughts.²¹⁰ The research suggested this could be a result of clinicians not asking the right questions, not understanding the individual's level of risk, or not understanding what the person wanted to convey.²¹¹

Research by Orygen Youth Health states that the current workforce is 'ill-equipped to respond to self-harm effectively and sensitively', and that in many cases, 'poor service responses increase stigma and barriers to help-seeking, thereby compounding the harm'.²¹²

For the Beyond the Emergency study, Turning Point and Monash University, in partnership with ambulance services across Australia, conducted a national study of ambulance responses to men's mental health. The study found that 'fewer than fourteen per cent of paramedics reported having received comprehensive training for mental health responses (except for intoxication)', and more than two out of three felt 'underprepared to use communication skills as a response to the presenting person's need'.²¹³ Suicide Prevention

Australia highlighted that there is a lack of training for clinicians and emergency department workers in dealing with presentations of suicidality and suicidal crisis and suggested that an 'overhaul of training' is needed to support them.²¹⁴

The 2014 National Review of Mental Health Programmes and Services recommended that first responders and health professionals who are likely to encounter suicidal people be trained in therapeutic communication and other 'soft skills' such as empathic understanding.²¹⁵

The evidence presented above highlights the importance of suicide education and training for professionals who are likely to see people experiencing suicidal distress. The 'suicide prevention workforce' spans many disciplines, occupations and backgrounds. It includes psychologists, psychiatrists, nurses, GPs, paramedics, social workers and other allied health professionals, as well as police, counsellors and support workers.

Lived experience workers provide important person-centred support and recovery-oriented care. Increasingly, lived experience workers work as part of multidisciplinary mental health teams.²¹⁶ The Commission considers that lived experience workforces could make an important contribution to suicide prevention, but this contribution is yet to be consistently utilised.

There is a need to build workforce skills in suicide prevention so more people are trained and feel confident in providing support to people affected by suicidal behaviour.²¹⁷ Primary Health Networks have been encouraged to identify potential 'gatekeepers'—people such as teachers and sports coaches who are in contact with at-risk individuals—throughout the community and to promote gatekeeper training to support the place-based suicide prevention trials.²¹⁸

Frontline workers have a particularly important role in working alongside people experiencing suicidal behaviour, validating help-seeking behaviour, de-escalating a crisis and supporting safety and recovery.

Suicide Prevention Australia told the Commission that while there needs to be more investment in the mental health and suicide prevention workforce, 'an overhaul of training for all clinicians in dealing with both potential suicidality and immediate suicidal crisis is paramount'.²¹⁹ Similarly, Mr Woodward said:

Those who are working in the professions to do with mental health need to have a level of basic understanding around suicide and suicidal behaviour and be equipped with skills so they are competent to recognise where a person is recognising suicidality and respond effectively, and that requires large-scale universal training of health professionals.²²⁰

The Commission's attention was directed to the Connecting with People program as a promising approach to suicide risk mitigation.²²¹ The approach alters the focus from assessing the risk of a person's suicidality to safety planning and mitigation of risk that focuses on individual factors.²²² Mr Woodward told the Commission that Connecting with People provides an example of how a short program can equip workers with the skills and knowledge to respond appropriately to consumers showing signs of being suicidal.²²³ Under its Suicide Prevention Plan 2017–2021, the South Australian Government has committed to retrain its clinicians, including most emergency department staff, Primary Health Network workers and private providers, using the Connecting with People approach.²²⁴

11.7 Concluding comments

Fundamental to the Commission's vision for the future mental health system is the belief that one life lost to suicide is one too many. The Commission has made interim recommendations on suicide prevention in Part Five, building on successful existing programs, and will use the remainder of its term to develop recommendations on other evidence-based interventions to prevent and respond to suicide attempts and self-harm.

The Commission considers that there is an opportunity to make real inroads into reducing suicides. The commitment of both the Commonwealth and Victorian governments to 'towards zero suicides'.

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- 1 *Witness Statement of Alan Woodward*, 18 July 2019, para. 21.
 - 2 *Witness Statement of Associate Professor Dean Stevenson*, 4 July 2019, para. 33; RCVMHs, *Melbourne Community Consultation – May 2019*; RCVMHs, *Ballarat Community Consultation – April 2019*; Victorian Auditor-General's Office, *Access to Mental Health Services*, March 2019, p. 45; *Witness Statement of Associate Professor Simon Stafrace*, 7 July 2019, paras 77(b), 81 and 82.
 - 3 Eastern Health, *Submission to the RCVMHs: SUB.0002.0028.0585*, July 2019, p. 18.
 - 4 RCVMHs, *Werribee Community Consultation – May 2019*.
 - 5 Anonymous 64, *Submission to the RCVMHs: SUB.0002.0018.0045*, 2019, p. 2.
 - 6 Anonymous 240, *Submission to the RCVMHs: SUB.0002.0023.0047*, 2019, p. 2.
 - 7 *Witness Statement of Alan Woodward*, para. 60.
 - 8 On the basis of the 652 deaths by suicide in 2016 and assuming no growth in the number of suicides as a result of population growth.
 - 9 Department of Health and Human Services, *Victorian Suicide Prevention Framework 2016–25*, July 2016, p. 1; Victorian Government, *Towards Zero 2016–2020: Victoria's Road Safety Strategy and Action Plan*, p. 3.
 - 10 *Witness Statement of Alan Woodward*, para. 33.
 - 11 Commonwealth Department of Health, 'Commonwealth Towards Zero Commitment' <<https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-national-suicide-prevention-adviser>> [accessed 14 November 2019].
 - 12 'Suicidal behaviour' refers to a variety of actions and behaviours, among them thinking about suicide (ideation), planning for suicide, attempting suicide, intentional injury or self-harm (which might or might not have a fatal intent or outcome) and suicide itself. World Health Organization, *Preventing Suicide: A Global Imperative*, 2014, p. 12.
 - 13 *Witness Statement of Bruce Crossett*, 18 July 2019, para. 93.
 - 14 Commonwealth Department of Health, *The Fifth National Mental Health and Suicide Prevention Plan*, August 2017, p. 24.
 - 15 *Evidence of 'Susan Trotter' (Pseudonym)*, 22 July 2019, pp. 1474–83; *Witness Statement of 'Susan Trotter' (Pseudonym)*, 22 July 2019.
 - 16 Coroners Court of Victoria, *Data Summary Prepared to Assist the Royal Commission into Victoria's Mental Health System*, 17 July 2019, p. 8. This figure includes suspected and coroner-determined suicides.
 - 17 Australian Bureau of Statistics, *3303.0 – Causes of Death, Australia 2018: Summary – Australia's Leading Causes of Death*, 2019, p. 12.
 - 18 Royal Commission's analysis of: Coroners Court of Victoria, *Suicide Data Summary 2018*; Department of Health and Human Services, *Integrated Data Resource, Victorian Emergency Minimum Dataset, 2017–18 and 2018–19*.
 - 19 *Witness Statement of Alan Woodward*, para. 17; Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing*, 2008, p. 40; Australian Bureau of Statistics, *3303.0 – Causes of Death, Australia, 2008*, p. 41.
 - 20 Tim Slade and others, *The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing* (Commonwealth Department of Health and Ageing, May 2009), p. 41.
 - 21 Suicide Prevention Australia, *The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia*, 2016, p. 7.
 - 22 *Witness Statement of Alan Woodward*, para. 19; Suicide Prevention Australia, *The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia*, p. 32.
 - 23 *Witness Statement of Alan Woodward*, para. 19; Suicide Prevention Australia, *The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia*, p. 32.
 - 24 Suicide Prevention Australia, *The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia*, p. 11.
 - 25 *Witness Statement of Jeremy Dwyer*, 17 July 2019, para. 42.

- 26 In this section the Commission has primarily drawn on data provided by the Victorian Suicide Register managed by the Coroners Court of Victoria. Australian Bureau of Statistics data is also referenced to understand how the Victorian suicide rate differs to suicide rates in other states. However, caution is urged if comparing ABS rates to VSR data given the discrepancies between annual frequencies, due to the different counting rules of ABS and VSR, and the different material ABS and VSR coders use when classifying the deaths. The Coroners Court has access to a wider range of information than the ABS, which allows for a comprehensive understanding of the circumstances in which a death occurred, including the deceased's probable intent.
- 27 Australian Bureau of Statistics, *3303.0 – Causes of Death, Australia 2018: Summary – Australia's Leading Causes of Death*, 2019, p. 9.
- 28 World Health Organization, *Preventing Suicide: A Global Imperative*, p. 17.
- 29 Australian Bureau of Statistics, *3303.0 – Causes of Death, Australia 2018: Summary – Australia's Leading Causes of Death*, 2019, p. 10. Note that this figure of 9.1 deaths per 100,000 is based on ABS data for 2018, which recorded 593 Victorian deaths to suicide in 2018. As described by the ABS: 'The Victorian Registry of Births, Deaths and Marriages (RBDM) implemented a new registration system in February 2019. As part of this system implementation, certain policies and procedures have changed within the registry. Of note, the Victorian RBDM has changed their procedures regarding the registration of coroner-referred deaths. Previously coroner-certified deaths were not submitted to the ABS until the case was finalised in the Victorian Coroners Court. From 2019, this has changed and interim registrations (open cases) have been submitted to the ABS. This procedural change has resulted in an additional delay to registrations in 2018 and previous years, but the change to procedure is expected to lead to an increased number of coroner-referred registrations in 2019.' See Australian Bureau of Statistics, 'Causes of Death, Australia 2018 – Explanatory Notes', sec. 111 <<https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3303.0Explanatory%20Notes12018?OpenDocument>> [accessed 8 November 2019].
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- 31 *Witness Statement of Alan Woodward*, para. 59.
- 32 *Witness Statement of Alan Woodward*, paras 64 and 67.
- 33 *Witness Statement of Alan Woodward*, para. 68.
- 34 World Health Organization, *Preventing Suicide: A Global Imperative*, p. 30.
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- 38 Angela Clapperton, Lyndal Bugeja, and others, 'Identifying Typologies of Persons Who Died by Suicide: Characterizing Suicide in Victoria, Australia', *Archives of Suicide Research*, 2018, pp. 1–16.
- 39 *Witness Statement of Professor Jane Pirkis*, para. 19.
- 40 Angela Clapperton, Stuart Newstead, and others, 'Relative Risk of Suicide Following Exposure to Recent Stressors, Victoria, Australia', *Australian and New Zealand Journal of Public Health*, 43.3 (2019), 254–60 (p. 3).
- 41 *Witness Statement of Alan Woodward*, para. 11.
- 42 *Evidence of Georgina Harman*, 4 July 2019, p. 180.
- 43 Suicide Prevention Australia, *Turning Points: Imagine a World Without Suicide*, September 2019, p. 9.
- 44 Suicide Prevention Australia, *Turning Points: Imagine a World Without Suicide*, p. 9.
- 45 *Witness Statement of Alan Woodward*, para. 24.
- 46 *Evidence of Alan Woodward*, 22 July 2019, pp. 1490–91.
- 47 *Witness Statement of Professor Jane Pirkis*, para. 21.
- 48 For example, see: JTO Cavanagh and others, 'Psychological Autopsy Studies of Suicide: A Systematic Review', *Psychological Medicine*, 33.3 (2003), 395–405 (p. 395).
- 49 Coroners Court of Victoria, *Data Summary Prepared to Assist the Royal Commission into Victoria's Mental Health System*, p. 5.
- 50 Coroners Court of Victoria, *Data Summary Prepared to Assist the Royal Commission into Victoria's Mental Health System*, p. 26.
- 51 Coroners Court of Victoria, *Data Summary Prepared to Assist the Royal Commission into Victoria's Mental Health System*, pp. 19–20.
- 52 Coroners Court of Victoria, *Data Summary Prepared to Assist the Royal Commission into Victoria's Mental Health System*, pp. 19–20.
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- 54 Coroners Court of Victoria, *Submission to Law Reform, Road and Community Safety Committee into Drug Law Reform Inquiry*, March 2017, p. 3.
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- 56 Australian Bureau of Statistics, 3303.0 – *Causes of Death, Australia 2018: Summary – Australia's Leading Causes of Death*, p. 11.
- 57 National Rural Health Alliance Inc., 'Mental Health in Rural and Remote Australia Fact Sheet', 2017, p. 1.
- 58 National Rural Health Alliance Inc., p. 2.
- 59 *Evidence of Jeremy Dwyer*, 22 July 2019, p. 1449.
- 60 Department of Health and Human Services, *Victorian Suicide Prevention Framework 2016–25*, p. 2.
- 61 Department of Health and Human Services, *Victorian Suicide Prevention Framework 2016–25*, p. 2.
- 62 Professor Patricia Dudgeon and others, *Solutions That Work: What the Evidence and Our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report* (School of Indigenous Studies, University of Western Australia, November 2016), p. 7.
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- 68 Coroners Court of Victoria, *Data Summary Prepared to Assist the Royal Commission into Victoria's Mental Health System*, p. 8.
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- 72 Commission for Children and Young People, *Lost, not forgotten. Inquiry into children who died by suicide and were known to child protection*, November 2019, p. 60.
- 73 David Lawrence and others, *The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing* (Commonwealth Department of Health, August 2015), p. 103.
- 74 Stewart Muir, Jade Purtell, Kelly Hand, and Megan Carrol, *Beyond 18: The Longitudinal Study on Leaving Care Wave 3 Research Report: Outcomes for young people leaving care in Victoria*, (2019) Melbourne: Australian Institute of Family Studies, p. 26.
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- 77 *Witness Statement of Professor Jane Pirkis*, para. 28.
- 78 *Witness Statement of Professor Jane Pirkis*, para. 28(c).
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- 81 *Witness Statement of Alan Woodward*, para. 31.
- 82 World Health Organization, *Preventing Suicide: A Global Imperative*, p. 11.
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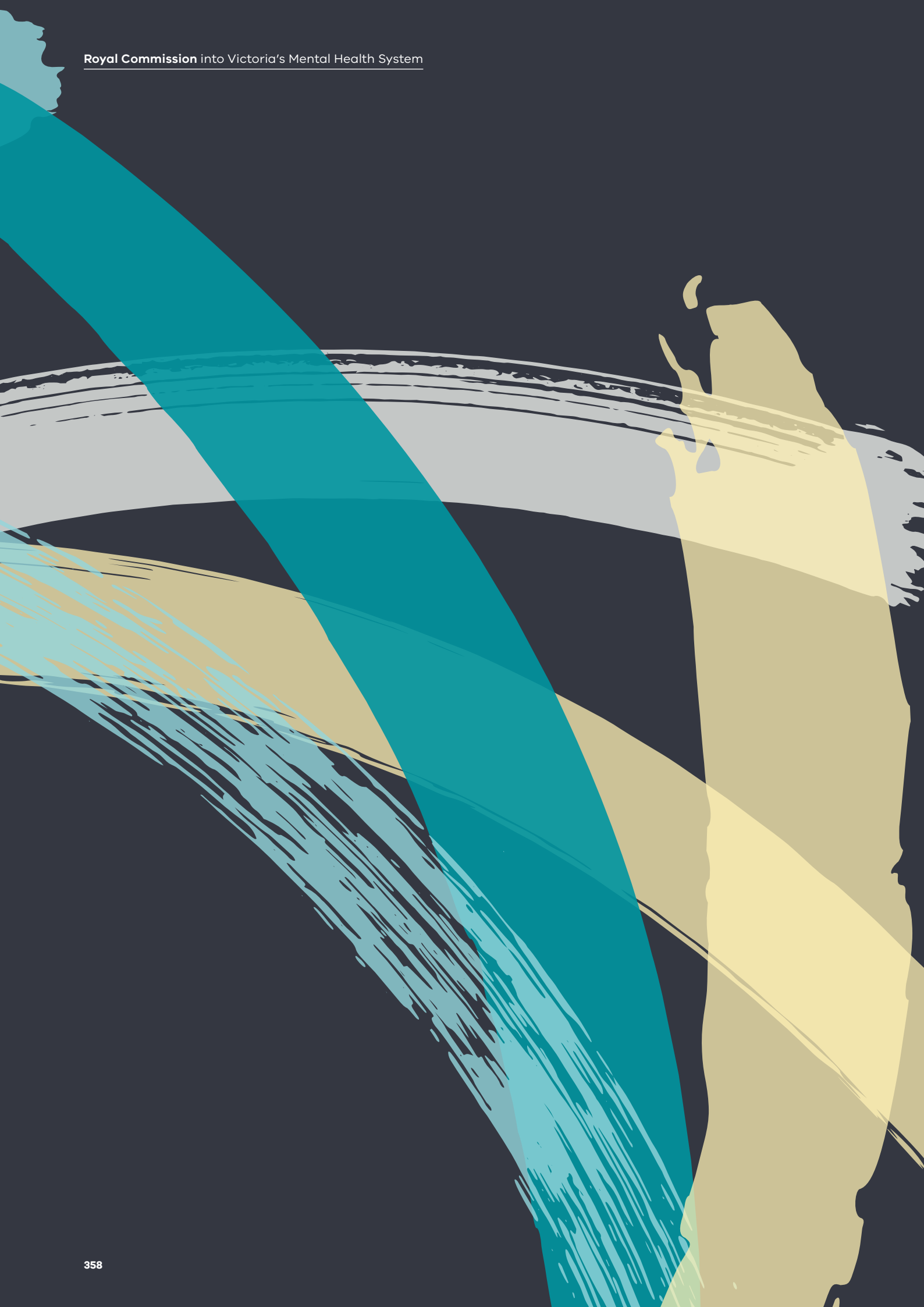
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Part Four

The economic case for mental health reform

Chapter 12

The economic case for mental health reform

As explored throughout this report, many people will experience mental illness at some point in their life, either directly or indirectly. The way people experience mental illness varies, but it is clear that Victoria's mental health system is failing to provide treatment, care and support to people when and where it would offer the greatest benefit.

The need for full-scale, fundamental reform to mental health services has been well established throughout the report. This will require significant economic investment.

This chapter examines the economic costs of poor mental health, including how costs are borne by people living with mental illness, their families and carers, along with organisations and governments, and changes over time. It also explores the benefits of increased investment in mental health for both the individual and the state.

12.1 The high costs of poor mental health

Without adequate services, people living with mental illness, their families and carers are exposed to the social, personal and economic costs of poor mental health. These costs can be exacerbated in the context of stigma and discrimination, for example, and social isolation. The economic costs of poor mental health are also borne at an organisational governmental level.

12.1.1 Cost estimates

It is well established that poor mental health has an economic cost. The Commission estimates that the economic cost of poor mental health to Victoria is \$14.2 billion a year (see Table 12.1).¹

This aligns with other estimates. The Organisation for Economic Cooperation and Development conducted an analysis of numerous countries between 2010 and 2013 and found that poor mental health could cost more than 4 per cent of all economic activity (measured by gross domestic product).² For Victoria this is equivalent to \$17.7 billion in 2018–19.³ The Royal Australian and New Zealand College of Psychiatrists estimated that poor mental health costs Australia about \$60 billion a year, which is equivalent to \$15.6 billion in Victoria.⁴ The Productivity Commission has estimated the cost of poor mental health and suicide to the national economy to range from \$43 to \$51 billion in 2018–19, or \$11.0 billion to \$13.1 billion in the Victorian context.⁵

By their nature, these calculations rely on a range of assumptions and should be considered cautiously. The Commission considers, however, that they provide a valuable indication of the size and nature of the economic cost of poor mental health.

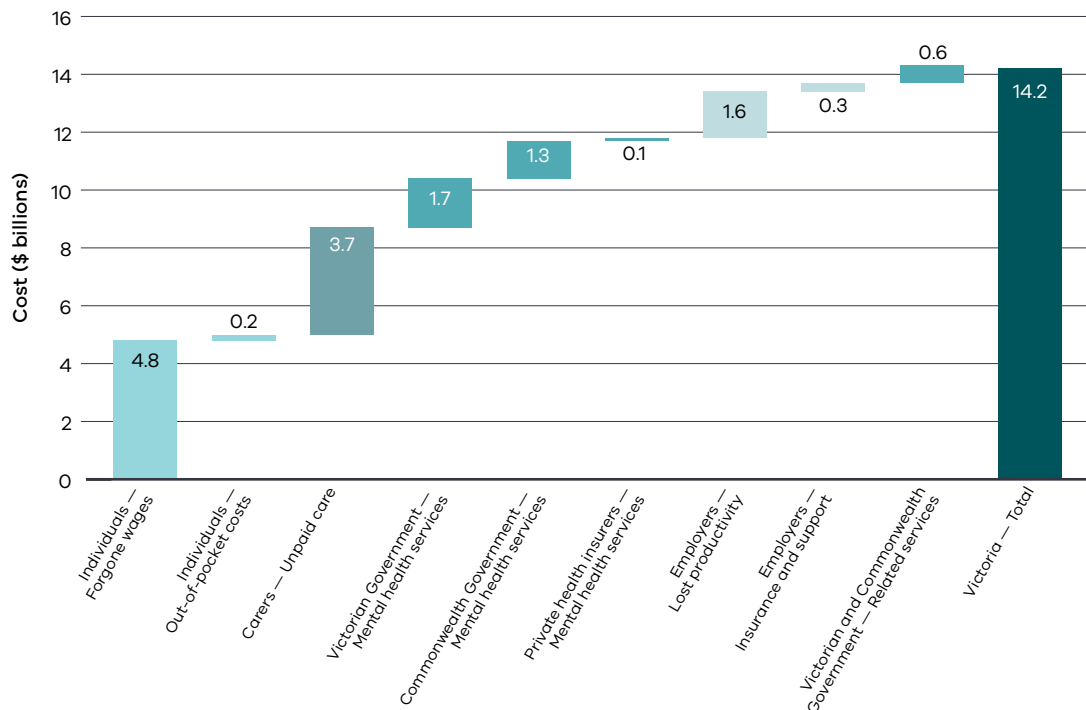
The full costs of poor mental health—social and personal costs, as well as economic costs—are even greater than the foregoing figures suggest (see Figure 12.1).

Figure 12.1: The different costs of poor mental health: economic, social, personal

	<p>Individuals, families and carers</p>	<ul style="list-style-type: none"> • Discomfort, pain and suffering when mental health services are not responsive • Premature death and increased likelihood of experiencing physical health problems • Social isolation and distress due to stigma, discrimination (direct and indirect) and denial of rights • Denied access to services, receipt of inadequate help or a poor service experience • Out-of-pocket costs and wait times to access services • Lower income or poverty due to missed educational and employment opportunities • Increased likelihood of experiencing other hardships such as homelessness
	<p>Broader community</p>	<ul style="list-style-type: none"> • Lower levels of social connection • Donations, volunteer time and taxes to help provide mental health supports and services
	<p>Governments and private providers</p>	<ul style="list-style-type: none"> • Provision of mental health and broader services (e.g. housing) • Realising limited outcomes from these services, resulting in: <ul style="list-style-type: none"> – Clients having more complex mental health needs in the future – Services becoming more inefficient, tightly rationed and focused on the most acute and costly care
	<p>Employers</p>	<ul style="list-style-type: none"> • Providing insurance and programs to fulfil responsibility to provide safe and healthy workplaces • A smaller workforce to draw on • Lost productivity because staff must be away from work or try to continue to work while unwell

This chapter concentrates on the economic costs of poor mental health such as forgone wages, out-of-pocket costs and unpaid care. Figure 12.2 and Table 12.1 outline the Commission's estimate of the economic costs of poor mental health. These are borne by every Victorian; people living with mental illness are affected the most, and families, carers, governments and employers also incur costs.

Other 'personal' costs, including many things much more valuable to an individual's day-to-day life such as health and wellbeing and social connections, are outlined here but considered in more depth elsewhere in the report.⁶

Figure 12.2: Estimated economic costs of poor mental health in Victoria, 2018–19

Source: Commission estimate. See Appendix C: Background to economic analysis (Section C.2) for details of assumptions and data sources used.

12.1.2 Personal costs

The personal cost of poor mental health can be profound, particularly when the mental health system does not support people to access high-quality treatment, care and support where and when it would offer the greatest benefit. Social and emotional costs are difficult to express in monetary terms, and the Commission has not tried to do so. Understanding these impacts, however, position the economic costs within the context of individuals' experiences.

People living with mental illness can experience emotional distress and pain, social isolation, discrimination, and lack of the freedom and rights enjoyed by others (see Figure 12.3). They can may also experience costs to their quality of life—for example, being inhibited from participating in activities that are important in their lives. Without responsive, safe and high-quality services, it might be difficult for people living with mental illness to lead the contributing lives they otherwise would—with close connections and having something to do each day that provides meaning and purpose.⁷

Poor mental health is also linked to poorer overall health and premature death. Although not always linked to mental illness, deaths by suicide can also have a huge impact on individuals and communities. It is estimated that in 2018 more than 100,000 years of expected life were lost in Australia as a result of intentional self-harm and suicide.⁸ While each circumstance is unique, and different people live with different levels of social connection, for every suicide, on average, up to 135 other people—friends, carers, colleagues and community members—could be affected.⁹

Table 12.1: Estimated economic costs of poor mental health in Victoria, 2018–19

Type of costs	Annual estimate (billions)
Individuals—forgone wages due to individuals experiencing poor mental health facing greater barriers to participate in the labour force, compared to other Victorians	\$4.8 (possible range: \$3.6—\$6.0) ^a
Individuals—out-of-pocket costs for individuals to access mental health treatment, care and support	\$0.2
Carers—unpaid care provided by families and other carers to individuals experiencing poor mental health	\$3.7
Victorian Government—mental health services funded by the Victorian government	\$1.7
Commonwealth Government—mental health services funded by the Commonwealth Government	\$1.3
Private health insurers—mental health services funded by private health insurers	\$0.1
Employers—lost productivity due to people needing to be away from work when they are unwell	\$1.6 (possible range: \$1.2—\$2.0) ^b
Employers—workplace injury and insurance responsibilities and employee support programs related to mental health	\$0.3
Victorian and Commonwealth governments related services—additional use of broader government services, compared to other Victorians, by people accessing the public specialist mental health services	\$0.6
Total	\$14.2b (range: \$12.7b—\$15.8b)

Source: Commission analysis. See Appendix C: Background to Economic Analysis (Section C.2) for details of the assumptions and data sources used.

- a) Estimating forgone wages relies on assumptions, so the Commission has estimated a range of scenarios for this. See Appendix C: Background to Economic Analysis for details of the assumptions and data sources used.
- b) Estimating productivity losses relies on assumptions, so the Commission has estimated a range of scenarios for this. See Appendix C: Background to Economic Analysis for details of the assumptions and data sources used.

The Commission has also been told about the personal costs borne by families and carers, including emotional costs. One person told the Commission:

Family and carers are the forgotten people in any mental health journey. I think that these people should be approached and offered advice if they want it. These people are integral to the improvement of the person suffering.¹⁰

Although many families and carers speak of the positive aspects of their role—companionship, fulfilment, enjoyment, satisfaction—an estimated one in four primary carers has ‘high or very high levels of psychological distress’ or is ‘frequently worried or depressed’ as a result of the caring role.¹¹

As noted, it is difficult to express social and emotional costs in monetary terms, but the Commission notes that mental and substance use ‘disorders’ were the second highest contributor to the overall age-standardised disease burden in Victoria in 2015.¹² As the OECD has stressed, these costs ‘should not be underestimated’.¹³

Figure 12.3: The estimated personal costs of mental illness

Source: 1) David Lawrence, Kirsten J. Hancock, and Stephen Kisely, 'The Gap in Life Expectancy from Preventable Physical Illness in Psychiatric Patients in Western Australia: Retrospective Analysis of Population Based Registers', *BMJ*, 346.f2539 (2013), p. 1 and 2) Australian Bureau of Statistics, 3303.0 - Causes of Death, Australia 2018: Summary - Australia's Leading Causes of Death, p. 2. Note this estimate is for 2018. 3/4) Australian Bureau of Statistics, General Social Survey: Summary Results, Australia 2014: Tables 10.1-10.4, 2015. Table 10.3 All persons, Selected personal characteristics—by whether person has mental illness or a long-term health condition.

12.1.3 Economic costs

The economic costs of poor mental health can be significant, particularly for people living with mental illness, and their families and carers, with a direct impact on their livelihoods. At the system level, organisations and government also bear these costs.

People living with mental illness

People living with mental illness experience the greatest economic costs of poor mental health, especially in a context where mental health services are lacking. They tend to have lower incomes and are less likely to be in the labour force or employed than someone who is not living with a mental illness.¹⁴ This is for a range of reasons, not least that people are not always obtaining high-quality treatment, care and support, along with the prevailing stigma and discrimination in the community.

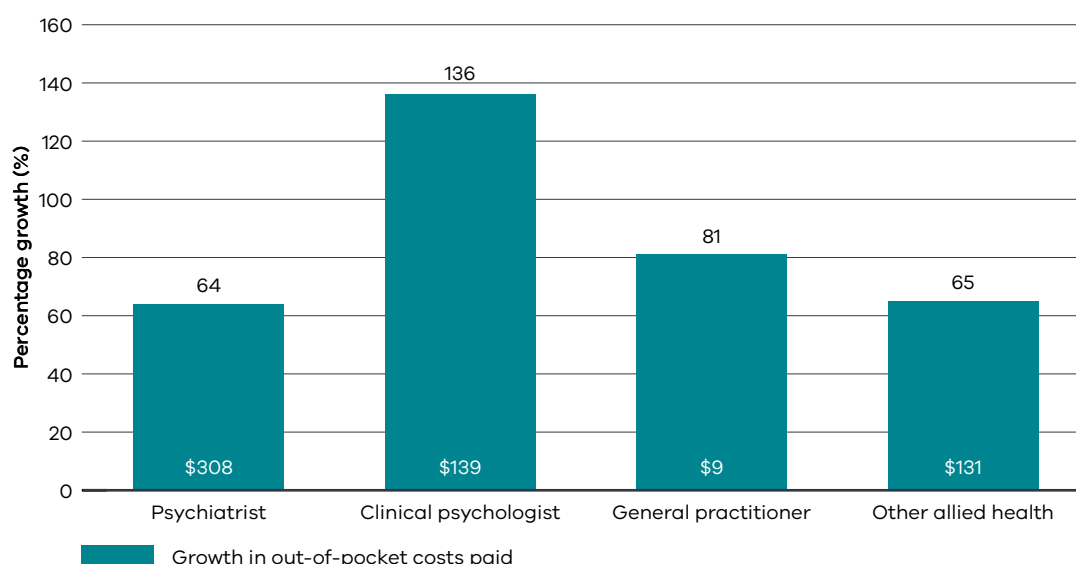
An estimated 104,200 fewer Victorians of working age living with mental illness are in paid employment than might be expected if participation and employment rates were similar to those for other Victorians.¹⁵ This translates into \$4.8 billion in lost wages,¹⁶ or \$3.2 billion after accounting for welfare payments received.¹⁷

Forgone wages directly affect individuals, who might have to rely on others such as family and the government for support. Sometimes the forgone wages relate to systemic failures such as the system's lack of recovery-oriented approaches to service delivery. This can represent a sizeable loss of potential activity in the broader Victorian economy, equivalent to 1.1 per cent of gross state product in 2018–19.¹⁸

People living with mental illness also face out-of-pocket costs associated with using mental health services such as medical care and pharmaceuticals. The Commission estimates that individuals in Victoria paid \$182 million in out-of-pocket costs for mental health-related services and prescriptions in 2018–19.¹⁹ The true cost is, however, undoubtedly higher, since this estimate covers Medicare-subsidised services (such as seeing a general practitioner or clinical psychologist) and Pharmaceutical Benefits Scheme prescriptions but not other costs.²⁰

Out-of-pocket costs are increasing across all relevant mental health services under the Medicare Benefits Schedule (see Figure 12.4), which appears to be a result of an increasing gap between subsidies and the cost of delivering and using services.²¹ The Commission has been told about the negative effect these out-of-pocket costs can have—a person 'might have to spend \$220 a week to see the psychiatrist in order to sustain life. Life can be very, very unsustainable if you don't have the support'.²²

Figure 12.4: Percentage growth in out-of-pocket costs of mental health services under the Medicare Benefits Schedule, Victoria, 2011–12 to 2016–17 (bars) and average cost per patient in Victoria, 2016–17 (listed dollar value)



Source: Commonwealth Department of Health. Medicare Benefits Scheme Mental Health Data by Primary Health Network by Mental Health Service Type 2011-12 to 2016-17, 2017.

Families and carers

The work of families and carers is crucial, not only for the people they look after but also for the functioning and sustainability of the mental health system as a whole.²³

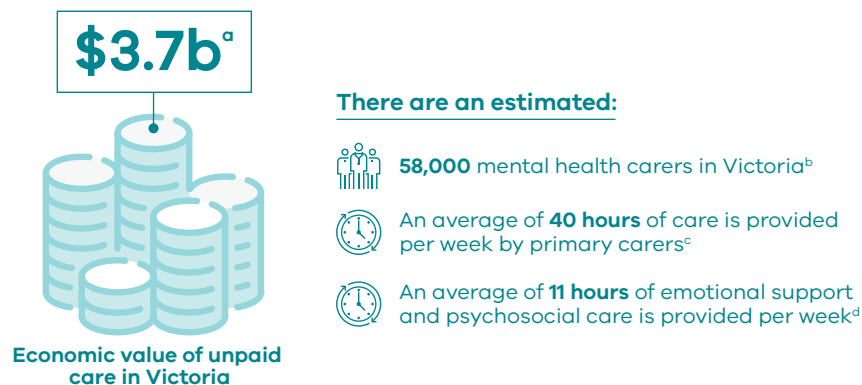
The Commission estimates that \$3.7 billion worth of unpaid care is provided annually in Victoria by more than 58,000 carers of people living with mental illness (\$3.1 billion after accounting for welfare payments) (see Figure 12.5).²⁴

Carers experience a broad range of higher economic costs compared with non-carers. Primary carers are less likely than non-carers to be in paid employment or to be on a higher household income, despite having comparable education levels.²⁵

Carers also experience other costs that are not commonly reported at the state level. One carer told the Commission:

The carer role often requires carers to pay out of pocket for other associated medical costs and reduce their work commitments, directly reducing carer disposable income and overall carer career prospects.²⁶

Figure 12.5: The costs of mental health to families and carers, Victoria, 2018-19



Source: a and b) Commission estimate. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used; c and d) Sandra Diminic and others, *The Economic Value of Informal Mental Health Caring in Australia: Summary Report* (Commissioned by Mind, March 2017), p. 139.

Employers

In addition to people living with mental illness, their families and carers, the Commission estimates that poor mental health costs Victorian employers \$1.9 billion a year.²⁷

Some of these costs are direct costs stemming from the legal duties of employers under the state's *Occupational Health and Safety Act 2004* to provide and maintain a working environment that is safe and free of risks to health. In s. 5 of the Act, health is defined as including psychological health.²⁸ Employers also have other responsibilities—for example, monitoring employees' health, monitoring conditions at the workplace under the employer's management and control, and ensuring that the conduct of the business does not endanger other people (including visitors, the public and other workers).²⁹

As part of their obligations, employers are responsible for workplace insurance and compensation, which WorkSafe Victoria oversees.³⁰ 'Work-related mental injury resulting in psychological harm' currently accounts for 11 per cent of workers compensation claims in Victoria and is the second most common cause of workers compensation claims in Australia.³¹ Each year, Victorian businesses pay approximately \$263.4 million in workers compensation insurance premiums associated with these claims.³²

Employers also cover employee support and assistance programs for maintaining workers' mental health. Finding statewide information on these programs is difficult, but a previous estimate suggests Victorian employers spent \$34.5 million on these programs each year.³³

About two-thirds of people living with mental illness are in the workforce.³⁴ Inadequate supports in the workplace, along with inadequate mental health services, can mean that people living with mental illness are more likely to require time away from work³⁵ or are more likely to be less productive while at work.³⁶ The Commission estimates that lost productivity at work as a result of time away due to poor mental health costs Victorian employers \$1.6 billion a year.³⁷

Governments and private providers

As explored earlier in this report, the Victorian and Commonwealth governments cover the bulk of the cost of delivering mental health services.

The Victorian Government

The Victorian Government provides \$1.7 billion worth of mental health services each year. The mix of services this covers is shown in Figure 12.6, which includes activity by emergency health services—ambulance and hospital emergency departments—to respond to people experiencing mental illness.³⁸

In addition to this, the Victorian Government contributes funding to the National Disability Insurance Scheme. This contribution will be \$2.6 billion a year, across all types of disabilities.³⁹ Since the National Disability Insurance Scheme is a national scheme and the Commonwealth Government has primary responsibility for its delivery, the proportion of this funding relevant to mental health is included in the Commonwealth Government estimate of mental health service costs in the following paragraphs.⁴⁰

Figure 12.6: Victorian Government mental health service provision: an overview, 2018-19



Source: Victorian Government, Submission to the RCMHS: SUB.5000.0001.0001, July 2019, p. 9; Department of Health and Human Services, Victoria's Mental Health Services Annual Report 2017-18, 2018, p. 64; Productivity Commission, Report on Government Services 2019: Public Hospitals - Attachment, Part E, Chapter 12: Table 12A.59; Witness Statement of Simon Thomson, 24 June 2019, p. 7; Productivity Commission, Report on Government Services 2019: Ambulance Services - Attachment, Part E, Chapter 11: Table 11A.10 and 11A.2.

This differs from the presentation in the Victorian Government submission due to different definitions of the scope of mental health services. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.

The Commonwealth Government

The Commonwealth Government provides \$1.3 billion for mental health services in Victoria. This includes services subsidised through the Medicare Benefits Schedule and medications subsidised through the Pharmaceutical Benefits Scheme, as well as funding for national mental health programs, alcohol and other drug services, and support for people living with severe mental illness under the NDIS.⁴¹

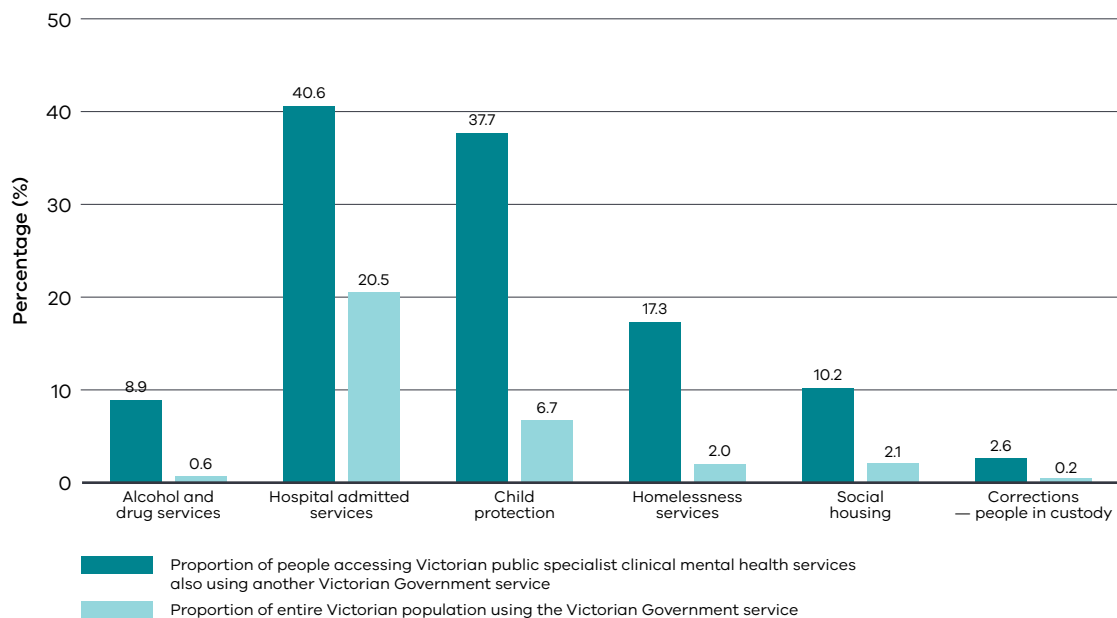
The Commonwealth also makes financial contributions to state-funded health services—\$5 billion in 2018–19.⁴²

Further, the Commonwealth funds welfare payments related to mental health—\$2.1 billion is provided each year for people with a psychological or psychiatric disability (as their primary disability) via the Disability Support Pension or to their carers via the Carers Allowance and Carer Payment.⁴³ These costs have not been added to the total economic cost estimate for Victoria but are significant.⁴⁴

Broader government services

People living with mental illness are more likely, on average, to come into contact with other government services. Figure 12.7 shows the proportion of people accessing Victorian public specialist clinical mental health services who are in contact with other government services within the same year, and the proportion of the general population who are in contact with these services.

Figure 12.7: Proportion of people accessing public specialist mental health services utilising other Victorian Government services, 2017–18



Source: Commission analysis of Department of Health and Human Services, Integrated Data Resource. Client Management Interface/Operational Data Store, State Alcohol and Drug Treatment Service Utilisation Data Collection Victorian Admitted Episodes Dataset, Child Protection – Case Management, Victorian Homelessness Services Collection, Victorian Housing Register, E-Justice, 2015–16 to 2017–18

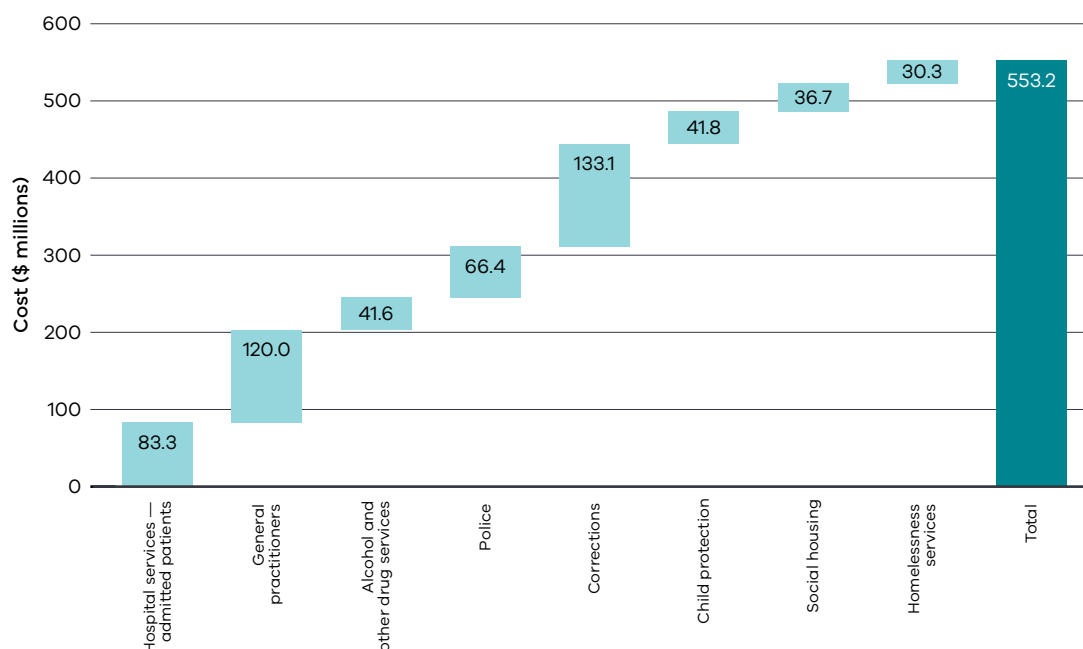
This estimate only considers service use amongst people accessing the public specialist clinical mental health service and other service systems in 2017–18. It does not account for people who a) may be accessing private mental health services or b) may have a mental illness but are not accessing the public specialist clinical mental health service in 2017–18. Child Protection refers to children in contact with the system, not parents.

There is a two-way relationship here. Unmet demand for mental health services might increase a person's need for or use of other services delivered by government. In turn, unmet demand in these aligned services systems can increase demand on the mental health system. Homelessness services exemplify this relationship. A study of more than 4,000 homeless people in Melbourne found that 15 per cent were experiencing mental illness before becoming homeless, and a further 16 per cent had developed a mental illness since experiencing homelessness.⁴⁵

Another example is physical health services. A recent Lancet Psychiatry Commission study examined the interaction between physical and mental illness and found that people experiencing a mental illness had an increased risk of also experiencing multiple chronic diseases.⁴⁶ Other evidence suggests that, on average, people living with mental illness do not receive the same level of diagnosis and treatment for physical health conditions⁴⁷ and are more likely than other people to be exposed to some physical health risk factors (for example, smoking, alcohol and drug use, and insecure housing).⁴⁸

It is difficult to attribute the flow-on costs of poor mental health to other government services—where inadequate treatment, care and support for people experiencing poor mental health leads to higher demand and service requirements in other areas of government responsibility. In part, this is due to the two-way nature of the relationship just described. In addition, it may be that other underlying factors, such as experiences of trauma or violence, are leading to a need for both mental health and other related services.

Figure 12.8: Estimated flow-on costs of related government services as a result of poor mental health, Victoria, 2018–19



Source: Commission estimate. See Appendix C: Background to economic analysis (section C.2) for details of the assumptions and data sources used.

This is a conservative estimate as it only considers multiple service use amongst people accessing public specialist clinical mental health services in 2017–18. It does not account for people who a) may be accessing private services or b) may be living with mental illness but are not accessing public specialist clinical mental health services in 2017–18.

The Commission has, however, estimated that the flow-on costs to other government services as a result of poor mental health is \$0.6 billion a year (see Figure 12.8 and Table 12.2).⁴⁹ This is calculated using a conservative approach—for example, it considers only cross-service use among people accessing public specialist clinical mental health services in 2017–18⁵⁰—but still includes notable costs in the broader Victorian health (\$244.8 million a year), justice (\$199.5 million a year) and human services portfolios (\$108.8 million a year).

Table 12.2: Estimated flow-on costs of related government services as a result of poor mental health, Victoria, 2018–19

Portfolio	Related service	Additional costs due to poor mental health (millions 2018–19)
Health	Hospital services—admitted patients	\$83.3
	General practitioners	\$120.0
	Alcohol and other drug services	\$41.6
	Health total	\$244.8
Justice	Police	\$66.4
	Corrections	\$133.1
	Justice total	\$199.5
Human services	Homelessness services	\$30.3
	Social housing	\$36.7
	Child Protection	\$41.8
	Human services total	\$108.8
Total		\$553.1

Source: Commission estimate. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.

Private health insurers

Private health insurers provide an estimated \$137 million worth of mental health services in Victoria each year.⁵¹ This includes expenditure on psychiatric hospital services for Victorians with private health insurance and paying the associated premiums.

These services provide an alternative to the public mental health services and may include a greater choice in treatment, support and care (including coverage for services not covered by Medicare) and shorter waiting times for some services.⁵²

The Commission is aware of concerns about the accessibility of private health insurance for people living with mental illness, including limited coverage in most basic and medium-level hospital products and significant out-of-pocket costs. The Commission notes the Commonwealth Government's recent reforms to improve access to in-hospital mental health services under private health insurance.⁵³

12.2 Costs are likely to increase

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

Almost one in two people will be affected by mental illness during their lifetime,⁵⁴ and a variety of factors are pushing up demand for mental health services.⁵⁵ Not all of these factors are well understood, but the apparently steady population-level prevalence rates, increasing rates of diagnosis and Victoria's growing population have combined to produce a substantial increase in the reported number of people living with mental illness.⁵⁶

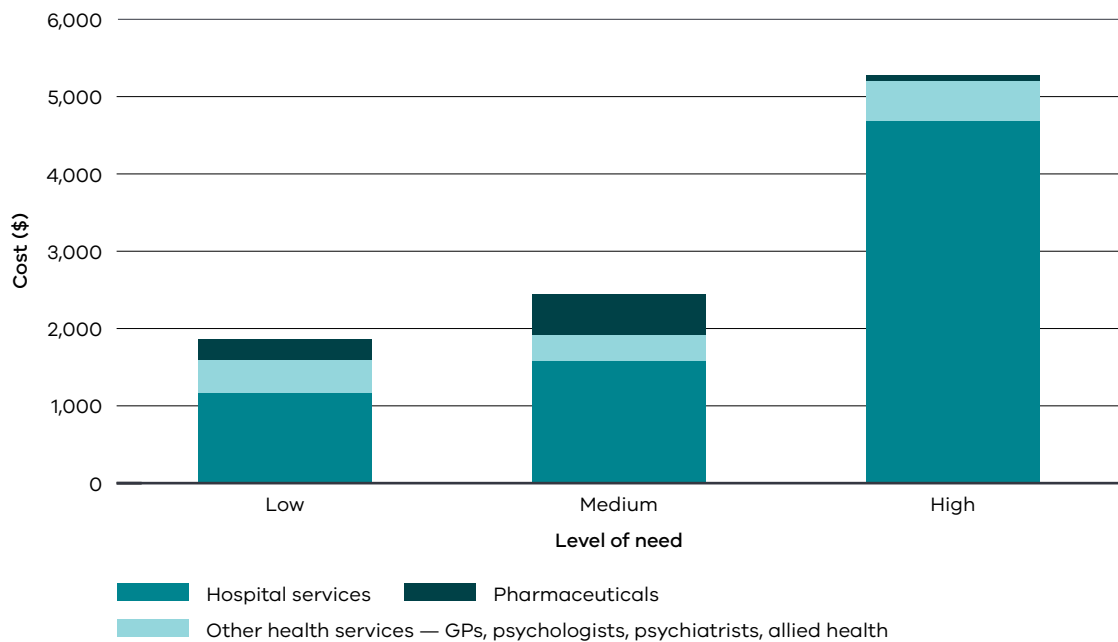
As in health and human services generally, achieving large productivity gains and associated cost savings is difficult in mental health services. Health care is fundamentally based on people providing care to other people, even where there are opportunities to adopt new technologies to facilitate this. Compared with other sectors such as agriculture and manufacturing, it is more difficult to standardise such services or reduce inputs without compromising the safety and quality of services.⁵⁷

The current design of Victoria's public mental health services is exacerbating these broader cost pressures. As detailed earlier in this report, people living with mental illness are waiting longer and becoming sicker before they can gain access to services. This means that mental health services are now seeing people with higher levels of need. As a result, individuals are more likely to need more acute and costly forms of care. They might also have become disconnected from other supports (such as stable employment and housing) that would help their recovery. Fundamentally, people are not receiving the treatment, care and support when and where it would offer the greatest benefit; this also affects the experiences of families and carers.

Figure 12.9 gives an indication of the cost implications of this approach. It estimates the average cost to provide public mental health care to an individual living with mental illness and experiencing varying levels of need (based on the intensity of a person's symptoms and capacity to engage in day-to-day activities as they would like).⁵⁸ It shows that waiting for someone to reach a high level of need for care, treatment and support will result in much higher costs because the person increasingly needs more care and more costly care—that is, hospital services as opposed to primary care and other services in the community. Further, the trend is for people to be treated for shorter periods, making it more likely that they will need to receive acute care again in the future.⁵⁹

Chapter 5 describes a number of structural challenges that make it difficult for mental health services to deliver efficient and effective care. This includes a lack of system-level planning, few meaningful measures of performance and outcomes, and funding models that fail to encourage value for money. These foundations make it more challenging to achieve efficiency gains.

Figure 12.9: Annual average cost per person experiencing a mental illness for government funded or subsidised care, by level of need, Victoria, 2013-14



Source: Commission estimate. See Appendix C: Background to economic analysis (Section C.3) for details of the assumptions and data sources used.

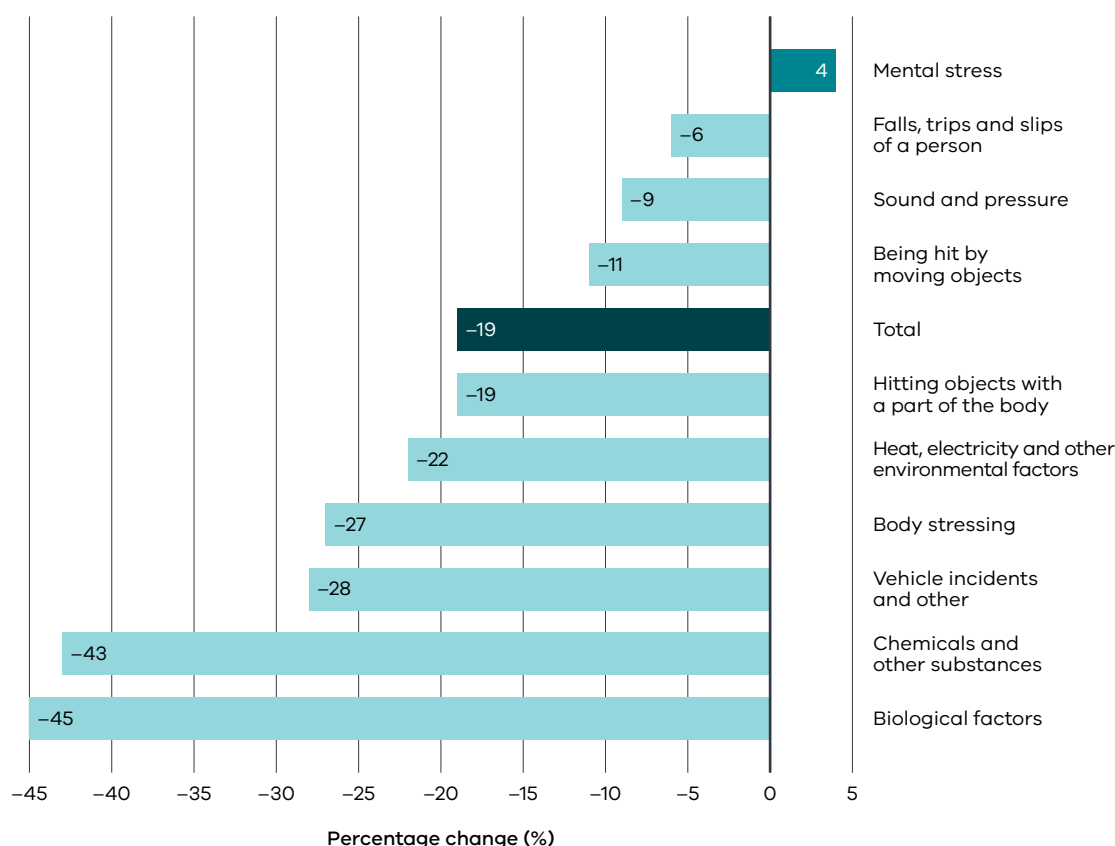
Level of need is based on the intensity of a person's symptoms and capacity to engage in day to day activities as they would like.

Pharmaceuticals refers to those provided outside of hospital services.

The current approach of employers might also be failing to mitigate increasing costs associated with poor mental health. While overall workplace injury rates are decreasing, rates of injury resulting from 'mental stress'⁶⁰ are not (see Figure 12.10). The main causes of serious mental health condition claims are work pressure (21 per cent), work-related harassment and bullying (20 per cent) and exposure to workplace or occupational violence (10 per cent).⁶¹ This suggests employers are placing greater priority on, and achieving, improved physical health in the workplace, as opposed to mental health. Victorian respondents in a survey of employees found that 76 per cent felt their workplace performed well on physical safety, but only 51 per cent felt the same about mental health.⁶²

The economic costs of poor mental health are greatly exacerbated by a mental health system that does not enable people living with mental illness to live the full and contributing lives they otherwise would. The range of factors that contribute to these costs will be considered in the Commission's redesign of the mental health system.

Figure 12.10: Change in number of serious workplace injury claims, by cause, Australia 2001–01 to 2015–16



Source: Safe Work Australia, 2018, Australian workers' compensation statistics 2016–17, Table 28.

In this instance, mental stress refers to the mechanism of injury describing work-related stress in claims data as defined by Safe Work Australia.

For more information, see <<https://www.safeworkaustralia.gov.au/topic/mental-health>>.

12.3 Benefits of increased investment

Increased investment in Victoria's mental health system would provide a range of benefits for all Victorians—most particularly people living with mental illness and their families and carers. While increased funding alone will not redress the depth of problems that are examined throughout this report, it is absolutely necessary to realise the reform required to achieve a high-quality, contemporary mental health system. While the need for increased funding is examined in Chapter 20, this section explores the benefits of an increase in terms of equity and economic and health benefits.

12.3.1 Equity

A well-functioning mental health system goes to the heart of an inclusive and fair society where people have confidence that they and their loved ones, and the people around them, will have access to treatment, care and support when they need it. As explored throughout this report, mental illness will affect most Victorians throughout their lifetime, either directly or indirectly. In this regard, economic investment in mental health is of great concern and benefit to everyone.

Health inequality is not only an economic consideration—it is a matter of fairness and social justice.⁶³ The causes of mental illness are beyond an individual's control and reflect many injustices evident in broader community life.⁶⁴ For example, trauma, violence⁶⁵ and financial hardship⁶⁶ are associated with an increased likelihood of experiencing mental illness,⁶⁷ which can be exacerbated by stigmatising and discriminatory attitudes.

Additionally, mental illness typically has an early onset, often as people are transitioning into adulthood. Research shows that 75 per cent of mental illnesses develop before the age of 25.⁶⁸ In the absence of early intervention, adequate treatment and support, young Victorians can find they are unable to participate in many of the formative experiences that typify this age group—for example, completing education, forming intimate relationships outside of their immediate family and entering employment.⁶⁹ Such disruption can have lifelong consequences.

It is imperative that Victoria has a mental health system that is responsive and accessible and that provides the highest quality treatment, care and support. However, the depth of problems throughout Victoria's mental health system is clear. The only way to enable improved outcomes for Victorians and for them to enjoy good mental health is through full-scale changes to mental health services across the state.

Reform of this scale requires significant investment. This investment will contribute to redressing the inequity that currently exists for those who live with mental illness, and their families and carers, who are not receiving the support they need and deserve, and for generations to come.

12.3.2 Economic benefits

At the individual level, there is great opportunity to improve the accessibility and quality of treatment, care and support to better enable the social and economic participation of people living with mental illness, and their families and carers. At the state level, this would yield economic benefits to the economy. Much of this is related to the fact that many people living with mental illness are in the workforce or are of working age.⁷⁰

The Productivity Commission has reviewed ways to increase productivity growth across the Australian economy and has identified significant opportunities in health and education.⁷¹ Looking more specifically at mental health, the Productivity Commission has also identified reforms—such as additional community mental health services and improved social and emotional learning in early childhood and school education—that would provide a significant economic boost for Australia.⁷²

It is envisaged that a reformed mental health system will provide more timely access to quality care, with improved early intervention and prevention, reducing or delaying the onset of mental illness. Treatment, care and support will be recovery-oriented, enabling people to lead their own recoveries and to live full and contributing lives—participating in education, employment and communities.⁷³ This in turn provides economic benefits for Victoria.

These benefits are difficult to quantify because there are few comparable examples of high-performing mental health systems. At the service level, there are examples of models delivering good outcomes in a range of jurisdictions, including Victoria. As such, most of the existing knowledge base demonstrates the impact of individual interventions rather than systemic impacts.⁷⁴

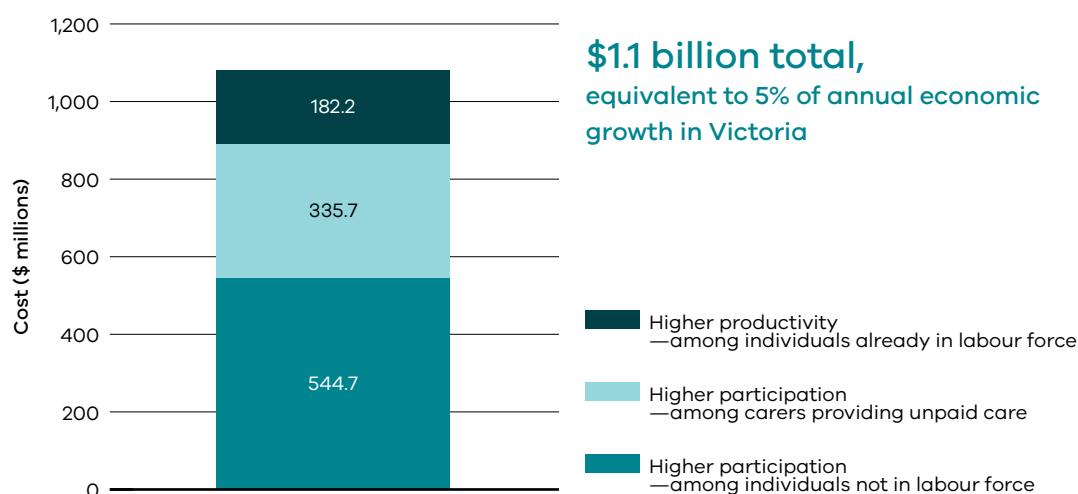
In view of the fact that the Commission is yet to determine the full suite of interventions needed in Victoria's future mental health system, the Commission has modelled the impact of hypothetical scenarios of possible mental health outcomes under an improved mental health system.⁷⁵ This is indicative of the potential scale and distribution of the economic benefits compared with the current situation. Although the scenarios are hypothetical, the analysis is based on individual survey data on Australians' experience of mental illness, their consequent use of health services and the impact on their engagement with paid work.⁷⁶

The Commission's analysis found that a 15 per cent reduction in the 'level of need' experienced by Victorians diagnosed with mental illness—via providing improved treatment, care and support that helps to reduce the intensity of symptoms and to improve engagement in day-to-day life—would deliver \$1.1 billion in additional economic activity in the Victorian economy.⁷⁷ This economic benefit would be delivered through higher workforce participation and greater productivity at work (see Figure 12.11).⁷⁸

Other countries achieve higher rates of workforce participation among people living with mental illness than Australia (see Figure 12.12).⁷⁹ If similar rates were achieved in a Victorian context, the projected economic benefits could be even higher—about \$1.8 billion, or equivalent to 8 per cent of the state's annual economic growth.

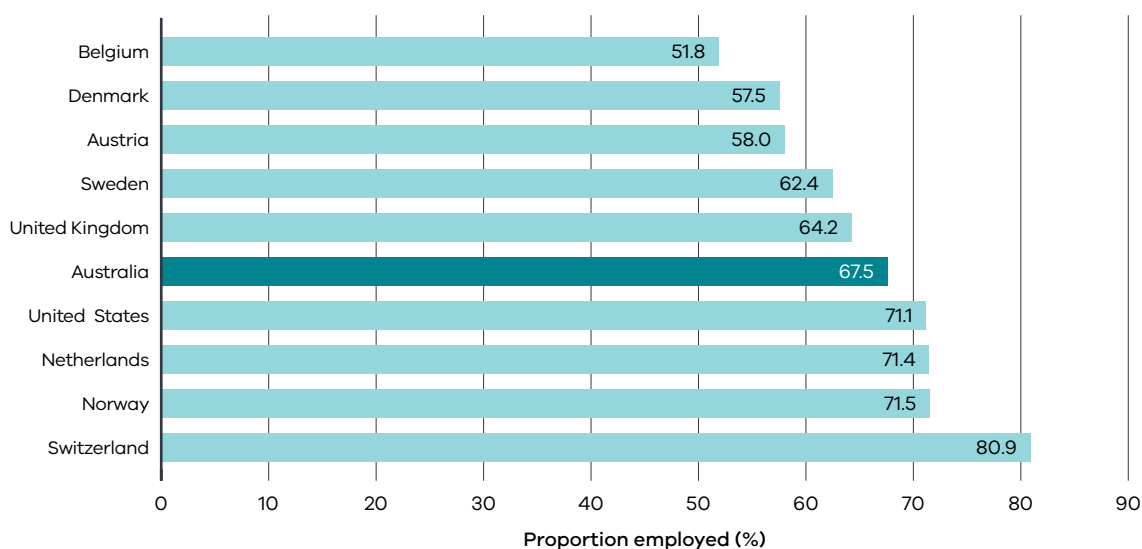
These economic benefits would support people living with mental illness, their families and carers, predominantly through improved engagement in paid work. They include both the social and the economic benefits that come with employment. This would also benefit employers, who would have access to a more productive and larger workforce than is currently the case, and through the flow-on increase in demand for goods and services. Finally, although it was not estimated, governments would indirectly benefit from higher tax revenue resulting from the increase in economic output.

Figure 12.11: Estimated additional economic activity in Victoria from an improvement in mental health outcomes, 2018–19



Source: Commission estimate. See Appendix C: Background to economic analysis (Section C.3) for details of the assumptions and data sources used.

Figure 12.12: Proportion of people with a mental illness that are employed in different countries (various years)

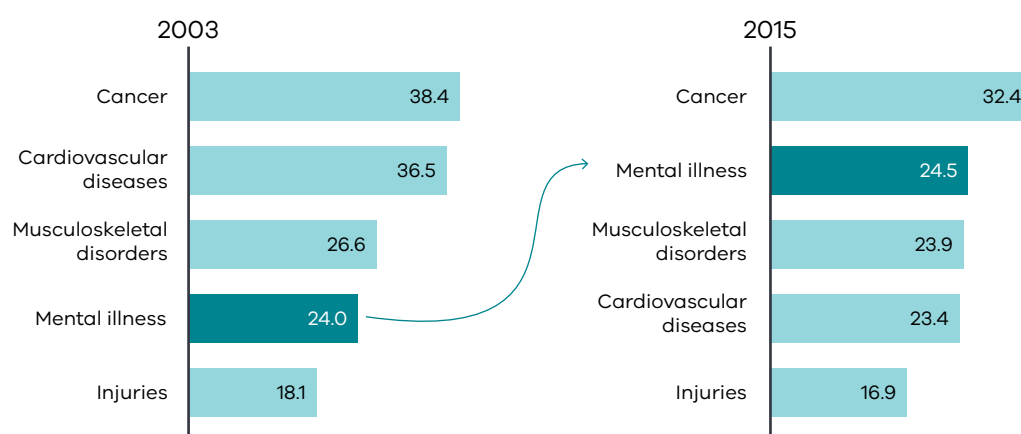


Source: Organisation for Economic Co-operation and Development, Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work, 2015, p. 31.

In this instance, mental illness refers to working age people living with a mental health condition, in moderate ill health, as defined by Organisation of Economic Co-operation and Development.

The figure draws upon a number of national health surveys. Australia: National Health Survey 2011–12; Austria: Health Interview Survey 2006–07; Belgium: Health Interview Survey 2008; Denmark: Daneish National Health Survey 2010; Netherlands: POLS Health Survey 2007–09; Norway: Level of Living and Health Survey 2008; Sweden: Living Conditions Survey 2009–10; Switzerland: Health Survey 2012; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 2008.

Figure 12.13: Change in Australian burden of disease 2003 to 2015, measured via age-standardised Disability-Adjusted Life Years per 1,000 population



Source: Australian Institute of Health and Welfare, Australian Burden of Disease Study: Impact and Causes of Illness and Death in Australia 2015. Australian Burden of Disease Series No. 19. Cat. No. BOD 22. Canberra: AIHW. Data Tables: Australian Burden of Disease Study 2015. National estimates for Australia. Table 1B. Disease group.

Data shown is the age-standardised rate.

In this instance, mental illness includes mental and substance use disorders as defined by the Australian Institute of Health and Welfare; Injuries are injuries due to an external cause and include suicide and self-inflicted injuries.

12.3.3 Health benefits

The most valuable benefit of an improved mental health system is improved health outcomes for people living with mental illness, including improvements in a person's quality of life and life expectancy. The Productivity Commission recently estimated that the monetary cost of diminished wellbeing from mental health is \$130 billion a year across Australia.⁸⁰

The overall disease burden has decreased in Australia since 2003, and the burden from the top five diseases has also decreased except for mental illness (Figure 12.13).⁸¹ According to the Royal Australian and New Zealand College of Psychiatrists, research suggests as much as 28 per cent of the current burden of disease relating to mental illness could be averted.⁸²

The Commission analysed the potential impact of an improved mental health system in terms of burden of disease. This analysis used quality-adjusted life years, a measure of how an intervention can deliver improvements in a person's quality of life as well as their life expectancy.⁸³

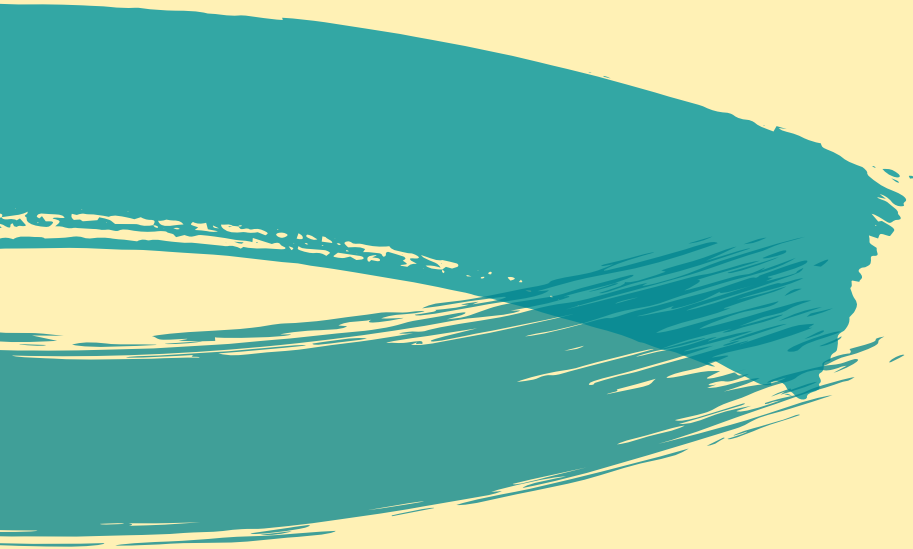
The Commission found that a 15 per cent reduction in the level of need experienced by Victorians diagnosed with a mental illness would deliver an additional 23,500 quality-adjusted life years to nearly 140,000 Victorians currently living with a mental health diagnoses.⁸⁴ This is a conservative estimate.

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- 1 See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
 - 2 Emily Hewlett and Valerie Moran, *Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care*, OECD Health Policy Studies (OECD, 2014), p. 16.
 - 3 The Victorian estimate is based on applying the OECD estimate to Victoria's gross state product and is for 2018–19.
 - 4 The Royal Australian and New Zealand College of Psychiatrists, *The Economic Cost of Serious Mental Illness and Comorbidities in Australia and New Zealand*, 2016, p. 5.
The original national estimate has been indexed to 2018–19 dollars and the Victorian estimate found by applying the state's proportion of the total national population (25.7 per cent) to the national estimate.
 - 5 Productivity Commission, *Draft Report on Mental Health: Volume 1*, October 2019, p. 171. The Victorian estimate is based on applying the state's proportion of the total national population to the national estimate and is for 2018–19.
 - 6 See Chapter 2 for further consideration of these issues.
 - 7 National Mental Health Commission, *A Contributing Life: The 2012 National Report Card on Mental Health and Suicide Prevention*, 2012, pp. 4–5.
 - 8 Australian Bureau of Statistics, *3303.0 – Causes of Death, Australia 2018: Summary – Australia's Leading Causes of Death*, 2019, p. 2.
 - 9 Julie Cerel and others, 'How many people are exposed to suicide? Not six', *Suicide and Life-Threatening Behavior*, 49.2 (2019), 529–34, p. 532.
 - 10 Clive Kempson, *Submission to the RCMHS: SUB.0002.0001.0066*, 2019, p. 3.
 - 11 Carers Victoria, *Submission to the RCMHS: SUB.0002.0028.0712*, July 2019, pp. 6–8. See also Part Three for the experiences of families and carers.
 - 12 Australian Institute of Health and Welfare, 'Australian Burden of Disease Study: Impact and Causes of Illness and Death in Australia 2015. Australian Burden of Disease Series No. 19. Cat. No. BOD 22. Canberra: AIHW. Data Tables: Australian Burden of Disease Study 2015 State and Territory Estimates for Australia', 2019. Table 1B. Disease group. Note the term 'mental and substance abuse disorders' is used to be consistent with the Australian Institute of Health and Welfare analysis.
 - 13 Organisation for Economic Co-operation and Development, *Focus on Health: Making Mental Health Count*, July 2014, p. 1.
 - 14 Commonwealth Department of Health and Ageing, *National Mental Health Report 2013: Tracking Progress of Mental Health Reform in Australia, 1993–2011*, 2013, p. 76.

- 15 The potential to improve these rates is consistent with international evidence that comparable countries achieve a higher participation rate than Australia for people with a mental health disorder. Organisation for Economic Co-operation and Development, *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*, 2015, p. 31. Commission estimate. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
- 16 Lost wages are estimated to sit between \$3.6 and \$6.0 billion, with a mid-point of \$4.8 billion. Commission estimate. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
- 17 Commission estimate. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
- 18 As a proportion of Victoria's nominal gross state product 2018–19. Department of Treasury and Finance, *Macroeconomic Data 2019–20 Budget*, May 2019.
- 19 See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
- 20 For example, these figures do not cover the additional out-of-pocket costs that consumers face from using other private health services and Medicare-subsidised services that aren't classified under mental health-specific codes.
- 21 *Witness Statement of Professor Malcolm Hopwood*, 27 June 2019, para. 41.
- 22 *Evidence of 'Nina Edwards' (Pseudonym)*, 26 July 2019, p. 1840.
- 23 For example, not all informal care is provided voluntarily; 48.1 per cent of primary carers in Victoria cited 'Could provide better care' as a reason for taking on a caring role, 21.1 per cent cited 'Had no other choice', 18.5 per cent cited 'Alternative care too costly' and 14.2 per cent cited 'No other care arrangements available'. Australian Bureau of Statistics, 2015, *Survey of Disability, Ageing and Caring*, 2015, Table 43.1.
- 24 Commission estimate. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
- 25 Note, the labour force participation rate is for carers aged 15–64 years; the two other indicators are for 15 years or older. Australian Bureau of Statistics, *Survey of Disability, Ageing and Carers: Psychological Disability 2012 – Australia: Tables 1–11.1*, 2015. Table 32.3.
- 26 Brendan Gillespie, *Submission to the RCMHS: SUB.0002.0028.0521*, 2019, p. 3.
- 27 Commission estimate. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
- 28 WorkSafe, 'Mental Health: Safety Basics' <<https://www.worksafe.vic.gov.au/mental-health-safety-basics>> [accessed 9 October 2019].
- 29 WorkSafe, 'Occupational Health and Safety – Your Legal Duties' <<https://www.worksafe.vic.gov.au/occupational-health-and-safety-your-legal-duties>> [accessed 9 October 2019].
- 30 WorkSafe, 'Do I Need to Register for WorkCover Insurance?' <<https://www.worksafe.vic.gov.au/do-i-need-register-workcover-insurance>> [accessed 11 November 2019].
- 31 WorkSafe, 'Mental Injury Support' <<https://www.worksafe.vic.gov.au/mental-injury-support>> [accessed 9 October 2019]. Note, the term 'mental injury' is used here to be consistent with analysis published by WorkSafe and Safe Work Australia.
- 32 Note, this excludes funding paid by Worksafe in weekly payments to avoid double-counting the cost to employers of lost productivity. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
- 33 Commission estimate using Medibank and Nous Group, *The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design*, 2013. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
- 34 For example, the employment rate of Australians with a mental or behavioural condition was 62.1 per cent in 2017–18. Australian Bureau of Statistics, *National Health Survey: First Results, 2017–2018 – Australia*, 2018, p. 40.
- 35 For example, it is estimated that Australians experiencing mild depression take approximately three sick days a year more than those with no depression, an additional six days for those experiencing moderate depression and 16 for those experiencing severe depression. Wesley P McTernan, Maureen F Dollard, and Anthony D LaMontagne, 'Depression in the workplace: An economic cost analysis of depression-related productivity loss attributable to job strain and bullying', *Work & Stress*, 27.4 (2013), 321–38, p. 331.
- 36 For example, estimates suggest those experiencing major depression experience a productivity loss that is equivalent to being absent for over two full days each month. Ron Z Goetzel and others, 'Health, absence, disability, and presenteeism cost estimates of certain physical and mental health conditions affecting U.S. employers', *Journal of Occupational and Environmental Medicine*, 46.4 (2004), 398–412, p. 404.
- 37 Lost productivity is estimated to sit between \$1.2–2.0 billion, with a mid-point of \$1.6 billion. Commission estimate. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
- 38 Commission estimate. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.

- 39 Note, the Victorian Government will contribute \$2,586 million in 2019–20 and this will be escalated by 4.0 per cent per annum. Council of Australian Governments, *'Bilateral Agreement between the Commonwealth of Australia and Victoria on the National Disability Insurance Scheme'*, 2019, p. 15.
- 40 See Appendix C: Background to economic analysis (Section C.2) for more details on payments between the Commonwealth and Victorian governments relevant to mental health.
- 41 Commission estimate. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
- 42 National Health Funding Body, 'National Report: Public Hospital Funding – June 2019' <<https://reports.publichospitalfunding.gov.au/Reports/national?month=jun2019>> [accessed 21 October 2019]. Given the states have primary responsibility for these services, the mental health proportion of this funding is captured under the Victorian Government figures in Figure 12.6. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
- 43 Commission estimate. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
- 44 As per standard practice in economic cost analysis, welfare payments are considered in this analysis to be a transfer rather than a cost to society via lost potential production.
- 45 Dr Nicola Brackertz, Alex Wilkinson, and Jim Davison, *Housing, Homelessness and Mental Health: Towards Systems Change* (Australian Housing and Urban Research Institute, November 2018), p. 13.
- 46 Joseph Firth and others, 'The Lancet Psychiatry Commission: A Blueprint for Protecting Physical Health in People with Mental Illness', *The Lancet Psychiatry*, 6 (2019), p. 675.
- 47 Angelina Chadwick and others, 'Minding our own bodies: Reviewing the literature regarding the perceptions of service users diagnosed with serious mental illness on barriers to accessing physical health care', *International Journal of Mental Health Nursing*, 21.3 (2012), 211–19, p. 216.
- 48 The Royal Australian and New Zealand College of Psychiatrists, *Keeping Body and Mind Together: Improving the Physical Health and Life Expectancy of People with Serious Mental Illness*, 2015, p. 11.
- 49 Commission estimate. See Appendix C: Background to economic analysis (Section C.2) for details of the assumptions and data sources used.
- 50 Further, this approach does not account for people who (a) may be accessing private services or (b) may be living with mental illness but are not accessing the public specialist clinical mental health services in 2017–18.
- 51 Commission estimate based on Australian Institute of Health and Welfare, *Mental Health Services in Australia: Expenditure on Mental Health Services 2016–17*. Table EXP.34
- 52 The Royal Australian and New Zealand College of Psychiatrists, 'Private Health Insurance Policies for Psychiatric Care in Australia' <<https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/private-health-insurance-policies-for-psychiatric>> [accessed 30 October 2019].
- 53 Commonwealth Department of Health, 'Private Health Insurance Reforms: Supporting Mental Health', 2018.
- 54 The Actuaries Institute, *Mental Health and Insurance: Green Paper*, October 2017, p. 8.
- 55 See Chapter 2 for further explanation and evidence.
- 56 Harvey A Whiteford, 'The Disparity between changes in the prevalence of mental illness and disability support rates in Australia', *Medical Journal of Australia*, 206.11 (2017), p. 486.
- 57 William J. Baumol, *The Cost Disease. Why Computers Get Cheaper and Health Care Doesn't* (Yale University Press, 2012), pp. 20–21.
- 58 Commission analysis. See Appendix C: Background to economic analysis (Section C.3) for details of the assumptions and data sources used.
- 59 See Chapter 7 for further explanation and evidence.
- 60 Safe Work Australia uses the term 'mental stress' to refer to the mechanism of injury describing work-related stress. Safe Work Australia, 'Mental Health' <<https://www.safeworkaustralia.gov.au/topic/mental-health>> [accessed 15 October 2019].
- 61 Safe Work Australia, 'Work-Related Mental Health', 2018, p. 2. The work pressure category includes work backlogs and deadlines, organisational restructures, interpersonal conflicts, disciplinary actions, performance counselling or promotion disappointment.
- 62 TNS Global and Beyondblue, 'State of Workplace Mental Health in Australia', 2014, p. 2.
- 63 Michael Marmot and others, *Fair Society, Healthy Lives: The Marmot Review, Strategic Review of Health Inequalities in England post-2010*, February 2010, p. 15.
- 64 See Chapter 2 for consideration of the prevalence and drivers of mental illness.
- 65 Roger Wilkins and others, *The Household, Income and Labour Dynamics in Australia (HILDA) Survey: Selected Findings from Waves 1 to 17* (Melbourne Institute: Applied Economic & Social Research, University of Melbourne, 2019) p. 135.
- 66 VicHealth, *Submission to the RCVMHS: SUB.0002.0029.0239 – Attachment 1: Evidence Review of Risk and Protective Factors*, 2019, p. 14.

- 67 Victorian Council of Social Service, *Submission to the RCVMHS: SUB.0002.0029.0282*, July 2019, p. 28.
- 68 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), p. 593.
- 69 See Chapter Two for consideration of these experiences.
- 70 For example, the employment rate of Australians with a mental or behavioural condition was 62.1 per cent in 2017–18. Australian Bureau of Statistics, *National Health Survey: First Results, 2017–2018 – Australia*, p. 40.
- 71 Productivity Commission, *Shifting the Dial: 5 Year Productivity Review*, August 2017, p. 8.
- 72 Productivity Commission, *Draft Report on Mental Health: Volume 2*, October 2019, p. 1042.
- 73 National Mental Health Commission, *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services: Summary*, November 2014, pp. 12–13.
- 74 See Chapter 3 for a summary of this topic.
- 75 The Commission has modelled three possible outcomes from an improved mental health system: lower need (a proxy for the intensity of an individual's symptoms and capacity to engage in day-to-day activities as they would like); lower prevalence of mental illness; and lower productivity loss due to poor mental health. See Appendix C: Background to economic analysis (Section C.3) for details of the assumptions and data sources used.
- 76 This analysis is based on a cost-of-illness study. It included diagnoses of affective disorders, anxiety disorders, substance use disorders, schizophrenia and other psychosis, eating disorders, personality disorders, and a general category for the remaining 'other' disorders. See Appendix C: Background to economic analysis (Section C.3) for details of the assumptions and data sources used.
- 77 'Level of need' is a proxy for the intensity of an individual's symptoms and capacity to engage in day-to-day activities as they would like. A 15 per cent improvement in the level of need has been modelled. Under this scenario, 15 per cent of those currently experiencing a high level of need would instead experience a medium level of need, and 15 per cent of those experiencing a medium level of need would instead experiencing a low level of need. A shift from a low level of need to no need is not assumed. Appendix C: Background to economic analysis (Section C.3) for details of the assumptions and data sources used.
- 78 See Appendix C: Background to Economic Analysis (Section C.3) for details of the assumptions and data sources used.
- 79 For example, there was a 21.9 percentage point difference between the country with the highest proportion of people with a mental illness employed and the lowest. This difference cannot be attributed to differences in working and employment conditions between countries alone because the difference in employment rates for people that do not have a mental illness is only 13.2. Organisation for Economic Co-operation and Development, *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*. Figure 1.2.
- 80 Productivity Commission, *Draft Report on Mental Health: Overview and Recommendations*, October 2019, p. 9.
- 81 Burden of disease analysis uses disability-adjusted life years to measure overall life lost to disease and the overall impact of disease or injury on a person's health. It allows for comparison between diseases or disease groups. One disability-adjusted life year represents the loss of one year of healthy life as a result of either premature death or living with an illness or injury.
- 82 The Royal Australian and New Zealand College of Psychiatrists, *The Economic Cost of Serious Mental Illness and Comorbidities in Australia and New Zealand*, p. 17.
- 83 Quality-adjusted life years are calculated as a quality of life utility value between 1 (indicating perfect health) and 0 (indicating death) (with negative values indicating a health state worse than death, however, still alive) multiplied by years lived in that state.
- 84 This uses the same scenario analysis previously described. See Appendix C: Background to economic analysis (Section C.3) for details of the assumptions and data sources used, and the results of the alternative benefit scenarios.



Part Five

Preparing for a new approach to mental health

Preparing for a new approach to the mental health system

The Commission is acutely aware of the trust the community has placed in it. It has been granted a rare opportunity to design a contemporary and equitable mental health system that responds to the needs of communities across Victoria. A range of matters coming within the terms of reference continue to be explored. The challenge is to ensure the optimism Victorians hold for responsive, equitable and high-quality mental health services is not misplaced.

This interim report and the final report, due in October 2020, need to be considered as part of a continuum. The recommendations contained in each will influence the future direction of the mental health system in Victoria.

Part Five of this report outlines the Commission's interim recommendations. Some recommendations are made in response to pressing problems; others focus on building a foundation and supporting the investment needed to make the extensive changes to mental health services that the Commission is still contemplating. The Commission will present a comprehensive set of recommendations to transform the mental health system in Victoria in its final report. Among other matters, the final recommendations will consider how to offer more community-based treatment, care and support that focuses on responding early, reducing psychological distress and supporting people to live well in their communities.

The Commission expects that between now and October 2020 the Victorian Government will begin implementing all the recommendations presented in this interim report.

The Commission's opportunity

The current mental health system has several strengths, such as its many dedicated workers. But the very existence of this Commission suggests that these strengths are neither commonplace nor sufficient. There remain widespread variations and deficiencies in service access and quality, and these often have a negative impact on people's mental health outcomes and their ability to direct their own recovery.

Many inquiries, audits and reviews have preceded this Commission. Since the early 1990s the Victorian and Commonwealth governments have released many mental health plans.¹ They have traversed a broad range of topics and components of mental health services. Yet, despite the hard work of many, developing and maintaining an equitable and responsive mental health system has not occurred in Victoria. There is also a lack of structures in place for evaluating and improving the mental health system.

At the time of announcing this Royal Commission, the Premier, the Hon. Daniel Andrews MP, said, 'Something is wrong with the mental health system. Something is wrong, and we have to admit it. We have to find it. And we have to fix it.'²

The challenges experienced by people living with mental illness, their families and carers and the workforce as a result of the pressures on the mental health system are many and complex. The pressures are the result of entrenched social, structural and historical developments that have fallen short of the vision and changes proposed by previous inquiries and reviews, which have broadly emphasised early assessment and intervention as well as home-based and other out-of-hospital care and support.

In contrast with these previous inquiries and reviews, the context of this current inquiry affords the Commission unique opportunities.

First, the Commission's terms of reference are broad, extending beyond mental health and 'the system'. They require the Commission to look beyond Victorian Government-funded mental health services to other mental health services that fall within the Commonwealth Government's remit, as well as mental health services funded by private insurers, the not-for-profit sector and individuals.

Another central consideration for the Commission is the way services within Victoria's mental health system interact with other systems and services—such as housing, homelessness, disability, education, alcohol and other drugs, family violence, health, justice and employment services.

Such a broad scope is an acknowledgment that many factors, experiences and services influence a person's mental health. The terms of reference also allow the Commission to consider how best to support Victorians in their efforts to enjoy good mental health as well as respond to poor mental health.

Second, the Commission is operating at the same time as considerable activity is taking place at the Commonwealth level. This includes the Productivity Commission's work on the effects of poor mental health on Australia's economy and productivity, work on implementing the Fifth National Mental Health and Suicide Prevention Plan, and the appointment of Ms Christine Morgan, CEO of the National Mental Health Commission, as the Prime Minister's Suicide Prevention Adviser. All this activity presents an important opportunity to capitalise on renewed cooperation between governments in relation to supporting good mental health.

Third, the Commission's work is taking place at a time of unprecedented public discourse and consensus about the need for change. The Commission is heartened by the community's generosity in connection with its inquiry. Many people living with mental illness, family members and carers have spoken of their experiences—often under difficult circumstances—in the hope of improving the mental health system for others.

Throughout its work to date, the Commission has learnt of the widespread consensus on the depth of the problems in the existing mental health system. There is little disagreement between individuals and organisations about the need for change. Indeed, the Commission's attention has been drawn to an overwhelming sense of hope and expectation that Victoria's mental health system will once again lead the way, as has occurred in the past.

Finally, the Commission's terms of reference clarify that its focus is not about finding fault and attributing blame but is on reforming the mental health system. The current Victorian Government has made a commitment to implementing every recommendation the Commission makes. This means the Commission's responsibilities reach beyond responding to current challenges to the next decade and beyond; it must develop a system that responds to changing needs and captures the contemporary opportunities of human-centred design and digital and technological transformation.

Preparing for system transformation

The opportunities afforded to the Commission and the extent of the challenges facing the mental health system are at the heart of the Commission's pursuit of a fundamental redesign for the system in Victoria. Recommendations aimed solely at 'fixing' the current system would fail to deliver the profound and lasting changes that are both needed and expected.

There is also an opportunity to propose changes that allow for mental health services to be provided in a way that is equitable, responsive and adaptable. The Commission is developing an ambitious reform agenda that goes beyond patching gaps, problem solving and piecemeal solutions. Contemporary thinking is needed to give form to people's hopes and to make the best of this once-in-a-generation opportunity.

For the remainder of its term, the Commission will be working on redesigning the mental health system. People with lived experience will continue to be at the forefront of considerations. Such a program of work is ambitious since the Commission must deliberate on all the intricacies of contemporary mental health systems. This involves the Commission building on the evidence and submissions collected to date to reconfigure and redesign services so they meet the needs of individuals and communities and empower people in directing their own recovery and managing their own mental health.

The Commission is considering the 'architecture' required to support these changes. This includes reviewing responsibilities at all levels of government and between service providers, as well as examining funding models, workforce requirements, data needs and legal structures.

The Victorian Government has asked that the Commission's recommendations 'endeavour to achieve practical, prioritised, efficient and sustainable outcomes'.³ The Commission appreciates this emphasis and is conscious that effective implementation is critical to achieving a contemporary, equitable and responsive mental health system.

As noted, the current Victorian Government has already made a commitment to accepting the Commission's recommendations. It will also need to take the lead in ensuring the recommendations are effectively implemented. Further, the government will need to lead investment effort. Providing additional resources will be central to implementing the Commission's recommendations.

The necessary changes to the mental health system cannot, however, be achieved by government alone. A collective effort is essential—all tiers of government, service providers and the workforce in mental health, the media, the education system, other health and social sectors will all need to be involved. Individuals, families and communities will also need to contribute. For example, tackling stigma and discrimination in workplaces, schools and the health system will be a shared responsibility.

Most importantly, people with lived experience of mental illness must have an opportunity to lead positive reforms to the mental health system. Working together in new and coordinated ways at all levels is vital for responding to the multiple varying factors that affect mental health.

Having reflected on the many previous attempts to bring about change in the mental health system, the Commission has resolved that an early and sustained focus on implementation is necessary. It recommends that the Victorian Government immediately establish a Mental

Health Implementation Office to support a dedicated focus on delivering the changes proposed in this report. The Office should be viewed as a transitional measure while the Commission continues its work to determine governance for the future of the mental health system in Victoria.

Approach to the interim recommendations

The recommendations put forward in this interim report in no way resolve all the problems the Commission has been alerted to so far, nor do they describe the major system changes the Commission considers necessary. When viewed in the broader context of the Commission's task, these interim recommendations respond to only a very small portion of what the Commission must contemplate.

The Commission deliberated extensively about the nature and purpose of this interim report. The Commission could have refrained from making interim recommendations and instead presented an analysis of what the Commission has learnt about the difficulties besetting Victoria's mental health system and described the direction of the Commission's future work. The Commission concluded, however, that there is a moral imperative to capitalise on the opportunities afforded by the requirement to deliver an interim report. The interim recommendations are intended to provide clear guidance to the government through pragmatic and concrete proposals.

In preparing its interim recommendations the Commission has been careful to ensure what is put forward now does not limit its ambition or its future work. The purpose is to balance the requirement to take action now to start addressing problems with the mental health system while recognising further time and deliberation is needed to deliver transformational change.

In view of this, the recommendations in this part of the interim report are mainly about actions designed to prepare for building a transformed mental health system, recognising that considerable effort and investment will be required to implement the Commission's final recommendations.

Without pre-empting the Commission's continuing work on system design, the interim recommendations also constitute an initial response to the need for additional mental health services and for setting in train the move towards an equitable mental health system. The Commission's interim recommendations are outlined in the following chapters.

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- 1 Australian Health Ministers' Conference, *National Mental Health Policy 1992*, Cat No. 9216310, April 1992; Department of Health and Community Services, *Victoria's Mental Health Service: The Framework for Service Delivery*, 1994; Department of Human Services, *New Directions for Victoria's Mental Health Services: The Next Five Years*, 2002; The Boston Consulting Group, *Improving Mental Health Outcomes in Victoria: The Next Wave of Reform*, July 2006; Department of Human Services, *Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009–2019*, February 2009; Department of Health and Human Services, *Victoria's 10-Year Health Plan: Mental Health Workforce Strategy*, July 2016; Commonwealth Department of Health, *The Fifth National Mental Health and Suicide Prevention Plan*, August 2017.
 - 2 Victorian Government, 'Announcement: Royal Commission into Mental Health Speech', 2018, p. 3.
 - 3 Victorian Government, 'Royal Commission into Victoria's Mental Health System—Terms of Reference', 2019, p. 3.

Chapter 13

Victorian Collaborative Centre for Mental Health and Wellbeing

Recommendation

The Royal Commission recommends that the Victorian Government establishes a new entity, the Victorian Collaborative Centre for Mental Health and Wellbeing. As a first step, the Mental Health Implementation Office should establish the governance of the Collaborative Centre and begin planning for a purpose-built facility in Melbourne.

The Collaborative Centre will bring people with lived experience together with researchers and experts in multidisciplinary clinical and non-clinical care to develop and provide adult mental health services, conduct research and disseminate knowledge with the aim of delivering the best possible outcomes for people living with mental illness. The centre will work within a network of partners including service and research organisations in rural and regional areas.

The Collaborative Centre will:

- drive exemplary practice for the full and effective participation and inclusion of people with lived experience across the mental health system
- conduct 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.

Models of care for the services the Collaborative Centre provides to its local community will reflect the Commission's final redesign of Victoria's mental health system.

13.1 Exemplifying a new approach

Establishing the Victorian Collaborative Centre for Mental Health and Wellbeing will reflect many of the characteristics of a reformed mental health system that the Commission considers essential if Victorians are to experience good mental health.

These characteristics—which are fully detailed as part of the Commission's guiding principles presented in Part One—describe a future in which people living with mental illness have their dignity respected, with comprehensive treatment, care and support provided to ensure their full and effective participation in society. The characteristics also describe a mental health system that embodies responsiveness, collaboration and continuous improvement.

While the Commission continues its work to make this vision a reality for all aspects of the state's mental health system, the new approach can be exemplified in the development of the proposed Collaborative Centre.

The new Collaborative Centre will drive change through a new entity that will provide adult clinical and non-clinical services, emphasise the participation and inclusion of people with lived experience, and conduct interdisciplinary research. The Collaborative Centre should be established under legislation, with a skills-based board that includes people with lived experience and a multidisciplinary executive team led by co-directors—a clinical academic and an individual with lived experience of mental illness.

The Collaborative Centre, in its purpose-built facility and in its community, should provide adult mental health clinical and non-clinical services to its local population. Service delivery alongside interdisciplinary research is important because it enables people with lived experience to participate in the design, development and production of research programs and reinforces the translation of research and evidence into high-quality care.

Advances made by the Collaborative Centre should be shared and applied across the state's mental health system. The adult mental health services in the Collaborative Centre should reflect a spectrum of services and include community-based and mobile home treatment, services provided in outpatient clinics and other non-hospital settings, crisis responses and inpatient care (subacute and acute) for its local population. In recognition that patients may also require access to a wider suite of health services (including for physical needs)—and for reasons of clinical safety, efficiency and effectiveness—the entity will need to be proximate to and partner with an existing public health service.

The comprehensive services the Collaborative Centre will provide to its local community should be complemented by specialist (including statewide specialist) services. These specialist services should focus on areas of mental health care and treatment for people living with complex conditions who have not benefitted from traditional service models.

Non-clinical services within the Collaborative Centre should include programs that involve: a consumer's network and their choice of friends and family; psychosocial supports; and creative and supportive group therapy.

Models of care for the services should be informed by the Commission's ongoing work and final report.

Alongside service provision, a strong interdisciplinary research agenda will enable findings to be translated into practice across clinical and non-clinical domains. Translational research that bridges the gap between ‘discovery and practice’ will drive high-quality care. Interdisciplinary research should also inform practice changes and policy development. The Collaborative Centre should bring together individuals from different disciplines, perspectives and experiences, and support a wide range of academic appointments.

The Collaborative Centre should share its research findings through a network of partners, including in rural and regional areas. While it may begin with a small number of partners, the Commission’s vision for the Collaborative Centre is that it positively influences and enhances care, treatment and support, and that it promotes community understanding of mental illness across Victoria and beyond. The Commission is of the view that to facilitate this dissemination of knowledge, multiple and diverse partners, as well as supportive technology, will be necessary.

The Collaborative Centre will finally deliver what successive Victorian Governments have long identified as necessary for the Victorian mental health system—collaborative research that involves people with lived experience, enabling knowledge dissemination across the sector¹ and the continual translation of research into ‘world-leading practice’ that enables innovative service models to be developed.² It will build on the need identified by the National Mental Health Commission in 2014 to bridge the major disconnect between the research sector and mental health services.³

13.2 The knowledge translation gap

Victoria has a patchwork of disparate research and training organisations, strategies and programs, each of which aim to improve the mental health system and outcomes for people living with mental illness, but without a shared purpose or vision.

There are independent research institutes, universities, clinical mental health services, mental health community support services, other non-government organisations and private firms with an interest in mental health. Their efforts are noteworthy in their own right, and some outstanding examples of excellence are provided in this chapter. However, their impacts on and their potential to bring about wide-ranging change for the most part remain unrealised. In particular, there are deficiencies in a number of areas such as health service research and system sciences, efforts to support continued development of the workforce, and encouraging individual and community resilience in dealing with poor mental health.

The Commission has reached the conclusion that Victoria lacks an overarching approach to mental health research, including the evaluation of programs and services, and how best to improve them. The lack of knowledge sharing and the impediments to continuous improvement at the system level have been highlighted in a number of submissions and statements to the Commission and in other forums. For example, staff working at Alfred Health argued that structural deficiencies impede continuous improvement:

... 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. It was felt that in Victoria, there is limited public investment in research and training and there is no coordination of outputs, priorities and desired research.⁴

The Secretary of the Department of Health and Human Services, Ms Kym Peake, acknowledged that, although the sector is well serviced by experts, there remains a diversity of views in relation to system design:

A range of research organisations deliver valuable evidence on mental health and mental illness. However, there has not been a dedicated knowledge-sharing institute in Victoria that has been able to bring together the latest thinking on how to deliver system-level change.⁵

In its 2014 review the National Mental Health Commission concluded that mental health research in Australia was insufficiently aligned with the needs of people with lived experience of poor mental health, their supports and the wider mental health system:

Research is carried out in isolation of mental health strategic objectives, with a haphazard approach to evidence translation into practice.⁶

Our use of evidence is impeded by research priorities predominantly driven by investigators instead of the needs of people with mental illness, service providers and policy-makers. Findings are not consolidated or communicated, meaning examples of success often are not scaled-up or translated into practice.⁷

Systemically, the lack of knowledge sharing means opportunities for disseminating good practice and effecting large-scale positive change in the system are being missed. If Victoria is to have a contemporary mental health system, the knowledge translation gap—whereby no organisation or group of organisations has an explicit mandate to support the translation of mental health research results and other knowledge throughout the system—amounts to a deficiency that must be redressed.⁸

13.3 Models for knowledge sharing

The Commission has considered local and international models of collaboration including opportunities and lessons that might be applied in the Victorian context. Many of these models have significant merit and have informed the Commission's deliberations, but the Commission provides these examples as largely illustrative, recognising the history and current pressures in Victoria and also the opportunity to shape a strong alternative—a new entity with wide networks, a mix of services and multiple research aims.

13.3.1 Comprehensive cancer centres: a global perspective

Comprehensive and collaborative centre models have been adopted globally to advance efforts to improve life expectancy and develop responses to pressing health challenges in areas such as cancer, cardiac disease and communicable diseases. These models are based on the idea that integrating people and organisations that have a shared purpose—a specific disease or health challenge, for example—will produce greater benefits more rapidly than an individual or a single organisation could achieve alone.

Collaboration and knowledge sharing are fundamental to such centres. Collaboration is evident through bringing together organisations or functions from a range of interrelated disciplines and interests, often related to research, service delivery and workforce learning

and development. Knowledge sharing occurs through disseminating information about successes that are achieved and lessons to be learnt. This often occurs among organisations directly participating as part of these collaborations but also, importantly, throughout the system more broadly as part of the system leadership role these organisations organically assume over time.

The most prominent examples of comprehensive and collaborative centres involve efforts to prevent, treat and diagnose cancer. The first comprehensive centre for cancer was established in the early 1970s in the United States. Similar models have been adopted in Europe and the United Kingdom.⁹ The centres have been successful in bridging gaps between research and clinical care, and they derive considerable benefit from having access to sizeable cohorts of patients, high rates of recruiting patients to trials, and access to national evidence review groups to enable rapid implementation on a large scale.¹⁰

There is evidence that people treated in comprehensive cancer centres have better outcomes than those treated elsewhere.¹¹ One study has shown that cancer patients treated in the 11 largest comprehensive cancer centres in the United States had a risk-adjusted probability of death that was 10 per cent lower than that for patients treated elsewhere.¹² Another study has found that, among people aged 22–65 years, those treated in comprehensive cancer centres had better survival rates than those treated elsewhere.¹³

Box 13.1 summarises some of the notable characteristics of comprehensive cancer centres in Europe that the Commission considers should be included as part of the Victorian Collaborative Centre for Mental Health and Wellbeing.

Box 13.1

The hallmarks of comprehensive cancer centre models in Europe¹⁴

The following characteristics form the core domains the Organisation of European Cancer Institutes uses to assess comprehensive cancer centres in Europe:

- excellence in diagnosis, treatment and care of patients based on multidisciplinary teams
- high-quality outpatient and inpatient facilities delivering an optimal patient experience
- strong research infrastructure and teams and a breadth of open trials with a high rate of involvement of patients
- translational science with breadth and depth, bringing preclinical science to clinical implementation
- a consistent academic output in highly rated journals covering a wide spectrum of disciplines
- evidence of innovation in patents, spin-off companies and practice changes mediated through national bodies and regulators
- excellent e-hospital and information systems that allow clinical data to be collected and linked with big data analytics for research
- educational programs that comprehensively cover education and training of cancer clinicians and scientists and the education and support of patients and their carers
- good career advancement opportunities for staff
- a commitment to networking across the population, linking to other hospitals (via ICT interoperability infrastructure), primary care and supportive and palliative care services
- integration with national prevention, screening and early detection strategies.

13.3.2 Comprehensive centres and other collaborations in Victoria

The concept of comprehensive cancer centre models influenced the establishment of the Victorian Comprehensive Cancer Centre, which is the first comprehensive cancer centre in Australia, with multiple partners in the alliance (see Box 13.2). Although the VCCC might not treat every Victorian with cancer, it influences the care of many people throughout the state, nationally and internationally.

The \$564 million Victorian Heart Hospital is also based on a collaborative model. It is due for completion in 2022 and is a partnership between the Victorian Government, Monash Health and Monash University that will integrate clinical cardiology services as well as research and education.

The Peter Doherty Institute for Infection and Immunity is another Victorian example of collaboration between service delivery, academia and research. An unincorporated joint venture between the University of Melbourne and the Royal Melbourne Hospital, the institute combines research, teaching, public health, reference laboratory services, diagnostic services and clinical care in infectious diseases and immunity.

For children, the Melbourne Children's Campus sees the strategic and physical alignment of the Royal Children's Hospital, the Murdoch Children's Research Institute and the University of Melbourne's Department of Paediatrics, brought together under a council in 2007. In total the campus represents more than 6,000 health professionals working together to improve health outcomes for children and adolescents, including through collaboration between researchers and clinicians, and through population-based longitudinal studies.¹⁵

Box 13.2

The Victorian Comprehensive Cancer Centre¹⁶

Founded in 2009 and based on collaboration, inclusion and consultation, the VCCC alliance works to develop and support new research and technologies for the benefit of Victorian cancer patients. Its purpose-built home, located in the Melbourne suburb of Parkville, opened in early 2016.



VCCC Centre

The centre describes itself as a multidisciplinary, multi-site alliance of 10 leading research, academic and clinical organisations working together to accelerate research, knowledge and expertise to improve health outcomes.

The VCCC's Executive Director, Professor Grant McArthur, says that more than 250 people drawn from alliance members and other organisations are involved in committees, leadership roles, steering groups, working groups, advisory boards and programs as part of the centre's work:

This novel approach is already changing the way we tackle cancer in Victoria. The VCCC's success has been driven by commitment to a shared goal: to deliver better outcomes for Victorians. It is this collective focus that enables system level change and makes this alliance greater than the sum of its parts.

The alliance works together to facilitate research-led solutions, integrate consumer perspectives and deliver evidence-based outcomes to change the way in which cancer is responded to in Victoria.

In addition to my roles of clinician and researcher, I am also a cancer survivor. I am well aware of the often-catastrophic impact a cancer diagnosis can have on the physical and mental wellbeing of patients and their families.

We seek to address the complete patient path from diagnosis to treatment, survivorship and palliative care, delivering systems, structures, research and clinical care to overcome cancer together.

As well as drawing on the knowledge of some of Victoria's pre-eminent researchers, clinicians and experts, the alliance believes there is much to be gained from listening to consumers, placing them at the forefront of its work. Consumers are represented on all the steering committees, and there is also a consumer advisory committee that has input into the strategic and operational work of the VCCC alliance.

Although not everyone receives care or treatment through the alliance, the approach adopted means that scientific evidence and research are translated into broader patient and community gains, leading to earlier detection, prevention and treatment options:

Ultimately everyone reaps the reward of our activity. Our fundamental premise is that an alliance with a shared goal will achieve greater benefits more quickly than an individual organisation could achieve alone.

A highly skilled and capable cancer workforce is essential to research excellence and high-quality, patient-centred care. Since 2016 the VCCC has involved nearly 19,000 participants in education and training initiatives and launched Australia's first online Master of Cancer Sciences degree, which was designed and developed with the assistance of more than 160 subject matter experts. Sixty-three students have enrolled in the first year of the course.

To date, 11 trials have been supported through the VCCC with a total of 6,500 potential international and national patient enrolments and \$7.2 million in leveraged funding. The alliance has also provided professional development and support for regional clinical trial teams to expand the number of trials locally.

In addition, VCCC Regional Oncology Leads, representing the regional cancer community, have established methods for implementing clinical trials, fostered education opportunities and developed strategic partnerships and networks in metropolitan and regional cancer centres.

VCCC program outcomes have also contributed to:

- Victoria's first cancer teletrial—43 regional patients are currently enrolled in the trial and further cancer clinical trials have been identified
- a Centre for Cancer Immunotherapy, bringing six institutions together into one lab
- linking approximately 2.5 million health records between primary care and hospitals to help new research into cancer health services.

13.3.3 Collaborative models relating to mental health

The Commission has considered several examples of formal collaborations relating to mental health.

In Victoria formal collaborations that bring together clinical services and research are infrequent but dynamic. Orygen is a translational medical research institute, Australia's largest mental health research entity, and uniquely integrated with innovative clinical service models. It focuses on early intervention and treatment for mental illness in young people and is a global reference point for youth mental health care and reform. Orygen's translational research capability spans discovery, novel treatment, clinical trials, service delivery, health economics and practice improvement research.¹⁷ The organisation is founded on youth engagement and plays a role in supporting the professional development of the youth mental health workforce and in providing policy advice to governments.¹⁸

As a not-for-profit company limited by guarantee, Orygen was founded in 2002 through a partnership that brings together philanthropy, academia and research with a public health service; its members include the Colonial Foundation, the University of Melbourne and Melbourne Health.¹⁹

A recently completed \$78 million facility in Parkville, co-designed with young people, provides a hub for many of Orygen's preventive clinical services and allows translational research activities to be integrated.²⁰ The Orygen building won the top prize for Best Mental Health Design at the 2019 European Healthcare Design Awards, championing inclusive and universal design, where everyone is safe and welcome.²¹

In 2017–18 Orygen provided nearly 25,000 services to around 4,200 young people who accessed a headspace centre.²² Throughout the year, Orygen was involved in 51 research projects, published more than 200 articles, led 11 clinical trials, delivered 18 training programs, and supported more than 200 young people in its youth participation programs.²³ The Commission's deliberations on the Collaborative Centre have been influenced by the ambition of the Orygen model and the attention it has achieved nationally and internationally.

Some area mental health services also share links with research institutes and universities and other academic institutions. For example, the Victorian Institute of Forensic Mental Health (Forensicare), the statewide centre for excellence in forensic mental health, operates a research and training centre—the independent Centre for Forensic Behavioural Science—in partnership with Swinburne University of Technology.²⁴ The centre's Director, Professor James Ogloff AM, explains the direct benefits of this partnership:

... the research undertaken by Forensicare and the Centre for Forensic Behaviour Science translates to service development and evaluation. Our work has transformed people's understanding in a number of areas relating to mental illness and offending. This work is used to continuously improve evaluation and intervention work within Forensicare and in the broader forensic mental health, justice and mental health fields. In short, it helps ensure better outcomes for our consumers and contributes to a safer Victorian community.²⁵

Researchers at the Centre for Forensic Behavioural Science span a range of disciplines including psychology, psychiatry, nursing, social work, law, occupational therapy and epidemiology to transfer academic and clinical excellence into practice in the health, community service and criminal justice sectors. The work of the Centre for Forensic Behavioural Science is well regarded internationally.²⁶ Among some of its successes in 2017–18 was the publication of almost 100 scholarly articles and book chapters and the completion of 28 research projects and four service evaluations. Critically, it has more than 40 doctoral students undertaking either a PhD or Doctor of Psychology (Clinical and Forensic Psychology) degree, and a number of training and professional development programs have been developed to enhance skills across a range of professions. At the time of this report, the Centre for Forensic Behavioural Science had more than 260 students across the mental health and justice disciplines undertaking training and postgraduate training.

More broadly within the public mental health system, the Victorian Department of Health and Human Services has provided funding for the preceding two decades (amounting to \$4.7 million in 2018–19) for around 30 mental health clinical and non-clinical academic positions to enable senior mental health clinicians to do continuing research, teaching and training in various specialist areas. The funding is distributed to selected health services that employ clinicians who have an academic role in an affiliated university and a senior clinical role, and to public hospital research centres located in selected health services and selected universities.

In its submission to the Commission, the Adult Psychiatry Imperative noted the importance of adjunct academic appointments and corresponding research opportunities in encouraging psychiatrists into public mental health care.²⁷

Additionally, through a once-off \$10 million Mental Illness Research Fund, the Victorian Government funded a limited number of multidisciplinary and cross-sector collaborative research projects that began in mid-2013 with the aim of achieving tangible improvements for people with lived experience.

Elsewhere in Australia, examples of partnerships across clinical care and research also exist, albeit with varying emphases. For example, the Brain and Mind Centre, at the University of Sydney, employs a multidisciplinary research team to undertake preclinical, clinical and translational research in key areas of brain and mind sciences. Research laboratories are co-located with clinical services, and the centre promotes partnerships with community, health care providers and industry.²⁸

Box 13.3 provides examples of international arrangements, noting they are largely historical with an emphasis on hospital-based care, therefore not reflecting the full ambition for the Collaborative Centre.

Indeed none of these examples provided singularly capture the full ambition of the Commission. The Commission seeks a comprehensive approach to and colocation of a range of mental health research and services that can disseminate good practice on a systemic basis and effect large-scale positive change across Victoria's mental health system.

Box 13.3

International examples of collaborative arrangements for mental health

The Centre for Addiction and Mental Health, Canada

Formed in 1998, Canada's Centre for Addiction and Mental Health is a research centre affiliated with the University of Toronto. It has clinical care, research, education, policy development and health promotion functions and is the largest addiction and mental health organisation in North America.²⁹ In 2018–19 it employed more than 3,000 staff and provided care to more than 37,000 people.³⁰ It aims to achieve its vision and to transform lives 'through the core dimensions of clinical care, research, education and knowledge exchange'.³¹

Examples of research outcomes are: alternative approaches for depression treatments; methods for lowering the risk of postpartum depression; and evidence that, compared with antidepressant medication, mindfulness-based cognitive therapy provides equivalent protection against depressive relapse.³²

The Ontario Government has also recently introduced a Bill to establish the Mental Health and Addiction Centre of Excellence. The proposed objectives are fourfold: providing a central point of accountability and oversight for mental health and addictions care in Ontario; standardising and monitoring the quality of services; putting into operation Ontario's mental health and addictions strategy; and developing clinical, quality and service standards for mental health and addictions.³³

New York State Psychiatric Institute, United States

Established in 1895, the New York State Psychiatric Institute is located in Columbia University's Department of Psychiatry. The faculty has more than 400 psychiatrists, psychologists, social workers, nurses and neurobehavioral scientists, and the institute has space for 60 inpatient beds and 23 specialised outpatient research clinics, educational facilities and research laboratories.³⁴ Columbia Psychiatry's mission is to 'improve the quality of life for the world population by reducing the burden of mental illness and substance abuse'.³⁵

The following are examples of the institute's achievements: the earliest use of lithium in the United States; the first data describing a genetic predisposition to schizophrenia; and leadership in the discovery of the genes causing Huntington's disease.³⁶

Institute of Psychiatry, Psychology and Neuroscience, United Kingdom

Founded in 1948, the Institute of Psychiatry, Psychology and Neuroscience is Europe's largest centre for research and postgraduate education in psychiatry, psychology and related disciplines. It is a faculty of King's College London,³⁷ and its purpose is to work together to 'establish the best possible care for people who experience mental health problems'. A joint aim is 'promoting excellence in research and teaching in the sciences and disciplines, key to the understanding and treatment of mental disorders and related disorders of the brain'.³⁸

13.4 The value of collaboration

On several occasions the value of and need for combining research efforts, workforce education and training, as well as service delivery in mental health, has been impressed on the Commission, albeit with different views about the nature and scope of such collaboration. For example, the Adult Psychiatry Imperative recommended establishing new university-affiliated specialist mental health centres, with the aim of incorporating specialised, state-of-the-art mental health infrastructure, as in other areas of health.³⁹ As part of this proposition, the Adult Psychiatry Imperative submitted that the centres, focused on acute care and rehabilitation, should:

... combine the missions of clinical care, education and research—where patient care comes first, with teaching and research supporting recovery of patients within and beyond the Centre via highly-skilled care providers and the translation of discovery outcomes into clinical practice.⁴⁰

In its submission, Alfred Health noted that much is unknown about the causes of and treatments for mental illness and that there is high variability in people's experiences of care.⁴¹ In this regard it observed that there is a need to 'develop a culture of improvement and research in Victoria's Mental Health System, which combines clinical, academic and peer leadership and seeks interdisciplinary collaboration'.⁴²

As part of this approach, Alfred Health suggested establishing a mental health and neuroscience research institute. The institute would focus on adult mental and neurological illness, service design and evaluation, alongside greater epidemiological research into the impact of mental illness by the Department of Health and Human Services and expanded capability in area mental health services to use data and patient, family and clinician feedback to develop and test ideas for improvement.⁴³

The Program Director of Mental and Health Addiction at Alfred Health, Associate Professor Simon Stafrace, said:

I also believe an Adult and Aged Mental Health Research Institute must be established with campuses at several major mental health services, to drive the research, improvement and redesign agenda. The model should imitate the academic health science model and seek to ensure that research breakthroughs are rapidly translated into improvements in patient care. Academic linkages should create opportunities for inter-disciplinary collaboration and partnership in the areas of neuroscience, genetics, clinical trials and service design and evaluation. Such an academic centre could provide a focus for the efforts of Victoria to improve the care provided to the most vulnerable Victorians and create and impact on a global stage.⁴⁴

The Australian Medical Association recommended a national centre for inpatient mental health, noting that Australia has no main centre to carry out research into best practice inpatient care.⁴⁵ The centre would have strong relationships with mental health academic institutions and provide evidence-based treatment, particularly for people with 'complex needs'.⁴⁶

The AMA argued that a national centre would provide an opportunity for research aimed at understanding and optimising treatment to the highest standards of evidence-based treatment and also help to attract and recruit staff.⁴⁷

Monash Health called for the creation of a mental health co-design and leadership institute:

This unit would provide advice to the [Victorian] Department of Health and Human Services about preferred models of care, and foster expertise in the treatment of people with [severe mental illness]. Our vision is for design methodology, translational research, co-design and co-production; this will enable knowledge transfer to the community on mental health literacy.⁴⁸

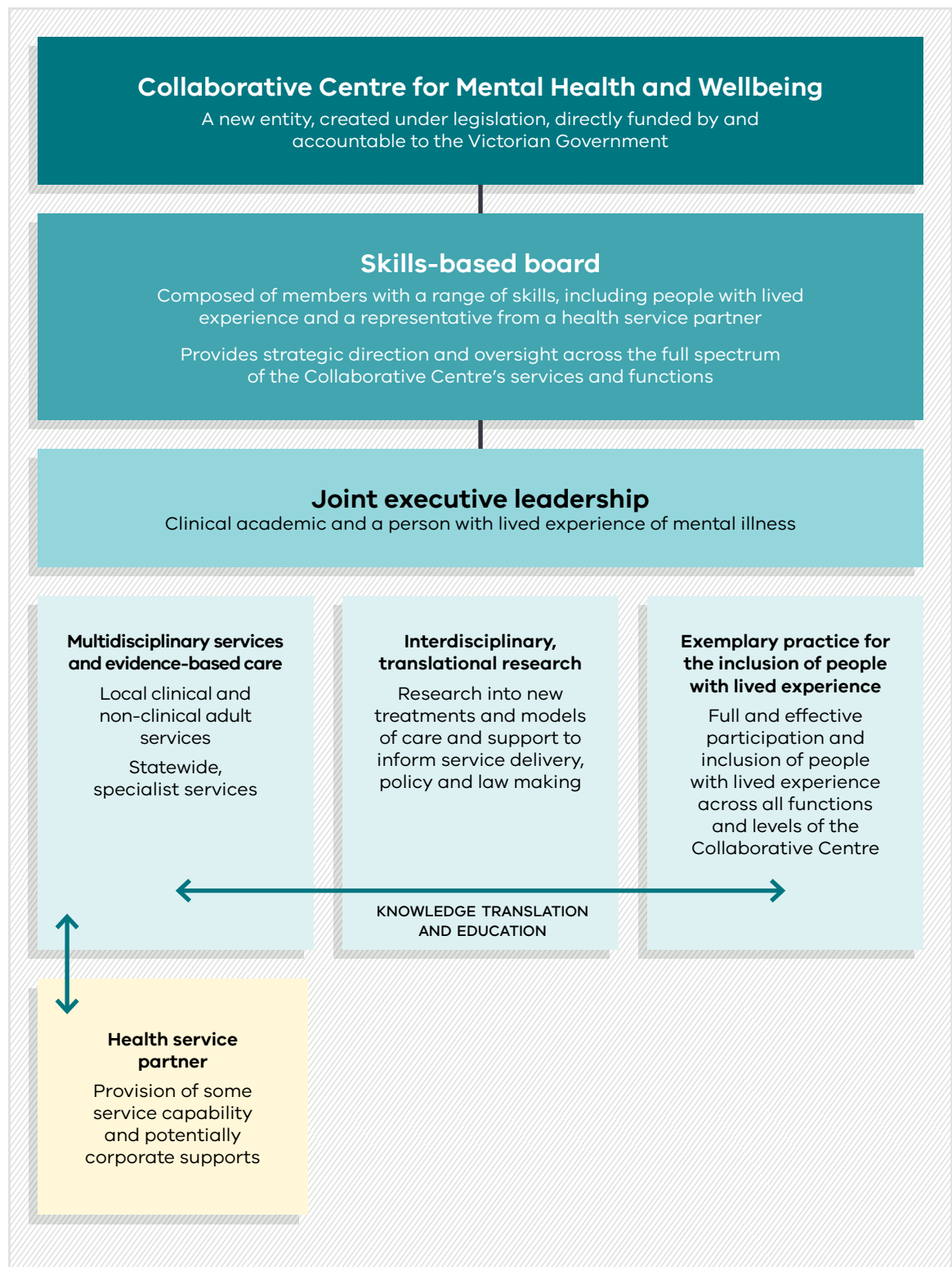
The Commission has considered these representations, collaborative approaches taken across other health disciplines and the evidence presented on the need for knowledge translation to improve the mental health system and outcomes for people living with mental illness. With all this information in mind, the Commission recommends establishing the Collaborative Centre as a new and networked entity with a bolder ambition than existing models and proposals, combining and disseminating knowledge—clinical and social—for the benefit of the entire system and community.

13.5 Core functions of the Collaborative Centre

Creating the Victorian Collaborative Centre for Mental Health and Wellbeing presents an opportunity to bring together people with lived experience (including consumers, their carers and families), researchers and clinicians to work together to improve service delivery and research.

It is envisaged that the Collaborative Centre will also provide a range of adult mental health clinical services, including specialist services, and non-clinical care and support to its local population. As shown in Figure 13.1, the entity would be constituted under legislation, with its own skilled board, and be accountable to the Victorian Government. For the purposes of clinical safety, efficiency and effectiveness, the Collaborative Centre should be proximate to and partner with, but not be auspiced by, an existing public health service.

Importantly, the primary functions of the Collaborative Centre will focus on the dissemination of knowledge—in the form of research findings, high-quality care and opportunities for workforce development—throughout the state's mental health system, through a networked approach, and to communities. The essential components of this unique partnership, and its benefits, are outlined in the sections that follow.

Figure 13.1: Collaborative Centre

13.5.1 Interdisciplinary research

Collaborations between researchers from different disciplines is an essential basis for a contemporary mental health system. Interdisciplinary research—which can be characterised as researchers with 'largely non overlapping training and core expertise collaborating to solve a problem that lies outside the grasp of the individual researcher'⁴⁹—should form part of the Collaborative Centre's research capability.

Research, and the evidence and information it generates, should be the basis for: delivering personalised treatment, care and support; workforce education and training; policy development; law making; priority setting; and community education initiatives.

When compared with physical health problems such as cancer and cardiovascular disease, mental health receives less funding and attracts less investment in research.⁵⁰ Despite both mental health and cancer being in the top four causes of disease, cancer attracts more than twice the amount of research funding from the Commonwealth Government (4.7 per cent) compared with mental health (2.0 per cent).⁵¹ The same pattern appears in National Health and Medical Research Council funding, with cancer receiving more than twice the funding (29 per cent) of mental health (11.7 per cent) over the past 18 years.⁵² Further, data reveals that private or family foundations provide comparatively low support for mental health research with it, receiving only 4 per cent of funding from corporate, community, family foundations and private charitable trusts.⁵³ Submissions made to the Commission confirm there is relatively little funding for mental health research,⁵⁴ and progress in translating research into high-quality practice is slow.⁵⁵ Australia has relatively few medical research institutes dedicated to mental health; this compares, for example, with its more than 20 neuroscience institutes.⁵⁶

Underinvestment in mental health research at the global, national and state levels has meant that advances in understanding the causes of, and better ways of managing and treating, many mental illnesses have been negligible:⁵⁷

In terms of major advances in how we manage and treat mental illness, the area of psychiatry has not changed much (as compared to, for example, the treatment of cardiovascular disease or cancer). We are becoming more sophisticated in understanding biological and psychological treatments and there have been improvements in areas such as borderline personality disorder, but there have not been any major game changers in terms of recovery options.⁵⁸

The need for further prominence and coordinated effort in mental health research has also been recognised in the Fifth National Mental Health and Suicide Prevention Plan, with all governments asking that the National Mental Health Commission develops a research strategy to promote better treatment outcomes in the mental health sector.⁵⁹

The proposed Collaborative Centre for Mental Health and Wellbeing offers a major opportunity to transform mental health research by bringing together teams from multiple disciplines and experiences. The centre's initial efforts should focus on developing a broad research strategy that includes priorities and projects, shaped by people with lived experience.

Recognising the Collaborative Centre will also be involved in delivering mental health services, translational research should be a priority, ensuring that promising findings are put into practice for the benefit of consumers, families and carers.

Translational research allows academic findings to be applied in care settings; it has a common goal, which is 'to accelerate the transfer of discovery to health benefit'.⁶⁰ Research into comprehensive centres indicates that integrated work in such centres can bridge the gaps that commonly obstruct translational research—for example, between early clinical trials and assessment of clinical effectiveness.⁶¹

Importantly, translational research necessitates involving people with lived experience—those living with mental illness, their families and carers—across the development, design and evaluation of treatment phases.⁶² 'Translational research depends not just on integrating basic research into clinical applications; it relies equally on feedback from clinical outcomes to drive the focus of basic research'.⁶³

Research collaboration in the Collaborative Centre should not be purely clinically oriented. Societal factors such as social determinants and diversity, changes in help-seeking patterns and online technologies warrant interdisciplinary research and focus. Such an approach is in fact emerging globally. For example, King's College London recently established the Centre for Society and Mental Health. Part of the centre's remit is to create and sustain new collaborations and alliances in social science, epidemiology, psychiatry and neuroscience within King's College London, and with partners, the United Kingdom Research and Innovation resources (UKRI) and other national and international alliances, networks and centres of excellence.

The Collaborative Centre's research program should also guide efforts to build community understanding of mental health. The centre will be in a unique position to draw on a range of evidence to examine the effectiveness of current policies and programs. For example, by better understanding the multilayered life experiences that shape mental health and wellbeing, it is possible to better inform the community about societal factors that may have an impact, and to also shape multidisciplinary care in the mental health system.

From a systemic perspective, the Collaborative Centre should use its research and its position to influence government policy development, law making and priority setting. The Collaborative Centre will be looked to as a national leader in mental health and should use this position to positively influence the way society thinks about mental health. Its role should extend to leading community-wide conversations that advocate for good mental health, for an inclusive community, and for public policies that respond to the needs of people living with mental illness, their families and carers.

In addition to community interest, the Collaborative Centre's research function is likely to attract interest and investment at multiple levels. Victoria has a long history of pioneering efforts in research that have led to national and international recognition. An example of this is the Victorian Institute of Forensic Medicine, which is recognised for its long history of excellence in forensic medicine and science.⁶⁴ Victoria's investment in cancer has now placed it as a national leader in cancer research, attracting more than 50 per cent of all National Health and Medical Research Council cancer research funds.⁶⁵ There is every reason to anticipate that the Collaborative Centre will also have wide influence and positive impact.

A world-class research capability will also make mental health a more prestigious area to work in and should be funded to attract high-quality researchers and academic staff.⁶⁶

13.5.2 Multidisciplinary services and evidence-based care

Consistent with the requirement to respond to both current and future needs of consumers and their preferences, the Collaborative Centre will need to be flexible and offer a suite of multidisciplinary services to its local population, capable of evolving and adapting over time. This will enable multidisciplinary care, treatment and support to be realised for those who have not benefitted from current treatment and service models.

The Collaborative Centre should include a spectrum of multidisciplinary services for adults—from community-based and mobile home treatment to services in outpatient clinics and other non-hospital settings, crisis responses and inpatient care (both subacute and acute and in addition to the expansion of acute beds, as recommended in Chapter 14) and specialist, including statewide, services.

Multidisciplinary services are crucial to delivering high-quality treatment, care and support that places people living with mental illness at the centre of care and to adapt treatment, care and support to their needs. In the mental health sector, consumers and service providers value multidisciplinary care. The Commission was told, for example:

Peer support and connections to multidisciplinary teams can make a very big difference.⁶⁷

Mental health services world-wide value the concept of 'the multi-disciplinary team' as the basis from which to deliver service.⁶⁸

Yet the current mental health system's capacity to formulate priorities and provide multidisciplinary care in an increasingly constrained environment has been eroded. Past and current administrators of clinical mental health services, Associate Professor Ruth Vine and Professor Patrick McGorry respectively, advised the Commission:

In terms of clinic-based assessment and treatment, some doctors have about 300 people in their caseload—the caseload pressure results in a greater emphasis on assessment and monitoring rather than multimodal treatment interventions. Ideally, clinicians should be able to provide the types of treatment that would be most beneficial. The public system has, however, a reduced capacity to deliver psychological treatments, such as a range of psychotherapies that may require regular lengthy appointments (including individual, group and family therapy).⁶⁹

The only way that the dramatically reduced number of inpatient beds that resulted from deinstitutionalisation and mainstreaming of mental health care into the major general hospital system could have functioned is if there had been strong, proactive and skilled multidisciplinary community mental health teams operating around the clock, or at least extended hours till very late, and resourced to scale.⁷⁰

Further, Dr Caroline Johnson, a GP, reflected on the contrast in approaches to multidisciplinary care between mental health and cancer:

If you had cancer, you'd have a multidisciplinary team meeting where they'd all sit around the table and say, 'This is a complex cancer to treat, what does everyone think we should do?', everyone agrees and the plan is implemented. Unfortunately in mental health that doesn't really happen, at least not in the community setting that I work in.⁷¹

The Collaborative Centre offers an opportunity to prioritise multidisciplinary care to ensure people living with mental illness have direct access to the expertise and work of clinical scientists, fellows, investigators and researchers. By involving research staff, consumer participation in trials will be facilitated and will enable access to emerging treatments and models of care that can produce better outcomes and experiences than is currently the case.

Expanded access to treatment, care and support must be based on rigorous research. This is essential because it incorporates in everyday practice the best and most current information available from consumer experiences and research outcomes, ensuring that individuals receive the most effective care based on the best available evidence.

The Commission has been told about inconsistent access to treatment based on scientific research throughout mental health services. Pressures on services contribute to increasing reliance on a crisis-driven model of care whereby mental health services focus on risk management rather than prevention, recovery and evidence-based treatments:

Our current model, largely driven by severe resource constraints, is one of risk mitigation, along with crisis and biomedical management. Specialist and evidence-based treatment can be found within pockets of the system of care but it is by no means commonplace.⁷²

Downstream efforts are needed to redesign the system to be focused on delivering up-front evidence-based treatment rather than the status quo of generic case management, and multiple touch-points that result in repeated engagement with the system and sub-optimal clinical outcomes.⁷³

While the system currently has examples of evidence-informed practice and service models, systemic mechanisms to support continuous development and improvement of mental health services are required.⁷⁴

The second Australian National Survey of Psychosis, conducted in 2010, found that fewer than a quarter of survey participants who had been diagnosed with a psychotic disorder had received any of the six evidence-based psychosocial interventions identified in the research literature as being effective in promoting recovery.⁷⁵ Similarly, Australian research into the quality of mental health treatments found that, of people with a mood or anxiety disorder who sought professional help, only 41 per cent received a minimally adequate evidence-based treatment.⁷⁶

In the context of recovery-oriented practice, experts have considered the reasons why the translation of evidence into widespread practice is poor and concluded that the resourcing required to implement the change is often missing, and that the systematic and sustained transformation of services required to reorientate towards recovery often fails.⁷⁷

The Collaborative Centre presents an opportunity to change this by delivering multidisciplinary and evidence-based care, treatment and support based on rigorous research. It will also be able to disseminate its research findings through networks and connections across the mental health system.

13.5.3 Exemplary practice for including people with lived experience

People living with mental illness—including consumers, their families and carers—have unique insights into how mental health services can best respond to individual needs and promote human rights and recovery. Ensuring they are involved in decision making about design and delivery will lead to services that are more person-centred and responsive.

Research indicates that co-production—working with people with lived experience from the outset in initial thinking and priority setting through to co-planning, co-design, co-delivery and co-evaluation⁷⁸—leads to the production of valuable services, programs and policies.⁷⁹ Sharing expertise, skills and experience can improve the capacity, quality and impact of mental health services and supports.⁸⁰

The Commission has concluded that in contemporary mental health care it is critical that consumers, families and carers are involved in all aspects of the mental health system:

Involving communities in decisions that affect them can result in outcomes that are more grounded in community and relevant to their needs. Enabling ongoing community participation in decision making can enhance trust in governments and services.⁸¹

I've been fortunate I think in my long career over 40 years to see the involvement of consumers and carers, which has been, I'd have to say, the single most important driver of improving safety and quality. We have to do this in partnership.⁸²

By incorporating principles of co-production with modest community development and practical resources, thousands more people can access support when they need it, in a model that is sustainable, rights-based and helpful.⁸³

I think we've constantly got to look at how do we further empower consumers, because I think they can become a significant driver of innovation, improvement and better outcomes.⁸⁴

Although there are positive examples of including people with lived experience in academic institutions, and some in co-production in mental health service design or delivery,⁸⁵ the practice is far from systemic and there is a great risk that it can become tokenistic. The Secretary to the Department of Health and Human Services, Ms Kym Peake, told the Commission:

.. lived experience advisory groups have been convened to hear directly from consumers and carers on the development and implementation of the policies and programs. However, these committees have typically been established for a time-limited period or to focus on a discrete reform agenda or program. In the case of people with a lived experience of mental illness, much of this engagement has centred around work already underway, meaning we have missed opportunities to support genuine co-production with consumers and carers.⁸⁶

The Collaborative Centre presents a unique opportunity to place people with lived experience at the centre of service design, delivery, research and evaluation.

People with lived experience should lead and be employed in a range of the Collaborative Centre's functions, in positions where they motivate and help determine outcomes. They must be on the Collaborative Centre's board, they must form part of its operational management,

and they must be involved in its design and establishment. The Collaborative Centre will present opportunities for people with lived experience to promote the social change that is needed if the power imbalance that underpins the current system is to be redressed.

13.5.4 Knowledge dissemination and continued learning

The dissemination of knowledge to improve systems and outcomes for individuals will be a fundamental function of the Collaborative Centre.

Dr Paul Denborough, Clinical Director of Alfred Child and Youth Mental Health Service and headspace, provided a unique perspective on knowledge sharing in mental health in his explanation of headspace's Discovery College. Discovery College creates a place where everyone is welcome to enable 'learning from each other, sharing experiences and ideas to explore who we are, what works for us, what we want and what we can do'.⁸⁷ These principles resonate with the Commission.

The Collaborative Centre should enable knowledge and research to be developed through inclusive practices that value a variety of perspectives. Its role will be to collect, consider and understand, and then disseminate, learnings across the mental health system through formalised networks, including to rural and regional areas and to people living with mental illness, their families and carers, and the community. It will embrace and drive the use of innovation and technology to push creative ways of working and sharing knowledge between services.

The Collaborative Centre's multidisciplinary teams should be supported by a well-designed program of continuing education that attracts and retains a high-quality workforce and facilitates the wider dissemination of knowledge derived from education, training and experience.

In this regard, the Collaborative Centre should support academic appointments, future-focused professional development programs, internships, traineeships, fellowships and scholarships in both research and service delivery. Examples of what the centre should offer and open to other services, organisations and the community are grand rounds, courses, masterclasses, symposiums, online learning, leadership programs, sponsored leadership opportunities and mechanisms for showcasing the latest news, standards, evidence and ideas.

13.5.5 A contemporary purpose-built facility

A new purpose-built facility that incorporates the latest design standards and information technology should be the centre of the Collaborative Centre's research and service activities. This will provide the optimal environment for collaborating, forming partnerships and sharing resources and ideas.

Because the new facility will provide clinical and non-clinical care, treatment and support for adults living with mental illness, it should be located in Melbourne and in close proximity to an existing health service, as well as to private hospitals, research institutes and universities. The precise location and size should be determined through planning led by the recommended Mental Health Implementation Office and the Victorian Health and Human Services Building Authority.

Although the Collaborative Centre will be based in Melbourne, its work and its positive impacts will be far reaching. The Collaborative Centre should work on new and networked technology platforms to facilitate care, treatment and support as well as information exchange throughout the state. This will allow more individuals and communities across Victoria to benefit from advances related to mental health.

13.6 Creating a new and dynamic entity

The positive impacts of the proposed Victorian Collaborative Centre for Mental Health and Wellbeing will be determined by the organisations and people who come together to form the entity, as well as their vision and the strength of their leadership and collaboration.

At its formative stage, the following will need to come together to give form to the entity: people with lived experience; an academic institution with a substantial record in health sciences; and an existing public mental health service with a record in delivery of care, treatment and support.

Strong, dynamic leadership will be fundamental to the success of the Collaborative Centre and its international standing. The board and two co-directors will have the task of delivering on the Collaborative Centre's goals and functions.

With a dynamic network and strong leadership, the Collaborative Centre will be well placed to have extended, strategic influence in the health sciences, among services, and in industry, government and the community. It must play an active leadership role, both within the mental health system and beyond, seeking to expand its partnerships and influence locally and internationally. In doing so, it will build on Victoria's reputation as a place for innovation and support the current emphasis on growing the research, education and technology sectors.

The Victorian public health service that supports the entity's development and is its ongoing partner should be an existing credible and influential provider of high-quality mental health services. It must be able to demonstrate a deep commitment to the pre-eminence of the Collaborative Centre.

The Collaborative Centre will have both the evidence and the prestige to press for good mental health to be a continuing priority. It will have the advantage of a rich evidence base built from the diversity of expertise within it and the wide-ranging research it does. Importantly, its work will help to demystify perceptions that perpetuate the stigma and discrimination that people living with mental illness continue to experience.

In implementing the Commission's recommendation for establishing the Collaborative Centre, the Mental Health Implementation Office must develop and conduct a process to establish the governance of the new entity that enables the Commission's vision for inclusion to be realised. A focus on one part of the mental health system or one area of research, without taking account of current need or future considerations, will diminish the potential impact of the Collaborative Centre and run contrary to the Commission's ambition.

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Chapter 14

Targeted acute mental health service expansion

Recommendations

The Royal Commission recommends that the Victorian Government, through the Victorian Health and Human Services Building Authority and the Mental Health Implementation Office, provides funding for 170 additional youth and adult acute mental health beds to help address critical demand pressures. The allocation should be as follows:

- 135 additional acute inpatient public mental health beds or equivalent beds, with the majority of these delivered by the end of 2021 and the remainder by mid-2022, proportionally provided to Barwon Health and to Melbourne Health, the latter in alliance with Western Health and Northern Health, using the following criteria: predicted population growth, forecast bed availability, socio-economic need and the availability of primary and community-based health services
- 35 additional acute inpatient mental health beds or equivalent beds procured by the end of 2021 from a private provider to deliver clinical treatment, care and support for public patients who would otherwise be treated in a public inpatient mental health unit.

The design and establishment of the additional beds should:

- be contemporary, co-designed with people with lived experience, and provide high-quality care in a hospital setting
- involve public, private and community health service partnerships.

Assertive outreach should be used to enable acute care in a home or community residence, where possible, as a direct substitute for an inpatient bed.

14.1 The acute mental health service crisis

Prompt access to high-quality clinical and therapeutic treatment, care and support is vital if people living with mental illness are to improve their health and life outcomes.

It is well recognised that Victoria's public specialist clinical mental health services are operating in a state of crisis because of underinvestment and growing demand for services. Demand pressures have meant the thresholds to access acute care are higher, and people living with mental illness are receiving less and poorer quality care and experiencing worse outcomes. The scale of the problem is such that a comprehensive statewide approach is needed to address service shortages and to develop new models of care that will improve service quality and outcomes both in the community and in hospital settings. The Commission is considering the design of the full system in advance of its final report to address both the availability crisis and to improve quality.

14.1.1 Overview of the Commission's interim response

The Commission recognises that there are service capacity challenges across both community and bed-based services (acute and subacute) within specialist clinical mental health services. In particular, there is a need for more specialist clinical community-based service alternatives that offer earlier, evidence-based and recovery-focused care. These considerations continue to inform the Commission's ongoing work to redesign the mental health system, and both community and bed-based specialist clinical mental health services will feature in the design of Victoria's future mental health system.

In the interim, the Commission is concerned that there are very few additional acute mental health beds planned for in the Statewide Design, Service and Infrastructure Plan for Victoria's Health System 2017–2037, and given the expected population growth, immediate investment is necessary to address critical acute service demand pressures while a new mental health system is designed (see Box 14.1).

Appropriate scale will be essential to deliver new models of care and quality facilities; and new and innovative partnerships will be required to get the additional beds online by mid-2022. New and innovative models of care that are co-designed with people with lived experience—including the delivery of acute mental health treatment in the community—will be important to ensure quality services and better outcomes.

14.1.2 The need for more beds

Box 14.1

Mental health beds explained

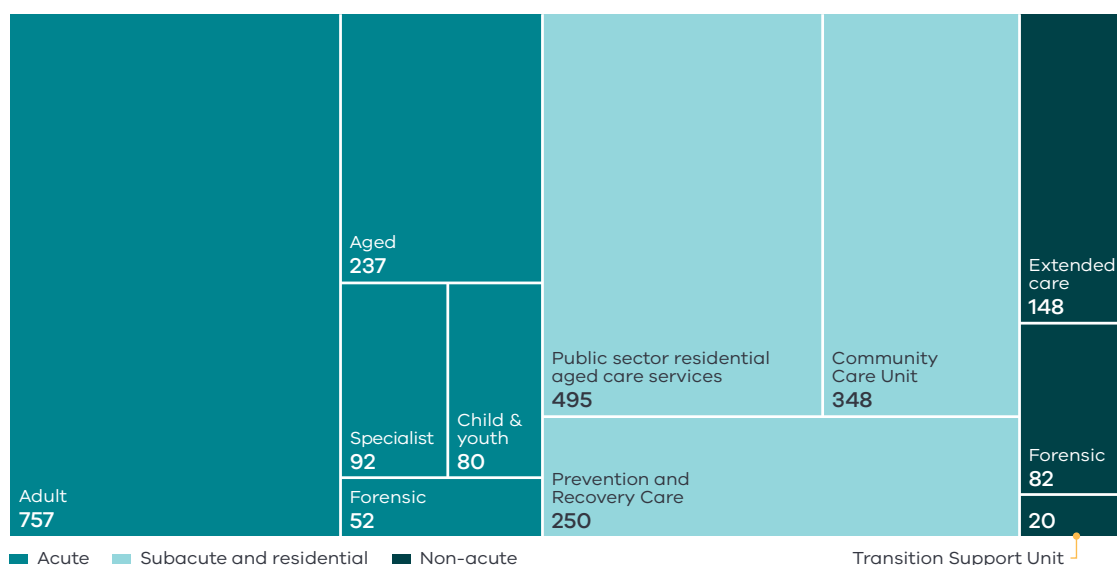
For the purposes of this interim report the Commission uses ‘bed-based care’ to refer to mental health treatment, care and support that is provided to a person with mental illness as some form of residential care—in a hospital, in the community or in their home.

In Victoria different models of bed-based care exist; among them are short- and medium-term subacute residential beds in the community, specialist (forensic, perinatal, neuro and eating disorder) beds, secure long-stay beds in hospitals, some alcohol and drug dual-diagnosis beds, and public and private acute inpatient beds.¹

Acute inpatient mental health beds are located in psychiatric wards or units in public hospitals, as well as in private hospitals. Inpatient units provide clinical treatment and care for people assessed as requiring inpatient treatment for a mental illness.² This treatment and care is for people in crisis or in the acute phase of care, as well as people on compulsory treatment orders (public beds). ‘Acute inpatient beds’ mean general mental health inpatient beds, intensive-care or high-dependency beds for people exhibiting behavioural problems, and short-stay (up to 72-hour) psychiatric emergency beds for people who need crisis assessment and treatment but who might not need a longer inpatient stay in hospital. There are acute inpatient beds for children and young people, adults and older people.

Inpatient beds have an important role in the service continuum in treating, supporting and caring for people who present to emergency departments in crisis and need to be admitted.³ In the past Victoria offered community- and home-based acute clinical treatment for people living with mental illness through crisis assessment and treatment teams, but as investment in community-based supports has decreased, acute treatment in a person’s place of residence or in the community has largely become a thing of the past.⁴

Figure 14.1: Types of public specialist clinical mental health beds, Victoria, 30 June 2019



Source: Calculation by the Commission using the Department of Health and Human Services, Policy and Funding Guidelines 2018–19.

Bed numbers as per the Department of Health and Human Services, Policy and Funding Guidelines 2018–19.

20 veterans' beds and 10 brain disorders beds at Austin Health are counted as specialist.

Excludes two adult beds funded at Barwon Health and nine adult beds at Eastern Health in 2018–19.

Includes 24 beds purchased from private providers in 2018–19.

Adult includes Orygen youth beds.

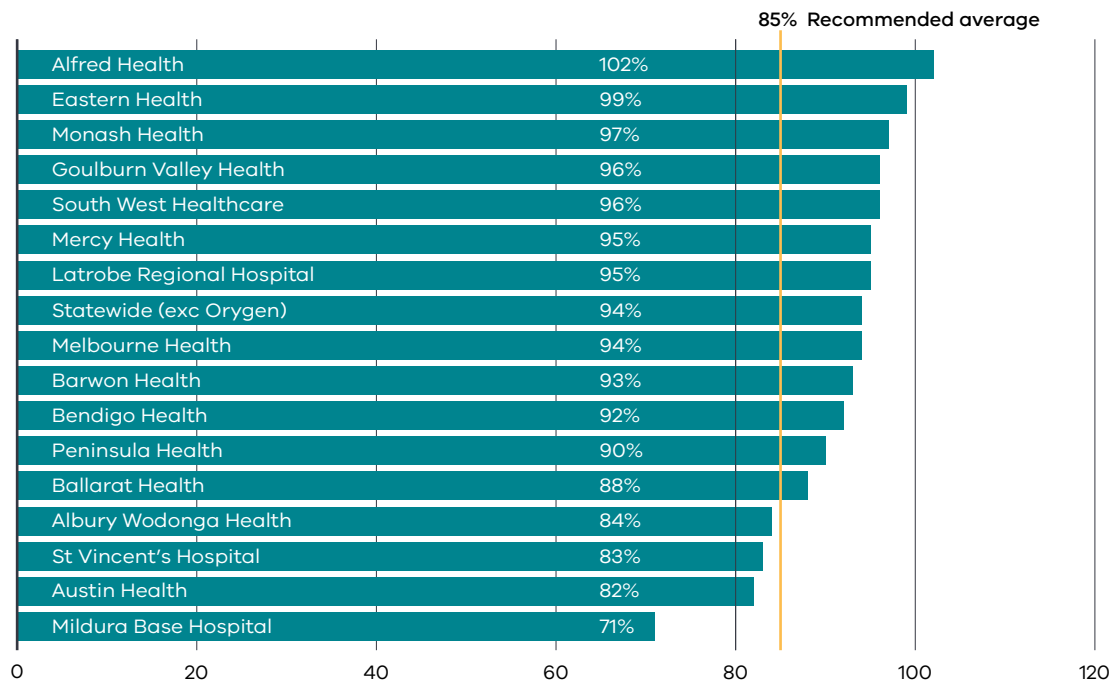
Figure 14.1 provides an overview of Victoria's current mental health beds.

The underinvestment in mental health services in the community has led to an increase in emergency department presentations and the need for more acute inpatient care. This is placing growing demand pressure on these services.⁵ As demand pressure has risen and very few beds have been added to the system, most acute inpatient units are operating with occupancy rates above 90 per cent,⁶ which is well above the recommended 85 per cent occupancy rate (see Figure 14.2).⁷

As outlined in Part Three, in order to manage demand pressures arising from population growth, area mental health services have had to raise the threshold for access to acute clinical treatment in hospitals. As a result, inpatient units can see only those who are most unwell and in crisis.⁸ The limited supports available in the community have meant that people living with mental illness must become sicker and sicker before they can gain access to treatment.⁹ This in turn risks higher rates of suicide, increased contact with the justice system and deteriorating social and economic outcomes.¹⁰

Area mental health services have also had to reduce mental health patients' length of stay below care guidelines, rationing treatment to manage demand.¹¹ For many patients, the current average duration of treatment is insufficient for stabilising and providing proper treatment.¹² In 2018–19 the average length of stay (excluding long-stay patients where length

Figure 14.2: Occupancy of public acute adult mental health beds by health services, Victoria, 2018–19



Source: Department of Health and Human Services, Client Management Interface / Operational Data Store 2018–19.

Bed occupancy rate is the total number of bed hours (excluding leave) in inpatient units divided by the total number of funded bed hours.

For further information, please refer to health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports/adult-performance-indicator-reports.

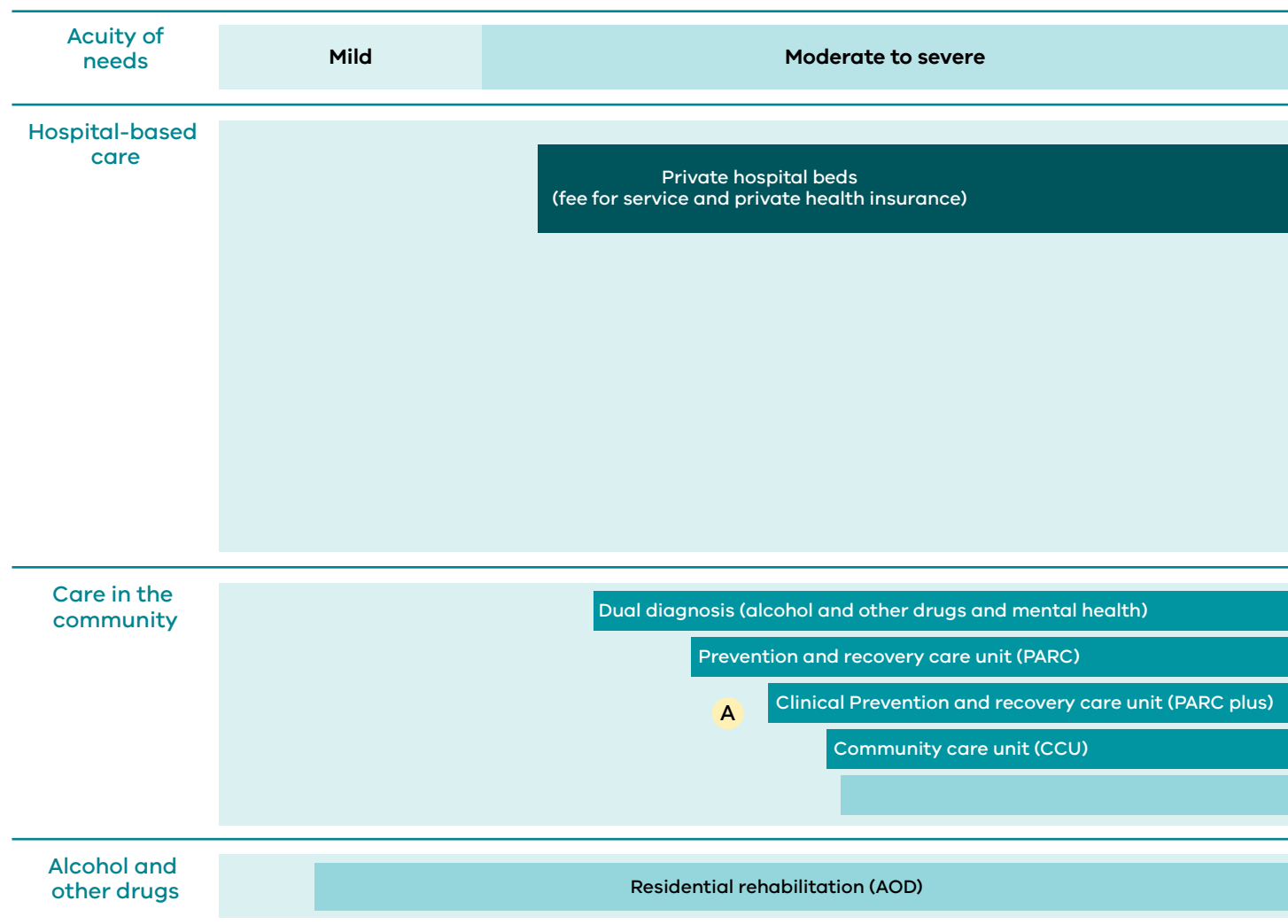
was longer than 35 days) was 9.2 days.¹³ Clinical staff are regularly called on to make quick decisions about who they can discharge to make room for urgent cases, and many patients do not receive the recommended care when they are discharged prematurely.¹⁴ Mental health workers also experience pressure to discharge people early to manage demand throughput. This outcome can be demoralising for the workers, who are unable to provide the care they know patients need and that they were trained to provide.¹⁵

As a consequence, some people living with mental illness are being readmitted into hospital soon after discharge, exacerbating pressure on units.¹⁶ In 2018–19, 14 per cent of people in inpatient units were readmitted within 28 days.¹⁷

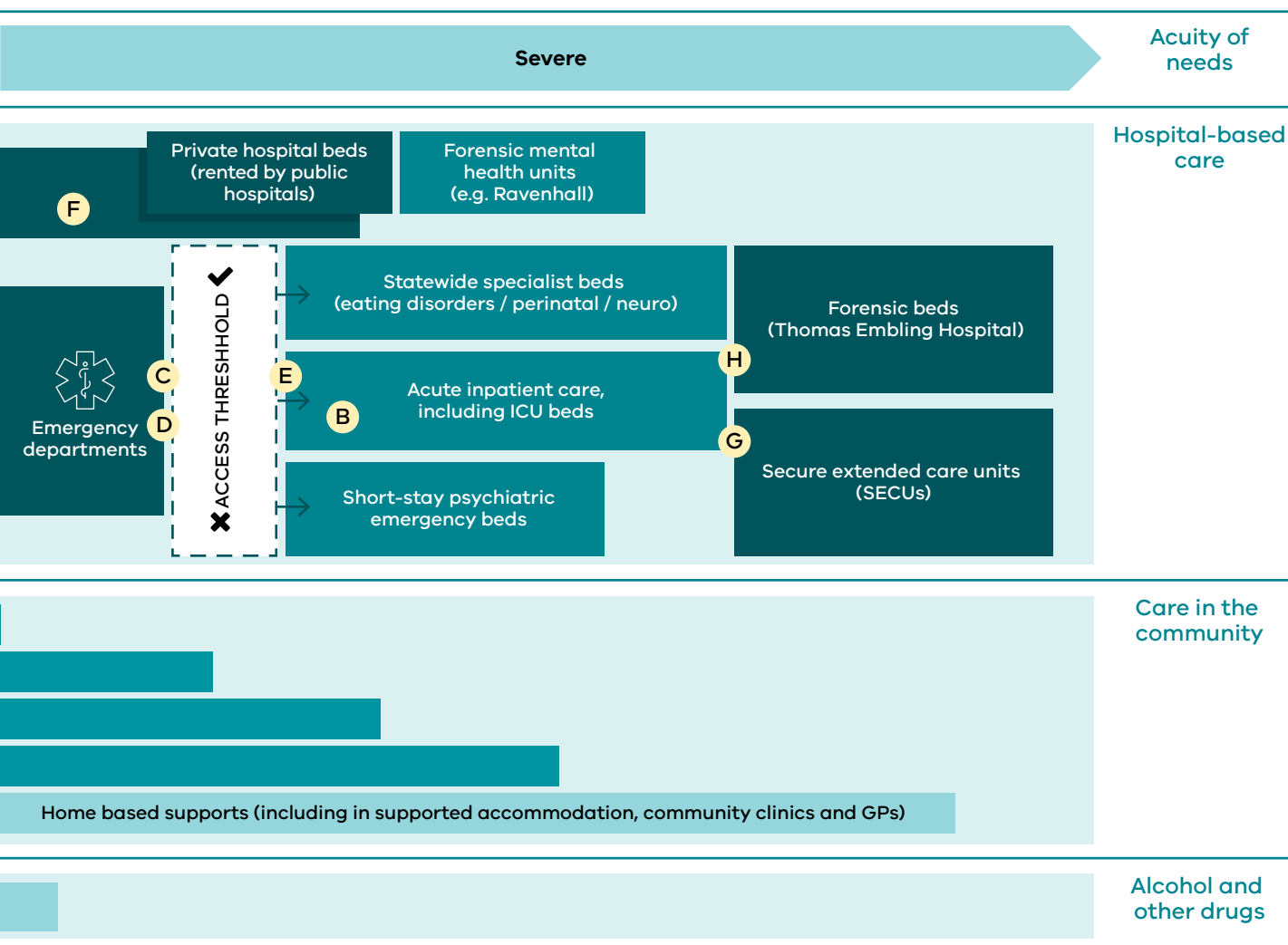
Another consequence of demand pressures is that acute inpatient units are admitting more acutely unwell consumers, with a corresponding increase in occupational violence and aggression.¹⁸ This can result in more frequent violence, harm to patients and staff, and generally negative environments.¹⁹ This presents challenges for staff and increases the risk of violence and behavioural disturbances.²⁰ As area mental health services struggle to manage their resources, workers who are less experienced are being hired to work in inpatient units, and they often struggle to manage the environment and the higher acuity levels.²¹

Figure 14.3 outlines the types of beds currently available in Victoria, organised by the acuity they typically support. It highlights just a few of the challenges associated with the current system.

Figure 14.3: Challenges for Victoria's bed-based mental health services: an overview



- A.** There has been significant underinvestment in community-based, genuine alternatives to hospital-based acute care. In the past home-based and community-based treatment for acutely unwell people was provided through specialist teams. This has greatly reduced as hospitals draw resources away from the community to manage rising demand for inpatient services, forcing people to seek inpatient care.¹
- B.** Acute inpatient wards are now operating at very high occupancy rates (over 90 per cent), with decreasing lengths of stay (currently 9.2 days).² This limits access and negatively affects recovery.
- C.** Increasing demand and higher acuity patients means that the threshold for access to acute care has risen, leaving people to become even more unwell before they can receive treatment.³
- D.** There are also long waiting times in emergency departments; 58 per cent of consumers wait for more than eight hours (the current Victorian standard for Emergency Department waiting times is eight hours).⁴ This leads to increased distress and behavioural problems, which can result in more restrictive practices.⁵ It also means that suicidal people can be left alone for long periods.⁶
- E.** More people are being placed on compulsory treatment orders as a result of rising thresholds and access problems. In 2017–18, 55 per cent of people in acute inpatient units were compulsory patients and 14.9 per cent of community-based patients were involuntary.⁷
- F.** There are currently more than 500 acute private mental health beds in Victoria.⁸ However, private hospital beds are currently not permitted to take compulsory patients, so they can only relieve some of the pressure on the public system for those people who can afford to pay.⁹
- G.** The limited availability of secure extended care unit (SECU) beds and appropriate community-based housing lead to more long-stay patients in acute units.¹⁰ In 2018–19, 11 per cent of acute inpatients were long-stay patients, compounding the crisis in acute units.¹¹ Some SECUs have high occupancy rates,¹² and the average length of stay in a SECU was 1.6 years in 2018. About 17 per cent of patients admitted to SECUs had been there for three or more years, the longest occupancy being 13 years.¹³



- H. Increasing acuity and volatility in inpatient wards, coupled with a lack of bed streaming and fit-for-purpose infrastructure and models of care lead to an increase in physical violence and safety incidents (physical and sexual) for staff and patients.¹⁴

Source: [1] Witness Statement of Professor Patrick McGorry, para. 13; Witness Statement of Associate Professor Ruth Vine, paras 50–52; Javier Vazquez-Bourgon, Luis Salvador-Carulla, and Jose L. Vazquez-Barquero, 'Community Alternatives to Acute Inpatient Care for Severe Psychiatric Patients', *Actas Esp Psiquiatr*, 40.5 (2012), 323–32 (pp. 323–32); [2] Department of Health and Human Services, 'Adult Mental Health Performance Indicator Report 2018–19 – Quarter 4', p. 8; [3] Victorian Auditor-General's Office, p. 11; [4] Department of Health and Human Services, 'Adult Mental Health Performance Indicator Report 2018–19 – Quarter 4', p. 9; [5] Monash Health, Submission to the RCMHS: SUB.7000.0003.0001, July 2019, pp. 37–38; [6] NorthWestern Mental Health (A division of Melbourne Health), p. 18; [7] Department of Health and Human Services, Victoria's Mental Health Services Annual Report 2017–18, pp. 50–51; [8] Australian Bureau of Statistics, 4390.0 Private Acute and Psychiatric Hospitals, Australia 2016–17: Tables 1–17, 2018; [9] Department of Health and Human Services, 'Designated Mental Health Services' <<https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/compulsory-treatment/designated-mental-health-services>> [accessed 2 October 2019]; [10] NorthWestern Mental Health (A division of Melbourne Health), p. 22; Barwon Health, Submission to the RCMHS: SUB.0002.0029.0222, 2019, pp. 4–5; South West Healthcare, Submission to the RCMHS: SUB.0002.0029.0138, 2019, p. 18; [11] Department of Health and Human Services, 'Adult Mental Health Performance Indicator Report 2018–19 – Quarter 4', p. 9; [12] Department of Health and Human Services, Extended Treatment Setting Mental Health Quarterly KPI Report: 2018–19 Q4, July 2019, p. 6; [13] Department of Health and Human Services, Internal Data Resource; [14] NorthWestern Mental Health (A division of Melbourne Health), p. 17; The Royal Australian and New Zealand College of Psychiatrists, p. 21.

Evidence from area mental health services, academic works and people with lived experience of mental illness, families and carers consistently shows that more acute mental health beds are needed to respond to the critical demand pressures in the system.²²

More than two-thirds of submissions from the state's area mental health services have said they have insufficient acute beds to meet demand and that the bed availability crisis needs to be urgently resolved so that people can receive appropriate treatment.²³ The Commission's analysis shows that, in 2018–19, six area mental health services have a bed–population ratio below the state average of 18.6 per 100,000, and most are on track to get worse by 2031–32 without additional acute beds.²⁴

The bed shortage is experienced as acute pressure by consumers and service providers alike:

The number of available beds in psychiatric units are criminally low [...] Sometimes there could be a ten-week waiting list—this would never, ever happen to any other illness in dire need of treatment.²⁵

Access to [intensive care] beds is the 'pressure point' in the acute mental health system at the present time. There is a daily mismatch between capacity and demand.²⁶

Reports prepared for the Department of Health and Human Services in the past 10 years also describe the scale of the demand crisis in acute inpatient settings. They have recommended an increase in the acute bed base to match population growth, alleviate system pressures and improve the quality of services.²⁷

14.2 The need for a statewide service and infrastructure plan

The Commission agrees there is a crisis in the supply of acute mental health beds in Victoria. However, the Commission notes that the demand for acute inpatient beds is and will continue to be unsustainable if there is not a much stronger investment in early intervention and community-based mental health services to support people before they become critically unwell. A systematic service plan needs to be developed before a comprehensive statewide expansion of acute mental health beds is commissioned, otherwise any additional acute inpatient beds will simply continue to be overwhelmed as people are unable to receive support in the community.

A new statewide service and infrastructure plan will be a key pillar in a redesigned mental health system. The statewide plan should ultimately balance the investment needs of the entire mental health system—especially the community-based service system—and take account of more appropriate streaming of beds and possible specialisation of beds. It should also better connect bed allocation with other service interfaces such as housing, education and employment in the long term.

In the past five years only incremental increases in the bed base have been commissioned.²⁸ Over the past 10–15 years, a number of reviews and reports have emphasised the need for acute mental health beds to address growing population, rising demand and reducing service capacity. Despite repeated calls for more acute mental health beds, including forensic mental health beds,²⁹ very few additional services have been made available to people living with mental illness. Evidence also indicates that business cases for large-scale acute bed increases—such as the proposed Sunshine expansion, which was knocked back multiple

times³⁰—require long-term service and infrastructure planning and commitment to be realised.³¹ They also need to demonstrate that there will be improvement in health and social outcomes.³² The 2019 Victorian Auditor-General's report *Access to Mental Health Services* found that there has been little system-level service and infrastructure planning for mental health to guide investment in new mental health services.³³

A further difficulty is that the lead times for building new inpatient beds can be over five years because of the need for master planning, suitable site location, permits and the design of good practice wards, meaning that any additional beds can be some time away.³⁴

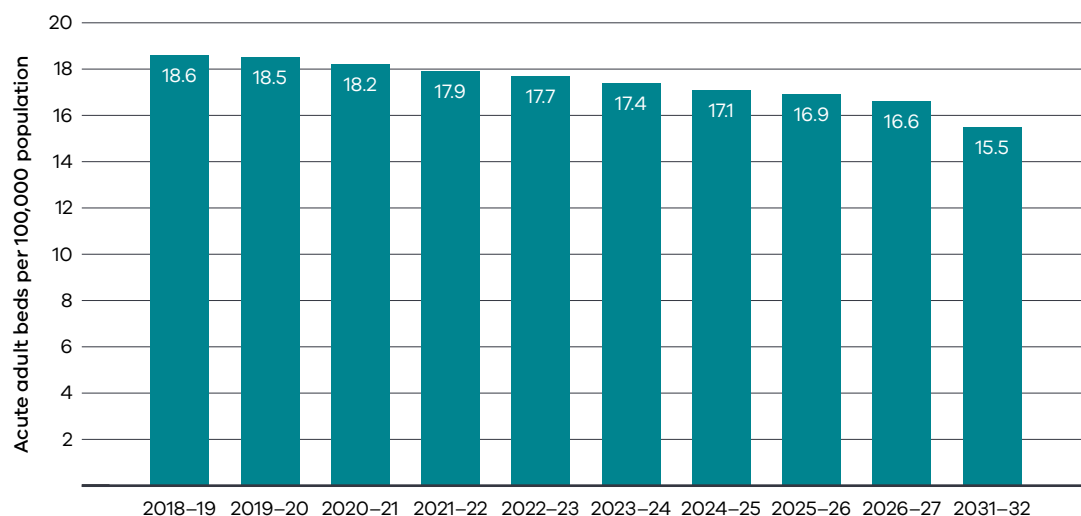
The Commission is concerned that proposing a statewide expansion of acute inpatient beds at this early stage without a comprehensive service plan would come at the expense of developing better quality service models that will improve access to care across the entire service continuum, from early intervention, primary mental health care and community mental health services through to acute inpatient beds. As outlined in Chapter 8, the current service models and infrastructure in many acute inpatient units creates negative experiences and poor-quality outcomes for people living with mental illness.³⁵ The Commission does not want to simply call for more of the same substandard services for people living with mental illness and for mental health workers.

14.2.1 Pipeline of acute mental health beds

There are currently very few additional acute mental health beds in the capital pipeline. Analysis indicates that by 2031–32, in the absence of additional acute beds, Victoria will have only 15.5 acute adult beds per 100,000 people,³⁶ which is a 16.7 per cent decline on the 2018–19 figure of 18.6 (see Figure 14.4). The 2018–19 levels are already not meeting demand for inpatient services. In other states and territories of similar size to Victoria, the average acute inpatient beds per 100,000 are higher, with the national average being 24.5 beds per 100,000 people in 2016–17.³⁷

In 2018–19 the Victorian Government invested in 89 newly built and existing acute inpatient beds and provided new funding for current acute beds.³⁸ It also commissioned the new Frankston and Footscray hospitals, which will include 50 and 48 new mental health beds respectively.³⁹ However, of these new beds, only 18 adult acute beds at Footscray Hospital are expected to be new beds, with the remaining beds being replacements for current ageing stock, and they are unlikely to reduce demand pressures. The Footscray Hospital is expected to be completed by 2025 and the Frankston Hospital by 2024. In October 2019 the government announced funding for a new nine-bed mental health unit at Box Hill Hospital to be opened in 2020;⁴⁰ however, the Commission is not aware of any more acute beds in the capital pipeline. The current pipeline is shown in Figure 14.5.

Figure 14.4: Public acute adult mental health beds per 100,000 population, Victoria, 2018–19 to 2031–32



Source: Calculation by the Commission using Department of Health and Human Services, Policy and Funding Guidelines 2018–19; Department of Environment, Land, Water and Planning, Victoria into the Future 2019.

Bed numbers as per the Department of Health and Human Services, Policy and Funding Guidelines 2018–19.

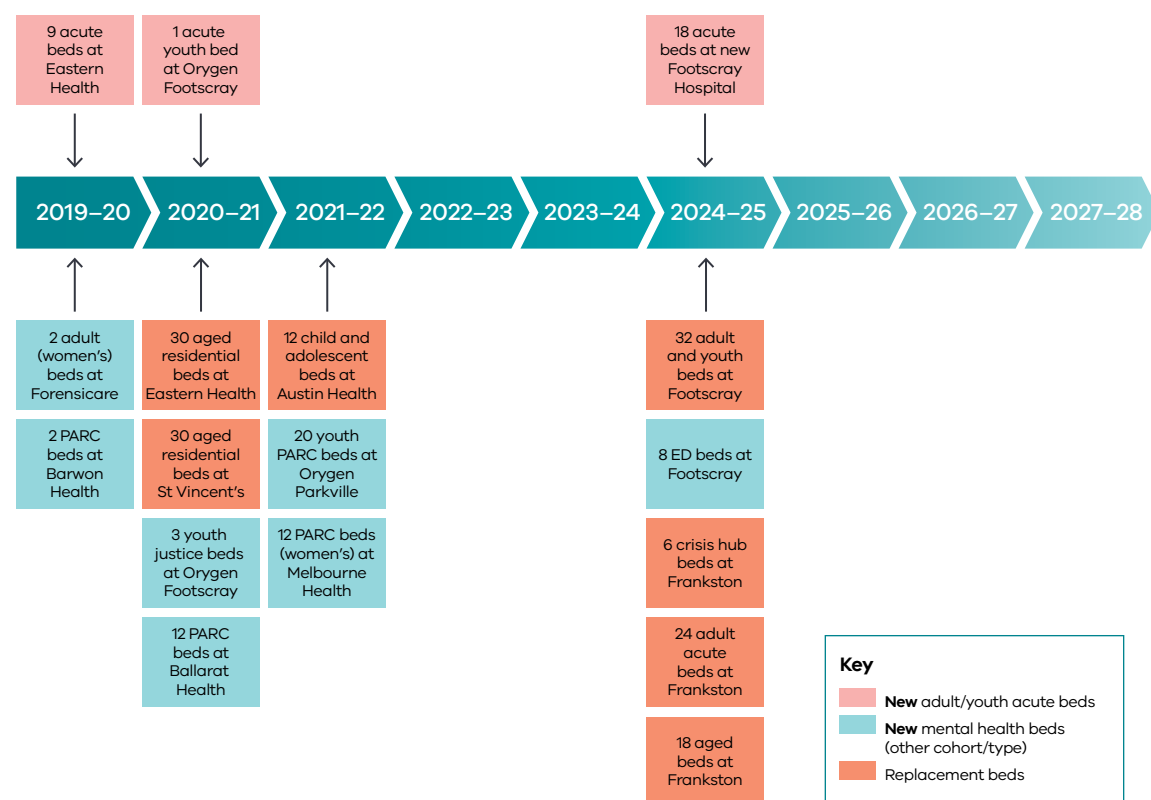
Excludes 20 veterans' beds and 10 brain disorders beds at Austin Health.

Excludes two adult beds funded at Barwon Health and nine adult beds at Eastern Health in 2018–19, but included from 2019–20 onwards.

Includes 24 beds purchased from private providers in 2018–19 and 32 beds from 2019–20 onwards.

Includes Orygen youth beds.

Figure 14.5: Statewide infrastructure pipeline for mental health overview by metro and regional areas



Source: Produced by the Commission based on capital infrastructure information provided by the Department of Health and Human Services and the Victorian Health and Human Services Building Authority.

14.2.2 Beds in the future mental health system

The Commission is in the process of designing a new mental health system that will not only take account of the need for acute mental health beds but will also greatly increase community-based services for people living with mental illness. This work should form the foundations to support a comprehensive service and infrastructure plan. The service and infrastructure plan should match levels of need across Victoria and be based on the Commission's design of the new system.

As part of its work on service design, the Commission will work with people living with mental illness, their families and carers, service providers and academics to explore whether more hospital bed-based services should be provided in alternative settings to improve capacity in hospitals and the models of care provided. For example, the Commission is exploring models of care for people living with severe mental illness who require long-term bed-based support. At present people living with complex and long-term needs are placed in secure extended care units in acute hospital facilities.⁴¹ The Commission is looking at opportunities for improving the models of care for long-stay consumers, and alternative support settings are expected to be an important component of the future system. This could include some community-based alternatives.

The Commission is also exploring models of care for community-based bed services and inpatient services to better integrate them into the continuum of care for people living with mental illness and psychological distress. One important consideration in service model and infrastructure planning is investigating how facilities and services can better support 'streaming' of patients with different needs. Streaming refers to creating specific service models and/or infrastructure and amenities for particular cohorts of patients to improve recovery outcomes, increase safety and provide more specialised and appropriate care based on levels of need. For example, evidence indicates that streaming of mental health beds could be appropriate for women and young people to enable care specific to their needs and improve their safety.

Streaming could also be considered for patients with high aggression, behavioural problems or high complexity, including those experiencing alcohol- or drug-induced psychosis. Currently, aggressive and violent patients are often mixed with very vulnerable patients in emergency departments and inpatient units, increasing the risk of physical violence and distress. Inpatient units are not often resourced to manage these types of behavioural problems or to address addiction problems properly. In the past, Victoria's forensic mental health services admitted people living with serious mental illness who were a danger to their carers or community, including non-forensic patients who had received treatment at an area mental health service.⁴² However, service capacity challenges in the forensic system have meant that this service for challenging patients has now been lost.⁴³ The Commission is exploring a wide range of options to determine the place of most appropriate care as part of its system design work.

Critically, and as part of this work, the Commission will need to examine opportunities for facilitating better access to specialist beds and services, including forensic beds and services. This work will include exploring stronger specialisation and role delineation across mental health services to ensure people receive high-quality treatment and care equitably and efficiently. The statewide plan could look at the per-population ratio for acute mental health beds in Victoria, proportions for different types of beds based on areas of specialisation, and the levels of competitive tension in the system that would encourage innovation and avoid market capture and stagnation of quality.

The Commission notes, however, that other system challenges that have a negative impact on service quality in inpatient units will not be resolved by simply adding more beds. Historically, funding levels for acute mental health beds have been inadequate and have limited the ability to provide suitable clinical and therapeutic care.⁴⁴

The Department of Health and Human Services' Policy and Funding Guidelines say the department has increased the bed-day price for inpatient care twice in the past two years.⁴⁵ It is not clear, however, that the current price is adequate for the actual average cost of acute inpatient service delivery.⁴⁶

To ensure the new models of care are accessible and easy to use, the Commission will review the current catchment and age-based eligibility policies for area mental health services and will consider new structures and stratification of mental health beds with a view to improving access according to diagnosis and level of care requirements.

In the interim, critical acute service demand pressures can be reduced by increasing the number of acute mental health beds and improving models of care.

14.3 Reducing critical demand pressures

14.3.1 A further 170 youth and adult acute mental health beds

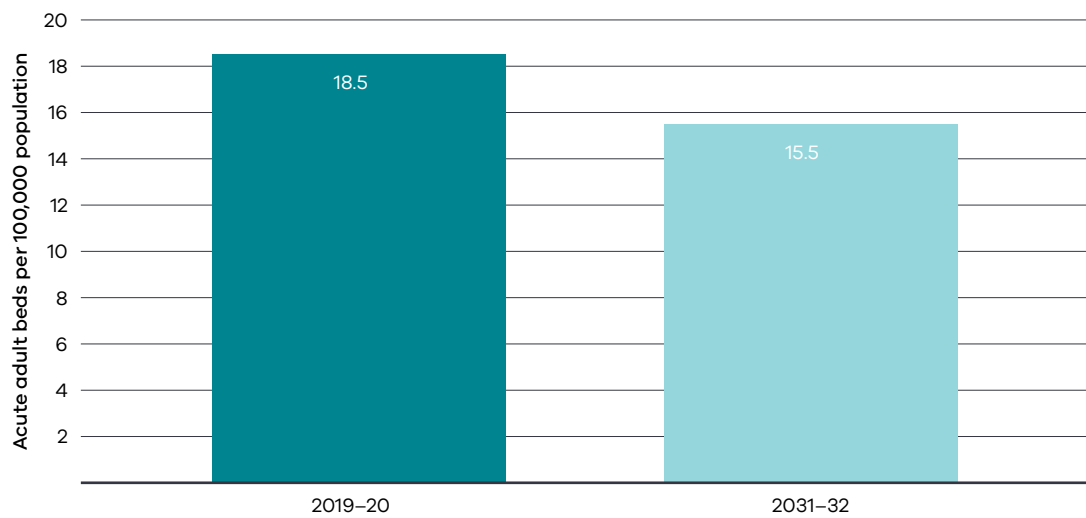
There are conflicting views about what the right number of acute mental health beds should be in Victoria.⁴⁷ The Commission is currently exploring the different types and numbers of beds needed as part of designing the new system. One tool to estimate the number of beds required is the National Mental Health Service Planning Framework, which provides 'national average benchmarks for optimal service delivery across the full spectrum of mental health services'.⁴⁸ However, the framework assumes a fully functioning and supported community clinical mental health sector, which Victoria currently does not have.

In the interim, the Commission's analysis of forecast population growth and current and planned acute beds indicates that a minimum of 170 additional youth and adult acute inpatient beds are needed if Victoria is to merely maintain its current ratio of youth and adult acute beds until 2031–32 (see Figures 14.6 and 14.7),⁴⁹ noting that in the current system this ratio does not fully service demand for beds.

Given the current critical demand pressures, the Commission recommends 170 additional youth and adult beds be added into the system as a priority to help alleviate areas of greatest demand pressure. The Commission has selected youth and adult beds because emergency department presentation data show significant challenges in meeting the performance target of admitting 80 per cent of adults to an acute mental health bed within eight hours.⁵⁰

These beds should be a net gain on top of any current beds or planned beds, not a substitution for current stock.

Figure 14.6: Public acute adult mental health beds per 100,000 population, Victoria, 2019–20 to 2031–32



Source: Calculation by the Commission using the Department of Health and Human Services, Policy and Funding Guidelines 2019–20; Department of Environment, Land, Water and Planning, Victoria into the Future 2019.

Bed numbers as per the Department of Health and Human Services, Policy and Funding Guidelines 2019–20 and held constant in 2031–32.

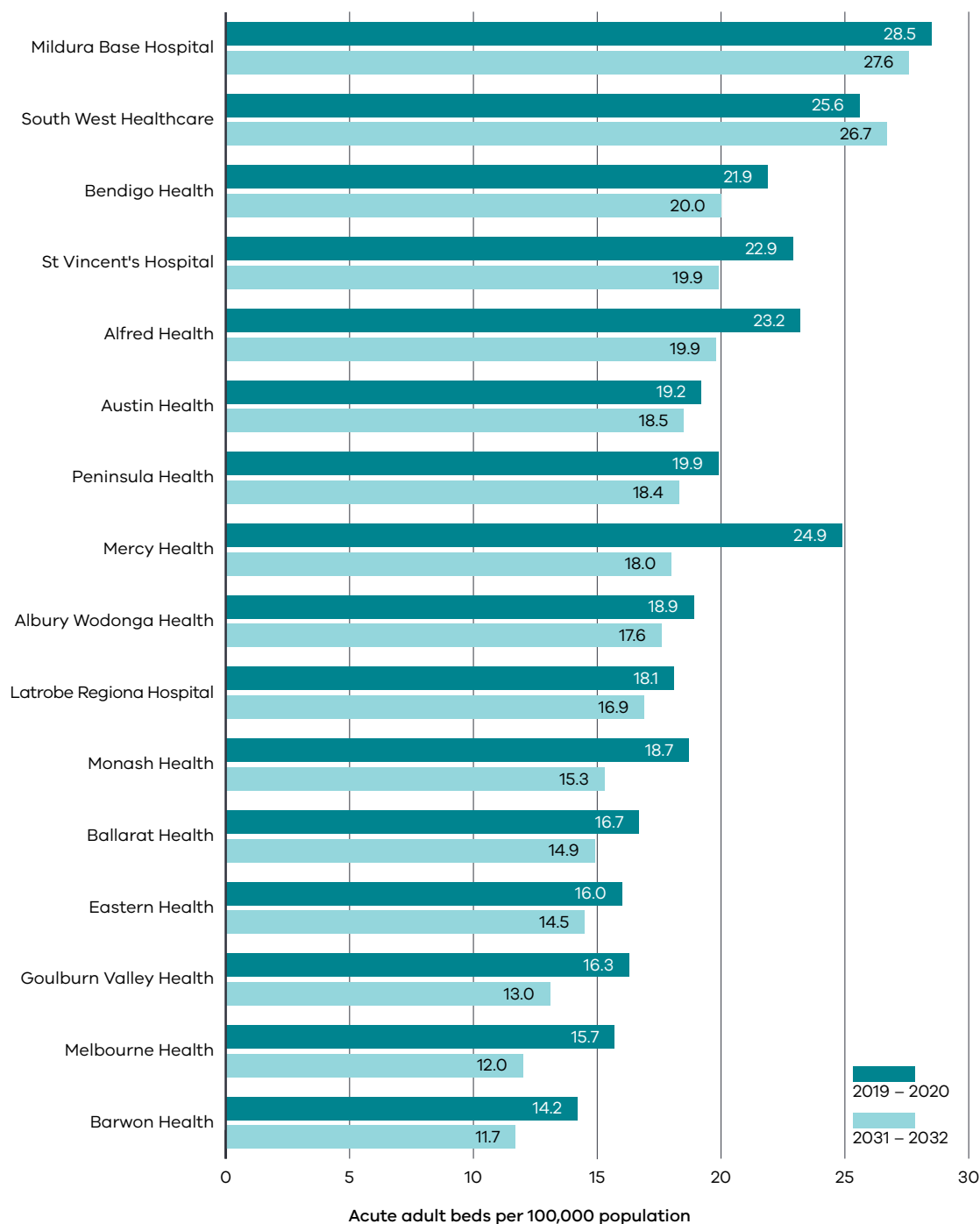
Excludes 20 veterans' beds and 10 brain disorders beds at Austin Health.

Includes two adult beds funded at Barwon Health and nine adult beds at Eastern Health from 2019–20 onwards.

Includes Orygen youth beds.

Includes 32 beds purchased from private providers from 2019–20.

Figure 14.7: Public acute adult mental health beds per 100,000 population by area mental health service, Victoria, 2019–20 to 2031–32



Source: Calculation by the Commission using the Department of Health and Human Services, Policy and Funding Guidelines 2019–20; Department of Environment, Land, Water and Planning, Victoria into the Future 2019.

Bed numbers as per the Department of Health and Human Services, Policy and Funding Guidelines 2019–20 and beds held constant in 2031–32.

Excludes 20 veterans' beds and 10 brain disorders beds at Austin Health.

Includes two adult beds funded at Barwon Health and nine adult beds at Eastern Health in 2019–20.

Includes Orygen youth beds.

Includes 32 beds purchased from private providers from 2019–20.

14.3.2 Distribution of the new beds

The Commission has carefully considered how the 170 beds should be distributed. In developing its recommendations, the Commission has been mindful of its obligation to make recommendations that are practical and that there is an urgency to this investment that requires a rapid and targeted approach to deliver benefits to people living with mental illness as quickly as possible. The Commission also considers that the additional beds should be used to stimulate innovative models of acute clinical service delivery that will lead to better quality care and improved experiences for people living with mental illness. This aim necessitates scale.

The Commission contemplated a statewide allocation approach based on population growth and bed availability. This approach would have provided more equity, but the Commission was concerned that simply distributing beds in small quantities to all area mental health services would only lead to 'more of the same' substandard facilities and care that many people living with mental illness and service providers have expressed concern about in their submissions and in consultations.⁵¹ There is also a risk that it would involve temporary substandard solutions that could well become permanent as time passes.

The Commission considered the utility of a competitive process but concluded that this would further delay the commissioning of additional beds and would require a significant amount of work for area mental health services, which are already under pressure.

The Commission proposes, therefore, that 135 of the additional beds be allocated to the two area mental health services with the most pressing current and forecast demand pressures on the basis of population growth and bed availability. Restricting the beds to only two regions will allow for enough scale to help alleviate current demand pressures and deliver a better quality of service.

Analysis of population growth and current and future bed availability leads the Commission to recommend that the following two area mental health services be proportionally allocated the 135 beds:

- Barwon Health—to service the Barwon region of Victoria
- Melbourne Health, in alliance and partnership with Northern Health and Western Health—to service the inner-west, mid-west, northern and north-western regions of metropolitan Melbourne.

The allocation of beds to Melbourne Health should not pre-empt future governance arrangements, so the Commission recommends that Melbourne Health, Northern Health and Western Health work in partnership to distribute the beds across Melbourne and the northern and western regions on the basis of local needs.

The Victorian Health and Human Services Building Authority, in coordination with the proposed Mental Health Implementation Office, should be responsible for allocating the 135 additional beds between Barwon Health and the Melbourne Health alliance. The funding should be allocated on the basis of demonstrated greatest need, using the following criteria:

- population growth
- forecast bed availability and the impact of current and future population growth
- socioeconomic need and the prevalence of mental illness requiring inpatient care in the region
- availability and accessibility of primary and community-based mental health care and treatment and the demand for and availability of acute inpatient care.

14.3.3 Community-based alternatives

Many people living with mental illness and their families and carers prefer to be treated in their home or in a community residential facility because it is less disruptive, more familiar and less stigmatising.⁵² For many people, a hospital-based setting can be intimidating and upsetting.⁵³

In the past, crisis assessment and treatment teams and mobile treatment and support teams provided more community outreach and comprehensive home treatment to people needing acute mental health care.⁵⁴ The evidence suggests the quality of care provided was good and that people living with mental illness often preferred this approach.⁵⁵ Many organisations have called for more community-based acute treatment options and cited the benefits of the model:⁵⁶

Assertive outreach to my mind has been the best model of practice so far that I've seen that supports the most vulnerable people in community.⁵⁷

There should be 'hospital in the home' mental health support programs for acute conditions that provide 24/7 nursing on call, daily doctor visits, delivered meals and cleaning. This intervention would support people to stay at home and involve their family and natural supports while they recover. At scale it would be cheaper than hospital.⁵⁸

... many people experience such disadvantage and mental ill health that they find it difficult to independently seek or maintain access to services. This means that mechanisms such as community outreach and assertive case management are incredibly important in identifying, building relationships with and linking people into appropriate services and supports, including housing, mental health, alcohol and other drugs and harm minimisation services.⁵⁹

Some pockets of excellence remain,⁶⁰ but over time underfunding has meant that most of these services have been dismantled and merged with case management, and acute treatment has retreated into the hospitals.⁶¹ Reviews of acute home-based treatment show that, compared with inpatient units, it has comparable, and often better, recovery outcomes for people living with mental illness and has high satisfaction rates. It has also been found to be more cost-effective than conventional inpatient care.⁶²

The general health portfolio has an established Hospital in the Home program that provides acute care to general health patients in their own homes. A 2009 review of the service found it to be effective and highly valued by staff and patients.⁶³ In 2019 Tasmania expanded this service to include mental health treatment, in recognition of people's preference for being treated in the community.⁶⁴

Some of the funding for additional beds should be directed to establishing multidisciplinary teams that provide comprehensive acute clinical and therapeutic treatment and care to people living with mental illness in their own home or place of residence. The service should have five important characteristics:

- It is a genuine alternative to an inpatient stay, yet the person is still regarded as a hospital inpatient and remains under the care of the hospital.
- The person is assessed as requiring the equivalent to an inpatient admission.
- Active clinical and therapeutic treatment, care and support are provided along with high-intensity engagement with the person with mental illness and their family and carers.
- Clinical support is available 24 hours a day seven days a week.
- Governance, admission and discharge policies are in keeping with hospital admissions policies, and key performance indicators (including length of stay, percentage of people admitted from the emergency department within eight hours and Health of the Nation Outcome Scale changes) are the same as those for inpatient units.

The home-based acute beds should be counted as part of the area mental health service's overall bed ratio per 100,000 population. A service could choose to establish the home-based model as an interim measure while new physical hospital-based acute beds are being built, or it might opt to substitute some of its total acute bed base for at-home beds in the longer term. Regardless of the approach taken, introduction of the new beds needs to intersect with and complement future long-term service planning.

14.3.4 Private mental health providers

Broadly, there is evidence to indicate that introducing competition into traditional public sector markets can lead to improvements in service quality, generating innovative new service models and better outcomes for service users.⁶⁵ In the health portfolio, evidence indicates that market monopolies by public providers can stifle quality and output, and result in inefficiencies.⁶⁶ Current structural and governance arrangements for area mental health services have effectively created a geographically-based public service monopoly with little ability to incentivise improvement and innovation.

Some private providers (Ramsay Health Care, Healthscope and Wyndham Clinic Private Hospital) consider there is both a need and a capacity for private providers to help alleviate pressure on the mental health system through providing mental health services to a far greater number of patients living with severe, low-prevalence mental illnesses.⁶⁷ They have called for more strategic partnerships between public and private hospitals and government to address the critical need for mental health services in Victoria.

Many people living with mental illness use private hospitals for inpatient treatment, and the number of overnight admissions to private hospital mental health beds has increased over time.⁶⁸ Some area mental health services also already purchase private beds on an ad hoc basis to help manage bed availability.⁶⁹ In 2018–19 three services purchased 24 private beds for public mental health patients. Such partnerships between private and public providers have the potential to improve the continuity and quality of care including access to services.⁷⁰

At present these purchasing arrangements have some shortcomings. Private providers (with the exception of the New Mildura Base Hospital) cannot take compulsory patients because they are not prescribed as 'designated mental health services' under the *Mental Health Act 2014* (Vic).⁷¹ In practice this limits private providers' capacity to treat patients with private health insurance who require compulsory treatment.⁷² Connections between private and public providers can also be 'poor due to communication issues, incomplete discharge summaries, and a lack of incentives'.⁷³

Victoria's Design, Service and Infrastructure Plan for Health Services recognises that, increasingly, partnerships with the private health sector are needed to maximise health benefits for all Victorians through better service configuration and access, improved service pathways, appropriate and high-quality services, and flexible use of technology and infrastructure.⁷⁴ The Commission agrees with this approach and considers that providing some additional public beds through the private health sector will start to stimulate more innovative models of care and improved outcomes for public mental health patients.

Based on this evidence, the Commission recommends that the Mental Health Implementation Office should immediately conduct a competitive tender to identify and fund one suitable private provider to deliver 35 additional acute inpatient beds or equivalent community-based acute alternatives to public mental health patients. The additional private beds should be used only for public patients in acute clinical distress who would otherwise be suitable for admission to a public inpatient unit. Further, their provision should be equitable, being offered to patients who would otherwise not be financially able to obtain a private bed.

The Implementation Office should allocate the 35 beds to a single provider and may commission a new private acute inpatient ward for public mental health patients who would otherwise be suitable for public inpatient admission. Reflecting that Barwon Health and the Melbourne Health alliance will already receive additional beds as part of this recommendation, the Commission recommends that the 35 additional private beds should not be allocated to Barwon Health, Melbourne Health, Western Health or Northern Health.

Importantly, the private sector provider should also be allowed to deliver the genuine community-based alternatives to inpatient care discussed previously. Private providers have indicated that the current ad hoc contract arrangements limit their ability to support public patients.⁷⁵ The Implementation Office should ensure that a more strategic relationship is developed with the private provider that offers the most appropriate level of certainty and stability needed to cultivate innovative new service models.

The new beds should result in a net increase of 35 beds in the private system for public use. Beds should not be redirected from existing stock (unless not used)—the initiative is designed to increase the available bed stock in Victoria, not to give rise to cost shifting.

The Commission is reviewing the broader mental health system's governance arrangements and exploring opportunities for better integrating, managing and coordinating inpatient beds among private and public mental health providers in a systemic way.

14.4 New and improved models of care

Introducing the additional beds will stimulate new models of care that improve treatment and outcomes for people in acute mental distress while alleviating some of the demand pressures in specific regions.

Although broader system changes and improvements are required to fully deal with the demand pressures in the system, introducing the additional beds will help improve the outcomes and experiences of people living with mental illness, their families and carers in several ways:

- reducing emergency department waiting times
- reducing pressure on chosen inpatient units, freeing them up to provide better quality and longer therapeutic treatment and care to people in acute clinical distress
- introducing new models of care and workplace cultures that will provide best practice clinical and therapeutic treatment and care that supports recovery.

To achieve this, the Commission recommends the new arrangements include the following elements.

14.4.1 Elements of new bed-based models of care

The following elements apply to all additional beds to be commissioned—both public and private.

Establishment of partnerships and collaborative models

The Commission wants to introduce the additional beds as quickly as possible. It recommends that the chosen area mental health services take an approach grounded in partnership—between public mental health services, providers of private mental health services and community organisations. There are local and global examples of partnerships between the public and private sectors to develop infrastructure and models of care that could bring high-quality beds online rapidly and creatively.⁷⁶

In the general health area, public hospitals have entered into partnerships with private hospitals and companies to deliver new clinical facilities. The Epworth partnership in Geelong and the new Casey Hospital build at Berwick are Victorian examples.⁷⁷

As part of the partnership, creating additional beds should include developing recovery-based models of care, enabling patients to participate in everyday living, leisure activities and structured programs. It has been estimated that ‘up to 70 per cent of a person’s day during an inpatient admission is ‘down time’ or not purposely occupied by the development or practice of everyday living skills’.⁷⁸ Both the physical environments of and models of care within acute inpatient units should promote everyday living, routine and structure to improve a person’s outcomes.⁷⁹

Appropriate streaming of mental health beds to create therapeutic and safe environments

Higher rates of crisis presentation, as well as changing patterns in the use of illicit drugs such as methamphetamine, mean that volatility in inpatient wards is increasing.⁸⁰ More people are being exposed to aggression and other problems that increase the risk of violence and reduce a ward’s therapeutic capacity to aid recovery.⁸¹ Staff are being exposed to occupational violence that is increasing the risk of burnout and physical and emotional harm.⁸²

It is suggested that inpatient wards need to be redesigned to allow for better streaming of various patient cohorts and illnesses and to prevent sexual and physical assaults.⁸³ Most inpatient wards do not at present have the infrastructure to offer dedicated units for different acuity levels and patient cohorts.

Better streaming is important to improve the experiences and outcomes of people living with mental illness. The design of the additional beds should be flexible and sensitive to local needs. It should also promote streaming according to cohort and complexity.

In 2020 the Commission will explore opportunities for redesigning service models to better stream mental health beds to treat acute and challenging patients separately during periods of high distress.

All additional beds and facilities meet the Australasian Health Facilities Guidelines

There is a growing body of research to indicate the importance of physical design of mental health wards and beds for reducing aggression and promoting healing.⁸⁴ The Australasian Health Facilities Guidelines describe current good-practice infrastructure design principles for inpatient mental health wards to create therapeutic environments that support recovery and wellbeing.⁸⁵ However, evidence suggests that some interpretations of the guidelines can come at the expense of delivering basic dignity and human rights (for example, having to use the toilet or shower with reduced rights to privacy and dignity)⁸⁶ and may inhibit innovative care. The guidelines were also designed with limited involvement from people with lived experience.

Notwithstanding the above, the current infrastructure in many inpatient units is ageing and does not comply with the guidelines. Ageing facilities that are not suited to their purpose can make people living with mental illness less willing to engage with the service, and many people can feel unsafe. Outdated facilities also make it challenging for workers to provide therapeutic care that assists recovery across different service settings and age demographics.⁸⁷

A suitable physical environment for a mental health facility is also an important tool for reducing stigma. The Commission recommends that all additional beds and facilities meet the standards in the Australasian Health Facilities Guidelines.

All new facilities and models of care are co-designed

People living with mental illness and their families and carers should participate in and actively contribute to service development. Co-design can result in more consumer and carer empowerment and ownership of services, and social and health services and policies are most influential when the users of the services actively contribute to their design.⁸⁸

All new facilities and care models should be codesigned with people living with mental illness and their families and carers to, among other things, ensure the facilities and services meet the needs of the communities they will serve.

14.4.2 Timelines

The Victorian Health and Human Services Building Authority should work with the Implementation Office, area mental health services and private providers to ensure the majority of beds are operational by the end of 2021 and the remainder by mid-2022. Of course, it takes time to build new facilities and beds, but the Commission considers that innovative partnerships offer an opportunity to accelerate delivery. The Building Authority and Implementation Office should consider providing the chosen regions with one-off funding to engage project managers to ensure the beds are delivered on time, on budget and to a high quality.

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Chapter 15

Expanding suicide prevention and follow-up care

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

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

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

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

Recommendations

The Royal Commission recommends that the Victorian Government, through the Mental Health Implementation Office, expands follow-up care and support for people after a suicide attempt by recurrently funding all area mental health services to offer the Hospital Outreach Post-suicidal after Engagement (HOPE) program. To facilitate access to HOPE, the statewide rollout should be complemented by:

- broad referral pathways to give people living with mental illness who are receiving care from clinical community-based teams within area mental health services access to HOPE
- additional clinical outreach services in each sub-regional health service, networked to a regional health service HOPE program, to provide support for people living in rural and regional areas
- extended service delivery that allows access to support whenever it is needed, including outside standard business hours.

The Commission also recommends the creation, delivery and evaluation of the first phase of a new assertive outreach and follow-up care service for children and young people who have self-harmed or who are at risk of suicide.

15.1 Improving suicide prevention

Improving Victoria's response to suicide prevention is fundamental to the design of a new mental health system to ensure people have the right treatment, care and support when they may be becoming, or are, at risk of suicide.

As discussed in Chapter 11, there are many examples where Victoria's mental health system has not responded effectively to the needs of people in deep psychological distress or at risk of suicide, their families, loved ones and carers. This too often manifests as a loss of human life.

The reasons for suicide are complex, and suicide prevention requires a multifactorial, integrated response. Further work is needed to design a new mental health system that effectively works to prevent suicide. However, there is evidence that one of the most effective ways to reduce the suicide rate is to provide follow-up care to people who have attempted suicide, given it is one of the biggest predictors of a future suicide attempt.¹

15.1.1 Overview of the Commission's interim response

In Victoria some area mental health services provide adults with follow-up care after a suicide attempt through the Hospital Outreach Post-suicidal Engagement (HOPE) program. There are no other programs that offer this type of support,² and access to HOPE services are not available statewide or to children and young people under 18 years of age.

Early insights from a formal evaluation indicate that the HOPE program has been well received and is having positive effects on those it supports. This view was shared by people who have used the program and by service providers:

It is [...] vital that the Victorian Government continues to deliver the HOPE Initiative, to ensure that Victorians at significant risk of suicide post discharge from hospital receive the right care, at the right time, in the right place.³

Recognising the supportive evidence for post-attempt follow-up care and the HOPE model, the Commission recommends that the program be expanded to ensure availability throughout the state, including in rural and regional areas through sub-regional health services.

The Commission also recommends that referral pathways be expanded to improve access and that a new follow-up service is designed and evaluated for children and young people who have self-harmed or who are at risk of suicide.

In parallel, the Commission will continue to develop a broader position on preventing suicide. A Towards Zero approach will be supported in consultation with people with lived experience, academic institutions, research institutes, multiple agencies and government departments, as well as with community organisations.

Box 15.1

Teresa⁴

Following the birth of her first child, Teresa was admitted as an inpatient for psychiatric care.

I was able to access doctors, and in particular a psychologist who seemed to really understand where I was coming from. I felt really heard and understood, and it was [as if they saw] my value as a human being and were interested in supporting me.

After being discharged Teresa was supported by an assertive outreach team under the HOPE program and given access to a peer support program offering her practical help day-to-day:

The outreach program helped me find a psychologist that I could work with, drove me to my appointments and de-briefed with me after. It was really important to have people say to me that it is normal and okay to not be coping and then ask me what they could do to help me. I also had the support of a peer worker who helped me normalise my experience. This support was amazing.

Teresa believes this service was critical for her recovery:

That service that I was able to access post the—well, during my hospital stay and post-hospital stay—was absolutely incredible and [...] I credit it with being able to get me to the point where I am able to sit here, I'm back at work full-time, and able to share my story.

15.2 The value of after-care and assertive outreach

Evidence indicates that a suicide attempt is one of the strongest predictors of future suicide attempts. An individual that has had a non-fatal suicide attempt is at an increased risk of suicide, with the period after a first suicide attempt being the highest risk.⁵ Individuals that have undertaken intentional self-harm are at a significantly higher risk of suicide compared with the general population.⁶

Intervention following a suicide attempt is an important element to preventing subsequent suicide. Contact with a health service immediately after an attempt presents an opportunity to provide treatment to the individual, and support to family and carers.⁷

15.2.1 Importance of after-care and assertive outreach

Rapid and proactive support following discharge from hospital is crucial for a person's recovery⁸ and can decrease the risk of future suicide attempts during this particularly high risk period.⁹ Recent studies demonstrate that approximately half of suicides occur within the first month of discharge from a hospital.¹⁰ This risk for repeated self-harm or death by suicide remains high for the first 12 months following discharge.¹¹

One four-year cohort study found that, people who have been treated for or admitted to hospital following deliberate self-harm, have a 30 times greater risk of suicide in the year that follows compared with people who have not self-harmed.¹²

As discussed in Chapter 11, capacity challenges in public specialist clinical mental health services mean that many people are discharged from emergency departments or inpatient units too early after attempting suicide, and without any form of follow-up care. Despite increased risk, approximately 50 per cent of people who attempt suicide do not engage with or attend any follow-up treatment after discharge. In addition, approximately 10 per cent of people only attend one week of treatment.¹³

Given that some people do not or are unable to actively engage with follow-up treatment, care and support following a suicide attempt, there is an important need for mental health services to provide assertive and intensive outreach to support people in this period of crisis.¹⁴

An assertive outreach model in this capacity refers to mental health services:

- actively supporting a person and their family and carers to develop safety plans
- facilitating connections to community-based supports that meet the person's needs
- helping a person to develop coping strategies and self-assessments when they are feeling vulnerable or in distress.

Follow-up care services typically involve some clinical and psychosocial support and non-clinical assertive outreach, focusing on connecting the person with immediate treatment and support but also helping to identify and resolve what contributed to the suicide attempt or crisis.

Assertive follow-up usually involves more frequent contact with people after they are discharged from hospital and may include home visits, intensive case management and support during care transitions, safety planning, and tailored psychosocial support in the community.¹⁵

15.2.2 Effectiveness of after-care and assertive outreach

Providing coordinated and assertive after-care to someone who has attempted suicide is likely to bring about the strongest reduction in suicide attempts and deaths by suicide.¹⁶

Multiple methods of engagement have been shown to reduce the risk of suicide following discharge from an emergency department. This includes personalised written and telephone contact over an extended period, case management, phone-based consultations and other modes of assertive psychosocial and emotional support.¹⁷

Friends, loved ones and parents often have an integral role in a person's recovery. Assertive outreach and follow-up care also provides a high degree of support for families and carers of people who have attempted suicide through deploying strategies for identifying and building on factors that protect against suicide. They can also provide psychological support for families seeking to manage their own mental health needs after an attempted suicide. The availability of workers to directly assist families, friends and loved ones, enables these groups to experience lower levels of stress and receive the help they need to support their loved one.¹⁸

Social support is also an identified protective factor against suicide. Social support reduces the risk of suicide associated with depression and may assist in developing psychological resilience for people at risk of reattempting suicide.¹⁹

Despite the evidence to support the need for follow-up care, the Commission understands that in Victoria there is no universal access to follow-up services for this greatly at-risk cohort, and their families and carers. Many people are unable to get support close to home and their community. The situation is exacerbated in regional areas, where, compared with metropolitan areas, people often have to travel longer distances to obtain help and there are fewer mental health services available. Where follow-up services do exist, they vary in their level of resourcing, referral pathways and models of care.²⁰

The Commission recommends that, as a minimum, access to high-quality mental health assessment and assertive after-care support is available to all Victorians who need it, regardless of where they live.

15.2.3 Models of after-care in Victoria

In the 2016–17 State Budget, the Victorian Government committed \$27 million over four years for two pilot suicide initiatives: the HOPE program and the place-based suicide prevention trials.²¹

Hospital Outreach Post-suicidal Engagement program

The HOPE program is a core component of Victoria's Suicide Prevention Framework 2016–2025, which aims to halve Victoria's suicide rate by 2025.²²

In Victoria, six sites have been funded for three years and a further six receive recurrent funding. An additional four sites will be established through funding under a bilateral agreement with the Commonwealth Government. Table 15.1 shows where each HOPE site is located and the nature of its funding arrangements (excluding the Commonwealth-funded sites). Box 15.2 provides an overview of the program.

In 2018–19 the Victorian Government announced an expansion of the after-care services provided through the HOPE program. The expansion increased the number of sites from six to 12. The initial six HOPE trial sites are only funded until 2020, and the uncertainty about the program's continuation makes it difficult to recruit and retain staff.²³

Health services retain flexibility in program design in their local area. The Department of Health and Human Services does, however, expect each health service to design and implement its HOPE program in such a way as to give effect to the program's core principles:²⁴

- *psychosocial*—addressing the unique social, economic, historical and environmental factors that might have contributed to, or continue to contribute to, a person's suicidality
- *family-inclusive*—recognising that family (including chosen family), carers and social and cultural communities form the immediate and continuous support network around people in psychological distress (for many, this kind of support is what makes the biggest difference to their mental health)
- *trauma-informed*—recognising that trauma is a significant event or series of events in a person's life that can affect mental health and wellbeing (trauma-informed care involves service providers proactively seeking to understand, acknowledge and respond to the impact of an individual's experience of trauma and do all they can to provide responses that do not retraumatise them)
- *person-led*—ensuring services are provided in a flexible, responsive and culturally safe way
- *recovery-oriented*—meaning that recovery is defined and led by the individual, and the service provider's role is seen as providing an environment that supports the individual's unique goals
- *strengths-based*—focusing on the factors that are within the person's control, the person's resilience and self-determination and the resources available to them
- *culturally inclusive*—culturally safe and welcoming for all people in need, including Aboriginal people, LGBTIQ+ people, people from culturally diverse backgrounds, refugees and asylum seekers.

The HOPE program forms one vital, targeted part of Victoria's network of suicide prevention and support programs designed to collectively reduce the rates of suicide in Victoria.

Box 15.2

Overview of the HOPE program

The HOPE program is a core component of Victoria's Suicide Prevention Framework 2016–2025, which aims to halve Victoria's suicide rate by 2025.²⁵ The program targets adults (aged 18 years or older) who are at significant risk of suicide following discharge from hospital after presenting for a suicide attempt or serious planning or intent.²⁶

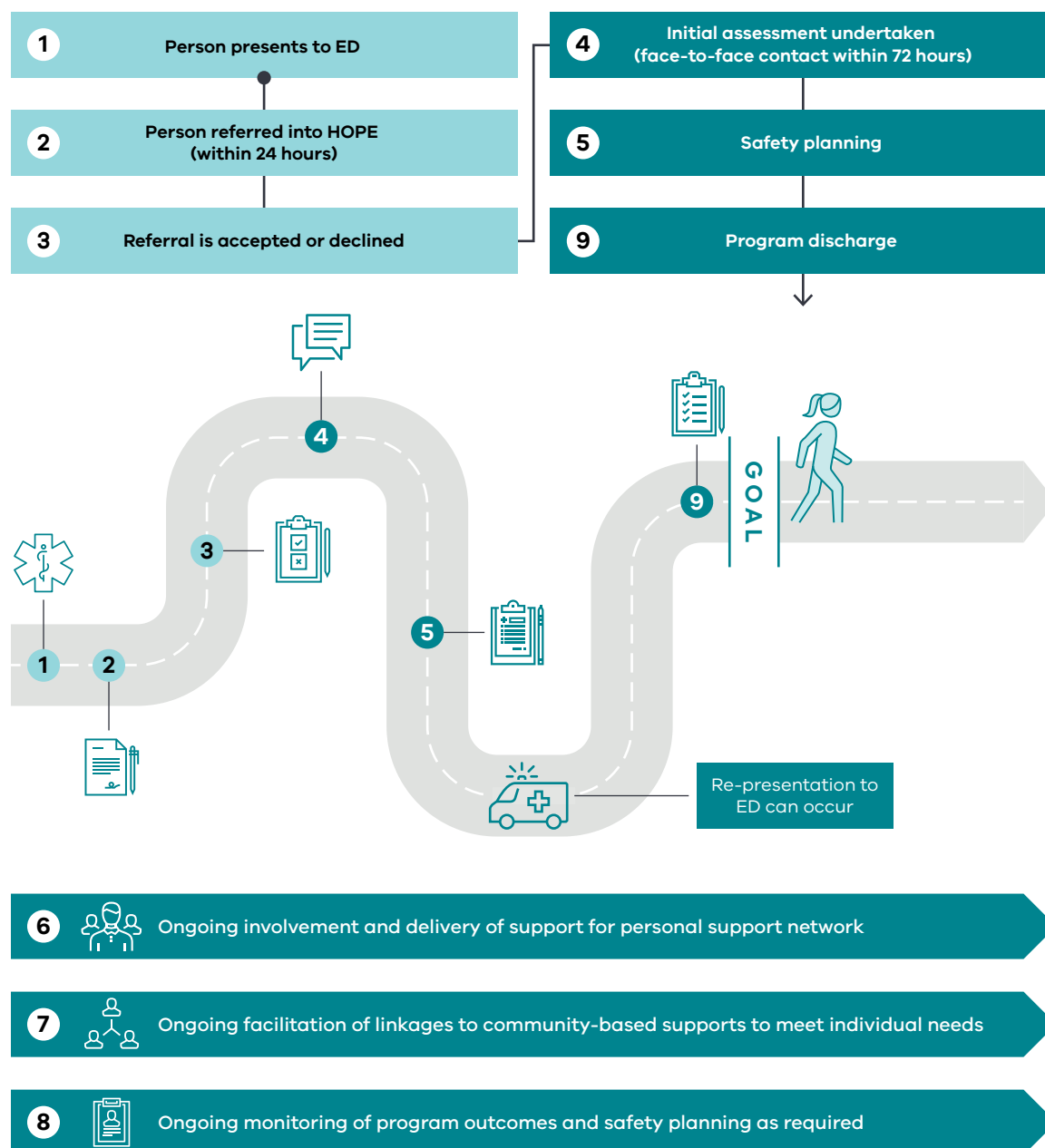
HOPE teams support individuals and their personal support networks—family, friends and other carers—for up to three months after discharge, helping them to identify and build protective factors against suicide.²⁷ Participants are contacted within 24 hours of hospital discharge and receive face-to-face contact within 72 hours. Following initial contact, the HOPE team provide clinical and/or community-based support that is flexible to individual needs (Figure 15.1). Core components of the support model include:

- team members—often key workers—providing regular contact and encouragement to participants via SMS, phone and face-to-face
- engaging peer support networks for participants
- developing safety plans that help participants to stabilise their mental health, identify and respond to mood changes, and implement coping strategies (safety planning also helps their supporters to understand the participant's risk factors, the supports required to make them feel safe, and how and where to access support)²⁸
- facilitating links to community-based supports to meet the specific needs of the individual and their supporters, including links to alcohol and other drug services, specialist accommodation services, family violence support services and longer term mental health services.²⁹

Table 15.1: Location and funding status of HOPE sites

Adult mental health service catchment	Initial six HOPE site funded for three years	Second tranche HOPE site funded recurrently	Recommended future HOPE sites
Barwon	✓ Geelong Hospital		
Gippsland		✓ Latrobe Regional Hospital, Sale	
Glenelg (South Western)			○ South West Healthcare, Warrnambool
Goulburn & Southern			○ Goulburn Valley Health, Shepperton
Grampians		✓ Ballarat Health Service	
Loddon Campaspe / Southern Mallee		✓ Bendigo Health	
North Eastern Hume	✓ Wangaratta District Base Hospital		
Northern Mallee			○ Mildura Base Hospital
Central East			○ Box Hill Hospital
Dandenong		✓ Casey Hospital	
Inner South East	✓ The Alfred Hospital		
Inner Urban East	✓ St Vincent's Hospital		
Inner West			○ Royal Melbourne Hospital
Mid West		✓ Sunshine Hospital	
South West		✓ Werribee Mercy Hospital	
Middle South			○ Monash Medical Centre
North East			○ Austin Health, Heidelberg
North West			○ Adult Psychiatric Inpatient Unit Broadmeadows
Northern			○ Northern Acute Inpatient Service, Epping
Outer East	✓ Maroondah Hospital		
Peninsula	✓ Frankston Hospital		

Figure 15.1: Typical consumer journey through the HOPE program



Source: Adapted from KPMG. Evaluation of the Hospital Outreach Post-suicidal Engagement (HOPE) Initiative - Lapsing Program Evaluation, October 2019. p.25.

15.3 Expanding the Hospital Outreach Post-suicidal Engagement program

To ensure universal state coverage, the Commission proposes that the Victorian Government funds the rollout of HOPE support and assertive outreach services to all area mental health services across the state.

This is in line with the Productivity Commission's recent recommendation that the Commonwealth, state and territory governments offer effective after-care to anyone who presents to a hospital, GP or other government service following a suicide attempt.³⁰

15.3.1 Positive results from the Hospital Outreach Post-suicidal Engagement program

The HOPE program is having a positive effect. Many people have expressed to the Commission their support for the HOPE model. For example, the Commission was told that:

The Hope Program/team is AMAZING. I was able to access this via an inpatient stay at the Alfred Psychiatric Clinic. With their support I am 1) Still alive, 2) Have incredible support for my family [...] and 3) the most resilient I have ever been ...³¹

The HOPE Initiative is a good example, and we would like to see more of these types of programs, including a greater focus on young people and priority populations.³²

Hospital outreach post-suicide engagement (HOPE) teams are catching people falling through the gaps after a suicide attempt and providing intensive support at the time that re-attempt of suicide is highest. Every mental health service/major hospital should have a HOPE team.³³

The Department of Health and Human Services commissioned an independent evaluation of the first tranche of HOPE sites funded as part of the 2016–17 State Budget—Albury Wodonga Health, Alfred Health, Barwon Health, Eastern Health, Peninsula Health and St Vincent's Health.³⁴

The evaluation found that the HOPE program is generating positive results for a high-risk participant group for which there was previously only limited direct support. While the findings are currently of limited strength, there is evidence that the program is achieving the following:

- *Increased numbers of actively engaged HOPE participants over time.* Between April 2018 and July 2019, a total of 604 people were actively engaged in the program. It is likely that without the HOPE program, many of these people would not have otherwise had access to specialist mental health support following hospital discharge.³⁵
- *Improved recovery results for the target cohort.* This is evidenced by improved outcome rating scale scores for a sample of 168 consumers (83 per cent of consumers), signifying better functioning at the individual, interpersonal, social and overall levels.

- *Increased access to community-based supports to meet the unique needs and circumstances of individuals and their personal support networks.* The evaluation found that 90 per cent of people surveyed who were using the HOPE services found the links to community-based services extremely or very useful.³⁶
- *Education and training programs to HOPE staff at all sites.* This is augmenting their ability to deliver effective support for individuals in the target cohort.

Surveyed consumers perceive the program very positively. All respondents reported that their experience with the program was excellent or good. Ninety-six per cent reported feeling extremely or very supported through the program, 'particularly due to the regular contact maintained with their key worker, being able to access support whenever they needed, and in an environment of their choice'.³⁷

15.3.2 New referral pathways

Despite its generally positive results, the HOPE evaluation found there is opportunity to expand referral sources beyond hospital-based referrals to include other parts of the public health system in order to support more people.³⁸

The evidence indicates that people who have attempted suicide or experienced major suicidal ideation do not always go to emergency departments; for example, they might go to their GP instead.³⁹ Similarly, there are current patients of community-based specialist mental health services within area mental health services who experience major suicidal ideation or attempt suicide. Although it is important for other services to have the ability to recognise and support people at risk of suicide,⁴⁰ there are times when a person's needs extend beyond the capacity of these services.

The Commission recommends that sufficient recurrent funding is progressively provided to all HOPE services (current and additional) to expand referral and entry pathways into the program. This would enable all area mental health services to provide assertive outreach and follow-up care for people after a suicide attempt, self-harm or suicidal ideation if they attend a hospital or a community-based specialist clinical mental health service.

15.3.3 Strengthening program fidelity

Evidence presented to the Commission has also highlighted the numerous models and interventions being implemented under the HOPE program and that each area mental health service will have its own criteria, its own assessment tools and its own interventions.⁴¹

The 2019 evaluation found, for example, that where HOPE teams have had the resources to support more consumers, the eligibility criteria has included people presenting to an emergency department with suicidal ideation. As resources to support new referrals diminished, some HOPE sites included only those who had presented to an emergency department following a suicide attempt. The HOPE evaluators concluded that an agile and responsive approach is critical because it 'enables and encourages the delivery of individualised care that meets the unique needs and circumstances of each consumer'.⁴²

The Commission observes the variation and notes the evaluators' views. However, although such an approach allows services to respond flexibly to local needs, there could also be risk of duplication of effort and inconsistent adoption of best practice approaches.

The Commission suggests that the proposed Mental Health Implementation Office draws on the evaluation's findings and makes clear to area mental health services what basic elements—based on available evidence—should be common to HOPE programs throughout Victoria. Elements might include:

- completing an initial assessment and safety plan
- involving and supporting family and personal networks
- facilitating links to community services
- access to peer support
- a balance of clinical and non-clinical staff in service sites.

The HOPE teams should also work closely with the Commission's recommended local Aboriginal social and emotional wellbeing teams. Research suggests that, for Aboriginal people, a key barrier to engagement with mental health services 'lies in a failure to acknowledge, and be able to work within, traditional methods of resolving mental health problems'.⁴³ The Productivity Commission has recently recommended that 'Indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal and Torres Strait Islander people'.⁴⁴

15.3.4 Lessons for implementation

The evaluation of the first tranche of HOPE sites identified specific lessons that should inform any expansion of the model.

Challenges experienced by the existing sites include the following:⁴⁵

- *Engagement of friends and family.* A core component of the program is engaging personal support networks. However, families and friends are not always able to engage, and sometimes consumers do not want to involve them. Standard guidelines should be developed to help staff make decisions about when it is appropriate to engage an individual's personal support network and to what degree.
- *Complexities associated with family dynamics and engagement.* Incidents of family conflict and/or violence can complicate the delivery of care. All HOPE teams should be formally trained in family violence assessment and management to respond appropriately.
- *Demand for after-hours support.* The program's business hours make it hard to fully meet the needs of consumers working full time or living outside the area. For the recommended expansion, operating hours and modes of contact (for example, by text, phone and online) should ensure all consumers receive timely care in a location or mode of their choice. Staff must be adequately resourced to provide out-of-hours support.

- *Limited exclusion criteria.* Different sites have different (and flexible) criteria for accepting referrals. Exclusion criteria can make it difficult for HOPE teams to determine whether someone is too acute for the program or not ready to receive support. Clearly defined exclusion criteria and decision-making protocols should be developed to minimise acceptance of inappropriate referrals and the unnecessary stress and escalation that can result.
- *Workforce capability and capacity.* While rewarding, the high-risk nature of the HOPE program means it can, at times, be challenging and confronting for staff. Some sites experience recruitment and retention challenges. Implementation should consider ways to prepare and support staff effectively, including responses at existing sites such as debriefing sessions, flexible working and external supervision. Further, planning should include selection and training strategies to ensure non-clinical staff have the capacity and confidence to deliver the psychosocial model of care. Lastly, retention of peer support workers is vital, as they are often able to connect with consumers on the basis of shared experience, creating a sense of comfort and shared understanding that enables consumer engagement.⁴⁶

The evaluation supports the evidence the Commission has received (see Chapter 11) that some demographic groups are at increased risk of suicide, including males, Aboriginal Victorians and people who identify as LGBTIQ+. ⁴⁷ While the HOPE program is intended to be implemented in an inclusive, accessible, safe and responsive way, the demographic reach of the program is not yet known. ⁴⁸ Area mental health services should ensure the development and delivery of their HOPE program is inclusive and localised, and that staff are appropriately linked in to the relevant networks and supports that will facilitate engagement with and positive outcomes for different cohorts.

15.4 Expanding support in rural and regional areas

The Commission has heard compelling evidence that people living in rural and regional Victoria experience significantly higher rates of suicide and self-harm⁴⁹ and that the demand pressure challenges for mental health services are hugely amplified in these areas.⁵⁰ Evidence before the Commission highlighted the 'tyranny of distance' and the numerous inequities people living in rural and regional communities are confronted with when trying to gain access to mental health services, including:

- having to travel considerable distances to obtain care and the isolation that can result from being away from family, friends and support networks
- mental health stigma, which can be acute in rural and regional communities and can affect help-seeking behaviour
- services and supports often being out of reach—for example, because farmers cannot be away from their land for an extended time.⁵¹

There is much strength and resilience in rural and regional populations, often demonstrated in a common commitment to community participation and leadership. At community consultations, people impressed upon the Commission the many instances of people banding together to support one another.⁵² This community strength was demonstrated in the aftermath of the 2009 Black Saturday bushfires: research shows that close friends and family, social networks and community groups were important influences on resilience and recovery.⁵³

Although the evidence suggests similar levels of psychological distress for city and country people in Victoria,⁵⁴ the suicide rate is around 50 per cent higher in regional Victoria than metropolitan Melbourne.⁵⁵ For males aged between 35 and 54 years, the suicide rate in regional Victoria is 60 per cent higher than in Melbourne.⁵⁶ Similarly, rates of presentation to emergency departments and hospital admissions for intentional self-harm are higher in rural and regional areas than in metropolitan areas (see Figure 15.2).

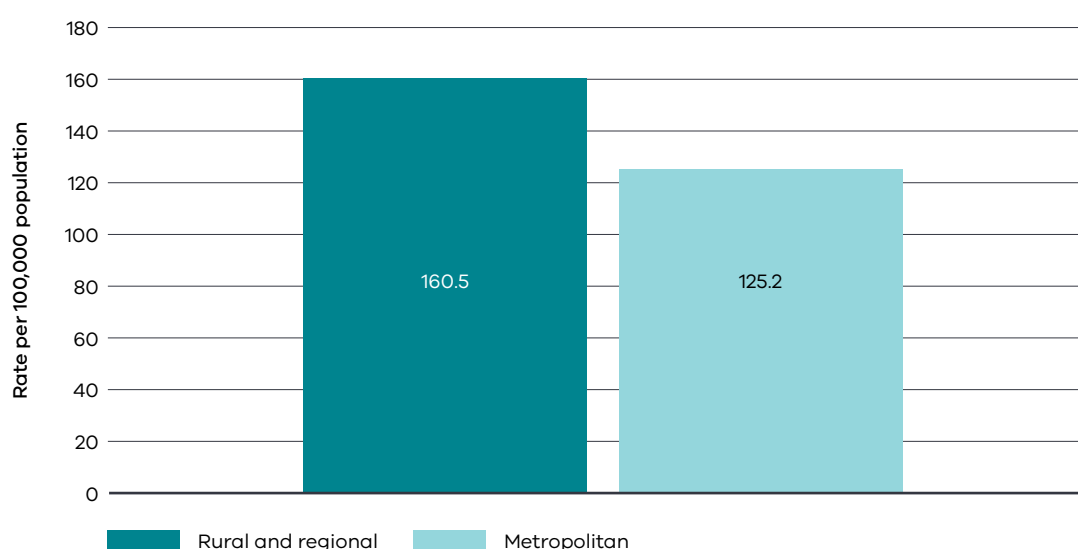
Rural and regional communities have poorer access to and lower levels of use of mental health services.⁵⁷ In addition, a series of stressors and risk factors can be seen more often in rural environments:

- social isolation and prolonged separation from family⁵⁸
- acclimatisation to risk as a result of increased familiarity with injury, accident and pain⁵⁹
- higher rates of alcohol and drug misuse⁶⁰
- the impacts of prolonged drought and extreme weather events⁶¹
- higher rates of socioeconomic disadvantage.⁶²

There is an immediate need to provide more support for people living in rural and regional Victoria.

The Commission recommends that a complementary and connected clinical outreach service in each sub-regional health service be established as part of the HOPE expansion to all regional area mental health services (see Box 15.3 for the definition of sub-regional health services).

Figure 15.2: Emergency department presentations involving self-harm per 100,000 population by area of residence, Victoria, 2013-2014 to 2017-18



Source: Department of Health and Human Services. Integrated Data Resource, Victorian Emergency Minimum Dataset 2013-14 to 2017-18. Australian Bureau of Statistics, Australian Demographic Statistics, June 2009 to June 2018, cat. no. 3101.0, Canberra

The rates have been calculated by dividing the total presentations relating to self-harm by the 2016 Victorian population, the midpoint of the time period.

Self harm defined as ICD-10AM codes R4581 (suicidal ideation) and X60-X84 (intentional self-harm), present in any one of the reported diagnosis codes.

Box 15.3

Definition of sub-regional health services

Sub-regional health services refer to state-funded health services and hospitals located in each sub-regional centre, which includes: Bairnsdale Regional Health Service, Central Gippsland Health, Echuca Regional Health, Mildura Base Hospital, Northeast Health Wangaratta, South West Healthcare, Swan Hill District Health, West Gippsland Healthcare Group, Western District Health Service and Wimmera Health Care Group.

Services delivering care at the sub-regional level often provide a range of more complex services than those delivered at the local level [...] These providers bridge the gap between the range of lower-complexity services provided by smaller local rural healthcare providers and the larger regionally based health services.⁶³

As part of the regional partnership model, each sub-regional outreach service should be networked to its regional health service's HOPE program. This will enable people living in rural and regional areas to receive support after a suicide attempt, as well as providing assertive outreach mental health services more broadly.

This could include facilitating strong collaboration and pathways between GPs, psychiatrists, psychologists and outpatient services. Regional HOPE services should provide clinical and psychosocial support as required (for example, advisory and consultative support).

Psychosocial assessment followed up by tailored psychosocial support should also be provided. Evidence suggests that, compared with medical admission, psychiatric admission and referral for specialist mental health follow-up is associated with a lower risk of repeated self-harm.⁶⁴

Regional outreach services should have a focus on working with other health and social service providers to respond to local community needs. It is vital that, as part of their recruitment and training, the outreach workers gain the ability to meaningfully interact with and support people in these areas. Services should be culturally sensitive and workers should possess an understanding of rural and farming life.

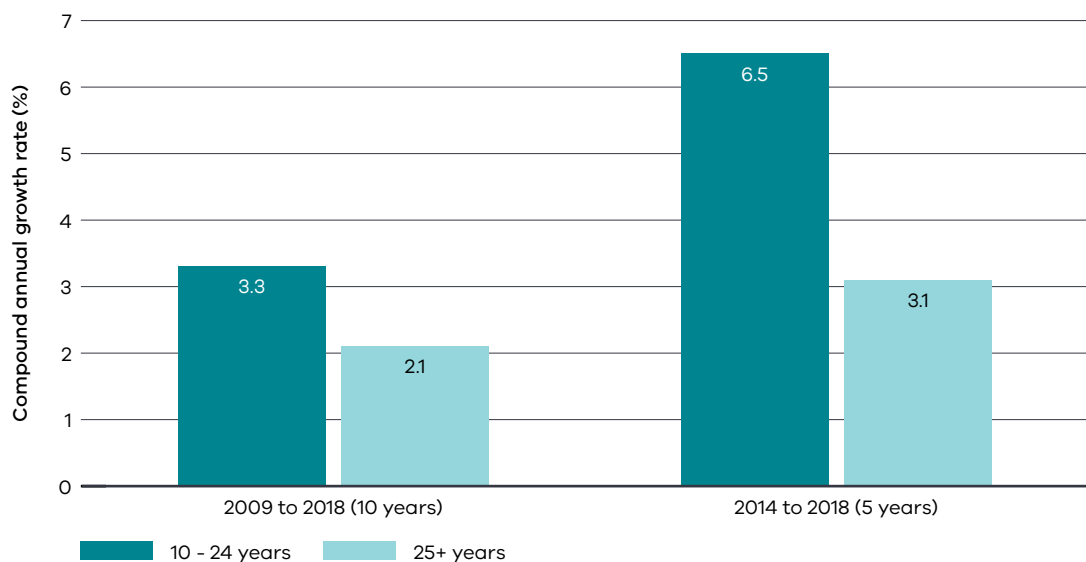
Where services are available, they're not always appropriate services [...] there may be service providers who don't have an understanding of work and life within a rural farming community, and that's often very important to build rapport with a client [...] to have that understanding of the situation that they're in.⁶⁵

15.5 Expanding support to children and young people

Despite the fact that Victoria's children and young people experience higher rates of suicide and self harm compared to adults, and that these rates continue to rise, the Commission found that there are significant service gaps to support this cohort following a suicide attempt or self harm. Chapter 11 established the size of this problem. The Commission concludes that appropriate and specific services are needed for children and young people at risk of suicide.⁶⁶

Between 2009 and 2018 in Victoria the annual growth in the rate of suicides among people aged 10–24 years was 3.3 per cent (1.1 per cent higher than for people aged 25 years or older). In the past five years, the average growth in the rate for suicides for people aged 10–24 years was 6.5 per cent, significantly higher (3.4 per cent) than for people aged 25 years or older (see Figure 15.3).

Figure 15.3: Annual growth rate in suicides by age, Victoria, 2009 to 2018



Source: Coroners Court of Victoria, Suicide Data Summary, 2009 to 2018.

Annual growth represented in this figure is compound annual growth. Compound annual growth rate is the smoothed annual change over the specified period (as if the growth had happened steadily each year over that time period).

On average, two to three Victorians aged 10–14 years take their own lives each year.⁶⁷ Across Australia between 2015 and 2017, suicide was the number one underlying cause of death for people aged 15–24 years.⁶⁸ Particular groups of young people are at greater risk of suicide, including young men, young people with an experience of mental illness, Aboriginal and Torres Strait Islander children and young people, young people recently in contact with the justice system, young people in out-of-home care, young people in rural and regional areas, young people who are trans⁶⁹ and young people who have been exposed to suicide or suicidal behaviour.⁷⁰

Several reports and submissions have highlighted that Victoria's suicide prevention policies and programs have identifiable gaps in evidence-based, appropriate and accessible programs and services for children and young people. In particular, young people who present to emergency departments or hospitals with self-harm or suicidal behaviour are often discharged without follow-up care, despite the elevated risk of suicide after discharge.⁷¹

headspace and the Orygen Centre for Excellence in Youth Mental Health have identified an urgent need for assertive outreach and follow-up care following presentations of children and young people to an emergency department for attempted suicide, suicidal ideation or self-harm.

Orygen's 2016 report *Raising the Bar for Youth Suicide Prevention* found that, in Australia, including Victoria, young people who are unable to access timely care are falling through the cracks, with tragic consequences. This was most evident in the period following discharge from an emergency department or hospital after a suicide attempt or self-harm.⁷²

The Commission has considered the proposal that a youth-focused assertive outreach and follow-up service like the HOPE model could be introduced to support children and young people.⁷³ The Commission accepts evidence from child and youth mental health experts that developing mentally and culturally appropriate approaches that address this cohort's individual help-seeking needs and behaviours should be central to any service model. Without this, evidence indicates that children and young people may not be able to effectively engage with services, or may not have their needs met.⁷⁴ Therefore, the Commission wants to ensure that not only can children and young people access follow-up care and support, but that it provides effective and evidence-based treatments specific to their needs.

The Commission recommends that the Victorian Government, through the proposed Mental Health Implementation Office, funds the Royal Children's Hospital, Monash Children's Hospital, Alfred Health and Orygen in partnership to create, deliver and evaluate the first phase of a new youth assertive outreach and follow-up care service (for children and young people who have attempted suicide, have suicidal ideation or have intentionally self-harmed) in their catchment areas.

The design of the service should be informed by the program guidelines and expanded referral pathways the Commission has recommended for the adult HOPE sites. Respecting the need for a youth-specific model of care, the Commission recommends that the four service providers work in partnership to develop an assertive outreach and follow-up service for children and young people that all providers can implement with fidelity. This should include an evidence-based multidisciplinary approach to care and the design of evaluation and screening tools.

The service should be delivered by a child and youth-friendly workforce and be connected and integrated into other mental health service offerings to ensure children and young people using the service are supported to transition into continuing care as required. Service design should also include connections to broader health, social and community services, including housing, youth justice, child and family support and education to ensure each person's holistic recovery needs are met.

Service systems in contact with vulnerable children have a shared responsibility to promote suicide prevention in children by ensuring they deliver a service response that prioritises the children's particular circumstances and experiences⁷⁵

The Royal Children's Hospital, Monash Children's Hospital, Alfred Health and Orygen should also ensure that appropriate referral pathways are established into the new service from emergency departments and clinical community-based teams within the area mental health services.

The Mental Health Implementation Office, in partnership with the service providers, should ensure a robust evaluation methodology and program is established to assess the efficacy

of the service. Subject to the findings of the phase 1 evaluation, the model of care should be considered for statewide expansion in the medium term. The voices of children and young people, as well as their families and carers, should inform the design of the new service and the evaluation methodology.

Any expansion should not pre-empt the final governance arrangements or models of care for children and young people that the Commission will recommend in 2020. The Commission is continuing to examine the necessary broader reforms to child and youth mental health services that will improve responsiveness, early intervention and quality, including alternative spaces for children and young people to seek and receive care. The Commission will consider the progress of this particular initiative, and the timing for its expansion, within that wider context.

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Chapter 16

Aboriginal social and emotional wellbeing

Recommendation

The Royal Commission recommends that the Victorian Government, through the Mental Health Implementation Office, expands social and emotional wellbeing teams throughout Victoria and that these teams be supported by a new Aboriginal Social and Emotional Wellbeing Centre. This should be facilitated through the following mechanisms:

- dedicated recurrent funding to establish and expand multidisciplinary social and emotional wellbeing teams in Aboriginal Community Controlled Health Organisations, with statewide coverage within five years
- scholarships to enable Aboriginal social and emotional wellbeing team members to obtain recognised clinical mental health qualifications from approved public tertiary providers, with a minimum of 30 scholarships awarded over the next five years
- recurrent funding for the Victorian Aboriginal Community Controlled Health Organisation to develop, host and maintain the recommended Aboriginal Social and Emotional Wellbeing Centre in partnership with organisations with clinical expertise and research expertise in Aboriginal mental health. The centre will help expand social and emotional wellbeing services through:
 - clinical, organisational and cultural governance planning and development
 - workforce development—including by enabling the recommended scholarships
 - guidance, tools and practical supports for building clinical effectiveness in assessment, diagnosis and treatment
 - developing and disseminating research and evidence for social and emotional wellbeing models and convening associated communities of practice.

16.1 The mental health of Aboriginal communities

It is 24 years since the Ways Forward report drew the nation's attention to the high levels of unmet need for culturally safe mental health services for Aboriginal people.¹ Since then, numerous reports have concluded that Aboriginal communities continue to live with the effects of trauma wrought by colonisation and post-invasion government activity.²

In Victoria it is estimated that more than 47 per cent of Aboriginal people have a family member who was forcibly removed from their kin under policies that gave rise to the Stolen Generations.³ Western Australia, South Australia and Victoria consistently have the highest proportions of their populations born before 1972 reporting being forcibly removed in multiple surveys conducted from 2002 to 2014–15.⁴ As the national Healing Foundation submitted to the Commission, Aboriginal people in Victoria carry the significant legacy of trauma caused by the forcible removal of children from Aboriginal families.⁵ A first-of-its-kind study commissioned by the foundation provided comprehensive data to illustrate the direct link between the removal of Aboriginal children and symptoms of trauma in families and their descendants. The study also documented higher levels of health, economic and social disadvantage in the affected families.⁶ The Commission was told of the negative impacts of this trauma:

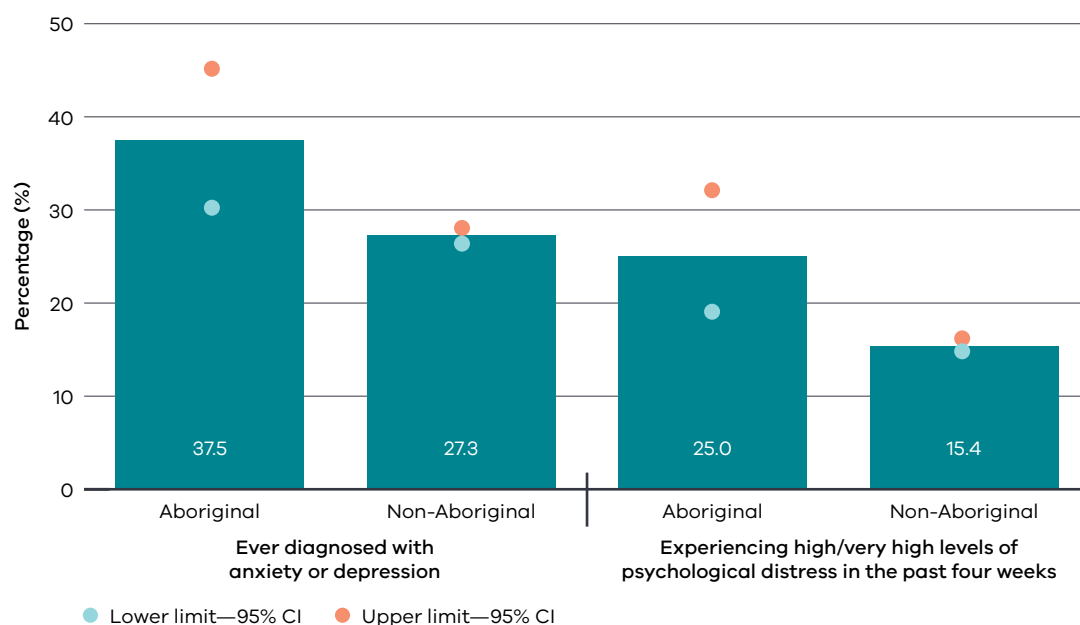
The prevalence of mental health within Victorian Aboriginal communities can be directly related to the loss of land, culture, identity, self-respect, self-worth and the breakdown of traditional roles within communities. Systemic racism has been a significant factor in ensuring Aboriginal communities remain fragmented and disjointed and has supported the social isolation, trauma and depression of many Aboriginal communities' members.⁷

It is important for the Royal Commission to understand that colonial violence is not a stagnant piece of history. Intersecting systemic racism and systemic sexism keep Aboriginal and Torres Strait Islander women trapped in violent situations and cycles of trauma. The mental health system can present as yet another form of violence.⁸

Post-invasion policies not only disrupted family attachments but severed Australian Aboriginal people's attachment to their land, cultures and identities. The historical trauma of Aboriginal people can be 'transmitted' intergenerationally to entire communities as well as individuals and families.⁹ Today, many Aboriginal communities face problems such as alcohol abuse and forms of violence that did not exist before colonisation.¹⁰ Aboriginal mental health is also affected by racism and discrimination. Research indicates that almost all Aboriginal people in Victoria have experienced racism¹¹ and that those who experience high levels of racism are more likely to also have elevated levels of psychological distress.¹²

As discussed briefly in Part One, trauma—and the everyday stresses associated with deprivation and social marginalisation—can have pervasive negative effects on mental health. In 2017, 25 per cent of Aboriginal people in Victoria (compared with only 15.4 per cent of non-Aboriginal people in Victoria) reported 'high' or 'very high' levels of psychological distress (Figure 16.1).¹³ Victorian data also suggests that the prevalence of depression and anxiety is greater among Aboriginal people compared with non-Aboriginal Victorians, with 37.5 per cent of Aboriginal people having been diagnosed with depression or anxiety compared with 27.3 per cent of non-Aboriginal people.¹⁴ Aboriginal people also have higher rates of suicide than the non-Aboriginal population,¹⁵ as discussed in Part Three.

Figure 16.1: Proportion of adult population ever diagnosed with anxiety or depression, or with high/very high levels of psychological distress in the past four weeks by Aboriginal status, Victoria, 2017



Source: Victorian Agency for Health Information, Mental Health and Wellbeing – Victorian Population Health Survey 2017 (preliminary draft and unpublished).

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.

The Commission has heard significant concerns from Aboriginal organisations¹⁶ and experts¹⁷ about the intersections between the mental health and justice systems for Aboriginal people. Systemic racism and intergenerational trauma contribute to the over-representation of Aboriginal people in the Victorian justice system—Aboriginal children and young people are 14 times more likely than their non-Aboriginal peers to be under youth justice supervision;¹⁸ and adults are 12 times more likely.¹⁹

When Aboriginal people enter the justice system, mental health supports are often inaccessible or inappropriate. As one Aboriginal worker stated:

When we go to the prison I think how the mental health system in there doesn't work for our women: it is too rigid, too exposed.²⁰

Importantly, the impacts of colonisation have not diminished Aboriginal people's connection to country and culture.²¹ Aboriginal cultures and communities provide unique protective factors that are sources of strength and resilience in the face of ongoing oppression.²²

Enabling communities to identify and address their own needs starts from the knowledge that communities have existing strengths and assets that make them part of the solution.²³

16.2 Culturally safe mental health services

Many Aboriginal people obtain mental health treatment from mainstream mental health services. According to census data Aboriginal people make up 0.8 per cent of Victoria's population.²⁴ However, Aboriginal people make up 2.8 per cent of people accessing clinical public mental health care, indicating that Aboriginal people are over-represented in these services.²⁵ This evidence indicates a high level of need for mental health care in Aboriginal communities.

Although some mainstream services—such as Mildura Base Hospital and Goulburn Valley Health²⁶—build cultural competency through partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs), a 2014 Victorian Auditor-General report indicated that such collaboration is not the norm.²⁷

Evidence also suggests that some Aboriginal people encounter racism in mainstream health settings. One study, involving 755 Aboriginal people in Victoria, indicated that nearly one-third had experienced racism—for example, being a target of racist names, jokes or teasing, being told they 'didn't belong in Australia', or hearing comments based on stereotypes of Aboriginal Australians—in a health setting in the preceding year.²⁸ Research also indicates that experiencing racism in health settings is associated with increased psychological distress.²⁹ The Commission was told of the negative impact of racism on Aboriginal people's mental health:

We spend a lot of time dealing with racism and this impacts on time and mental health.³⁰

There's just a lot of stigma and we need to remove racist systems so people get the support they need.³¹

Systemic racism is not only affecting our communities but also our workforce. As patients, we are often stereotyped. You are talking about traumatised Elders who are exposed to systemic racism when they seek treatment.³²

In addition to overt racism, the usual practices of health services can be culturally unsafe for Aboriginal people. Research indicates that failure of health professionals to recognise and respond to cultural differences and communication gaps can reduce positive health outcomes for Aboriginal clients, or even increase the risk of life-threatening outcomes.³³ The Commission has been told that many mainstream mental health services' approaches are problematic for Aboriginal communities. For example, diagnoses may be based on misinterpretation of behaviour or symptoms related to trauma, grief and social factors: 'In the [Aboriginal] community, grief is compounded and compounded'.³⁴

Ms Helen Kennedy, Chief Operations Officer of the Victorian Aboriginal Community Controlled Health Organisation, and a witness before the Commission explained that experiencing racism and culturally unsafe care can lead to profound distrust of mainstream health services.³⁵ This is consistent with research indicating that experiencing racism or culturally unsafe practices can reduce treatment adherence or result in complete disengagement from health services.³⁶

The experiences of Aunty Nellie Flagg, an Elder and a Taylor-Charles, whose traditional countries are Wemba Wemba, Dja Dja Wurrung and Boonwurrung, and a witness before the Commission, are recounted in Box 16.1.

Box 16.1

Aunty Nellie Flagg³⁷

Aunty Nellie Flagg was born in 1957 and grew up as the second-last of ten children.

My life growing up was one of joy, but also a lot of racism that impacted on me, my family and the Aboriginal community.

Aunty Nellie told the Commission about the impacts of racism, recalling times she wasn't served in shops and when other girls at school would talk to her on the sports field but ignore her elsewhere.

I believe that they did not see me as Nellie; they see me as an Aboriginal person.

She also talked about the impact of trauma and loss on her and others in the Aboriginal community and said that often the trauma comes from family stories, including experiences of death or abuse, which can have a significant impact.

When her son tried to take his own life, he found an Aboriginal counsellor who made a difference.

He didn't have to explain his culture; the Aboriginal counsellor made him feel at ease because he understood where my son was coming from.

As part of her work with government and community organisations and in Aboriginal Affairs for more than 40 years, Aunty Nellie worked as a suicide prevention worker in an Aboriginal social and emotional wellbeing team.

A lot of our young people die by suicide because of the traumas that they have felt or were dealing with. It was heartbreaking to hear these stories and see the impact with the communities.

For Aunty Nellie, trauma and loss in her own family led her to experiencing depression. She also recognises the effect of hearing other people's stories as part of her work.

I walked this journey with the people who told me about these things. This affects me and my mental health because I am living not only with my own traumas, but also with other people's traumas.

When talking about challenges with the mental health system, Aunty Nellie states the importance of access to culturally sensitive services, and also the way Aboriginal people talk about their health and labels.



When Aboriginal people talk about our health, we don't do it in isolation. Mental, physical and spiritual health is holistic.

Non-Aboriginal people who work with Aboriginal people should receive ongoing cultural training (not just a one-off tick a box). Many Aboriginal people will be more likely to seek the help they need if the person who is helping them understands where they are coming from.

My family has been afraid of people judging them for their mental health issues. They have been afraid to talk about it for fear of being labelled 'mental' or being unable to hold a job.

For future services, Aunty Nellie recognises that more funding is needed and should focus on young people and education. She also refers to more needing to be done to address family violence and drug and alcohol abuse and wants more Aboriginal people to share their stories.

... I continue to talk hoping that other Aboriginal people, women and men, are able to talk about what is hurting them.

16.3 Past inquiries and reviews

In developing recommendations that respond to the needs of Aboriginal communities, the Commission has examined the findings of previous inquiries into Aboriginal health and wellbeing, including unimplemented and partially implemented recommendations from a previous royal commission³⁸ and a major national review.³⁹ Figure 16.2 lists some of the reports examined and provides a sample of their recommendations.

The Commission has also reviewed the 2015 Gayaa Dhuwi (Proud Spirit) Declaration, which was developed by the National Aboriginal and Torres Strait Islander Leadership in Mental Health group, a group of senior Aboriginal and Torres Strait Islander people working in the areas of social and emotional wellbeing, mental health and suicide prevention. Gayaa Dhuwi sets out principles of Aboriginal and Torres Strait Islander social and emotional wellbeing for governments and other entities for shaping mental health system responses to Aboriginal mental health.⁴⁰

Several themes relevant to providing mental health services for Aboriginal people emerge from the past inquiries the Commission has reviewed.

16.3.1 Self-determination

The right to Aboriginal self-determination is enshrined in international law⁴¹ and can be applied in different ways in different contexts. In the context of mental health, it means transferring power and resources to Aboriginal communities to design and deliver their own mental health services while drawing on the skills and expertise of others where needed. Australian and international evidence shows that self-determination is crucial to achieving lasting improvements in health and social outcomes for Aboriginal people.⁴² The Commission notes that, while the Victorian Government has made significant commitments to advancing Aboriginal self-determination, for example through treaty processes, a lack of self-determination has limited progress to date:

Some might say that what's blocked change is that Aboriginal people were excluded.⁴³

16.3.2 The centrality of family and kinship groups

While Western psychiatry, particularly for adults, focuses on individuals, the centrality of Aboriginal family and kinship connections to a person's mental health must be recognised and respected. One person told the Commission:

People need to understand that for Aboriginal communities, the framing is:
I am better if we are all better.⁴⁴

16.3.3 Recognition of trauma and the impacts of racism and social disadvantage

Service responses for Aboriginal communities must be sensitive to the trauma many Aboriginal people have experienced and the ongoing impact of racism and social disadvantage on their mental health and wellbeing.

Figure 16.2: A sample of previous recommendations and current commitments relating to Aboriginal social and emotional wellbeing, Victoria and Australia

Previous recommendations		
1990s	1991	Royal Commission into Aboriginal Deaths in Custody 'That Aboriginal community-controlled health services be resourced to meet a broad range of functions, beyond simply the provision of medical and nursing care, including the promotion of good health, the prevention of disease, environmental improvement and the improvement of social welfare services for Aboriginal people.' ¹
	1995	Ways Forward report 'At least 2 major and comprehensive Aboriginal Community Mental Health Programs should be developed initially in each State, one in an urban centre and one in a rural region with a linked remote region. In other regions "seed teams" should be commenced incorporating male and female Aboriginal Mental Health Workers and at least another Mental Health Professional.' ²
	1997	Bringing Them Home report 'That all government-run mental health services work towards delivering specialist services in partnership with Indigenous community-based services and employ Indigenous mental health workers and community members respected for their healing skills.' ³
2000s		
2010s	2010	Victorian Aboriginal Suicide Prevention and Response Action Plan 'Strengthen partnerships between local alcohol and drug services, with community health, local policy, local government and local Aboriginal Community Controlled Health Organisations (ACCHOs) to ensure inclusive, coordinated and appropriate responses to address alcohol and drug use, misuse and treatment.' ⁴
	2014	National Mental Health Commission Contributing Lives Review 'Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services), linked to Aboriginal and Torres Strait Islander specialist mental health services.' ⁵
	2016	Always was, always will be Koori children 'DHHS, in partnership with VACCHO, to develop and implement a strategy and practice standard to ensure all Aboriginal children in out-of-home care have a specific Aboriginal children's health check upon entry to care, and then annually, at an ACCHO.' ⁶
Current commitments		
2020s	2017–2027	Balit Murrup 'Where we want to be in ten years' time – Interagency, multi-disciplinary Aboriginal social and emotional wellbeing teams exist across Aboriginal community controlled organisations and mainstream services agencies. They will provide culturally appropriate support and treatment to Aboriginal mental health consumers. Teams to include psychologists, psychiatrists, counsellors, mental health nurses, allied health and Aboriginal mental health and community mental health support workers.' ⁷
	2017–2027	Korin Korin Balit-Djak 'Over the next three years, the Department will: <ul style="list-style-type: none"> • Partner with Aboriginal communities to co-design healing, grief and loss, trauma-informed and recovery approaches and tools delivered through Aboriginal and mainstream services. These will focus on transgenerational trauma, children and young people in child protection and the justice system. • Consolidate and expand an evidence base for initiatives and approaches proven to be effective in strengthening Aboriginal resilience, healing, suicide prevention and recovery from mental illness.'⁸

1 Recommendation 259, see Deloitte Access Economics, *Review of the Implementation of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody*, August 2018, p. 528.

2 Pat Swan, Professor Beverley Raphael, and National Aboriginal Community Controlled Health Organisation, *Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy: National Consultancy Report*, 1995, p. 9.

3 Recommendation 33c, see Human Rights and Equal Opportunity Commission, *Bringing them home – Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*, 1997, p. 347.

4 Action 2.9, see Department of Health, *Victorian Aboriginal Suicide Prevention and Response Action Plan 2010–2015*, 2010, p. 4.

5 Recommendation 18, see National Mental Health Commission, *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services: Summary*, November 2014, p. 17.

6 Recommendation 8.1, see Commission for Children and Young People Victoria, *Always Was, Always Will Be Koori Children: Systemic Inquiry into Services Provided to Aboriginal Children and Young People in out-of-Home Care in Victoria*, 2016, p. 19.

7 Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027*, October 2017, p. 44.

8 Strategic direction 5.1.1 g–h, see Department of Health and Human Services, *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017–2027*, August 2017, p. 67.

16.3.4 Strengths-based care

Developing culturally appropriate models of mental health care calls for approaches that build on the strengths of Aboriginal people, as shown by their strength and creativity in the face of enormous loss and adversity.

16.3.5 Culturally valid understandings of mental health

The assessment and treatment of mental illness, and approaches to mental health service delivery, must be based on culturally valid understandings of mental health.

Mainstream biomedical explanatory and treatment models for mental illness are considered at odds with Aboriginal cultural understandings of mental health, which are based on beliefs about the inextricable connections between the physical, emotional and spiritual wellbeing of a person, their community and the environment. These domains of life are believed to be closely interconnected and explicable only through understanding the whole. As highlighted in the Ways Forward report, for Aboriginal people:

Health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well-being of their communities.⁴⁵

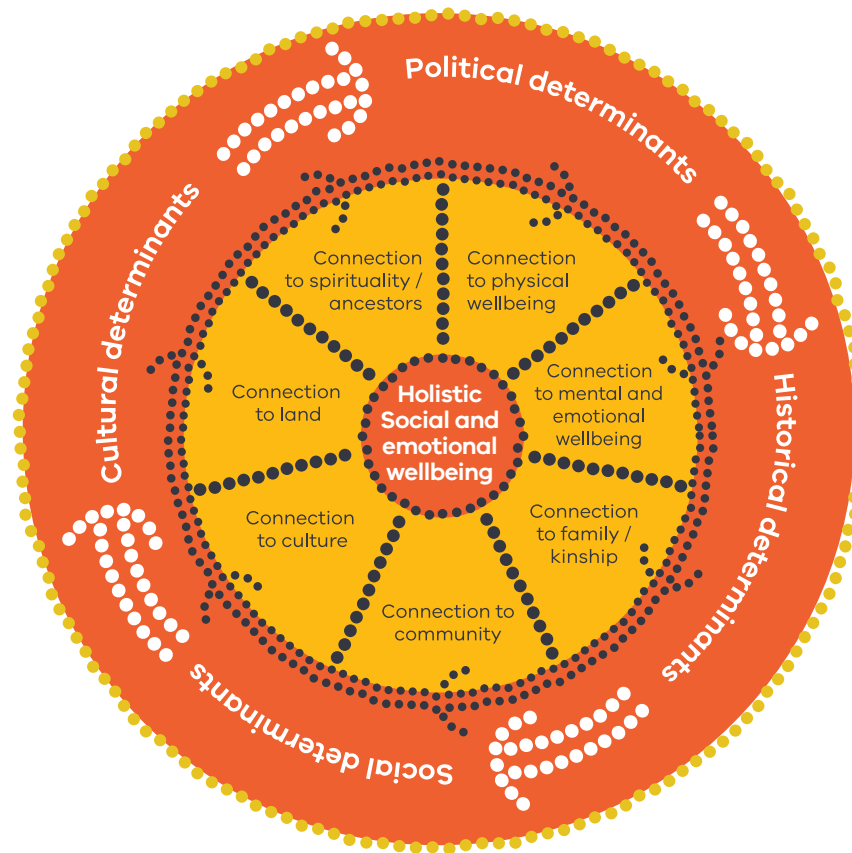
The shorthand term 'social and emotional wellbeing' encapsulates this conceptualisation of mental health. Social and emotional wellbeing means being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life.⁴⁶ Dr Graham Gee, Clinical Psychologist and Senior Research Fellow at the Murdoch Children's Research Institute and a witness before the Commission, told the Commission: 'We've used that term for going on three decades now, and it really refers to a more holistic view of health than the conventional understandings of mental health'.⁴⁷

The need for a holistic approach was highlighted to the Commission:

What's happening now doesn't complement our people.
There's a clear need to be more holistic.⁴⁸

We need holistic responses that are developed and led
by Aboriginal people and community organisations in partnership.⁴⁹

As Figure 16.3 shows, this holistic view is not limited to connections between the mind and the body: it also captures Aboriginal people's connections to land, to spirit, spirituality and ancestors, to culture and to community, family and kinship.⁵⁰

Figure 16.3: Aboriginal social and emotional wellbeing

Source: Gee, G., Dudgeon, P., Schultz, C., Hart, A., & Kelly, K. (2014). Aboriginal and Torres Strait Islander social and emotional wellbeing. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (pp. 55– 68). Canberra: Commonwealth of Australia.

16.3.6 Multidisciplinary care and service partnerships

Reflecting Aboriginal understandings of mental health, services should offer holistic treatment, care and support that responds to the multiple domains of the person's experience rather than just the symptoms of an illness. Mental health services for Aboriginal people therefore require a multidisciplinary workforce and partnerships with a range of Aboriginal and mainstream services.

16.4 Social and emotional wellbeing as the preferred model

The Commission has received compelling proposals from Aboriginal witnesses and communities for expanding multidisciplinary models of care that apply the Aboriginal concept of social and emotional wellbeing. Aboriginal leaders and organisations told the Commission that communities have been calling for self-determined social and emotional wellbeing models of care for decades.

16.4.1 Current Victorian policy

The Commission has taken account of the advice of Aboriginal experts, who have urged the Commission to support implementation of existing Victorian Government commitments⁵¹ to Aboriginal social and emotional wellbeing and to avoid 'reinventing the wheel'.⁵²

The Victorian Government has made a commitment to self-determined Aboriginal social and emotional wellbeing programs. In 2017 it released two 10-year frameworks for improving the mental health of Aboriginal and Torres Strait Islander people—Korin Korin Balit-Djak⁵³ and Balit Murrup.⁵⁴ Korin Korin Balit-Djak is an overall framework for action to advance Aboriginal self-determination and improve the health, wellbeing and safety of Aboriginal people in Victoria over 10 years.⁵⁵ Balit Murrup, meaning 'strong spirit' in the Woi-wurring language,⁵⁶ is a companion framework informed by the Aboriginal social and emotional wellbeing model.⁵⁷

Balit Murrup and Korin Korin Balit-Djak both include commitments to expand multidisciplinary social and emotional wellbeing models and to build the evidence base for clinically effective models of care. The Victorian Government has funded demonstration projects involving four multidisciplinary social and emotional wellbeing teams in Aboriginal Community Controlled Health Organisations (ACCHOs);⁵⁸ the funding is over three financial years to 2019–20.⁵⁹

Aboriginal clinical and therapeutic mental health positions have also been established in 10 Aboriginal organisations, and 10 Aboriginal mental health trainees are currently working in mainstream services while completing a Bachelor of Science (Mental Health).⁶⁰

16.4.2 Evidence for social and emotional wellbeing models

Dr Gee told the Commission that evidence supporting Aboriginal social and emotional wellbeing models is in the early stages of development: 'We've got a limited evidence base here in Victoria, primarily because there's such little money gone into community-driven research and evaluations'.⁶¹

While the Commission acknowledges there are limitations in the evidence base (for example, few controlled outcomes trials),⁶² the evidence that is available suggests that these services have resulted in positive outcomes such as:

- increased access to mental health services⁶³
- significant decreases in rates of depression at six-month follow-up⁶⁴
- improved outcomes for children and families, increased service use and satisfaction, and better health outcomes.⁶⁵

In addition to the academic literature, evidence before the Commission includes internal evaluations that indicate positive impacts such as reductions in service users' substance use, fewer contacts with the justice system and inpatient hospital admissions and strengthening of their connections to culture, country and family.⁶⁶

Early findings of an evaluation of the new multidisciplinary social and emotional wellbeing demonstration projects indicate positive outcomes such as reduced stress in clients' lives, longer periods of engagement with ACCHOs, increased access to supports and increased help-seeking.⁶⁷

International evidence also indicates the success of locally owned healing programs in indigenous communities in Canada, New Zealand and the United States.⁶⁸ For example, the recent He Ara Oranga Inquiry into Mental Health and Addiction in New Zealand found that some Māori communities have made substantial gains in reducing fragmentation between services by forming community collectives that provide frontline mental health functions including mental health assessment, triage, early intervention, respite care and ongoing support.⁶⁹

16.4.3 Unmet need for social and emotional wellbeing services

Although there have already been important social and emotional wellbeing initiatives in Victorian Aboriginal communities, the level of need for culturally respectful models of care outstrips service availability and resources.

The Commission has received evidence of considerable unmet demand for social and emotional wellbeing services in ACCHOs. One submission pointed out that at present there are only a limited number of ACCHOs in metropolitan Melbourne, and they have the task of servicing about half of the state's Aboriginal population: this is contributing to overwhelming demand in the metropolitan area.⁷⁰ In 2017–18, 22 out of 24 organisations providing Aboriginal primary health services in Victoria named social and emotional wellbeing as one of the top five areas of unmet need faced by the community they serve.⁷¹

Ms Kennedy told the Commission that services provided by ACCHOs have high rates of use when they are available and that more than half of ACCHOs report that depression is the most prevalent issue they come across, followed by anxiety.⁷²

16.5 Lessons for mainstream mental health services

The Commission's proposed expansion of Aboriginal social and emotional wellbeing services in ACCHOs is not only a response to the pressing mental health needs of Aboriginal people. The Commission also expects that the services will indicate ways in which mainstream mental health services could be improved.

ACCHOs, which offer many different programs and services under one umbrella and often form strong partnerships with other local organisations, represent an approach that avoids the service fragmentation and poor continuity of care characterising mainstream mental health services. One Aboriginal worker told the Commission, 'Integration works well in our space and this is something that other parts of the system can learn from Aboriginal communities'.⁷³

When visiting Aboriginal services and speaking with Aboriginal leaders, the Commissioners were impressed by how models of care being developed for Aboriginal communities aligned with the calls of non-Aboriginal consumers and carers for mental health services that are:

- flexible and able to be delivered outside traditional hospital and clinic settings
- focused on the needs of the whole person rather than solely on medical management of specific symptoms
- focused on strengths, recovery and healing from trauma rather than managing 'deficits' and risks to the person or others
- respectful of consumers' cultural—as well as religious, social, sexual and gender—identities
- welcoming of family and carer involvement.

Aboriginal social and emotional wellbeing approaches exemplify a comprehensive, person-centred, trauma-informed model that could benefit all Victorians with mental illness.

Evaluation of the new social and emotional wellbeing services should seek lessons for the broader Victorian mental health system.

16.6 Expanding social and emotional wellbeing services

The recommendations in this interim report focus on taking steps to expand and improve Aboriginal social and emotional wellbeing services in ACCHOs throughout the state. In 2020 the Commission will work with Aboriginal communities to discuss a broad system redesign through improving service access and navigation, developing effective and equitable funding models, workforce considerations and opportunities for further service responses, as well as prevention and early intervention programs.

The Commission recommends that the Victorian Government provides dedicated funding to establish or expand multidisciplinary social and emotional wellbeing teams in ACCHOs, with statewide coverage within five years. This indexed funding should be allocated on a recurrent basis. Aboriginal witnesses, evaluations of Victorian programs, non-Aboriginal organisations and previous inquiries have all called for long-term sustainable funding for Aboriginal organisations to facilitate strategic planning, to develop partnerships and for workforce attraction and retention. Internationally, the Organisation for Economic Co-operation and Development (OECD) highlights evidence from Australia, Canada and the United States that identifies short-term funding as a major risk for reforms in indigenous self-governed sectors.⁷⁴

The teams will initially focus on Aboriginal adults (aged 16 years or older) with moderate to severe mental health needs. The recommended Aboriginal Social and Emotional Wellbeing Centre will continue to build the evidence base for best practice and clinical effectiveness in working with Aboriginal children and younger people.

The Commission's intentions for expanding and strengthening Aboriginal social and emotional wellbeing services are explained in the sections that follow.

16.6.1 Design and delivery of social and emotional wellbeing teams

Because of the clinical requirements of its proposed model, the Commission considers that ACCHOs are best placed to employ social and emotional wellbeing teams.

At present there are approximately 25 ACCHOs⁷⁵ operating in Victoria, noting that some services have satellite clinics⁷⁶ or multiples sites⁷⁷ in other areas and that some organisations are applying to become ACCHOs. These organisations have primary health expertise and have been shown to be effective in improving the health of Aboriginal people.⁷⁸

ACCHOs throughout Victoria will be funded, in a staged rollout over five years, to establish or expand multidisciplinary social and emotional wellbeing teams with appropriate professional supervision and cultural mentoring.⁷⁹ Each team should contain the following expertise:

- mental health clinicians—such as psychiatrists, psychologists, mental health nurses, mental health occupational therapists and clinical social workers—to assess and treat clients (a lead clinician should be identified to provide clinical supervision, mentoring and support for other team members)
- lived experience workers
- other specialist expertise—for example, alcohol and other drug workers
- one or more (depending on the size of the population served) cultural experts (such as an Elder or an Aboriginal health and community worker, or both) to provide connection to culture and community, as well as cultural safety training and supervision for team members.

There are seven primary functions to be delivered by every ACCHO funded to establish or expand a social and emotional wellbeing team:

- develop long-term care relationships with clients to support healing and wellbeing over time
- provide best practice clinical mental health services to clients, supported by clinical supervision, mentoring and robust clinical governance (clinical treatment and care should incorporate therapeutic approaches for addressing the impacts of trans-generational trauma, racism, discrimination, social marginalisation and disadvantage)
- provide after-hours support and outreach services such as home visits and/or assertive outreach—particularly for clients at risk of or affected by suicide
- ensure smooth transitions to and from mainstream acute services (such as hospitals), where necessary, through facilitated referral, discharge and care coordination (continuity of care should be maintained through the development of partnerships and collaborative working arrangements between the ACCHO concerned and mainstream mental health services)
- help clients gain access to other services such as justice, housing and employment services
- engage with families, carers and communities to support clients' healing
- meet clients' immediate and emergency needs, where necessary, through access to brokerage funds.

The Commission is aware that there is no single Aboriginal or Torres Strait Islander culture; rather, there are numerous groups, with different languages, beliefs, cultures and ways of living. International evidence⁸⁰ and recent evaluations of Victorian social and emotional wellbeing programs⁸¹ highlight the ineffectiveness of imposing 'one-size-fits-all' programs on communities. Therefore, although all ACCHOs should ensure the fidelity of the core functions just listed, implementation should enable ACCHOs to adapt services to meet the needs of their communities and to take advantage of their unique local resources and relationships with other service providers.⁸²

16.6.2 Readiness assessment, funding and service monitoring

The Commission proposes a staged expansion of social and emotional wellbeing teams over five years, with funding being allocated to up to five ACCHOs a year. Phasing should be determined by each ACCHO's readiness to deliver social and emotional wellbeing services.

Over time, responsibility for assessing ACCHOs' readiness to implement social and emotional wellbeing services, allocating funds and monitoring services should be transferred to Aboriginal communities. Aboriginal experts have, however, told the Commission they require time and support to build the structures and workforce needed to ensure organisational readiness for extending services.⁸³ In the meantime, the Mental Health Implementation Office will perform these functions, working closely with Aboriginal communities and organisations.

The Mental Health Implementation Office should co-design with Aboriginal communities:

- *Processes for assessing ACCHOs' readiness to implement the new services.*
To demonstrate readiness, ACCHOs must have in place clinical governance arrangements, including accreditation according to relevant clinical governance standards, appropriate quality and safety assurance processes, critical incident reporting systems and capacity to assess and appropriately manage risks.
- *A funding model.* This should be based on the proportion of Aboriginal people and the level and complexity of mental health need in the area an ACCHO serves. The model should allow for differences in the costs of recruiting, developing and retaining staff, noting that staff remuneration and benefits should be competitive with those offered by mainstream health organisations.
- *Funding contracts and contract management processes.*
- *Mechanisms for monitoring service quality, safety and outcomes.*

In view of evidence that onerous reporting and compliance requirements for ACCHOs can compromise service delivery and impede innovation,⁸⁴ implementation should aim to minimise the administrative burden for ACCHOs.

16.6.3 Evaluation

Based on the evidence and analysis presented above, the Commission expects the following outcomes from expanding social and emotional wellbeing teams:

- increased access to mental health services for Aboriginal people
- improvements in clients' levels of depression and other clinical mental health outcomes
- increased satisfaction with services and better engagement of clients in their own health care.

Monitoring and evaluation should measure service outcomes such as those just listed rather than focusing on outputs and targets.

16.7 Scholarships

The proposed statewide expansion of Aboriginal social and emotional wellbeing teams will lead to increased demand for Aboriginal health professionals. Although ACCHOs can employ non-Aboriginal clinicians in the teams and can purchase clinical expertise from non-Aboriginal services, the Commission considers that building the Aboriginal workforce is integral to the success of social and emotional wellbeing services in the longer term. Evidence suggests that Aboriginal health professionals apply unique technical and sociocultural skills to improve client care.⁸⁵

16.7.1 Shortages of Aboriginal health professionals

Aboriginal people are currently greatly under-represented in the health workforce. In 2011 only 1.6 per cent of the Aboriginal population were employed in health-related occupations nationally; this compares with about 3.4 per cent of the non-Aboriginal population.⁸⁶ Large shortages exist for every health profession.⁸⁷ Data from 2014 and 2015 indicate that very small numbers of Aboriginal health professionals were employed in Victoria:

- 19 Aboriginal psychologists—0.3 per cent of all Victorian psychologists in 2014⁸⁸
- six Aboriginal occupational therapists—0.2 per cent of all Victorian occupational therapists in 2014⁸⁹
- 444 Aboriginal nurses and midwives—0.5 per cent of Victorian nurses and midwives in 2015.⁹⁰

The gap between Aboriginal and non-Aboriginal students for health-related university course completions widened from 11 per cent in 2008 to 23 per cent in 2017.⁹¹

16.7.2 Scholarships to improve workforce supply

The Commission proposes that 30 flexible scholarships be awarded over the next five years to help employ Aboriginal people while they obtain clinical qualifications.

While recognising that the proposed scholarships will not resolve broader systemic problems relating to retention and career structures for Aboriginal health workers, the Commission considers that scholarships will be an effective first step in building the Aboriginal workforce to staff social and emotional wellbeing teams. The Commission will explore further workforce initiatives in 2020.

Aboriginal⁹² and non-Aboriginal organisations⁹³ have informed the Commission that funded training would help Aboriginal people gain or enhance their qualifications in mental health. The academic literature on mental health-specific course retention suggests that receiving financial assistance such as scholarships encourages students to remain in their courses.⁹⁴ Previous reviews and reports have recommended scholarships and training support for Aboriginal students in fields such as psychology, nursing and relevant allied health disciplines.⁹⁵

16.7.3 Targeting and implementing the scholarships

The proposed scholarships will be available only to Aboriginal people. Their purpose is to enable recipients to complete a recognised tertiary-level course that will qualify them as mental health clinicians while working full time or part time in Aboriginal social and emotional wellbeing teams. The scholarship program should ensure that recipients can be offered full time ongoing employment in an ACCHO following successful course completion.⁹⁶

The Mental Health Implementation Office should work in close partnership with the proposed Aboriginal Social and Emotional Wellbeing Centre to design and implement the scholarship program and to ensure the centre is equipped to provide appropriate clinical and cultural supervision and support for scholars. This should include working together to determine the most appropriate administrative arrangements for the scholarship program. Flexibility should be embedded in the program's design to ensure all scholars have the best chance to complete their chosen qualification.⁹⁷

The scholarships should be promoted to existing Aboriginal health workers and within Aboriginal communities generally to ensure awareness and uptake. Aboriginal people who are not currently working in ACCHOs could undertake scholarships—for example, by becoming employed through the statewide expansion of social and emotional wellbeing teams and then applying for the scholarship program. Program design should incorporate the following supports for applicants and scholars:

- culturally appropriate recruitment and selection processes
- orientation and pre-entry programs
- tutoring and assistance with academic studies where required—this could include flexible learning options such as online and after-hours support
- access to Aboriginal student peer networks and mentoring programs and support from Aboriginal Elders
- opportunities for scholars to attend relevant conferences, regional and local networks and communities of practice.

16.8 A centre to lead, coordinate and empower

The Commission has proposed that the Victorian Aboriginal Community Controlled Health Organisation is recurrently funded to host an Aboriginal Social and Emotional Wellbeing Centre, in partnership with other organisations that have clinical and research expertise in Aboriginal mental health.

The role of the new centre will be to ensure that ACCHOs can deliver effective mental health care. The Victorian Aboriginal Community Controlled Health Organisation currently provides professional development, governance coaching and a range of other supports for ACCHOs⁹⁸ and is well-placed to host a centre with this role.

Aboriginal experts and organisations have called for investment in a central body to lead the development and implementation of mental health services for Aboriginal people.⁹⁹ The Commission heard that Victoria lacks a coordinated approach to evaluating services, commissioning and collecting evidence of best practice and sharing lessons. The Commission was also informed of a need for culturally appropriate assessment tools and models of care for Aboriginal people.¹⁰⁰

The Commission proposes that the Mental Health Implementation Office supports and resources the Victorian Aboriginal Community Controlled Health Organisation to establish and host the recommended Aboriginal Social and Emotional Wellbeing Centre. The office should ensure that the Victorian Aboriginal Community Controlled Health Organisation, in conjunction with its service partners, has appropriate human resource capability, as well as legal, contracting, data management and reporting mechanisms, to deliver a centre with four primary functions:

- to support ACCHOs in preparing for and establishing social and emotional wellbeing services—including planning and developing clinical and cultural governance processes
- workforce development—including training and other professional development activities and management of the proposed scholarships program
- to provide guidance and practical supports to build clinical effectiveness in assessment, diagnosis and treatment
- to develop and disseminate research and evidence for social and emotional wellbeing models and for convening associated regional and local communities of practice.

Box 16.2 lists the activities through which the centre would perform its primary functions.

Box 16.2

Activities of the proposed Aboriginal Social and Emotional Wellbeing Centre

Supporting ACCHOs in preparing for social and emotional wellbeing teams:

- flexible guidance on implementing effective social and emotional wellbeing teams—including their roles, scope of practice and responsibilities
- support in establishing clinical, cultural and organisational governance arrangements—including clinical supervision and quality assurance mechanisms
- practical assistance, where necessary, to help ACCHOs procure clinical expertise from other organisations as necessary and to develop effective service partnerships.

Developing workforce capability and clinical effectiveness:

- professional supervision, secondary consultation, counselling, debriefing and cultural support to improve cultural and clinical skills and reduce the risks of burnout and vicarious trauma for workers
- training and other forms of professional development
- support for recipients of the proposed scholarships
- dissemination of existing tools (for example, validated questionnaires) as well as developing and validating new tools to support culturally appropriate clinical assessment, diagnosis and treatment
- identification of attractive clinical and non-clinical career pathways for the social and emotional wellbeing workforce.

Building the evidence base for effective practice:

- commissioning of research and evaluation to identify effective approaches to Aboriginal mental health care, including models for Aboriginal children and young people
- convening of communities of practice, online information platforms and other forums that enable learning about effective practice to be shared across the sector.

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Chapter 17

A service designed and delivered by people with lived experience

Recommendation

The Royal Commission recommends that the Victorian Government establishes Victoria's first residential mental health service designed and delivered by people with lived experience. This should be facilitated through the Mental Health Implementation Office in co-production with people with lived experience.

This service should provide short-term treatment, care and support in a residential community setting as an alternative to acute hospital-based care, and be:

- delivered and operationally managed by a workforce comprising a majority of people with lived experience, working across a range of disciplines
- facilitated through a partnership between an area mental health service and a mental health community support service or a community health service
- independently evaluated, with findings to inform continuous improvement and guide the expansion of similar services.

17.1 Developing new models of care

A contemporary mental health system must offer people a range of treatment, care and support services. Services led, designed and delivered by people with lived experience should feature prominently, as part of a broad and responsive offering that recognises the diverse needs and preferences of consumers, as well as the roles of their families and carers.

Consumers, their families, carers and advocates have consistently emphasised the importance of choice and the value of holistic responses, along with their frustration about the limited range of responses currently available from the mental health system:

A little bit of choice can go a long way.¹

There is no ideal prescription for all, as the needs of each individual are different, and our system needs to reflect this better by providing person-centred care.²

The Commission continues its work on redesigning the mental health system centred on the people who use it. As part of this, the Commission is considering the range of settings where people are seeking treatment, care and support. This work is prompting consideration of mechanisms for offering greater choice in the mental health system, including through alternative therapeutic models and aspects of workforce design. The Commission will continue to consider options for consumer-led and -delivered services (see Box 17.1) and alternative service delivery environments as part of a future system.

Working now to implement a mental health service that is designed and delivered by people with lived experience will complement the Commission's ongoing efforts to broaden the service offering that is available. It also reflects the Commission's desire to incorporate lived experience in all aspects of the mental health system, including service delivery.

One service designed and delivered by people with lived experience will not be enough to change existing power structures, but it will lay the groundwork for a future that elevates the voices of people with lived experience throughout all areas of the mental health system.

Box 17.1**Mental health services that are designed and delivered by people with lived experience**

Various expressions are used to describe and define services that are designed and delivered by people with lived experience for people living with mental illness or experiencing psychological distress. Often there is a distinction made between the following two terms:

- *Consumer-led services.*³ This refers to services that are delivered and managed by consumers for consumers. An example is a residential service that employs a workforce consisting of a majority of people with lived experience under the leadership of an organisation (including its board and governance structures) that is also led by people with lived experience.
- *Consumer-delivered services.*⁴ This refers to services that are delivered by consumers and that sit within the broader governance arrangements of an organisation that is not consumer-led. An example is a drop-in centre that employs people with lived experience but sits within the broader governance structures of an area mental health service or hospital.

For the purposes of this report, the expression ‘services designed and delivered by people with lived experience’ is premised on a partnership approach—that is, a service delivered in a manner that reflects genuine partnership with people with lived experience.⁵ For this partnership to be successful, people with lived experience must be involved in every aspect from initial thinking and priority setting to service planning, design, delivery and evaluation.⁶

The Commission deliberately uses the term ‘lived experience’ to capture people with personal experience of mental illness, along with families and carers who have experience in supporting someone living with mental illness.⁷

17.2 Increasing the prominence of lived experience

Services designed, led and/or delivered by people with lived experience can vary in their scope and functions. They include drop-in-style centres, residential homes, post-discharge support programs and support services delivered via a range of mediums, among them in person, by phone or online.

Although these services vary in scope and function, central to all of them is people who can draw on their personal experience, along with other skills, to connect with and support others who might be having a similar experience.

When compared with service models in other jurisdictions in Australia and abroad, the current suite of services in the Victorian mental health system that are designed, led and delivered by people with lived experience is very narrow. Many existing Victorian mental health services rely on traditional lived experience roles such as peer support workers. A mental health service that is designed and delivered by people with lived experience and is a true alternative to acute hospital-based care is a notable absence from the state's service system landscape.

There have been calls to 'evolve' the mental health system in Victoria in this regard:

Having consumer-delivered and consumer-led services would show a commitment to true reform that will push services to be more innovative about what they deliver.⁸

It is now time for consumer-led services to be brought into the community, for and by people with lived experience.⁹

Peer support and peer respite should be prevalent. Peer respite should involve access to home-like environments that are calm and containing, with peer workers present and access to clinical support if needed and desired.¹⁰

We need peer-run respite and drop in services [...] run for consumers by consumers.¹¹

17.3 Lived experience services: some examples

The following are examples of services delivered by people with lived experience and organisations that are led by people with lived experience:

- *Safe Haven Café in Melbourne, Victoria.* Operating as an after-hours drop-in centre for people living with mental illness or experiencing psychological distress at St Vincent's Hospital Melbourne, Safe Haven Café began operations in May 2018. It was designed by people with lived experience and is run by peer support workers and volunteers with lived experience. Staff work alongside clinicians to provide a therapeutic alternative to an emergency department.¹²
- *The Peer Operated Service in Hervey Bay, Queensland.* Delivered by Flourish Australia, the Peer Operated Service is a community-based service that provides recovery-oriented supports for people living with mental illness. Among the specific services are a resource centre where people can involve themselves in one-on-one support or group activities, a phone line, and a rest and recovery house where people can take time out. The service is delivered by peer support workers and volunteers, all of whom have lived experience.¹³
- *The Red House in Mount Gravatt, Queensland.* Delivered by Brook Red—a peer-managed and operated community mental health organisation—the Red House was established in 2001 and offers a four-bedroom residential service that enables people living with mental illness to have a planned stay lasting up to three weeks. The Red House focuses on recovery strategies, and the service is delivered entirely by people with lived experience.¹⁴ All members of Brook Red's workforce bring with them their personal lived experience of mental illness, and this arrangement is reflected in the service's governance structures.¹⁵
- *Expanding Post Discharge Support, Victoria.* This initiative is available in all adult area mental health services and one youth service in Victoria. It offers tailored outreach support to people in their home immediately following discharge from a public specialist clinical mental health service and is delivered by consumer and carer peer support workers. The peer support workers make a minimum of three contacts in the first 28 days after discharge.¹⁶
- *Hospital to Home, New South Wales.* This service offers support to people following their discharge from hospital and is delivered by qualified peer support workers, all of whom have lived experience of mental illness. Supports are tailored to the individual, and there is a focus on practical and emotional support as well as establishing links and initiating referrals to other services.¹⁷
- *The National Perinatal Anxiety and Depression Helpline.* Delivered by Perinatal Anxiety & Depression Australia, the helpline has been operating since 2010. It provides information, counselling and referral services for families throughout Australia. Professional counsellors and people with lived experience of perinatal anxiety and depression deliver the service.¹⁸

Box 17.2 profiles a peer-led service in New Zealand.

Box 17.2

Piri Pono: a case study⁶⁰

'Piri Pono' is a Maori term meaning to be loyal, faithful and devoted.

Piri Pono offers a peer-led, community-based residential service in the outskirts of Auckland, New Zealand. It is run by Ember (a non-government organisation) and its services are delivered in collaboration with Waitemata District Health Board. It is set up as a home, providing a comfortable environment and an alternative to an acute mental health inpatient admission. The residents are called guests, not patients or clients.

Operating as a five-bed, 10-day-stay service since 2013, all the support staff have lived experience of mental illness. For six days of the week, the registered nurses at the service also have lived experience. General Manager of Operations at Ember, Mr Lee Reygate said:

Every shift we have two peer support workers on. Most of our staff were actually guests at Piri Pono. Our two main nurses both spent time here as guests and both said, 'We want to work here'. Half of our staff have previously been guests and have come back and asked for a job.

All our support staff have lived experience. They use their stories to help others.

Guests have the chance to be part of a household that provides a safe and supportive environment, creating opportunities to learn from one another and from the peer support staff. Guests are active in their own recovery—they make plans, set goals, take part in structured daily programs and are involved in developing the documentation about their stay. They have a planned exit and receive follow-up from outreach peer support services and help with connecting to follow-up agencies.

Through close working relationships with Waitemata District Health Board, guests also have access to clinical mental health services. Waitemata District Health Board clinical teams coordinate the admissions process into Piri Pono, providing a single-entry point into the service and ensuring future guests are suited and well placed to focus on recovery as part of their stay at the service. Nurses are part of the care team, and regular visits are made by consultant psychiatrists. Clinical responsibility for consumers remains with the Waitemata District Health Board.



Piri Pono

Mr Reygate said it was important to build trust and understanding in the early days because there was some resistance to a peer-led model, with some psychiatrists concerned the risk to clinical treatment was too high:

We don't accept that argument. We have great systems and great communication. It's important to get the balance right. We have a psychiatrist who has been with the service for a long time; she knows us well, there's a strong trust there.

People often have a cautious approach to new ideas. Some clinicians are very sceptical, and from a research perspective this is understandable.

As we aren't in a position to bring them over with research, the best method of bringing them on side is to do well and get the clinicians to win over their colleagues.

According to Mr Reygate, the power of Piri Pono lies in having those peer-to-peer conversations. Guests and staff echo this sentiment:

Having someone to talk to, cry with, laugh with, but always feeling safe and cared for. Most of all, never judged. (Piri Pono guest)

It feels like we are doing something new and that we're stretching ourselves and the way that people view mental health and, yeah, it just feels right, it feels the right way forward for so many people. (Piri Pono staff member)

For the first time I wasn't the only one with an illness in the room, for the first time I was understood, listened to and respected, for the first time I realised that I can possibly have a worthwhile life ... (Piri Pono guest)

Mr Reygate said an early evaluation noted the success of the service but made a number of suggestions for organisations looking to establish acute alternatives: the need to be clear about the responsibilities of staff, crisis teams and police; having robust recruitment and staff-support processes; and ensuring that individuals making referrals understand the peer support model and expectations.

17.4 Positive impacts on consumer outcomes and experience

There is a small but growing body of academic research and evaluation dealing with the positive impacts of services that are delivered by people with lived experience. This includes consumer-led and -delivered services that take on a variety of forms and functions.

Recurrent themes in both the literature and the evaluations are that these services improve consumer experiences and outcomes by instilling feelings of hope, self-determination, responsibility for self and personal empowerment.¹⁹ Feeling welcomed, understood and connected to people who have been on a similar journey are also commonly cited.²⁰

Recent evaluations also show that these services increase quality of life, support an individual's progress towards recovery and reduce levels of psychological distress.²¹ For example, an evaluation of Piri Pono (see Box 17.2) found that 84 per cent of people reported diminished levels of psychological distress following their stay.²² It should be noted, however, that these results were based on a small sample and participation in the evaluation was voluntary.²³

Further, an evaluation of a UK peer respite centre that provides a homelike environment for people experiencing suicidal ideation found that consumers reported short-term relief from stressful events. Some consumers reported longer term benefits, although the analysis of long-term effects was restricted to a relatively small sample.²⁴

A Canadian study examined the participation of people from four consumer-run services against a comparison group, at nine, 18 and 36 months. The consumer-run services in the study differ from one another and provide a variety of supports including drop-in centres, one-to-one peer support and self-help groups.²⁵ The study showed that those who participated in the consumer-run services experienced greater improvements on a range of measures, among them a reduction in hospital stays, increased involvement in employment and educational activities, and improved quality of life.²⁶ Some of these results were reported to continue for three years, although there was a reduction in the number of study participants over time.²⁷

A series of US studies assessing eight-month outcomes for people using community mental health services, as opposed to people using a combination of consumer-operated services (including peer support groups, drop-in centres and direct services)²⁸ and community mental health supports, produced mixed results.²⁹ For example, a 2010 study indicated that combined consumer-operated services and community mental health services were significantly more able to promote many aspects of recovery in consumers.³⁰ Conversely, a 2011 study in the same series showed that social integration, personal empowerment and self-efficacy improved to a greater extent for people using community mental health supports alone.³¹

There is also a small body of research indicating that services delivered by people with lived experience might contribute to a reduction in hospital admissions and emergency department presentations. For example, an independent evaluation of the Safe Haven Café at St Vincent's Hospital Melbourne showed a reduction in the number of mental health-related emergency department presentations following the café's opening, although the results were based on the best available estimates over a short period.³²

Similarly, a US study that compared the impacts on people who used a residential peer respite service as opposed to people who did not, showed that the probability of using an inpatient or emergency service was significantly lower among people who used the peer respite service.³³ Among people who stayed longer than nine days, however, use of emergency services was equal to or higher than in the comparison group. This could be attributed to complexity of need before admission.³⁴

A further study from the United States—a randomised trial of the effectiveness of a crisis residential program delivered predominately by people with lived experience compared with a traditional inpatient facility—indicated that people who used the crisis residential program had higher rates of post-discharge readmission.³⁵ This may reflect, however, the fact that people using the crisis residential program received assertive outreach post-discharge, as compared with people in the inpatient facility, who did not.³⁶

In terms of value for money, research also supports the cost-effectiveness of services delivered by people with lived experience in terms of reduced costs of service provision,³⁷ avoided emergency department presentations³⁸ and reduced pressure on local health services.³⁹ There are likely related benefits too—such as potentially reduced treatment delays for consumers wanting to use health services.⁴⁰

More broadly, an evaluation of the Peer Operated Service in Hervey Bay indicated that the service achieved considerable value for people who used the service, the peer workforce and surrounding services, with every \$1 invested creating approximately \$3.27 in social and economic value.⁴¹

Caution is necessary when considering the applicability of these evaluations, particularly those of international studies, to the Victorian context. Further, the variation in service delivery models and inconsistency in research methodologies might affect the validity and comparability of findings. On balance, however, the Commission concludes that emerging research supports the benefits of services delivered by people with lived experience in terms of results for consumers, as well as the potential for wider system benefits.

17.5 Victoria's first lived experience residential service

The Commission considers that a future service designed and delivered by people with lived experience should:

- be developed and implemented in genuine coproduction with people with lived experience
- deliver improved experiences and outcomes for people living with mental illness
- provide short-term residential treatment, care and support in a community setting as a genuine alternative to acute hospital-based care
- provide treatment, care and support (including access to clinical and mainstream health services) to meet people's mental health needs, including offering a combination of therapeutic and clinical supports that are person-centred
- provide treatment, care and support that is inclusive, safe, welcoming, accessible and valued by people living with mental illness
- be delivered and operationally managed by a workforce comprising a majority of people with lived experience working across a range of disciplines

- be offered in a standalone, small therapeutic residential community-based setting, with ample outdoor space for social and physical activities
- be funded on an ongoing basis to ensure the service endures, with an independent formative evaluation beginning immediately to inform continuous improvement and guide the expansion of similar services.

At the time of preparing this interim report, the mental health system in Victoria lacks an organisation that is led by people with lived experience and is able to offer a true alternative to acute hospital-based care. These circumstances reflect broader structural failings of the mental health system.

The Commission wants this to change and expects that future services will be more diverse. The Commission will be actively pursuing opportunities to facilitate this diversity as part of the final report.

For now, in response to calls for the system to offer more choice and an alternative to an acute inpatient stay, the Commission regards a partnership model between an area mental health service and a community mental health support service or community health service to be the best way forward at this point in time. The Commission has drawn on the Piri Pono model and recommends that:

- the area mental health service is responsible for triage, clinical oversight and crisis management, referral pathways and providing in-reach and follow-up clinical services
- the area mental health service and community mental health support service or community health service are equally responsible for ensuring that services meet the needs of consumers and that services are designed and delivered by people with lived experience.

17.6 Genuine coproduction

Coproduction is a fundamental tenet of the design and delivery of a successful lived experience service. Responsive service delivery can be achieved only by bringing the voices of people with lived experience to the forefront of service design and implementation.

This sentiment has been expressed on a number of occasions—by people with lived experience, advocates, peak bodies and service providers alike. For example, Ms Janet Meagher AM, an advocate for people with lived experience of mental illness, told the Commission:

The mental health system and mental health professionals need to listen to the people using the services. The system needs to 'make real' the desire of those people to participate and work together in genuine partnerships for change.⁴²

The value that can be derived by involving people with lived experience in decision making was also a significant focus of submissions to the Commission, such as:

The first-hand, lived experience of the mental health system is extremely valuable, whether from consumers, carers [or] workers, and this knowledge should be respected.⁴³

Governments and policy makers must be willing to share power. People with direct, first-hand, lived experience of ill mental [health] have some really good ideas about what works and what we need. We should be listened to and centred.⁴⁴

I believe that people experiencing poorer mental health outcomes need to be asked what they need, what they would like, and be given the opportunity to co-design services that suit.⁴⁵

The Victorian mental health system would benefit from significantly increased alignment to the wisdom and recovery expertise of the people the system exists to serve.⁴⁶

These sentiments are corroborated in the academic literature, which suggests that coproduction is creating services that are highly valued.⁴⁷ Research also indicates that coproduction brings intrinsic value to individuals through improved outcomes and experiences, increases the capacity and impact of services, and provides a return on investment.⁴⁸

If a service designed and delivered by people with lived experience is to be successful, coproduction with consumers, families and carers must occur from the outset, in initial thinking and priority setting, and flow through to service planning, design, delivery and evaluation.⁴⁹

17.7 A residential service with a broad offering

A service based on a partnership between an area mental health service and a community mental health support service or community health service ensures that consumers have access to a diverse range of supports and services. This includes access to recreational, educational, social and physical activities as well as clinical in-reach and follow-up mental health services.

Such an approach reflects the strong desire of people with lived experience for an expanded range of treatment, care and support that is personal, holistic and creative. For example, the Commission was told:

Services should be staffed with therapists, counsellors and peer support workers, and different service models could be piloted, such as peer-run respite houses.⁵⁰

There should be more of a mix of disciplines—not just community and clinical but a blend of expertise that could provide a holistic model of care.⁵¹

A partnership approach, bringing together these services, will also promote links to clinical and mainstream health services and broader community supports, which can be continued post-discharge if necessary.

17.8 Broadening the benefits of lived experience workers

The value of lived experience workforces and the need to expand their roles and further embed their expertise throughout the system, including clinical mental health services, is readily apparent. Associate Professor Simon Stafrace, Program Director of Alfred Mental and Addiction Health, told the Commission, 'The peer workforce must continue to grow and exert an influence on a changing culture of clinical practice'.⁵²

A service designed and delivered by people with lived experience will create opportunities for lived experience workers in a variety of roles that go beyond traditional peer support roles. This includes roles for people with lived experience in direct treatment and support and through operational management, leadership, consultation, system advocacy, education, training, research and supervision.

Opportunities should also be created for clinicians who have lived experience. The Commission sees the potential for clinicians to apply their lived experience to their work when and where appropriate. For example, an evaluation of Piri Pono found that registered nurses who had lived experience of mental illness, in addition to their clinical qualifications, were well received by consumers.⁵³

A service designed and delivered by people with lived experience will generate opportunities to broaden the reach and influence of the consumer–family–carer workforce by increasing its overall visibility and elevating its status. For example, an evaluation of the Peer Operated Service in Queensland reported that hospitals and health services in the local area increased the employment of peer workers in their own mental health programs, in part because of the success of the service delivered by people with lived experience.⁵⁴

More broadly, the Commission sees value in bringing together lived experience workforces and clinicians to co-deliver a service that has been designed by people with lived experience. A multidisciplinary workforce will generate opportunities for collaboration, imaginative leaps and shared learning in a range of disciplines.

17.9 A safe and inclusive environment

Experience from comparable service models suggests that for many people a homelike setting can be a peaceful, safe and comfortable place in which to recover.⁵⁵ In the Commission's view, co-locating a service with a hospital risks creating an environment that is medicalised and might not be conducive to the Commission's notion of a service that is personal and holistic and is designed and delivered by people with lived experience.

Notable features of comparable services are access to outdoor environments and areas set aside for social and physical activities.⁵⁶ Individual and group activities should be self-directed depending on individuals' preferences; examples are cooking classes, creative writing groups, music groups, walking, yoga, meditation, support groups and workshops, and outings.

17.10 Clear entry criteria and referral pathways

Applying clear eligibility criteria is often central to the success of services delivered by people with lived experience and the benefits consumers can derive.⁵⁷ Such services should be made available to people who are likely to benefit from the unique approach to treatment, care and support. They might not, however, be suitable for all consumers, and additional eligibility criteria may be necessary.

Concurrently, the sustainability and effectiveness of the service will depend on establishing discharge planning and clear referral pathways—to the service itself and into other services. A plan that clearly establishes roles and responsibilities and describes the process for discharge and referrals will be required to facilitate this.

17.11 Continuous learning and improvement

An evaluation of the service should begin immediately on implementation to allow for continuous improvement and to ensure the service is delivering on its original intent, as derived through the coproduction process to design the service. The evaluation should be conducted independently and in coproduction with people with lived experience.

The evaluation model should be aligned with the philosophy of services designed and delivered by people with lived experience and should measure outcomes that are meaningful to consumers.⁵⁸ As one study of the effectiveness of lived experience–delivered services concluded:

Research should be considered that faithfully reflects the philosophical values of consumer work. This does not necessarily preclude quantitative research modalities, but it should mean involving consumers [...] in the conceptualization, design and implementation of research studies to ensure that research measures are meaningful to consumers.⁵⁹

Incorporating rigorous evaluation at the outset will also contribute to the evidence base and guide the expansion of services designed and delivered by people with lived experience throughout a range of settings across the future mental health system.

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Chapter 18

Lived experience workforces

Recommendation

The Royal Commission recommends that the Victorian Government, through the Mental Health Implementation Office, expands the consumer and family-carer lived experience workforces and enhances workplace supports for their practice. This program of work should be co-produced with people with lived experience and representatives of lived experience workforces and be implemented across area mental health services and identified non-government organisations comprising:

- the development and implementation of continuing learning and development pathways, educational and training opportunities and optional qualifications for lived experience workers, including adding the Certificate IV in Mental Health Peer Work to the free TAFE course list
- new organisational structures, capability and programs within services to enable practice supports, including coaching and supervision for lived experience workers
- delivery of a mandatory, organisational readiness and training program for senior leaders, and induction materials for new staff, that focus on building shared understanding of the value and expertise of lived experience workers
- implementation of ongoing accountability mechanisms for measuring organisational attitudes and the experiences of lived experience workers, including establishing a benchmark in 2020 of the experience of lived experience workers.

18.1 Lived experience workers as part of the future mental health system

In a contemporary mental health system, the principle of 'nothing about us without us'¹ is evident in all aspects of the system, from service design and delivery to service and system leadership, policy development, research and evaluation, and system accountability and oversight. That is, people with lived experience of mental illness are front and centre in the mental health system and are heard and valued as leaders and active contributors.

Moving towards fulfilling this vision necessitates establishing strong foundational structures that will support future success. Integral to the vision is a future state where the consumer, family and carer lived experience workforces are recognised, understood and valued, with the support structures afforded to any other profession.

As outlined in Box 18.1, this encompasses lived experience workers who are at the frontline of service delivery—people in peer support roles, along with those who shape change through their advisory, advocacy, consultancy and leadership work.

Box 18.1

Understanding lived experience workforces

In this interim report the Commission uses 'lived experience workforces' as a broad term to represent two distinct disciplines—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 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 and research.²

The paid lived experience workforce is distinct from the volunteer workforce, many members of which would consider themselves peer workers and are vital to the care and support of people living with mental illness. Moving towards a more professionalised workforce gives people a greater opportunity to make the decision to do paid or voluntary work.

Grassroots and self-initiated peer support networks are also emerging from people's own experiences outside mainstream services—people sharing their experiences and running workshops and groups to help other people going through similar situations.³ This signals a new generation of lived experience leaders and innovators, some with an online presence—using avenues such as social media and podcasting to reach out, welcome and support people.⁴

This builds on the earlier, and ongoing, examples of mutual support and self-help groups, usually formed by peers who come together to provide information and support to people with lived experience of mental illness.⁵

Consistent among all these roles is the criterion of 'lived experience'. Individual experiences are unique, and the value of personal experience cannot be taught, but there is a skill involved in understanding how to apply experience effectively and influentially, along with other competencies and knowledge relevant to the different roles and settings in which people work.

Having 'lived experience' alone is not, however, the only competency required of a lived experience worker: a person's overall life experience, their employment and education history, and their ability to engage and communicate, are all elements that apply to the spectrum of roles.⁶

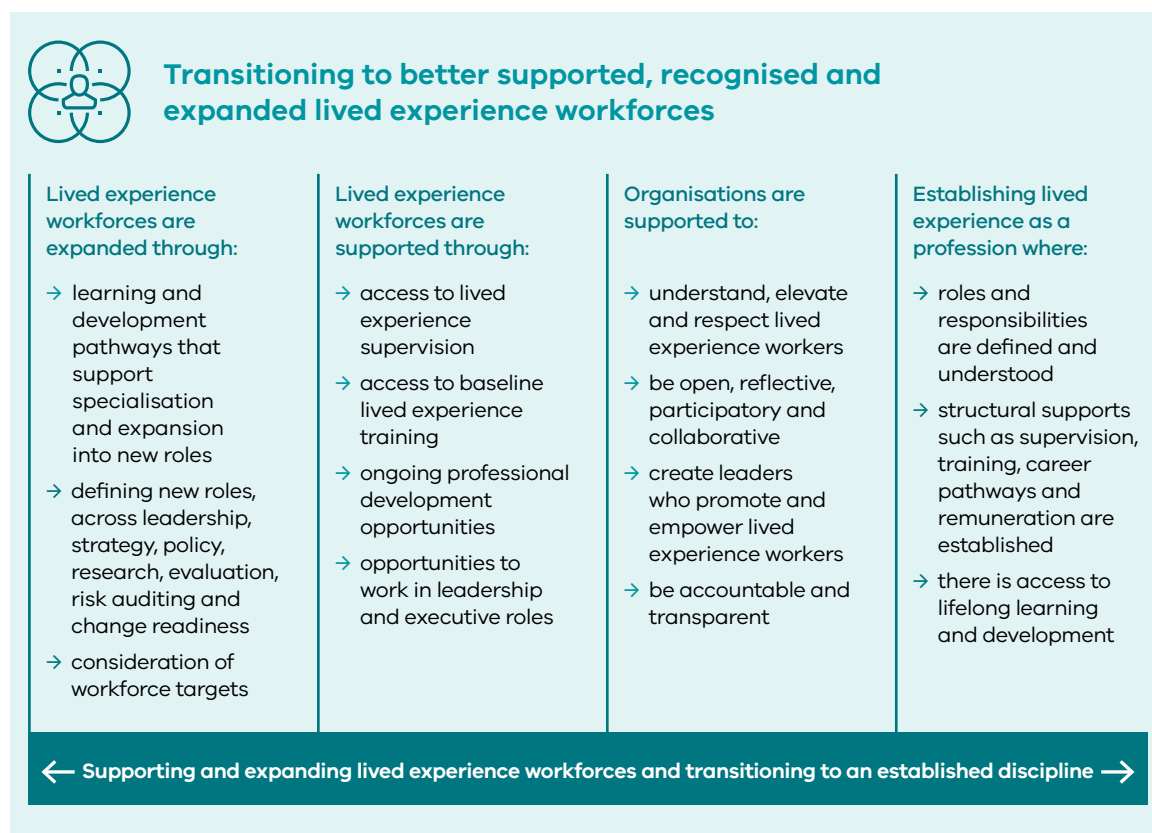
The purpose and function of particular roles might differ, but each role is underpinned by a unique and powerful accumulation of knowledge and perspectives and insights gained from personal experience.

Developing lived experience workforces is seen as complementary to and an essential part of—but not a replacement for—a skilled and capable broader mental health workforce.

Every aspect of the existing system needs to be ready for this change, even those services that are already embracing and supporting lived experience work. There are organisations—particularly in the non-government sector—that can be regarded as strong exemplars in relation to achieving this vision. One non-government organisation submitted, 'We believe that people close to the problems of mental health are closest to finding the solutions'.⁷

As Figure 18.1 shows, the Commission's recommendations are designed to initiate the major transition that is necessary to better support current lived experience workforces, expand those workforces over time, and establish lived experience as a recognised profession.

Figure 18.1: Transitioning to better supported, recognised and expanded lived experience workforces



18.2 An emerging workforce

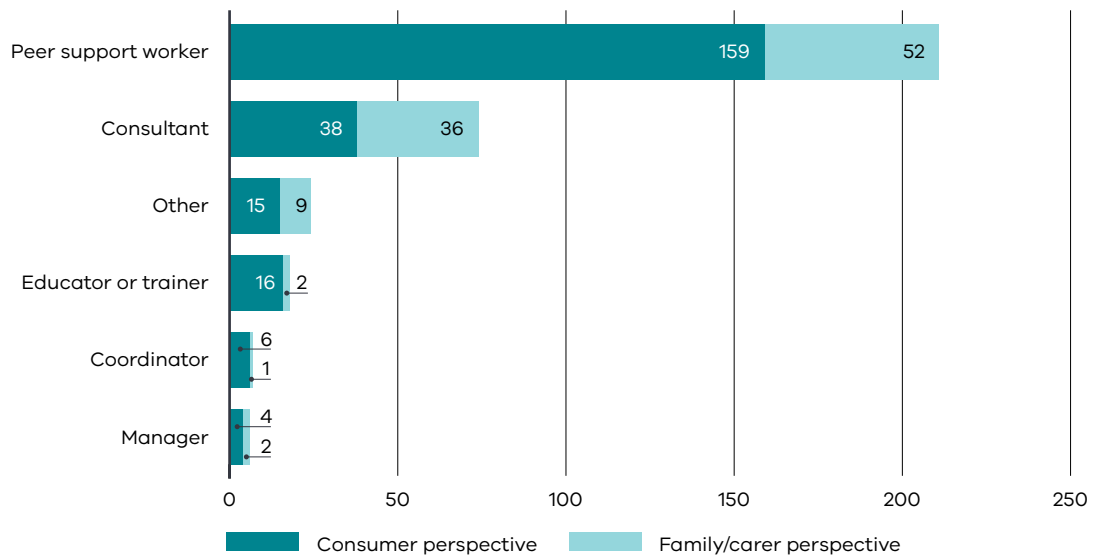
Lived experience work had its origins in self-help and mutual support movements that were voluntary in nature: people came together to help one another or to press for better services.⁸ These services remain essential, providing connections and shared hope and empathy—for example, Perinatal Anxiety and Depression Australia, Beyond Blue and Lifeline. There are also positive instances among diverse communities; an example is Switchboard, which provides peer-directed support services for LGBTIQ+ communities. Self-initiated, innovative, contemporary and accessible support networks continue to emerge.⁹

More recently, lived experience positions have evolved into more formal paid positions. People with lived experience were first employed in Victorian area mental health services in 1996 when four consumer consultant roles were created.¹⁰ After that, lived experience workforces emerged slowly until there was a rapid increase in 2016, when the Expanding Post Discharge Support program was introduced.¹¹

The first paid lived experience positions in the mental health community support service sector were established in 2003, and there was a big increase in numbers when the Personal Helpers and Mentors program was rolled out in 2007.¹²

In 2017 there were 341 occupied lived experience positions in Victoria's public mental health services, amounting to 187 full-time equivalent positions.¹³ More than two-thirds of these positions were operating from a consumer perspective (239 positions) and the remainder

Figure 18.2: Lived experience workforces in Victoria's public mental health services, by role type, 2017



Source: Department of Health and Human Services. Lived Experience Workforce Positions in Victorian Public Mental Health Services, October 2017, p. 17.

from a family—carer perspective (102 positions).¹⁴ Of the 341 positions, 238 (69 per cent) were in clinical mental health services and 103 were in mental health community support service settings.¹⁵ Figure 18.2 shows the distribution by role type.

As the value of lived experience work has begun to be recognised, advisory and consultancy roles have emerged throughout the sector. Examples are the Tribunal Advisory Group, which advises the Mental Health Tribunal,¹⁶ and advisory roles in workforce peak bodies and service providers.¹⁷

Nationally, the concept of creating a consumer-centred health system by partnering with consumers to develop and design quality health care became part of the National Safety and Quality Health Service Standards, which came into force in 2013.¹⁸

Recently the Productivity Commission made recommendations to the Commonwealth Government to 'strengthen the peer workforce'. This includes establishing a professional organisation to represent lived experience workforces and a national review to develop a comprehensive system of qualifications and professional development for peer workers.¹⁹

Despite this history of lived experience work, however, a professional identity has been slow to develop,²⁰ and the structural supports that reflect a profession (such as training, career pathways and remuneration) are still being established. Ms Vrinda Edan, acting CEO of the Victorian Mental Illness Awareness Council told the Commission:

There's no career structure for consumer workers. So, you come into a role and that's it basically. We need to be thinking about this as a discipline, we need to be developing senior roles with appropriate remuneration and developing them into leaders and managers of those services.²¹

The Commission envisages a system in which everyone can choose to have access to peer support workers and advocates and services are shaped by lived experience educators, trainers, researchers and consultants.

Lived experience work will be a central pillar of the future mental health system: new lived experience roles will be established and supported, spanning service design and delivery, service and system leadership, research and evaluation, and system accountability and oversight. As one community member said:

I don't think the service will get better until lived experiences are heard. There needs to be more lived experiences in the services. I also want to see peer-run services. People feel shame in our current system but wouldn't if it is someone in their own same position.²²

Expanding and enhancing lived experience workforces is an important step towards a more open, participatory and peer-led system. That step may be characterised as embracing a 'new power',²³ which challenges existing structures rooted largely in professional, historical and statutory hierarchies.²⁴ As Associate Professor Simon Stafrace, Program Director of Alfred Mental and Addiction Health, Alfred Health, told the Commission:

New power must be harnessed in order to ensure communities, patients and families are enabled to participate in service leadership, co-design and co-production.²⁵

It is not, however, the lived experience workforces' role to work against old power alone; it is about designing a system that elevates and integrates the consumer, family and carer voice. The Commission envisages a system in which the lived experience workforces complement the mental health workforce of the future and will be integral to multidisciplinary teams and care models and shape the design and delivery of services.

During 2020 the Commission will consider further opportunities for expanding lived experience workforces throughout all aspects of the reformed mental health system. New roles will be considered in the context of the entire system and the crucial areas of influence and change.

This will include consideration of the requisite number of lived experience workers per service. For example, targets might be considered in relation to the number of peer workers per multidisciplinary team and the number of lived experience workers in leadership and executive positions. The National Mental Health Commission made similar observations in 2014 in connection with building the Aboriginal workforce, proposing requisite numbers of Aboriginal workers in mental health professions in proportion to population catchments.²⁶

18.3 The value of lived experience workers

A deep respect for lived experience work has been expressed in the evidence the Commission has received, particularly in relation to peer support workers. Many organisations have recommended that lived experience workforces be better supported and expanded.²⁷ Community members spoke of positive experiences with peer support workers—particularly in helping others find the services they need, inspiring a sense of hope and sharing a common experience:

Talking to someone who has been there and done that relieves the tension immediately.²⁸

Give Peer Workers a bigger voice as they hold the key to relating to consumers and carers that are going through this traumatic experience.²⁹

Expanding of the peer support workforce has been invaluable to have that voice in the space. It empowers people. They have a lot to offer.³⁰

Staff that have lived experience are extremely helpful in supporting clients in their recovery—you can't learn everything from a book.³¹

Peer work was described as the 'most revolutionary thing that's happening in mental health at the present time'³² and as integral to developing relationships with people living with mental illness to improve their wellbeing and promote human rights.³³ Ms Nicole Juniper, a witness before the Commission, relayed her own experience of being a peer worker:

We need to employ people that have experience. I'm a peer worker myself, and being able to share my stories with other young people especially, and have them tell me that they connected with something that I said, is incredible.³⁴

In the Victorian Mental Illness Awareness Council's declaration launched on 1 November 2019, the council asked people from all around Victoria with lived experience of emotional distress, trauma, neurodiversity and mental health challenges about the kind of people they need to support them and what skills and values they should have.³⁵ The two disciplines that were most often in people's preferences were peer workers and therapists, and the two qualities were listening and compassion.³⁶

The Commission has also been told about the importance of developing inclusive and affirmative workforces that reflect diverse communities—especially among peer support workers.³⁷ For example, the Commissioner for Gender and Sexuality, Ro Allen, said, 'peer support programs for our mental health run by LGBTI organisations governed and run by LGBTI people are so important in the system'.³⁸

Non-government organisations have been building service models delivered by people with lived experience of mental illness who also come from diverse communities or have had varying experiences.³⁹ Inclusive and diverse workforces will be integral to expanding lived experience workforces.

At the service level there is evidence that consumer peer support work is effective in facilitating positive service outcomes, including reducing readmission rates and the length of inpatient stays,⁴⁰ and achieving value for money.⁴¹

More formally, while there is evidence relating to the effectiveness of consumer peer support work, research on other aspects of lived experience work, such as family—carer workers and roles other than peer support workers, is still emerging.

One evaluation undertaken by Eastern Health regarding the Carers Offering Peers Early Support program demonstrated positive results for family—carer peer workers: 75 per cent of the respondents said they felt empowered, more confident and less isolated after their involvement with a program worker.⁴² There is scope for further research.

18.4 Challenges for lived experience workers

As explored in Chapter 6, members of lived experience workforces face a number of structural challenges that impinge on their ability to be as effective as possible. The principal challenges are:⁴³

- lack of organisational support and leadership
- limited access to supervision
- unclear roles and responsibilities
- workers not feeling valued in their roles
- mental health stigma
- inadequate remuneration
- the limited number of full-time positions and career opportunities, particularly in leadership roles
- the burden of being a 'lone worker'.

18.4.1 Work underway

Work is already underway in Victoria to define, promote and support lived experience workforces. The newly established Centre for Mental Health Learning has begun to take a leadership role in developing and promoting lived experience workforces; it has been described as a strong building block to support cultural change.⁴⁴ The centre was established in response to the Victorian Government's 2016 Mental Health Workforce Strategy.⁴⁵ It is responsible for public mental health workforce development in Victoria and for supporting access to quality and contemporary learning and professional development.

Considerable work is based in the strategies for the consumer mental health workforce, the family—carer mental health workforce, and the alcohol and other drug peer workforce.⁴⁶ These strategies consist of essential foundational tasks including definitional work, online resource hubs and communities of practice, lived experience frameworks, forums, training and organisational readiness tools.⁴⁷

In the development, implementation and stewardship of these strategies collaborative leadership is at the fore. Consumer, family, carer and alcohol and other drug workforce representatives are coming together from various services and government to share learning and best practice and to work towards common goals. Working together across professions is an example of collaborative leadership that the Commission considers pivotal to a strengthened mental health workforce overall and a contemporary future mental system.

This crucial work is, however, inadequately funded and resourced.⁴⁸ Without the requisite support, its outputs will not be implemented at the pace and scale required to support an emerging and growing workforce.

There is an immediate need to develop priorities for foundational actions that will support and enhance current lived experience workforces, along with establishing the pathways for growth in their size and reach.

18.5 Early training and ongoing learning and development

18.5.1 A standardised level of requisite training

As emerging professions, consumer and family—carer lived experience workforces do not yet have broadly recognised ‘entry to practice’ requirements such as those that apply to other professions associated with mental health.

Workers involved in challenging and complex environments tend to particularly benefit from having minimum training that ensures they are enabled and equipped with the skills to work to the best of their ability. Like any other profession, lived experience workforces need guidance on how to effectively and appropriately translate their knowledge into practice.

The Commission was told there is an inconsistent approach to training and learning and development in lived experience workforces, exacerbating the difficulties associated with unclear and inconsistent role definitions.⁴⁹

Although ‘lived experience’ cannot be taught and a large part of its value resides in shared experience, compassion, empathy and hope,⁵⁰ applying it to a range of roles and settings and within an established practice framework necessitates training.⁵¹ The Commission understands that, although all peer workers were required to receive minimum training⁵² as part of the Expanding Post Discharge Support initiative, implementation problems (such as inadequate resourcing) have meant that not all lived experience workers have had access to the training.⁵³

All lived experience workers should have access to a minimum, standardised level of lived experience training; this includes those currently working who have not previously received training.

For all lived experience roles, training in lived experience work should build on best practice models and be tailored to the Victorian context. Common baseline training in Australia involves intentional peer support and peer zone training, and localised training modules are emerging.⁵⁴ For example, in response to the Evaluation of the Lived Experience Workforce in South Australia’s Public Mental Health Services,⁵⁵ South Australia partnered with a non-government organisation to deliver a statewide training program focusing on the primary skills involved in peer work.⁵⁶ The perception of the program has changed from it being seen as an ‘add on’ to it being a central component of lived experience workers’ development.⁵⁷

These types of baseline training modules should form part of a framework of continuing professional development, supervision and training in connection with the mental health system and working in different settings and roles. The training should be enduring, with a sustainable pool of resources for training provision, review and enhancement as new roles and functions are built into future system design.

Further, the Certificate IV in Mental Health Peer Work is a nationally consistent and accredited qualification that focuses on applying peer work practices in the mental health sector, working effectively in trauma-informed care, promoting and facilitating self-advocacy, applying lived experience in mental health peer work, and using business technology (among a number of electives).⁵⁸

The certificate was available in 2012 and was superseded by a second version in 2015.⁵⁹ Some stakeholders have argued that it should be reviewed to ensure it is fit for purpose,⁶⁰

but a number of organisations regard it as important baseline training for employees. For example, Mental Health Victoria offers a qualification in Certificate IV, Brook Red in Queensland supports staff in achieving the qualification,⁶¹ and Mind Australia supports people to do the course.⁶² The course costs about \$5,400,⁶³ which can present a barrier for some seeking the qualification.⁶⁴

On balance, the Commission has reached the view that, as a minimum, the Certificate IV in Mental Health Peer Work should be added to the free TAFE course list. In doing so, the Victorian Government must consider what is required to prepare for an increase in the number of students. There must be an adequate number of qualified educators and practical placements available among a range of public TAFE providers in Victoria. The expected increase in student numbers would support the Commission's ambition to expand lived experience workforces over time.

There would also be great benefit in working with the Commonwealth Government—particularly the National Mental Health Commission—to review the Certificate IV in Mental Health Peer Work to ensure it evolves and remains relevant in a changing system and to redress the course limitations identified by the National Mental Health Commission.⁶⁵

18.5.2 Lifelong learning, professional development and educational pathways

The Commission envisages that lived experience work will span all aspects of the mental health system and associated services. This is a longer term endeavour, and it calls for consideration of the skills and capabilities that will be needed to support the growth of lived experience workforces, particularly in areas involving new functions and roles.

The Commission has been advised of a fragmented approach to learning and development in lived experience workforces: workers have reported that access to learning and development varies from service to service and often depends on the value organisations attach to lived experience work.⁶⁶

There is value in a learning and development pathway created and implemented to support the expansion and variation of lived experience work, including offering options for progressing and specialising. For example, specialist advancement could allow for development of business or management skills; it could also include skills in particular settings or supporting people experiencing specific mental illnesses.

This should build on the work of the Centre for Mental Health Learning in consolidating information about available opportunities and helping workers with lived experience make their way through what is a complex training system.⁶⁷

Creative ideas for supporting the learning and development of lived experience workforces have been put forward for the Commission's consideration, among them the following:

- learning opportunities similar to apprenticeship programs, work placements and internships to allow people to concurrently study and work⁶⁸
- more widely available lived experience rotation programs⁶⁹ whereby people are supported in moving through different settings, levels and roles

- membership of consumer advisory groups, allowing prospective lived experience workers to gain workplace experience, form networks and consider a career in lived experience work.⁷⁰

As the value of lived experience work becomes more widely recognised, there is potential for new gains supported through expanded qualification and career opportunities. Ultimately, these features can provide for more career options and the potential for better pay.

Qualifications offer opportunities for supporting workforce expansion and increasing career options in a variety of areas—for example, working in different settings, leadership, strategy, policy, research, evaluation, risk auditing, change readiness and specific disciplines such as recovery specialists.

This could include a package of qualifications that can lead to specialist tertiary degrees—for example, working in particular settings, supporting people living with specific mental illnesses or supporting growth into new roles such as evaluation and auditing. Pathways should also have multiple exit points to facilitate breaks in study, entry into the workplace and the gradual uptake of new opportunities. Such opportunities must be flexible to support and attract prospective students from a range of backgrounds and different experiences of mental health—for example, by providing an extended period of time to achieve qualifications.

Services should also be mindful of how to help people in non-lived experience roles (such as social work, psychology, psychiatry, occupational therapy and nursing) to apply lived experience to their work, if they wish to and where it is appropriate.

This calls for very deliberate planning and could include developing a training program run by lived experience educators that teaches people how to apply lived experience to non-lived experience roles. It might also provide a pathway from other professions into lived experience positions, and it could build on other initiatives seeking to destigmatise mental illness.

18.6 Practice supports, including supervision

Lived experience workforces cannot be expanded in isolation from the structural and foundational support necessary for an emerging workforce.

As a primary step, members of lived experience workforces must have access to the practical tools and guidance required to develop an effective and supported workforce. This could include access to supervision, mentoring and regular debriefing to reduce the risk of burnout and vicarious trauma for workers, and to ensure quality and safety of practice.

Supervision is a basic professional and practice norm for most established professions such as psychiatry, psychology, social work, occupational therapy and nursing, helping people to develop their skills and feel positive and engaged in the workplace. Supervision is distinct from line management. The former is about deepening knowledge and skills and responding to challenges relating to a specific profession; the latter relates to allocating workloads, overseeing completion of work and performance development.⁷¹

While supervision is generally attached to qualified professions or accreditation standards, or is embedded in industrial instruments, it is just as important for members of lived experience workforces. Consumer and family—carer roles 'are unique in that they require a person to invest their most personal, often painful and distressing experiences and information, into

their work⁷² at the same time as being careful to maintain their own mental health while directly working with consumers, families and carers.

Further, members of lived experience workforces retain a set of values and practices that might not be accommodated in pre-existing models of supervision, such as self-disclosure of lived experience and personal experience of the mental health service in which they work.⁷³

As such, lived experience workers must have access to regular support and guidance that deepens their knowledge and skills and provides a safe space where challenges can be identified and shared, and where workers can regularly reflect on their practices and experiences.⁷⁴

While lived experience workforces emerge and expand, this support and guidance can be provided through a range of mechanisms including online networks, group supervision, mentoring programs and practice coaches.

In the longer term, as lived experience workforces move towards a more established profession, it is envisaged that they will have access to supervision. Noting the unique elements of lived experience work, the Commission considers that this supervision should be provided by other lived experience workers who share similar experiences and values. In this regard the Commission acknowledges the early work that has already been done for the Consumer Perspective Supervision Framework.⁷⁵

In the interim, as this pool of resources is developed, Box 18.2 proposes alternate models of supervision to support an emerging workforce and to optimise existing expertise.

Box 18.2

Supporting lived experience workforces to develop supervision capacity at scale

Creating a sustainable pool of lived experience supervisors will take time.

Primarily, consideration should be given to structural changes in organisations that would support lived experience workers in gaining access to supervision. This could include team structures allowing for junior workers being supervised by senior lived experience workers (who are trained in providing supervision), the creation of more lived experience manager roles over time, and funding external lived experience supervision for senior workers as the workforce grows and expands its reach.

Formalising the requirement for lived experience supervision would create demand for the emerging workforce to start generating suitable levels of supply. At present the few lived experience leaders providing supervision often do so on a voluntary basis.

The Commission acknowledges that increasing the number of available lived experience supervisors will be supported through implementing the Consumer Perspective Supervision framework. The Commission notes this may take time. There may be opportunity to grow capacity by providing accessible learning modules and creating networks of experienced and emerging supervisors who can exchange skills.

In the interim the Commission considers that lived experience workforces could utilise a broad array of supervision models. While one-to-one practice supervision is optimal, many professions use other models of supervision to enable workers to gain the benefit of supervision when the supply of supervisors is small. This can involve group supervision and online supervision.

There may also be benefit in drawing on the support of other disciplines from which experienced practice supervisors could provide support and mentorship where desired.

Should it be deemed helpful, these networks of supervisors could include non-lived experience professions who do not have lived experience but who do have experience in the practice of professional supervision. Most mental health professions—among them psychiatrists, psychologists, social workers, occupational therapists and nurses—apply established (and often prescribed) supervision principles. For example, professional supervision is a practice standard for social workers, with the purpose of augmenting professional skills and competencies and engaging practitioners in continuing professional development. Social work supervision is underpinned by three core values: respect for persons, social justice and professional integrity.⁷⁶

Supervisors from other disciplines or professions could work with organisations advancing consumer and family—carer lived experience supervision by sharing their experiences of becoming proficient at the common fundamentals of practice supervision and provide workplace support to emerging lived experience supervisors as they build their supervisory skill set. This would be designed to supplement, not replace, the training and mentoring provided by experts in lived experience supervision.

18.7 Promoting the value of lived experience workers

There are individuals, leaders and service providers who are already promoting the value of lived experience workforces, and positive examples of peer-led services and leadership are evident. Empowering and supporting these workforces is, however, a systemic challenge and calls for statewide effort and leadership.

The Commission has heard evidence that a great inhibitor to lived experience workforces working optimally is the lack of organisational support and leadership in understanding, elevating and respecting workers' roles.⁷⁷ This places pressure on individuals to speak up and try to effect change in a context of resistance.

The Commission has been told about the success of lived experience work resting on the shoulders of lone individuals, rather than being engrained in organisational structures and cultures. One person shared:

I want my co-workers to not see me as different, but to see me as another part of the team that is complementary to the work they are doing. We need more integration in the team and to not be in silo roles.⁷⁸

An understanding of lived experience work at all levels of an organisation is central to the introduction, ongoing support and sustainability of lived experience work, and this requires deliberate, systematic effort accompanied by accountability measures.

To achieve this, the Commission calls for a statewide approach to establishing consumer and family—carer lived experience workforces as recognised, understood and valued professions. This will require developing and rolling out a statewide, mandatory organisational readiness program for all agencies receiving government funding for mental health services. The program should focus on preparing mental health services for promoting, supporting and empowering lived experience workforces.

In turn, this should build on existing organisational readiness training⁷⁹ and centre on generating a shared understanding of lived experience roles and functions, the values and capabilities underpinning the professions, and the structures and resources required to support workers.

The requisite structures and resources are those that will enable immediate use of lived experience work such as:

- a component on lived experience work in all organisational induction materials
- executive championship programs
- advisory roles for the consumer and family—carer workforce at executive and board levels
- greater consumer and family—carer workforce representation on executive committees and governance bodies
- preparing mental health services to understand, value and promote lived experience workforces.

As they implement change, organisations should seek advice from lived experience workforce experts and lived experience representative organisations. Whether sought internally or externally this type of consultancy and advisory work should be appropriately remunerated.

18.7.1 Accountability

To ensure organisations are transparent in their commitment to empowering and supporting lived experience workforces, accountability mechanisms should be part of their operations.

The Commission proposes that mechanisms, such as surveys, are implemented across organisations to measure the organisational attitudes and the experiences of lived experience workforces. To establish a benchmark, these should be operational before and after implementing organisational readiness programs, with the capacity for ongoing measurement.

In the future, service funding agreements and systems of accreditation and audit will be further mechanisms for ensuring accountability.

18.8 Implementation

In the immediate term, the Commission's recommendation in relation to lived experience workforces should be implemented by the proposed Mental Health Implementation Office, in co-production with consumers, families, carers and representatives of lived experience workforces.

In carrying out this task, the Mental Health Implementation Office should consider consulting the Centre for Mental Health Learning, noting that the centre has begun to take on a leadership role in developing and supporting lived experience workforces.

There is also an opportunity to optimise the collaborative work and governance that is already occurring to advance and oversee the work contained in the respective consumer, family—carer and alcohol and other drug mental health workforce strategies.

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Chapter 19

Workforce readiness

Recommendation

The Royal Commission recommends that the Victorian Government, through the Mental Health Implementation Office, prepares for workforce reform and addresses workforce shortages by developing educational and training pathways and recruitment strategies by providing:

- public mental health services in areas of need, including in rural and regional locations, through an expression of interest process that each year offers a minimum of:
 - 60 new funded graduate placements for allied health and other professionals
 - 120 additional funded graduate placements for nurses
- postgraduate mental health nurse scholarships to 140 additional nurses each year that covers the full costs of study
- an agreed proportion of junior medical officers to undertake a psychiatry rotation, effective from 2021, with it being mandatory for all junior medical officers by 2023 or earlier
- overseas recruitment campaigns, including resources to assist mental health services to recruit internationally, new recruitment partnerships between organisations, and mentoring programs for new employees
- a 'mental health leadership network' with representation across the state and the various disciplines, including lived experience workforces, supported to participate collaboratively in new learning, training and mentorship opportunities
- the collation and publication of the profile of the mental health workforce across all geographic areas, disciplines, settings and sub-specialties
- mechanisms for continuing data collection and analysis of workforce gaps and projections, and the regular mapping of the workforce to meet these gaps.

Positive outcomes for people living with mental illness, their families and carers are related to the composition, values and skills of the workforce. An empathetic and consumer-driven workforce is integral to delivering evidence-based, safe and responsive services. A capable and skilled workforce will be a key enabler of a reformed mental health system.

As explored in Chapter 6, many people have spoken to the Commission about the important role workers have played in their recovery, along with the workforce's commitment and passion. The workforce has also told the Commission about the challenges they experience in delivering best practice treatment and care.

This chapter sets out the actions that can be taken now to place the current system on a stronger footing. Because the workforce is overstretched, actions will need to be taken to develop and expand a pipeline of well-trained, well-supported and willing graduates to bolster the workforce. Workers will need to be inspired and engaged by a compassionate and open culture, with bold and innovative leadership. And workforce strategists will need to be supported to expand, mobilise and transition the workforce towards a future state.

19.1 Thinking ahead

The Commission will continue to carefully consider the attributes, skills and composition of the workforce, as well as the supports they will need to work in a future mental health system.

The workforce's values and skills will need to adapt and keep pace with community expectations and societal changes. The workforce must be empathetic, responsive, respectful and see individuals in their own context—building on the good work of so many already in the system. Services must be delivered by highly skilled workers who are culturally sensitive, with a strengthened focus on consumer-centred and recovery-oriented treatment, care and support.

The workforce must be supported by cultures that are engaging, reflective and accountable, and emboldened by strong leaders who are open to change and new ideas. Workers should be supported in environments that enable them to learn, excel and continuously improve their practice. These workforces must be diverse, reflecting Victoria's varied communities.

The Commission will examine new capabilities and skills; the workforce will be increasingly expected to work in different ways, noting 'as we expect them to do more and more in a different way, we've got to make sure they have the right skills to actually do this'.¹ Services will have a continuing role to support the workforce develop skills and capabilities to work in a new system.

The Commission will also consider the optimal composition of the workforce, particularly in the context of expanded and strengthened community-based models of care and multidisciplinary approaches.

The Commission will also be mindful of the general skills and knowledge of the broader health workforce—such as general nurses, doctors, emergency service workers and those working in adjacent care roles—who play a vital role in identifying, supporting and referring people living with mental illness.

As to the role of families and carers, the workforce's ability to optimally engage them will also be explored:

This should be a key part of adult mental health services. We should always be considering a consumer in the context of the people around them: whether it's family, social network, whatever that might be.²

Planning for developing and expanding a future workforce must also take account of what is required to create attractive and flexible workplace conditions—for example, the structures needed to support work-life balance, such as different approaches to leave entitlements, leave cover and flexible working arrangements.

The Commission will work with the Commonwealth and consider the Productivity Commission's draft recommendations relating to the mental health workforce, taking into account the shared responsibilities of the states and the Commonwealth in connection with workforce growth.

19.2 Technological and digital opportunities

As the population expands and becomes more varied, the types of services needed will change. The internet has transformed the way people engage with services, and digital and technological advances create potential to reimagine services. Younger people are more likely to seek help online and to reach out to virtual networks and support groups.³

Technology will continue to transform workplaces, requiring new skills such as mobile app development, social media management, data science and user experience design.⁴ Questions of technology will also need to be considered in the context of providing mental health services in rural and regional areas. In its Draft Report on Mental Health, the Productivity Commission places great emphasis on the potential to expand and integrate supported online treatments.⁵

This means a future workforce must have the ability to adapt to change and take advantage of opportunities in different digital and social landscapes. Workforce planners must consider how the world is progressing, what opportunities this presents and what skills are required to take advantage of the opportunities.

One of the priority outcomes in the Commonwealth's Australian Digital Health Strategy of 2016 was to enable the medical workforce to use digital technology to deliver health care.⁶ There are some emerging examples of the mental health workforce using digital technology—for example, psychologists delivering therapies through online platforms⁷ and online-supported approaches to cognitive behaviour therapy.⁸

In the National Digital Health Strategy there is a greater focus on digital opportunities in the broader health sector, but there is potential to take advantage of these initiatives in mental health. For example, as outlined in the strategy, improved information sharing, better availability of and access to prescriptions and medicines information, digitally enabled models of care, and a workforce that can confidently use digital health technologies.⁹

Although technology offers an opportunity for positive change in the way services are provided, it will never supplant positive interactions and therapeutic relationships between workers and consumers, families and carers.

19.3 Expanding the workforce

To support reform, structural pressures on emerging and future workforces need to be resolved. Worker shortages adversely affect services' ability to create the right mix of capabilities, competencies and cultures, in the right place at the right time.

As explored in Chapter 6, mental health services are experiencing workforce shortages across most professions. These shortages are more pronounced in rural and regional areas and in particular settings, disciplines and sub-specialties.¹⁰ Workers have told the Commission how overstretched workplaces lead to staff burnout, low morale and deskilling.

Workforce shortages have powerful negative effects on access and quality of care, ultimately compromising outcomes for people living with mental illness, their families and carers.

Workforce shortages compromise a workforce's ability to be responsive to change and advance effective practices. The Commission has been told how under-resourcing has hindered the workforce in building knowledge and effectively implementing the *Mental Health Act 2014* (Vic), including promoting choice and control and using advance statements.¹¹

On a day-to-day level services are under pressure to fill their rosters and meet demand. To the extent possible, some services have reported that vacancies are filled with locum staff,¹² agency staff¹³ and overtime in inpatient units.¹⁴

Structurally, workforce shortages are having negative effects on efforts to improve and expand services. Associate Professor Dean Stevenson, Clinical Services Director, Mercy Mental Health reported that 'retention and development of the workforce is a challenge in maintaining and expanding mental health services'.¹⁵ Several health services also reported that they have been unable to open newly built beds because they have been unable to recruit staff.¹⁶ For example:

Forensicare, as a result of rapid service expansion, has experienced firsthand the impact of workforce shortages, including delay in the opening of critically required new services. For example, Forensicare's Apsley Unit was not open immediately after commissioning due to a shortage of appropriately skilled staff such as nurses, clinicians and psychologists with endorsement in both clinical and forensic psychology.¹⁷

19.3.1 Graduate programs

Action must be taken now to begin to deal with workforce shortages, with a view to expanding the workforce over time. In the immediate term there is an opportunity to expand graduate programs to both redress shortages and attract the competencies required to deliver best practice services.

Positive experiences in the workplace—through graduate programs, internships and placements—are important in encouraging people to pursue a career in mental health.¹⁸ In 2017 the majority of mental health services retained 100 per cent of their 2017 nursing graduates, and most had retained 75 per cent of their 2016 graduates.¹⁹

Graduate programs are 'designed to consolidate knowledge, skills and competence to assist graduates to make the transition to practice as safe, confident and accountable professionals'.²⁰ They are also an effective way of attracting a younger workforce (at present the mental health workforce is ageing), allowing more experienced workers to support, educate and inspire younger workers.

The Commission proposes that the Mental Health Implementation Office runs an 'expressions of interest' process to determine in which mental health services to locate the allied health, other professional and nursing graduate positions. The office should form a statewide picture of where graduate positions need to be located—particularly in rural and regional areas. Position allocations should be based on need and agreed standards of what constitutes best practice graduate programs; for example, features could include preceptorship, mentoring, rotations where available, inclusive workplaces, formal learning opportunities and team-based work.

Allied health and other professionals

Psychologists, social workers, occupational therapists and other health professionals (such as clinical pharmacists) play a fundamental part in delivering therapeutic and evidence-based treatments to support people living with mental illness. Examples are behavioural therapy, behavioural and cognitive interventions, counselling, group therapy, and strategies to resolve psychological as well as social and environmental factors.²¹ The proportion of psychologists, social workers and occupational therapists working in the mental health sector has, however, remained static over the past 10 years, at 18 per cent.²²

The Commission understands that there are limited graduate programs to help these health professionals to transition into the workforce, although some services have developed their own programs.²³ Psychologists, social workers and occupational therapists are well equipped to work in the mental health sector. Their undergraduate degrees are structured to include a focus on mental health.²⁴

The Commission is of the view that there is scope to increase the number of allied health and other professionals working in mental health services through 60 funded graduate positions annually.

The Mental Health Implementation Office should determine the type of professional—for example, psychologist, social worker, occupational therapist or pharmacist—on the basis of an 'expressions of interest' process and identified areas of need. In choosing where graduate positions are to be located, the office should ensure that graduate programs are tailored to each profession and based on best practice guidelines such as those outlined in the Statewide Interprofessional Allied Health Graduate Program Manual.²⁵

Graduate positions should be in addition to services' current full-time equivalent profile to enable the growth of the allied health sector and to encourage career progression.

Box 19.1 takes a look at pre-qualification pathways.

Box 19.1

Pre-qualification pathways²⁶

The Commission has observed that there is potential to attract people into a career in mental health by engaging prospective graduates early in their education to work part time in mental health settings while completing their studies.

The educational pathway for psychologists, in particular, is extensive. They might consider working in mental health during or immediately after their initial undergraduate degree as a way of gaining workplace experience during their pre-registration period and beyond.

Pathways of this kind could be considered 'apprenticeships' or 'cadetships', with clearly defined roles in multidisciplinary teams. Such schemes should tap into a supply of workers who could provide valuable supports to senior staff and offer a set of capabilities that otherwise might be lost to other sectors.

Nurses

Mental health nurses account for the largest proportion of the mental health workforce working in specialised mental health care facilities. In 2016–17 there were 67.0 nurses per 100,000 population working in Victoria's specialised mental health care facilities; this compares with 13.6 medical officers and 24.0 psychologists, social workers, occupational therapists and diagnostic health professionals.²⁸

In 2014 the National Mental Health Commission reported that improving the supply of mental health nurses would be essential for supporting system change.²⁹ The Department of Health and Human Services reports, however, that mental health nursing vacancies are sitting at an average of approximately 10 per cent across the state.³⁰

Although there is a shortage of mental health nurses, there is apparent interest among nursing students in pursuing a career in mental health; this may in part be due to such programs as the Victorian Government's Hello Open Minds campaign.³¹ Each year more than 800 people apply for between 150 and 175 graduate nursing positions in the public mental health system.³² Similarly, a 2017 survey found that, for the three years preceding, the number of graduate applications exceeded the number of positions available.³³

There is potential for capitalising on this interest and augmenting the mental health nurse workforce through 120 additional funded graduate positions in mental health services annually.

The Mental Health Implementation Office should be tasked with determining the location of the nurse graduate positions on the basis of an 'expressions of interest' process, with consideration being given to areas of need and best practice graduate programs.

Mental health graduate positions should also be supernumerary to the current full-time equivalent profile, to encourage and sustain growth.

19.3.2 Postgraduate mental health nurse scholarships

There is also scope to expand the mental health nurse workforce through postgraduate mental health nurse scholarships. In 2019, 167 nurses applied for a postgraduate scholarship in mental health and only 64 offers were made, a trend that has been consistent over the past five years.³⁴

Postgraduate scholarships offer an opportunity to enable people with an evident interest in mental health, along with existing foundational clinical skills, to expand their knowledge for application in the mental health system.

The Commission proposes that 140 postgraduate scholarships are offered annually to meet the shortfall between applicants and current scholarships. The offering of the scholarships should be commensurate with the number of postgraduate positions across services: if there is an imbalance, the Victorian Government should consider funding additional postgraduate positions.

The government should engage with relevant universities early to ensure they have the resources to support an increase in the number of postgraduate students.

19.3.3 Psychiatry rotations for junior medical officers

An important influence on whether psychiatry will be the vocational choice of a junior medical officer is whether the person receives early and positive exposure to the speciality. It is reported that the more often junior medical officers are exposed to positive experiences of psychiatry, the more they choose to specialise in it.³⁵

During a junior medical officer's first postgraduate year they must do one medical, one surgical and one emergency department rotation. A psychiatry rotation is currently not required. In view of the strong influence early exposure to a discipline has on later career choices, it is the Commission's position that junior medical officers should be required to do a rotation in psychiatry during their postgraduate years. This should be across a diverse range of mental health care and treatment settings.

Increasing junior medical officers' exposure to psychiatry would also enhance doctors' skills in and knowledge of mental health, regardless of whether they choose to pursue a career in psychiatry. These skills can be used throughout their medical careers, to the benefit of the community.³⁶

As an interim step, the Commission proposes that the Mental Health Implementation Office works with relevant stakeholders, including the Royal Australian and New Zealand College of Psychiatrists and the Postgraduate Medical Council of Victoria, to determine a proportion of junior medical officers who must do a psychiatry rotation in Victoria, effective from 2021.

This should be informed by mental health services' capacity to appropriately support junior medical officers to undertake psychiatry rotations, including adequate supervision. It has been reported to the Commission that some people find psychiatry rotations challenging because they often do not receive appropriate support as a result of overstretched workplaces.³⁷

The Royal Australian and New Zealand College of Psychiatrists observes that, based on the number of health services in Victoria where a psychiatry rotation can be undertaken, the proportion of junior medical officers undertaking a psychiatry rotation can be at least 70 per cent.³⁸ As the initiative matures and interest grows, along with the structures required to support psychiatry rotations, the Victorian Government should work towards mandating a psychiatry rotation for all junior medical officers by 2023.

Box 19.2

Alison: frontline worker²⁷

Alison* is a social worker at an acute adult mental health inpatient unit in Victoria, and she believes that the way services are currently provided in acute mental health can be much improved.

Social workers are key players in acute mental health precisely because we focus on the psychosocial stressors that have triggered relapses, first episodes or crises leading to admission. The role of social workers on the ward is to support individuals to overcome some of their major psychosocial stressors by advocating for them and supporting them to navigate other systems (Centrelink, housing) to move towards an improved quality of life outside the ward.

Alison sees a huge imbalance in supply and demand. On the ward Alison works in, there is only one full-time graduate social worker and one part-time senior social worker for 25 consumers.

The medical model and the role of medication is indisputably important; however, the funding of public mental health facilities needs to be more balanced across disciplines to allow for holistic, ethical treatment and to further enable consumers' recovery in the community.

In Alison's experience, it is often psychosocial stress that leads to people experiencing poor mental health. Psychosocial stressors that she witnesses on her ward include child protection involvement, family violence, forensic and legal issues, seeking asylum and migration, neighbourhood safety, substance use, homelessness (or risk of), unemployment, Centrelink and other financial stressors.

Psychosocial stressors define the role of social workers like Alison. Some examples are:

- advocating for consumers' rights on and off the ward
- support for consumers who are experiencing homelessness to engage with the appropriate services
- involving child protection services when there are children at risk
- creating safety plans and referring consumers to family violence services
- providing support letters for those trying to navigate the Commonwealth Department of Home Affairs to stabilise visa issues.

Alison is very aware that medication cannot fix psychosocial stressors; it simply helps to reduce the person's symptoms to allow them to try to navigate the stressors themselves.

We are in a society where, cruelly, the most disadvantaged and impoverished people are often engaged with and have to navigate the most complex and under-resourced services that exist, for example Centrelink and Office of Housing. These stressors do not disappear when they are in hospital—they simmer in the background creating only more stress.

Alison would like to see more social workers on acute inpatient wards, indicating that if it remains as it is acute mental health service provision and recovery for consumers will be significantly compromised and discharges will be less sustainable.

Community mental health is managing to harness the focus on the link between psychosocial stress and mental health well, however acute mental health lingers in the medical model.

For a sustainable and ethical approach to treating consumers in acute mental health, and to act on the commitment to consumers and to a best practice recovery framework, more funding for social work on wards is vital.

**not her real name*

19.3.4 Overseas recruitment

The Commission sees an opportunity for the Mental Health Implementation Office to work with mental health service providers and relevant colleges to provide the support necessary for conducting overseas recruitment campaigns in areas of need—in metropolitan, regional and rural areas and in all mental health professions.

The Commission was told that the public health system relies on internationally recruited medical officers.³⁹ A number of organisations reported that they conduct international recruitment campaigns to help redress workforce shortages; these are largely directed at mental health nurses and psychiatrists.⁴⁰ Organisations' ability to do this recruitment depends on their resources and experiences, which will vary for small, medium and larger organisations and according to geography.

Preferred approaches should be canvassed through consultation and could include a spectrum of centralised and devolved activity. For example, the Mental Health Implementation Office should consider:

- undertaking statewide and state-led approaches to overseas recruitment
- facilitating collaborative partnerships across areas or providers
- exemplar toolkits, such as recruitment materials and training to support organisations with their own recruitment campaigns.

Recruitment strategies should also include promoting Victoria as a positive place to live and work—building on government promotional work such as 'delivering for rural and regional Victoria' and 'liveability Victoria international'.⁴¹

The Mental Health Implementation Office should also consult the workforce colleges to identify opportunities for streamlining assessment processes to expedite qualified and skilled people joining the Victorian mental health workforce. This could, for example, involve providing additional resources for assessing applications.

The design of the employment program should also optimise positive workplace experiences and provide for the additional supports required to support international workers transitioning into the Victorian system. It should offer mentorship, for example, as a critical way to assist new workers to settle in a new country and working environment. Other opportunities include international recruits rotating through different service settings and geographies to provide a diverse range of experiences and target areas of need.

This development work should consider the concern expressed by some stakeholders that overseas recruitment can be slow and expensive.⁴²

Although the objective is to expand the mental health workforce by attracting qualified and high-quality recruits, the Commission notes that this proposal is complementary to—and does not replace—domestic workforce growth strategies.

19.4 Collaborative leadership

Leadership in the mental health system—including leadership from all disciplines and lived experience workforces—is essential if responsive workplace cultures and practices are to be established and ready for reform. Leadership is linked to promoting continuous improvement in quality and safety and creating cultures that are positive and engaging to work in.

Workplace practices are also connected to leadership—for example, the ability to provide quality supervision, mentoring, practice leadership and lifelong learning. Identifying and supporting those who are interested in driving workplace and clinical excellence will be important to optimise in the future. At the system level, people who excel in driving improvement—such as innovation, clinical excellence and promoting the lived experience voice—should be recognised and rewarded through mental health awards.

Effective leadership will be a crucial element in the success of the Commission's recommendations. Ultimately, the next generation of leaders will be progressing a reformed mental health system: they will be central to the promotion and understanding of the need for change and renewal.

At present existing and emerging leaders are constrained by systemic factors that limit the fostering and sustaining of cultures of inclusion, where people feel connected and supported. Dedicated and impassioned workers have been deterred from 'leading', challenged by historical and ingrained hierarchies that are made worse by system pressures.⁴³ For example:

... services which are crisis-driven become very inward-looking. The focus is on managing the demand from hour-to-hour to day-to-day [...] doesn't give leaders [...] the ability to step back and to have a look at how things might be done a little differently.⁴⁴

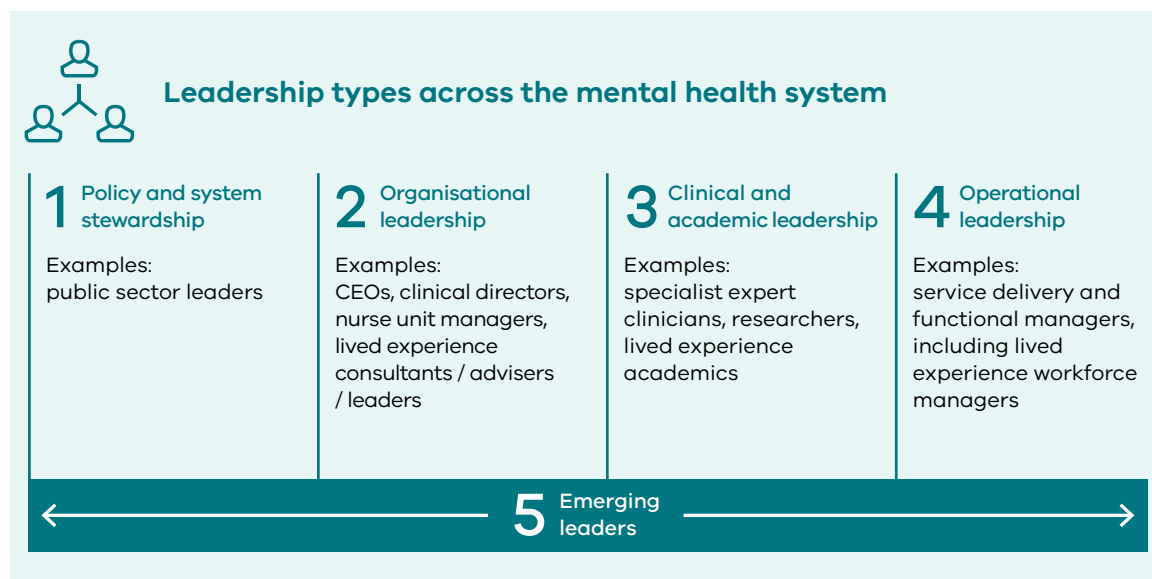
The division between strategic and operational within a service like ours is greatly challenging because the operational pull is very, very strong, so one doesn't have the scope and the time to spend strategising on how to improve.⁴⁵

... we've got to make those leadership positions more attractive, and also to actually train and recruit and groom and nurture the next generation of leadership, because the current generation has wilted in the face of these sorts of pressures.⁴⁶

Central to moving forward is developing emerging and existing leaders to foster cultures that are open to creativity and continuous improvement. There are various potential mechanisms for regulation and system oversight, but collective stewardship of the new mental health system—and the journey of reform involved in building it—will be a powerful enabler of change that can be developed from within.

Effective leadership must come from different places and positions within the mental health system. As outlined in Figure 19.1, there are five main domains in the mental health system where, in the Commission's view, leadership must be strengthened and sustained to provide for strong personal capabilities and organisational cultures and system-wide collaboration and oversight.

Figure 19.1: Leadership types across the mental health system



The Commission proposes that a network of mental health leaders be established across these five domains—people who have the ambition and the competence to work in a collaborative, collective way in organisations, services, disciplines and locations.

Collaborative leadership challenges embedded and hierarchical structures of power; it guides rather than controls and motivates rather than directs.⁴⁷ Common qualities of collaborative leadership are a willingness to take risks, an eagerness to listen, passion, optimism and an ability to share knowledge, power and credit; these traits must be grounded in political, interpersonal and process knowledge and skills.⁴⁸

As a first step, the Mental Health Implementation Office should seek nominations for leaders in all domains, geographies and disciplines to form a leadership network. This should take into consideration balanced gender representation. It has been reported that in some professions, such as psychiatry, there is a disproportionately low number of women in leadership positions.⁴⁹

Members should participate in an intensive leadership training program that has its foundation in the skills and qualities of collaborative leadership. This program should involve a combination of stratifying training across disciplines and levels of career progression, noting the varied points people are at in their careers, as well as bring people together to share learnings across different levels of experience and expertise.

The training program should build on best practice leadership programs, with a focus on collaborative problem-solving skills,⁵⁰ innovation in mental health, leadership in complex environments, and applied learning.⁵¹ For example, course outcomes could include the ability to negotiate, collaborate and build impactful networks, to design strategic and operational plans, to manage resistance to change, and to anticipate trends and innovations.⁵²

As part of this leadership network, leaders should emerge—figureheads that contribute to the public debate and bring with them informed and insightful perspectives.

To cultivate and sustain leadership skills, the network should have access to continuing learning and development opportunities including:

- ongoing training opportunities and regular network meetings to build and sustain connections and foster and test new ideas
- regular opportunities to engage with leaders in adjacent sectors and jurisdictions
- sponsorship programs for participation by existing senior leaders and heads of organisations (such as CEOs) to build collaborative connections and facilitate organisational accountability in supporting participating leaders
- mentorship programs to inspire, support, listen to and counsel emerging leaders
- participating in and/or promoting system-wide sharing, such as statewide conferences.

In consultation with the Mental Health Implementation Office, the network could also have a role in building awareness of the Commission's recommendations.

In the longer term, developing and sustaining leadership is linked to the proposed Collaborative Centre for Mental Health and Wellbeing, which will bring together leaders of the various disciplines associated with mental health to encourage research, innovation and collaboration across a system-wide perspective and open up a range of clinical and research positions.

19.5 Workforce data and analysis

In the absence of a centralised and comprehensive approach to workforce data collection and analysis, the Victorian Government is inhibited in its ability to plan for and respond to workforce challenges. Many submissions have called for a statewide approach to workforce planning, one that is systemic and forward focused.⁵³

The Victorian Government acknowledges the gaps in workforce data collection, describing existing approaches to demand forecasting as 'unrefined' and stating that data limitations inhibit planning and outcomes monitoring.⁵⁴ Other organisations, such as the Health and Community Services Union, have pointed to limitations in data collection that compromise understandings of some professions such as allied health.⁵⁵

Supporting, developing and expanding the future workforce requires a reliable evidence base from which to plan and project; this is crucial to responding to workforce needs and developing a workforce that reflects the community it serves.

Without a strong evidence base, government and others involved in workforce strategy will continue to be obstructed in developing and shaping the workforce, particularly in priority areas of need and in the context of system-wide change.

The Commission sees a strong need for improved and integrated mental health workforce data and intelligence that regularly collates sufficiently granular data to present a comprehensive profile of the mental health workforce in Victoria and in community and clinical settings.⁵⁶ One service submitted that, 'In order for broader service reform to occur, a deeper understanding of workforce demographics, needs, numbers, targets and a particular focus on rural and regional services is needed'.⁵⁷

The Mental Health Implementation Office should develop the systems and resources to regularly collect and collate data across mental health services in Victoria. The data should be regularly published to ensure accountability and transparency and to enable innovators in the system to participate in solutions.

This should be used as a foundation from which to plan, project and strategise to address workforce shortages and to build capable and skilled workforces that can respond to changing needs and demand.

Also integral to workforce planning is understanding what the future of work looks like for the mental health system and the trends and disruptions that will affect it. It is important to consider how the world is changing, what opportunities this presents for the workforce, what they need, and what skills and capabilities will be required to optimise changes and meet the expectations of people living with mental illness, their families and carers.

A simulation model in the Netherlands provides a good example of workforce planning (see Box 19.3).

Box 19.3

Netherlands simulation model for health professionals⁵⁸

The Netherlands simulation model for health professionals provides an example of dynamic workforce planning.

The Netherlands Institute for Health Services developed the model in 2000 to estimate the yearly number of health professionals in training required to meet future demand. Several sources of information are used to inform the model, among them demographics about health professionals (for example, surveys of health professionals and registration databases), the demand for care (for example, population projections and expert estimations) and the training of health professionals (for example, the number of female students and the drop-out rate). The models account for a range of scenarios, including changes of working hours, technical developments, sociocultural developments and epidemiological developments.

A study concluded that the health workforce planning model has significant policy value and has been successful in stabilising the labour market.

We can conclude that the health workforce planning model that has been in use in the Netherlands for the last ten years, has significant policy value and has been successful in stabilizing the labour market for physicians [...] other countries that are starting or re-evaluating workforce planning in health care can learn from the strengths and weaknesses of the Dutch model ...

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Chapter 20

A new approach to mental health investment

Recommendation

The Royal Commission recommends that the Victorian Government designs and implements a new approach to mental health investment comprising:

- a new revenue mechanism (a levy or tax) for the provision of operational funding for mental health services
- a dedicated capital investment fund for the mental health system.

This new approach should support a substantial increase in investment in Victoria's mental health system, supplementing the current level and future expected growth of the state's existing funding commitments.

20.1 Funding for a better mental health system

When making recommendations, the Commission has been asked, among other things, to put forward solutions that provide 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'.¹

A substantial increase in investment will be required to deliver the scale of reform needed to achieve a contemporary mental health system in Victoria. To support that investment, the Victorian Government should design and implement a new revenue mechanism (a levy or a tax).

This will allow for historical underinvestment to be addressed and for the community to have confidence that reforms to the mental health system will be enduring.

The specific level of funding required for Victoria's mental health system will not be known until the Commission completes its work designing a contemporary and equitable mental health system. This work will help identify both the total investment required and the opportunities to ensure the available funding is best distributed and used.

There is crucial work to be done by the Victorian Government to design and implement a new revenue mechanism. Starting this work now will ensure adequate funding is available to implement the Commission's final recommendations and support enduring reform of the mental health system.

This section discusses how the Victorian Government can increase investment in mental health. To do so it draws on a range of financial and budgetary concepts such as investment, revenue and funding, which are defined in Appendix C: Background to economic analysis.

20.2 Need for increased investment

The Commission considers that there is a clear and significant need for increased investment in Victoria's mental health system, as the existing level is insufficient and incommensurate to need. The current level of investment is insufficient on the basis that:

- the mental health service system does not provide enough treatment, care and support to meet the needs of even the most acutely in need
- the system has been increasingly unable to meet its stated objectives for access and effectiveness and so is providing many consumers, families and carers with poor experiences
- the current infrastructure is old, outdated and hindering the system's capacity to provide suitable care.

Together, these issues demonstrate that Victoria's mental health system is currently underfunded and a new approach is required.

20.2.1 Base level of funding does not support enough Victorians

The Fifth National Mental Health Plan states that an estimated 3.1 per cent of the population lives with severe mental illness.² The Victorian mental health system currently only offers enough public specialist clinical mental health services for an estimated 1.1 per cent of the population.³ This has been relatively stable for the past decade: 1 per cent of the population also received clinical mental health care in 2007–08.⁴

Ms Kym Peake, Secretary of the Department of Health and Human Services, summarised that, as a result, '[d]espite the public mental health system's orientation towards people with acute mental health needs, there are still treatment gaps for people with severe mental illness'.⁵ The Commission estimates that this treatment gap includes 105,000 Victorians living with severe mental illness who are not currently receiving care from specialist clinical mental health services in the public or private system.⁶

Victorian Government funding for specialist mental health services has increased over time, averaging 3.0 per cent a year real growth between 2007–08 and 2016–17.⁷ Investment has been higher again in recent years; for example, funding dedicated in the Victorian State Budget for mental health services increased by 7.9 per cent in 2017–18, 13.6 per cent in 2018–19 and 2.8 per cent in 2019–20.⁸ However, as the Victorian Auditor-General notes, this will not be sufficient for Victoria to increase service provision significantly: 'the four-year growth funding will enable [the Department of Health and Human Services] to provide mental health services to 1.2 per cent of the population in 2018–19 and thereon, only a marginal improvement on the current 1.16 per cent coverage'.⁹ The Auditor-General also noted an estimate that the Department of Health and Human Services only funds 62 per cent of the full bed day costs of a mental health acute bed compared with general health, where a general acute hospital bed is funded for 82 per cent of the full cost.¹⁰

The Commission concludes that even with more recent increases in investment, the base level of funding provided to the Victorian mental health system remains insufficient to meet its core service responsibilities.

20.2.2 Service performance indicates insufficient funding

The Victorian Government uses an output funding model whereby departments use the investment allocated in the budget process to deliver on the government's objectives¹¹ and outputs.¹² Output performance measures are used to specify the expected performance standard at which these services are to be delivered,¹³ covering measures such as the quantity of services provided, timeliness, quality and cost.¹⁴

For mental health, the Victorian Government's objectives and outcomes include:

- that 'Victorians have good mental health'¹⁵
- providing 'a range of inpatient, community based residential and ambulatory services that target and support people with a mental illness and their families and carers, identifying mental illness early, and [...] reduce its impact through providing timely acute care services and appropriate longer term accommodation and support for those living with a mental illness'.¹⁶

The Commission is mindful of criticisms of the current output performance measures. For example, the Auditor-General has suggested the current measures do not adequately capture the performance of mental health services.¹⁷ Notwithstanding these criticisms, the output funding model and associated annual reporting of performance measures provides an indication of the Victorian Government's expectations of its investment—that it will be used to provide a consistent level of access and quality over time.

The underinvestment in Victoria's mental health system over time can be clearly seen in broader system performance indicators, which show:

- **Access** to mental health services has declined. For example, over the four-year period to 2016–17, the number of people seeking access to, but not accepted by, area mental health services increased by 63 per cent.¹⁸ Between 2009–10 and 2018–19, within emergency departments the number of people admitted to a mental health bed *within eight hours* declined from 71 per cent to 59 per cent, well below the state target of 80 per cent.¹⁹ Further, in 2017–18 people with mental health-related needs made up 80 per cent of all patients in emergency departments who had a length of stay of *more than 24 hours*, up from 19 per cent in 2012–13.²⁰
- **The scope of services** provided has declined with time, as acknowledged in the Victorian Government's submission: 'Despite rising thresholds at intake, severely unwell consumers now receive around one third of the number of contacts received ten years ago'.²¹ The average length of stay (excluding long-stay patients where length was longer than 35 days) in Victorian acute inpatient mental health units dropped from 10.3 days in 2009–10 to 9.2 days in 2018–19.²² For community mental health, services have reported having less service capacity to provide intensive support and treatment before referring people to primary care providers,²³ with the average length for all community cases during the year at 188.5 days in 2018–19, down from 217.5 days in 2009–10.²⁴
- **The effectiveness** of some services has declined; for example, the proportion of patients experiencing a significant improvement following community mental health treatment fell from 56 per cent in 2009–10 to 51 per cent in 2018–19.²⁵ Others have shown no improvement in effectiveness.²⁶

In addition to access, scope and effectiveness concerns, many people who have sought treatment, care and support from Victoria's mental health system told the Commission of their poor experiences. As noted in Chapters 7 and 8, this included a lack of respect, dignity and equity, and difficulty accessing treatment, care and support that met their needs. It is clear to the Commission that the historical and current underfunding of services has contributed to these poor experiences.

20.2.3 Capital investment in infrastructure is too low

There is also a clear need for additional capital funding for Victoria's mental health system. This includes investment in buildings, vehicles and information and communication technology to support service delivery.

As the Hon. Robert Knowles AO, a former Victorian minister whose responsibilities included the Health and Aged Care portfolios, told the Commission, 'there needs to be an acceptance that a capital injection will be required to build more appropriate facilities'.²⁷

Additional investment in other infrastructure—particularly information and communication technologies—is also required.

Current levels of capital funding are hindering the provision of adequate services for Victoria's population. As described in Chapter 14, more than two-thirds of submissions from the state's area mental health services have said they have insufficient acute beds to meet demand.²⁸ On current trends this will get worse; the Commission's analysis shows the number of adult area mental health services having fewer than 19 acute beds per 100,000 people (the current state average²⁹) will increase from eight to 11 (out of the total 16) by 2031–32.³⁰

The lack of capital investment in facilities over time means that funding allocated to expanding services is often used to replace ageing stock. For example, as noted in Chapter 14, of the 98 new mental health beds commissioned as part of the redevelopment of Frankston Hospital and the new Footscray Hospital, only 18 additional beds will be included.

The lack of capital investment over time has also resulted in facilities that are outdated, hindering the delivery of recovery-oriented treatment, care and support. The poor physical infrastructure can contribute to inadequacies in delivering therapeutic care.³¹ Safety can also be compromised; ageing infrastructure means that in some cases mental health services cannot offer separate care environments across genders, or for different experiences of illness.³² The issue is not limited to inpatient services: old and outdated facilities can also be found in community settings.

The Commission has witnessed first hand the poor condition of some of Victoria's inpatient infrastructure. In May, the Commission visited Monash Health's Clayton Mental Health Unit, P Block.³³ Monash Health has noted that the unit does not meet current Australian and international standards.³⁴ The Commission noted how this impedes staff–consumer interaction and contributes to safety concerns. The Commission toured the unit's dilapidated therapy and sensory rooms and noted that such facilities erode rather than support recovery. The unit's poor design significantly restricts natural light and provides insufficient breakout spaces, which contribute to patient boredom and risk increasing patient acuity.

The Commission was told that P Block at Monash Health is not unusual: many inpatient facilities were designed decades ago and are no longer fit for purpose.³⁵ Additional capital investment is required to replace or update these outdated facilities.

The Commission also visited modern, fit-for-purpose inpatient facilities and noted a stark contrast. This included visiting the new mental health units (administered as part of the justice system) at Ravenhall and Dame Phyllis Frost correctional facilities.³⁶ In designing the Ravenhall facility, the architects incorporated research on links between building design and improved mental health outcomes.³⁷ For example, clinician offices are located within prisoner community spaces so that prisoners can physically see clinicians throughout the day, building a sense of familiarity. During the site visit, the Commission noted the use of large, open communal areas designed to foster social interaction and the emphasis on accessible and diverse spaces that promote increased activity and engagement in therapy and reduce prisoner boredom.

Within health and human services, it is well accepted that the physical design of facilities can influence outcomes. Evidence shows that the design of healthcare spaces can improve clinical outcomes and safety and reduce stress for consumers and staff.³⁸ This evidence has been applied in recent health infrastructure projects in Victoria such as the redeveloped Royal Children's Hospital³⁹ and the new Bendigo Hospital.⁴⁰ Additional investment in mental

health infrastructure can be a catalyst for system reform and improved outcomes, including through creating facilities that encourage innovative treatment, care and support.

The need for investment is not limited to buildings. In particular, from the perspective of services, the current data and information systems used in the Victorian mental health system are inadequate. For example, the Victorian Government notes:

Current systems used to capture client and system performance data are no longer fit for purpose. A redesign of the client management system would facilitate the delivery of high-quality services.⁴¹

As discussed in Chapter 5, there is no current capital management plan for mental health services in Victoria, which makes addressing the current infrastructure shortfalls additionally challenging.

20.3 Future investment requirements

Substantial investment, and ensuring value is achieved from existing investment, is required to deliver a contemporary, high-performing mental health system for Victoria.

20.3.1 Efficiency and effectiveness of investment

The Commission notes the need for current investment in the mental health system to deliver greater value for Victorians. As the Commission was told during hearings:

Funding reform is critical. If the government is to invest in reform of the mental health system, it needs to be buying something better.⁴²

We should have a much stronger focus on the outcomes that are being achieved for the dollars that are being spent, not just on the activity, and in particular the outcomes that matter to the people who seek our assistance.⁴³

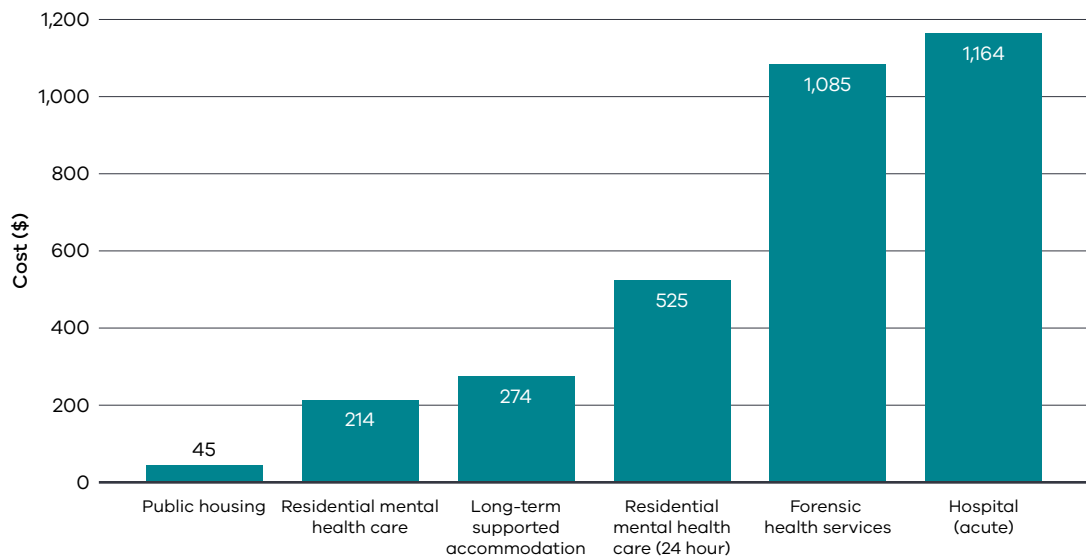
The Productivity Commission has similarly acknowledged that, alongside an increase in government spending in the short and medium term to implement reform,⁴⁴ there is an imperative to find opportunities to improve efficiencies and get greater 'bang from the taxpayer buck'.⁴⁵

For example, some people require long stays in acute mental health services because more appropriate accommodation and supports in the community are not available. Audits of five Victorian child and youth mental health services found that over a 12 month period there were 29 cases of patients staying for a combined 1,054 bed days without a clinical need to do so.⁴⁶ Across adult acute mental health units in 2018–19, an average of 11 per cent of all funded bed hours were used for long stays (over 35 days).⁴⁷ There is considerable variation in this rate across services (from 6 per cent to 20 per cent), suggesting greater consistency and improvements are possible.

In community mental health services across Australia it is estimated that only 29 per cent of staff time is spent on consumer-related activities (21 per cent with and 8 per cent without the consumer present) compared with the agreed national benchmark of 67 per cent.⁴⁸

More broadly, the Productivity Commission identified better use of online technology and care coordination as opportunities to better target supports.⁴⁹ Better connections and service planning with other government services, such as housing, will also provide efficiencies, as the average care costs can be significantly lower in related services (see Figure 20.1).

Figure 20.1: Estimated national average daily ongoing cost of accommodation per person, 2015–16



Source: Adapted from Productivity Commission. Draft Report on Mental Health: Overview and Recommendations, p. 32. <<https://www.pc.gov.au/inquiries/current/mental-health/draft>> [Accessed 10 November 2019].

Realising these opportunities to deliver a more efficient and effective mental health system will require redesigning models of care, governance and accountability mechanisms, funding models, data collection and performance monitoring processes. The Commission will focus on this comprehensive set of issues in 2020 as it designs a contemporary and equitable mental health system.

20.3.2 Increased investment

The Commission considers that additional investment is required to realise the ambition for a redesigned system.

The Commission has heard that more funding is needed to meet expectations of the level and quality of services delivered:

A considerable injection of new funds will be required by the State Government to move the public mental health services to a level of acceptability by consumers, carers, health professionals and the general public.⁵⁰

The Royal Commission into Mental Health will undoubtedly highlight many areas for improvement across the system. However, the need for planning and investment to meet demand is already known and as such work to address this should not await the Commission's recommendations. Further delay will only amplify the problems the Commission seeks to address.⁵¹

It is too early to determine the total annual investment required to fund a reformed mental health system. However, initial estimates suggest substantial additional investment is required.

The Commission considered several perspectives to estimate the potential scale of additional funding required for mental health. This analysis is based on inter-jurisdictional data, the most recent year available being 2016–17, where the Victorian Government's recurrent expenditure on specialised mental health services was estimated to be \$1.28 billion.⁵²

Two potential comparisons to consider the potential scale of increased investment are the national average and the past share of overall health spending in Victoria:

- **National average per capita funding rate:** Victoria's current per capita expenditure on mental health is lower than all other Australian states and territories (see Box 20.1 for details). If Victoria had matched the national average, mental health annual expenditure would have been 13 per cent higher.⁵³
- **Past share of total health expenditure:** In 1996–97 mental health received 18.3 per cent of all Victorian Government health services expenditure.⁵⁴ This declined to 12.8 per cent by 2016–17. If mental health had instead maintained its share of the overall state health spend, mental health annual expenditure would have been 43 per cent higher.⁵⁵

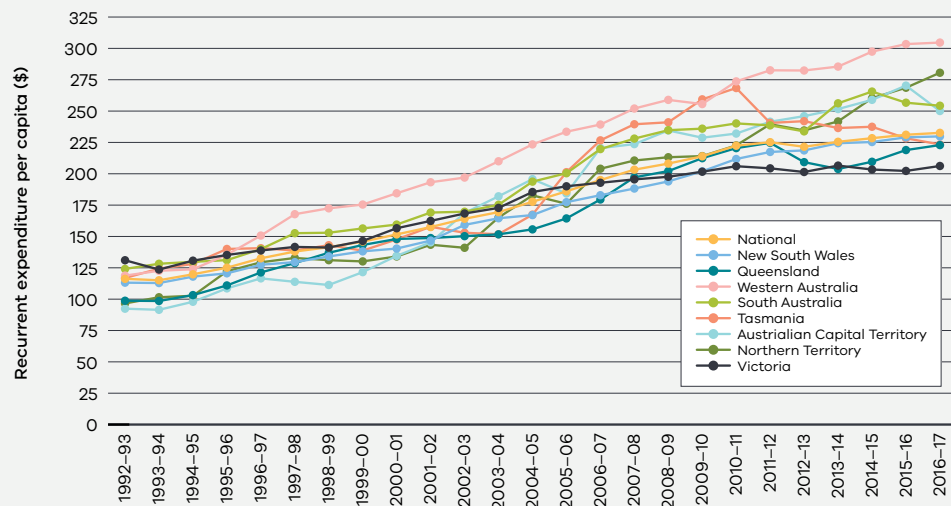
However, both of those examples are comparing Victorian spending with benchmarks where less than 3.1 per cent of the population were provided with public clinical specialist mental health services. If the Victorian mental health system was to provide specialist clinical mental health services to the estimated 3.1 per cent of the population experiencing severe mental illness, it would need to provide care for an additional 105,000 people.⁵⁶ At current levels of public funding and private service provision, and without any improvements in efficiency or effectiveness, mental health annual expenditure would need to have been more than double (107 per cent higher).⁵⁷

Box 20.1

National investment in specialist mental health services

In the early 1990s Victoria had the highest per capita state spend on specialist mental health services in Australia. By 2016–17 (the most recent national data available) Victoria had the lowest. Victorian expenditure has grown but has not met the level of increase seen in other jurisdictions (see Figure 20.2). This is unlikely to be due to increased efficiency, given Victoria has higher treatment costs for some services.⁵⁸

Figure 20.2: Recurrent expenditure per capita (\$) on state and territory specialised mental health services, constant prices, 1992–93 to 2016–17



Source: Australian Institute of Health and Welfare. Mental Health Services in Australia. Expenditure on mental health services 2016–17, Table EXP.4, <<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia>> [accessed 9 October 2019].

Collections and counting rules may have changed over the reporting period.

Along with increasing funding, other states and territories have also improved the coverage of mental health services. In 2016–17 Victoria provided clinical mental health services to 1.1 per cent of the population compared with the national average of 1.8 per cent of the population (see Figure 20.3).⁵⁹ While service provision in most states is still behind the estimated level of need at 3.1 per cent, Victoria's remains the lowest.

Figure 20.3: Proportion of population receiving clinical mental health care, states and territories, 2007–08 and 2016–17

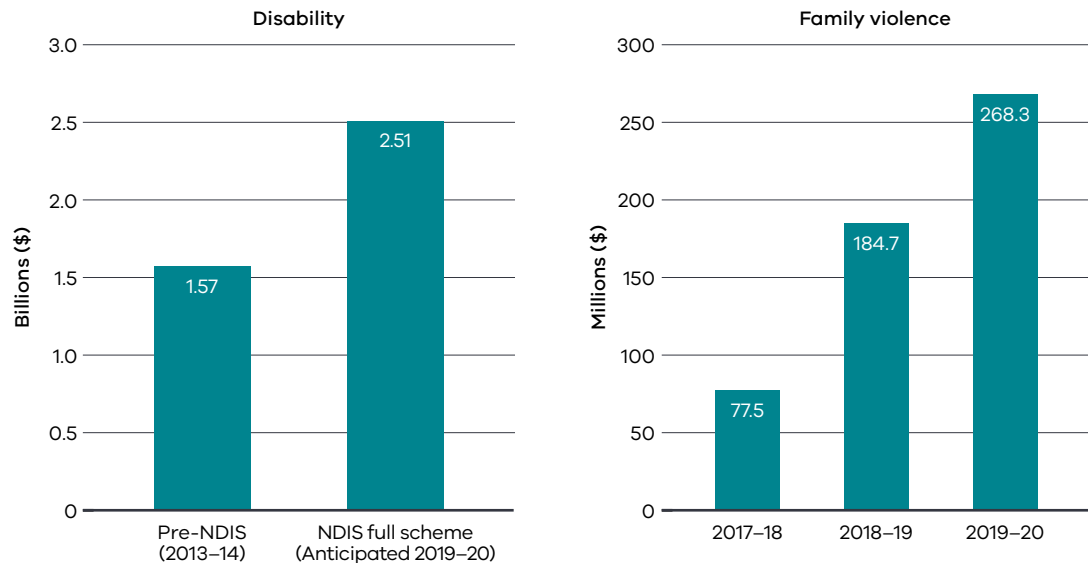


Source: Australian Institute of Health and Welfare. Mental Health Services in Australia. Key performance indicators for Australian Public Mental Health services 2019. Table KPI.8.1. <<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia>> [accessed 9 October 2019].

Another perspective on the need for investment is to consider the experience in other sectors that have undergone major reforms. For example, changes in community views led to major reforms of disability services and the introduction of the National Disability Insurance Scheme (NDIS). This required substantial investment: the introduction of the NDIS saw a 60 per cent increase in the Victorian Government's committed annual investment in disability services (see Figure 20.4).⁶⁰

The increased recognition of the harm family violence causes to Victorians and subsequent reforms also led to increased government investment. The Victorian Government committed \$1.9 billion (over four years, across portfolios) in its 2017–18 State Budget to help implement the recommendations of the 2016 Royal Commission into Family Violence.⁶¹ This investment included a broad suite of reforms and service areas;⁶² the annual output funding specific to family violence reform service delivery has also steadily increased from the estimated \$81 million spent in 2014–15 prior to the Royal Commission (see Figure 20.4).⁶³

Figure 20.4: Changes in Victorian Government investment in disability services relevant to the National Disability Insurance Scheme and family violence reform



Source: Victorian Government Submission to the Productivity Commission Review of NDIS Costs, p. 26; Department of Treasury and Finance, Output performance measures – Department of Health and Human Services, 2009–10 to 2019–20.

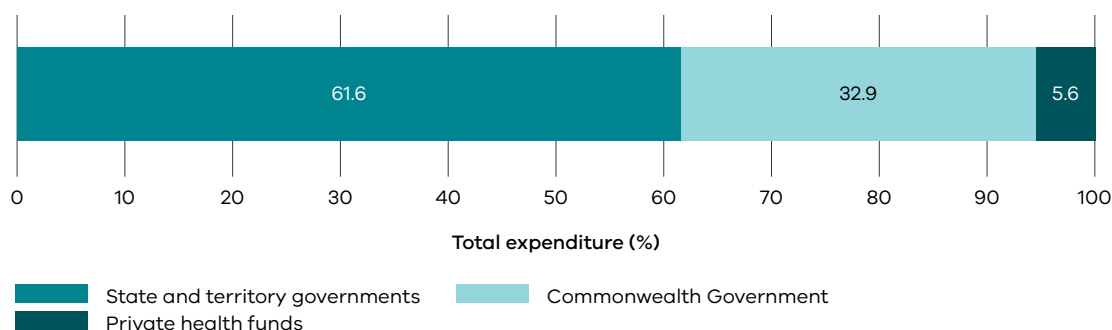
20.4 A new, sustainable investment approach

The Commission notes that many funders contribute to Victoria’s mental health system. Improved mental health outcomes will rely on greater investment by each of these.

For example, the current data suggest the Commonwealth Government’s investment in mental health services remains relatively low compared with other parts of health, accounting for only 4.0 per cent of its health expenditure in 2016–17.⁶⁴ The Productivity Commission is also of the view that some additional spending from Commonwealth and state and territory governments in mental health will be needed.⁶⁵ Members of the Australian community are also less likely to contribute to mental health than to other causes,⁶⁶ and private health insurers contribute a smaller proportion to total expenditure on mental health services than they do for health services generally.⁶⁷ Further, the imperative for employers to invest in mental health—including moving beyond compliance to invest in mental health prevention and promotion among employees and customers—appears to be increasingly acknowledged.⁶⁸

Currently, state and territory governments provide the majority of funding for mental health services (see Figure 20.5).⁶⁹ Levels of state funding are critical to the performance of the mental health system. Consequently, this analysis is focused on securing sufficient provisioning from the Victorian Government’s contribution.

Figure 20.5: Proportion of total expenditure on mental health related services in Australia, by source of funding, 2016–17



Source: Australian Institute of Health and Welfare. Mental Health Services in Australia. Expenditure on Mental Health Services 2016–17. Table EXP.34. <<https://www.aihw.gov.au/reports/mental-health-services/mentalhealth-services-in-australia/report-contents/summary-of-mental-health-services-in-australia>> [accessed 9 October 2019].

The number of options to fund increased investment in mental health is limited. Mr David Martine PSM, Secretary of the Department of Treasury and Finance, noted:

Generally there's only three ways that governments can pay for things: you either cut spending in another area to fund more spending in a particular area; you either raise taxes to fund something, or you increase borrowing.⁷⁰

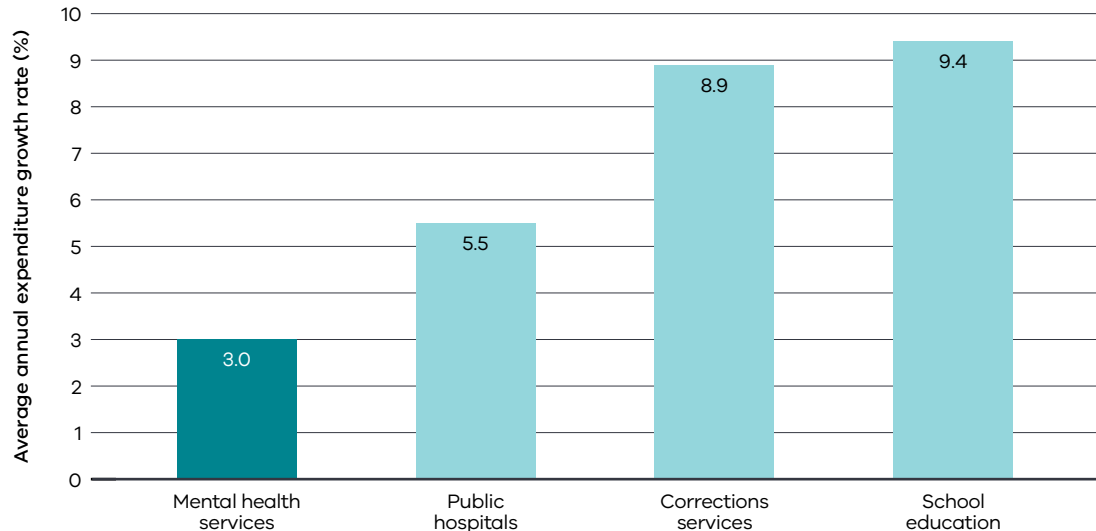
As outlined above, mental health has not secured adequate funding during the past decade. Higher funding in mental health in more recent years appears to be more of an exception. Ms Peake observed:

Taking the example of community mental health services, while considerable growth funding was allocated to community mental health services in 2016–17 (2.3 per cent) and 2017–18 (7.0 per cent), this followed a period of zero growth funding over the three years prior.

New funding has often been allocated to smaller initiatives to 'patch-up' service gaps, rather than to core service capacity.⁷¹

At the same time, other government services have on average experienced sustained operational funding growth (see Figure 20.6).⁷² This has possibly allowed other services to grow service capacity and better respond to demand while maintaining or improving the accessibility and quality of services. In contrast, the mental health system has struggled to secure sufficient investment to deliver adequate treatment, care and support.

Figure 20.6: Average annual growth rate of Victorian Government expenditure in mental health services, public hospital services, corrections services, school education services, 2007–08 to 2016–17



Source: Calculation by the Commission based on Productivity Commission. Report on Government Services 2013 and 2019: Corrective Services – Attachment, Part C, Chapter 8: Tables 8A.2, 2013 and 2019; Productivity Commission, Report on Government Services 2019: School Education – Attachment, Part B, Chapter 4: Tables 4A.10, 2019; Productivity Commission, Report on Government Services 2019: Public Hospitals – Attachment, Part E, Chapter 12: Tables 12A.1, 2019; Productivity Commission, Report on Government Services 2019: Mental Health Management – Attachment, Part E, Chapter 13: Tables 13A.3, 2019.

The Productivity Commission changed the method for calculating corrections expenditure for 2011–12 which meant comparisons in expenditure growth rates had to be done across two different reports, the 2019 Report on Government Services and the 2013 Report on Government Services. The annual growth rates for the periods 2007–08 to 2011–12 include growth in prisoner health expenditure, while the annual growth rates for the period 2011–12 to 2016–17 do not. Despite this, the annual growth over this time still provides a reasonable time series comparison.

The Commission has canvassed the reasons why mental health has not attracted sufficient funding under this process, where other service areas may have. The reasons appear to include the following:

- Prioritisation:** In the past two decades mental health has often not been a high spending priority in an environment of constrained resources. As evidence of this, mental health's share of all Victorian Government health services expenditure declined from 18.3 per cent in 1996–97 to 12.8 per cent in 2016–17.⁷³ This could be a structural manifestation of the stigma associated with mental illness: 'Mental health has historically been seen as the "poor cousin" of the health system, which perhaps explains in part why [it] has not been the priority it should have been'.⁷⁴ This lower priority has also been reflected in sometimes lower levels of political support for mental health compared with other service areas.⁷⁵
- Building a business case:** Limitations in measuring and reporting demand, the adequacy of service provision, quality and outcomes make it difficult to develop and prosecute the needs and benefits of additional funding towards mental health. Further, mental health services rely on block funding, where services are provided with a 'block grant' often based on historical budget allocations rather than a level of funding based on year-to-year changes in services delivered or demand for those services. Block funding provides fewer incentives (and often lacks the

supporting systems) to track and respond to changes in the mix, type and volume of service delivered.⁷⁶ In addition, current data collection makes it difficult to forecast demand,⁷⁷ assess whether consumers are accessing appropriate services,⁷⁸ or provide an indication of service quality.⁷⁹ Without this information, it is challenging to develop a strong and competitive business case for investment.

Where government has allocated additional funding to mental health services, this can often be for short-term or pilot projects, where a new initiative is introduced on a small scale rather than consistently across the state. As Mr Andrew Jackomos PSM, a Yorta Yorta/Gunditjmarra man and the Executive Director of Aboriginal Economic Development, Department of Jobs, Precincts and Regions, told the Commission in the context of funding for Aboriginal mental health services:

There's a lot of pilot projects that come in and go, you know, for about 12 months. A lot of times they set up communities for failure unless there's long term funding.⁸⁰

Without robust data, relying on budget processes to secure funding risks securing insufficient investment to maintain service access and quality. The budget process also relies on regular re-prosecution of the case for investment. The Commission is concerned mental health will struggle to secure a stable level of investment through this process, should the current focus on mental health reform subside.

Seeking funding through the budget process also risks that funding is reallocated to mental health from other service areas. People experiencing poor mental health often require additional government services, and underfunding these services risks ongoing poor mental health outcomes. For example, in 2017–18 approximately 38 per cent of children in Victoria's statewide specialist mental health services were also engaged by child protection services within the same year, 17 per cent of adults were engaged by homelessness services and 9 per cent by public alcohol and other drug services.⁸¹ Identifying an alternative to reallocation will avoid the risk of decreasing service availability in these areas and simply shifting of demand across portfolios.

It is also easier to secure additional funds via the budget process when there is a cohesive view across services of the need for increased investment and when that need is shared with the community. Professor Patrick McGorry AO, Professor of Youth Mental Health, The University of Melbourne and Executive Director of Orygen, told the Commission that there are many debates in mental health—such as over the value of drug therapies in comparison with psychological therapies—that generate a level of conflict not seen in other areas of health.⁸²

20.4.1 Other approaches available

Beyond the standard approach to allocating investment from general revenue in the annual budget process, a variety of more specific revenue mechanisms exist for funding government services. Examples of these are described in Box 20.2.

These demonstrate rationales for introducing specific revenue mechanisms. This includes designing fairer tax bases, investing to improve equality and outcomes across the community, and providing greater transparency about what is being invested in areas that have previously received relatively low levels of funding.

Box 20.2

Dedicated revenue mechanisms: some examples

The **Transport Accident Commission (TAC)**—which funds treatment and support services for people injured in transport accidents, promotes road safety and works to improve the state’s trauma system⁸³—is an example of service fully funded separately to general revenue.⁸⁴ Its revenue comprises payments made by Victorian motorists when they register their vehicles each year with VicRoads and any returns on the assets and liabilities the TAC manages. This provides the TAC with autonomy to establish the level of resourcing it needs to adequately meet its responsibilities and greater flexibility in how it uses its funds (for example, being able to make investments with higher up-front costs but with the potential to reduce long-term liabilities). The Victorian WorkCover Authority (WorkSafe Victoria) operates on a similar model.

The **National Disability Insurance Scheme (NDIS)** is an example of a service being significantly—but not fully—funded by a new and dedicated revenue mechanism. The Australian Government increased the Medicare levy from 1.5 to 2.0 per cent of taxable income from July 2014 to help fund the scheme.⁸⁵ This additional revenue has been held in the DisabilityCare Australia Fund.⁸⁶ The broad-based tax is akin to an insurance premium each person pays to gain access to disability services and support if needed. The tax has helped fund the notable step up in investment for disability services with the introduction of the NDIS and the transition from block-funded services to an ‘insurance based’ approach that supports funding early interventions if they can reduce a person’s lifetime support needs. The rationale for the tax increase was further described by the government of the day as ‘about a dollar a day from the average Australian towards a better life for hundreds of thousands of Australians with a significant and permanent disability, their families and carers ... This announcement [also] ensures that the Commonwealth, along with every State and Territory, is in a position to deliver this reform’.⁸⁷

The **Fire Services Property Levy** is an example of a revenue mechanism that primarily funds a government service. Following the recommendations of the 2009 Victorian Bushfires Royal Commission, Victoria introduced a levy applied to all ratepayers in place of the existing levy, which applied only to property owners with insurance. That Commission concluded the ‘the current funding model lacks transparency and is inequitable’.⁸⁸ The Fire Services Property Levy rates are set each year to help fund the services provided by the Metropolitan Fire Brigade and Country Fire Authority.⁸⁹ The Victorian Government increased the levy in 2015 to better meet these service costs, with the Treasurer commenting that the change ‘ensured there is no shortfall, because the safety of our communities matters most’.⁹⁰ The levy will collect an estimated \$709 million in 2019–20.⁹¹

Other mechanisms exist that are used to supplement revenue for specific services. These generally only cover a proportion of the cost of total service delivery and infrastructure. They include the following:

- In Victoria, some of the state's gambling tax revenue is placed in funds dedicated to health and human services; this includes the **Hospitals and Charities Fund** and the **Mental Health Fund**.⁹² The intent of this arrangement is to direct gambling revenue back into support for the community. The *Gambling Regulation Act 2003* allows the Treasurer to determine the respective allocation of monies to the two funds from this revenue source each year.⁹³ In 2018–19 the Mental Health Fund was allocated \$63.9 million and the Hospitals and Charities Fund \$1.6 billion.⁹⁴ The Act also specifies that money in the Mental Health Fund must be used for services defined under the *Mental Health Act 2014* or the *Disability Act 2006*.⁹⁵
- The Australian Capital Territory Government introduced the **Safer Families Levy** from 1 July 2016. It is a \$30 fee applied to every household in the ACT to fund initiatives aimed at preventing and responding to family and domestic violence.⁹⁶ The ACT Government described its motivation for introducing the levy as based on 'the values we hold—of caring for those who are vulnerable, who need a helping hand, of saying that this is an area of our community where good governments should and must act'.⁹⁷
- The **Growth Areas Infrastructure Contribution** is a Victorian Government levy imposed on certain types of property development. It was introduced in 2010 to 'ensure that developers in growth areas provide a fair contribution towards the provision of infrastructure',⁹⁸ noting that they benefit financially from planning rule changes in growth areas and could contribute further to the cost of infrastructure provision so that services can be delivered sooner.⁹⁹ One use of the levy funds is for new schools: \$184 million was provided in 2018–19 to acquire land and fund the construction of new schools in growth areas.¹⁰⁰

There are also examples where government has adopted a specific approach to dedicated infrastructure funding. These are outlined in Box 20.3.

Box 20.3

Dedicated capital investment mechanisms: some examples

The **Victorian Transport Fund** provides funding for major transport infrastructure projects.¹⁰¹ The fund was established under the *Delivering Victorian Infrastructure (Port of Melbourne Lease Transaction) Act 2016*. It receives funds from leasing the commercial operations of the Port of Melbourne through the 50-year lease transaction. Under the legislation, the Treasurer can authorise payments for the level crossing removal program and other transport infrastructure projects.¹⁰²

The **Regional Health Infrastructure Fund** was established in 2016 to provide upgrades for rural and regional public health services and public sector residential aged care services. Funding can be used to expand capacity, to improve safety, quality and efficiency and to deliver better care to patients. Services can apply for grants for construction projects, equipment, information and communications technology or new technologies.¹⁰³

The **Regional Jobs and Infrastructure Fund** was established under the *Regional Development Victoria Act 2002*. Within this, the Regional Infrastructure Fund provides 'grants for infrastructure projects that have the potential to stimulate economic activity in regional Victoria'.¹⁰⁴

Government has also established the **Victorian School Building Authority**¹⁰⁵ and the **Victorian Health and Human Services Building Authority**.¹⁰⁶ These authorities oversee multi-billion-dollar programs of investment in schools, hospitals and other education, health and human services infrastructure.

20.5 Recommended process

The Commission recommends that the Victorian Government adopts a new approach to secure a dedicated and stable level of investment for the mental health system. This will give Victorians experiencing poor mental health now and into the future more confidence that they will have access to reasonable support and services when they most need it. It will also allow the Victorian Government to implement sustainable reforms and provide predictability to families and carers, the mental health sector and the workforce.

To do this, the Commission recommends that government designs and implements a new revenue mechanism for providing operational funding, and a dedicated capital investment fund for the mental health system.

The Commission expects the government to share its planned approach to implementing this recommendation with the Commission in early 2020. This will assist the Commission in considering governance and related arrangements for the redesigned mental health system.

20.5.1 Revenue mechanism

The Commission recommends that the Victorian Government designs and implements a new revenue mechanism (a levy or a tax) for providing mental health operational funding.

The Commission intends that the mechanism:

- supports a substantial increase in overall operational funding for mental health and more appropriate growth over time, rather than simply replacing current and future scheduled growth of existing funding commitments¹⁰⁷
- allows for new spending, including funding of all the Commission's recommendations (including once-off items)
- has a strategic impact where possible—that is, provides incentives to minimise risks to Victorians' mental health (taking account of the social and economic determinants of mental illness) and encourages opportunities to realise better mental health outcomes.

Beyond these broad parameters, the Commission does not have a set view on the specific design and implementation of the mechanism. Government will need to consider the source of the revenue, how the introduction of the new revenue may be phased, the likely quantum to be raised, its variability over time and its impact across the community.

20.5.2 Capital investment fund

The Commission also recommends that the Victorian Government designs and implements a dedicated capital investment fund for the mental health system.

As noted in Chapter 14, the Commission is designing a new mental health system that will consider the need for acute services as well as increased community-based services. This will form the foundations for a comprehensive 2021 service and infrastructure plan. In addition to this, the mental health system will need a statewide plan that covers broader capital requirements such as data-sharing systems and information and communications technology.

The Commission intends that the capital investment fund:

- supports an increase in investment available for mental health capital
- provides greater transparency and certainty over the level of capital investment available to the mental health system and how it is allocated.

The fund should help the Victorian Government avoid ad hoc capital injections, and instead support continuous investments that allow the mental health system to be sustainably reshaped and improved over time. It should also seek to capture long-term efficiency and effectiveness gains available from capital investments (for example, via better data collection and monitoring).

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- 1 Victorian Government, 'Royal Commission into Victoria's Mental Health System – Terms of Reference', 2019, p. 3.
 - 2 Commonwealth Department of Health, *The Fifth National Mental Health and Suicide Prevention Plan*, August 2017, p. 20. Note this prevalence data is based on the National Mental Health Service Planning Framework.
 - 3 Australian Institute of Health and Welfare, *Mental Health Services in Australia: Key Performance Indicators for Australian Public Mental Health Services 2016–17*, Table KPI8.1. For a service provider perspective on this see *Witness Statement of Associate Professor Ruth Vine*, 27 June 2019, para 47.
 - 4 Australian Institute of Health and Welfare, *Mental Health Services in Australia: Key Performance Indicators for Australian Public Mental Health Services 2016–17*, Table KPI8.1.
 - 5 *Witness Statement of Kym Peake*, 24 July 2019, para. 66.
 - 6 Calculation by the Commission based on the National Mental Health Service Planning Framework; Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2017–18*, October 2018, p. 64; Department of Environment, Land, Water and Planning, *Victoria in Future 2019*, June 2019; Australian Institute of Health and Welfare, *Mental Health Services in Australia: Overnight Admitted Mental Health-Related Care 2017–18*. Table ON.4 and Table ON.12 and *Same Day Admitted Mental Health-Related Care 2017–18*, Table SD.19.
 - 7 Note this is based on Australian Institute of Health and Welfare data, which uses the definition of 'specialised mental health services' covering 'services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental illness or psychiatric disability'. Productivity Commission, *Report on Government Services 2019: Mental Health Management – Attachment, Part E, Chapter 13: Tables 13A.1 – 13A.65*, 2019, Table 13A.3 and pp. 13 and 39.
 - 8 Commission analysis of the total cost for the Mental Health Output over 2016–17 to 2019–20. Note this includes both ongoing and time-limited operational funding commitments. Department of Health and Human Services, *Output Performance Measures 2019–20*.
 - 9 Victorian Auditor-General's Office, *Access to Mental Health Services*, March 2019, p. 42.
 - 10 Victorian Auditor-General's Office, *Access to Mental Health Services*, p. 41.
 - 11 Department of Treasury and Finance, *Performance Management Framework: For Victorian Government Departments March 2016*, June 2017, p. 18.
 - 12 *Witness Statement of David Martine PSM*, 28 June 2019, para. 17.
 - 13 Department of Treasury and Finance, p. 12.
 - 14 *Witness Statement of David Martine PSM*, para. 17.
 - 15 Victorian Government, *Service Delivery 2019–20: Budget Paper No. 3*, May 2019, pp. 191–92.
 - 16 Victorian Government, *Service Delivery 2019–20: Budget Paper No. 3*, p. 208.
 - 17 *Witness Statement of Andrew Greaves*, 19 July 2019, para. 22 (iv).
 - 18 Victorian Auditor-General's Office, *Access to Mental Health Services*, p. 46; *Witness Statement of Dr Neil Coventry*, 28 June 2019, para. 108.
 - 19 Department of Health and Human Services, '*Client Management Interface / Operational Data Store*'. 2009–10 and 2018–19.
 - 20 Department of Health and Human Services, *Integrated Data Resource, Victorian Emergency Minimum Dataset*, 2012–13 and 2017–18.
 - 21 Victorian Government, *Submission to the RCMHS: SUB.5000.0001.0001*, July 2019, p. 24.
 - 22 Department of Health and Human Services, '*Client Management Interface / Operational Data Store*'. 2009–10 and 2018–19.
 - 23 *Witness Statement of Gail Bradley*, 26 June 2019, para. 27.

- 24 Department of Health and Human Services, '*Client Management Interface / Operational Data Store*', 2009–10 and 2018–19.
- 25 Department of Health and Human Services, '*Client Management Interface / Operational Data Store*', 2009–10 and 2018–19.
- 26 For example, the proportion of patients experiencing a significant improvement following inpatient mental health treatment was 76.2 per cent in 2007–08 and 75.7 per cent in 2016–17, and ongoing ambulatory mental health treatment was 27.9 per cent in 2007–08 and 27.7 per cent in 2016–17. Australian Institute of Health and Welfare, *Mental Health Services in Australia: Key Performance Indicators for Australian Public Mental Health Services 2016–17*, Table KPI1.
- 27 *Witness Statement of the Hon. Robert Knowles AO*, 16 July 2019, para. 39.
- 28 Alfred Health, *Submission to the RCVMS: SUB.0002.0028.0156*, July 2019, p. 7 and 13; Eastern Health, *Submission to the RCVMS: SUB.0002.0028.0585*, July 2019, p. 18; NorthWestern Mental Health (A Division of Melbourne Health), *Submission to the RCVMS: SUB.0002.0030.0061*, 2019, pp. 19–20; Monash Health, *Submission to the RCVMS: SUB.7000.0003.0001*, July 2019, p. 7; Mercy Mental Health, *Submission to the RCVMS: SUB.0002.0029.0267*, July 2019, p. 16; Bendigo Health, *Submission to the RCVMS: SUB.0002.0030.0051*, July 2019, p. 4; Goulburn Valley Health, *Submission to the RCVMS: SUB.0002.0029.0213*, 2019, p. 9; Albury Wodonga Health, *Submission to the RCVMS: SUB.0002.0032.0088*, 2019, p. 21.
- 29 Australian Institute of Health and Welfare, *Mental Health Services in Australia: Specialist Mental Health Care Facilities 2016–17*, Table FAC14, 2019.
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- 31 NorthWestern Mental Health (A Division of Melbourne Health), p. 23; Victoria Legal Aid, *Submission to the RCVMS: SUB.0002.0030.0217*, July 2019, p. 21.
- 32 NorthWestern Mental Health (A Division of Melbourne Health), p. 22.
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- 34 Monash Health, p. 36.
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- 39 The Royal Children's Hospital Melbourne, 'About The Royal Children's Hospital' <<https://www.rch.org.au/rch/>> [accessed 13 November 2019].
- 40 Victorian Health and Human Services Building Authority, 'Bendigo Hospital Infrastructure Planning and Management' <<https://www.vhhsba.vic.gov.au/health-infrastructure/bendigo-hospital>> [accessed 13 November 2019].
- 41 Victorian Government, *Submission to the RCVMS: SUB.5000.0001.0001*, p. 34.
- 42 *Witness Statement of Associate Professor Ruth Vine*, para. 126.2.
- 43 *Witness Statement of Dr Peggy Brown AO*, 22 July 2019, para. 10.
- 44 Productivity Commission, *Draft Report on Mental Health: Volume 2*, October 2019, p. 1052.
- 45 Productivity Commission, *Draft Report on Mental Health: Volume 1*, October 2019, p. 47.
- 46 Victorian Auditor-General's Office, *Child and Youth Mental Health*, June 2019, p. 10.
- 47 Department of Health and Human Services, '*Client Management Interface / Operational Data Store*'. 2018–19. Number of hours for 'long stay' admissions in inpatient units, as a proportion of funded bed hours. Excludes the first 35 days (840 hours) of admission.
- 48 Productivity Commission, *Draft Report on Mental Health: Volume 2*, p. 933.
- 49 Productivity Commission, *Draft Report on Mental Health: Overview and Recommendations*, October 2019, p. 19 and 27.
- 50 *Witness Statement of Jennifer Williams AM*, 22 July 2019, para. 67.
- 51 Victorian Auditor-General's Office, *Access to Mental Health Services*, p. 8.
- 52 Commission analysis of Australian Institute of Health and Welfare, *Mental Health Services in Australia: Expenditure on Mental Health Services 2016–17*, Table EXP33. Australian Institute of Health and Welfare data, rather than from the Victorian Budget papers is used to (a) adjust for Commonwealth Government funds and (b) allow for consistent comparisons across jurisdictions and mental health and health sectors over the past two decades. The most recent year of data provided is 2016–17.
- 53 Commission analysis of Australian Institute of Health and Welfare, *Mental Health Services in Australia: Expenditure on Mental Health Services 2016–17*, Table EXP. 33.

- 54 Commission analysis of Australian Institute of Health and Welfare, *Mental Health Services in Australia: Expenditure on Mental Health Services 2016–17*, Table EXP.33; Australian Institute of Health and Welfare, *Health Expenditure Australia 2016–17, Supplementary Tables and Figures*: Tables 2.1, October 2018.
- 55 Commission analysis of Australian Institute of Health and Welfare, *Mental Health Services in Australia: Expenditure on Mental Health Services 2016–17*, Table EXP.33; Australian Institute of Health and Welfare, *Health Expenditure Australia 2016–17, Supplementary Tables and Figures*: Tables 2.1.
- 56 Calculation by the Commission based on the National Mental Health Service Planning Framework; Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2017–18*, October 2018, p. 64; Department of Environment, Land, Water and Planning; Australian Institute of Health and Welfare, *Mental Health Services in Australia: Overnight Admitted Mental Health-Related Care 2017–18*, Table ON.4, Table ON.12 and *Same Day Admitted Mental Health-Related Care 2017–18*, Table SD.19.
- 57 Commission estimate. Note, this assumes that private services maintain their current share of all patients treated; for example, of the additional 105,000 people who are provided care, approximately 78,000 would be covered by public services and 27,000 by private services.
- 58 For example, on cost per treatment day for ambulatory care Victoria has a higher cost than the national average and higher in more recent years. Productivity Commission, 'Report on Government Services 2019' <<https://www.pc.gov.au/research/ongoing/report-on-government-services/2019>> [accessed 30 September 2019]. Chapter 13 – Mental Health Management, p. 13.28.
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- 63 Victorian Government, *Submission to the Royal Commission into Family Violence*, 2015, Appendix B. p. 3.
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Chapter 21

Mental Health Implementation Office

Recommendation

The Royal Commission recommends that the Victorian Government establishes a Mental Health Implementation Office—a new administrative office in relation to the Department of Health and Human Services under the *Public Administration Act 2004* (Vic).

The Implementation Office is to implement the Commission's recommendations as set out in the interim report. It will operate for two years while the Commission designs final governance arrangements for the mental health system and should:

- develop and publicly commit to a program of work and report annually through the Victorian Parliament on its progress against outcome measures and targets
- employ and commission people with specialist skills and diverse expertise, including people with lived experience, to respond to the Commission's recommendations
- work closely with the Commission to ensure implementation of the Commission's recommendations stay true to the original vision and intent.

21.1 An early focus on implementation

The Commission's terms of reference task it with making recommendations that 'achieve practical, prioritised, efficient and sustainable outcomes'.¹ This requires the Commission to take a balanced and deliberate approach to developing its recommendations, and for it to thoroughly consider implementation options.

The Commission considered deferring recommendations until its final report. It decided, however, that the interim report presents an opportunity to develop system, reform and implementation capacity to lay the foundations for change.

As such, the Commission recommends establishing the Mental Health Implementation Office, a new administrative office in relation to the Department of Health and Human Services. This office will capitalise on the opportunity to identify and support the leadership and teams that will be essential for transforming the mental health system. Importantly, it will develop capability within both government and the sector, the latter being critical to the success of implementing major reform.²

21.2 The challenges of successful implementation

This Commission is not the first to attempt to identify and respond to the problems of the Victorian mental health system. Many strategies, plans, reports and inquiries into different parts of the system, both in Victoria and nationally, have sought reform and to improve the experience of service users (see Figure 5.1 in Part Two of this report).

Victoria's mental health policy, legislation and services have evolved since deinstitutionalisation in the early 1990s. Reviews by the Victorian Auditor-General³ have identified an increasing distance between the goals of reform over the past decade and what is being delivered through mental health services. Despite the good intentions of initiatives in the past two decades, deinstitutionalisation has been described as an 'unrealised desire',⁴ and Mr Andrew Greaves, Auditor-General, Victorian Auditor-General's Office, has described progress with mental health reform in the state as slow:

Advice from [the Department of Health and Human Services] to government, supported by multiple DHHS-commissioned reviews, clearly articulates the existing funding and infrastructure gaps but DHHS's progress has been slow, and the most important elements of change such as funding reform, infrastructure planning, catchment area review, and improved data collection have only just, or not yet, commenced.⁵

Budget savings requirements, industrial relations obligations, safety concerns and workforce constraints have caused a loss of fidelity in connection with the intention of past reforms.⁶

Successfully implementing mental health reform has been an enduring challenge throughout Australia. Independent inquiries into mental health have consistently concluded that reform efforts have failed to meet expectations—in terms of both the anticipated service transformation and the outcomes people experience. Past efforts have been characterised in the following way:

While Australia has been world-leading in terms of setting national policy directions on mental health, opportunities to take advantage of these solid foundations have been lost due to poor implementation or the failure to sustain initiatives.⁷

The history of Australian mental health reform over the past three decades is one of world class policies and strategies let down by inadequate planning, poor implementation and our complex system of government. The results have been disappointing, wasteful of scarce resources and, all too often, devastating for the millions of Australians affected by mental illness.⁸

The implementation challenge is not unique to mental health. Timely and effective implementation of service reforms has proved challenging in Victoria⁹ and elsewhere in Australia. Even when reforms have been well designed, broadly supported and ultimately considered successful, implementation is rarely straightforward.¹⁰ Enduring reform—regardless of topic or service system—presents challenges:

It is one thing for governments to design and enact policy reforms, and quite another to ensure that they are fully implemented, particularly when dealing with complex challenges.¹¹

Time and time again, however, major policy reforms prove tough to become adopted in turbulent environments, and even tougher to anchor over time. This leads to considerable uncertainty and inefficiency as governments and societies try to keep pace with change and thrive. Policies that unravel are wasted opportunities and costly.¹²

Mental health reform, however, comes with the added complexities of stigma and lack of parity with physical health,¹³ as well as competing views and expectations within and beyond the sector:¹⁴

... there are diverse views about priorities for change and governments at times find the politics of change difficult to manage. The stakeholder groups can present different and at times competing priorities to governments at national and Victorian levels [...] the mental health service system is a very complex one with significant roles played by [public and private agencies, large private corporations, thousands of GPs, psychiatrists and allied health professionals] and a significant [non-government organisation] sector that has also has its own set of interests.¹⁵

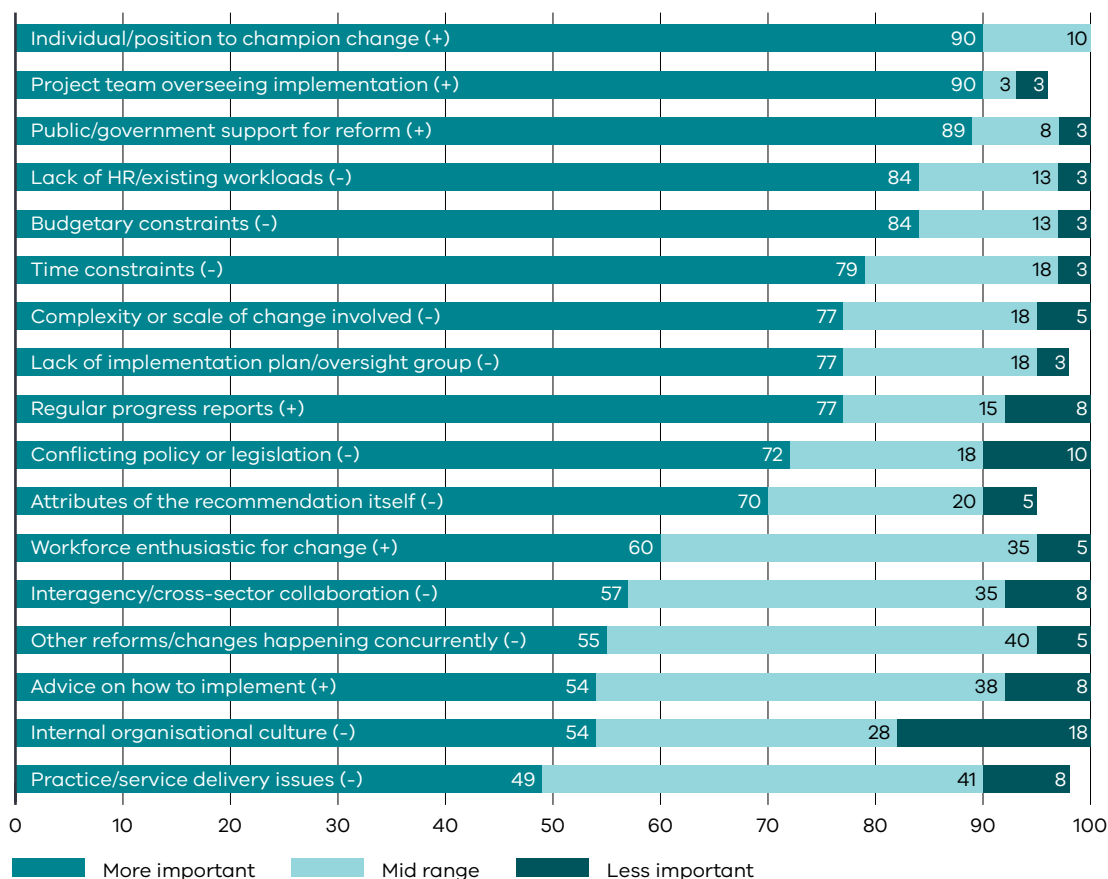
The nature and complexity of the mental health system also means that change takes time and is hard to achieve without bipartisan commitment¹⁶ that extends beyond single terms of government:¹⁷

It seems that, rather than having a good policy and sticking to it, and building on and growing a solid service system, we have been in a constant state of consultation and distraction. My concern is that this may reflect a lack of clarity about mental illness and state responsibility at government and departmental levels. 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 the challenges in the system cannot be overcome in a single term of government or by switching between partisan policies.¹⁸

Experiences from previous reviews in Australia show that governments' timely and complete implementation of recommendations is hard to achieve and is affected by many factors.¹⁹ Implementation can be delayed by indecision and debate about responsibilities, resources and alternative approaches.²⁰ Among the day-to-day pressures of existing workloads, the focus becomes acquittal²¹ and the ambition of recommendations is diluted.

The Royal Commission into Institutional Responses to Child Sexual Abuse examined the implementation of 288 recommendations from 67 relevant inquiries in Australia. Only 47 per cent of recommendations had been delivered on in full. As Figure 21.1 shows, among the reasons for failure are not having dedicated people to lead and champion implementation and lack of support from government, the sector workforce and the broader community.

Figure 21.1: Factors influencing implementation of recommendations



Source: Adapted from 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, May 2015. Tables 17 and 18, pp.79–81.

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.

21.3 Establishing responsibility for implementation

Broadly, two different views were put to the Commission in connection with where to place implementation, oversight and monitoring responsibility for executing the Commission's recommendations.

The first is that the Department of Health and Human Services absorbs these responsibilities as part of its existing departmental functions of stewardship and system management—for example, service planning, funding and purchasing services, setting policies, monitoring service performance and overseeing safety and quality.

Ms Kym Peake, the Secretary of the Department of Health and Human Services, stressed the difficulties that can arise when new institutions are tasked with leading reform and the opportunities afforded by making use of the capabilities in existing organisations to implement reform:

It can be difficult for new institutions to form and lead transformational change. For this reason, if a logical institution does not exist, it can be appropriate to consider whether a discrete section of an existing organisation can be repurposed or given an elevated role in owning or driving the delivery of new service models and pathways.²²

The Hon. Robert Knowles AO, a former Victorian minister whose responsibilities included the health and aged care portfolios, offered advice on the drawbacks of separate governance and accountability structures and the subsequent impacts on prioritising mental health:

In my view the way responsibility for mental health is allocated does affect prioritisation. Mental health should be understood as a significant component of health generally. The siloing of mental health by creating separate accountability structures (including at ministerial level) can work against it being prioritised.²³

In contrast a second view put forward by several leaders in mental health advised the Commission to consider establishing a new and separate body. For example, when asked how the Commission can make more than incremental change, Professor Patrick McGorry AO, Professor of Youth Mental Health at The University of Melbourne and Executive Director of Orygen said:

A standing commission on mental health with independent powers to monitor implementation, to safeguard and continue further reform and growth into the future, will be essential if these goals are to be met.²⁴

Mr Christopher Gibbs, CEO of the Mental Health Professionals' Network and a director of MIND Australia, highlighted the importance of a body that can attract and retain strong leaders and motivate change among agencies:

Whatever form the organizational response takes, it will only be effective if it can recruit and retain a body of high-quality individuals who have the leadership qualities and skill set to make it happen. This is a most powerful argument for an independent Mental Health Commission. There will be no effective solution to the difficulties facing the Victorian mental health system unless there is a commitment to properly fund a structure that can attract both thinkers and doers, including those from mental health services where pay structures make it almost impossible for leaders and experts to return to a central authority. The new structure will require the authority to drive the

necessary strategies at the relevant interfaces with housing, family support, justice and corrections and employment. Implementation across these fronts is too important to be left to trickle down bureaucratic actions and relevant 'Departmental' responses. Without such a structure the recommendations from the Royal Commission, despite the best intentions, will fall on fallow ground.²⁵

This view is consonant with some research, which argues that creating a new entity to lead reform and promote culture change can be more powerful than adding to old structures that might lack the capacity to deliver²⁶ or be constrained by established ways of doing things.²⁷

While the Commission saw the merit in each of these options it concluded that, for the short term, an administrative office, in relation to the Department of Health and Human Services, would most effectively drive implementation of the interim recommendations.

The office will provide genuine accountability for outcomes, clarity of responsibilities for program funding and delivery, and full participation of consumers and carers in policy design, all identified by the Productivity Commission in its recent draft report as critical.²⁸

The Commission considers that, as with the establishment of Safer Care Victoria, an administrative office needs to work with and alongside its department and be 'accountable for contributing to the delivery of several of the department's strategic directions and priority actions' but at the same time independent-minded and forthright in its approach to leading change.²⁹ (See Box 21.1 for more on administrative offices.)

The Commission will reach conclusions about longer term governance arrangements for mental health in Victoria as part of its final report.

21.4 Leading change

The Victorian community deserves to be confident that, this time, efforts to reform the mental health system will be different and that everything possible has been done to give transformative change the best chance of success.

The Implementation Office should provide dedicated focus to progress, at pace, implementation of the Commission's interim recommendations. With its CEO appointed by the Premier, and reporting directly to the Secretary, it will be in a position to lead sector change while also being collaborative with government departments. It will work closely alongside the Department of Health and Human Services, which will remain responsible, through its existing structures, for the management and oversight of the mental health system.

Like other administrative offices, the office should be 'purposely established for executing key projects [...] a purposeful administrative arrangement that works to the delivery, not to some kind of loosely defined goal'.³⁰ With its mandate clear, the office should be established quickly. It will have a two-year life span, but through its delivery and capability building, its outcomes will endure. As part of its proposals for ultimate governance arrangements for mental health in Victoria, the Commission will make recommendations in its final report on where the capabilities and resources established by the Implementation Office should transition.

Box 21.1**Administrative offices of government: an overview**

An administrative office of the Victorian Government is established under s. 11 of the state's *Public Administration Act 2004* in relation to a specified government department. The Premier has sole responsibility for such orders and would employ the head of the Mental Health Implementation Office.

As part of the Victorian Government, an administrative office is accountable to the relevant portfolio Secretary or Minister for its general conduct and effective management of its functions and activities. Such an office does, however, perform its functions independently of the department in question and does this with a view to best practice. It is expected to take account of government policies and legislation in performing its role, and it may develop strategic and corporate plans in consultation with the department and report on its primary activities and achievements.

Administrative offices are typically established to perform specific tasks. Examples of such offices in Victoria are Family Safety Victoria, the Major Transport Infrastructure Authority, Safer Care Victoria and the Victorian Agency for Health Information.

Source: Victorian Public Sector Commission, 'Machinery of Government' <<https://vpssc.vic.gov.au/about-public-sector/machinery-of-government/>> [accessed 25 September 2019].

A memorandum of understanding or a statement of expectations from the Minister for Mental Health should define the relationship between, and roles of, the new Implementation Office and the department's Mental Health Branch, which includes the Office of the Chief Psychiatrist.

This clarity is important, not only for the Victorian Government but also for the range of stakeholders and service providers that work and interact with the department—and ultimately the individuals who turn to and depend on the mental health system. The annual Statement of Priorities—through which public health services and the Victorian Government agree on key performance expectations, targets, funding and service priorities—should clearly state the respective roles and responsibilities of the new office and existing areas of the department.

21.4.1 Indicative functions

The Commission proposes that a suite of actions be initiated without delay. Its recommendations describe a complex and demanding program of work that involves: building new alliances; securing funds; recruiting experience and expertise; designing, commissioning and delivering new services; and managing interdependent projects. Table 21.1 lists the functions of the new office in relation to the interim recommendations.

Table 21.1: Functions of the Mental Health Implementation Office in relation to the interim recommendations

Area of focus	Indicative, early functions
Victorian Collaborative Centre for Mental Health and Wellbeing	<ul style="list-style-type: none"> • Establish the governance arrangements for the Collaborative Centre • In conjunction with the Victorian Health and Human Services Building Authority, begin capital and site planning for a purpose-built facility located in Melbourne
Targeted acute mental health service expansion	<ul style="list-style-type: none"> • Undertake service planning with the Victorian Health and Human Services Building Authority to identify: <ul style="list-style-type: none"> – suitable locations for, and the apportionment of, 135 additional adult and youth acute beds between Barwon Health and Melbourne Health, the latter in alliance with Western Health and Northern Health – options for the appropriate streaming of patients within the new services • Conduct a competitive tender for a private provider to deliver 35 additional acute beds • Facilitate involvement of people with lived experience in the co-design of the additional acute beds • Identify and support creative service partnerships with private and community providers to enable the delivery of the additional beds • Support mental health services to develop new multidisciplinary models of home-based care as a direct substitute for acute care in a hospital setting where possible
Expanding suicide prevention and follow-up care	<ul style="list-style-type: none"> • Use evaluation findings from the existing Hospital Outreach Post-suicidal Engagement sites to identify possible enhancements and design the core, common elements of the HOPE program to be rolled out throughout Victoria, in consultation with people with lived experience and area mental health services • Plan the sequenced expansion and funding arrangements for all HOPE sites • Engage sub-regional health services and co-develop the networked clinical outreach model, including staffing profile and recruitment and training strategies • In coordination with The Royal Children's Hospital, Monash Children's Hospital, Alfred Health and Orygen, create the first phase of an evidence-based standardised assertive outreach and follow-up care service for young people who have self-harmed or are at risk of suicide, and plan for its evaluation
Aboriginal social and emotional wellbeing	<ul style="list-style-type: none"> • Embed Aboriginal leadership and expertise in the Implementation Office • Establish the Aboriginal Social and Emotional Wellbeing Centre, hosted by the Victorian Aboriginal Community Controlled Health Organisation, and facilitate partnership arrangements between the centre and organisations with clinical expertise and research expertise in Aboriginal mental health • Lead co-production of the statewide social and emotional wellbeing service expansion across all Aboriginal Community Controlled Health Organisations including: <ul style="list-style-type: none"> – further developing the core functions of the social and emotional wellbeing teams – creating readiness assessment criteria and assessment processes to inform phasing of the expansion – developing a funding model for the services • Work with the Aboriginal Social and Emotional Wellbeing Centre to design and implement the proposed scholarship program, including determining the most appropriate administrative arrangements and ensuring the centre is appropriately resourced to provide supports for applicants and scholars

Area of focus	Indicative, early functions
<p>Victoria's first residential service designed and delivered by people with lived experience</p>	<ul style="list-style-type: none"> • In co-production with people with lived experience: <ul style="list-style-type: none"> – develop the high-level specifications and tender to support the implementation of Victoria's first residential mental health service designed and delivered by people with lived experience – create appropriate outcomes measures and arrange an independent evaluation of the service to commence from implementation • In conjunction with the Victorian Health and Human Services Building Authority, the relevant area mental health service and the mental health community support service or community health provider, establish the site for the service and develop the operating model including entry criteria and referral pathways • Prepare service agreements and facilitate partnership arrangements for delivering the new service
<p>Lived experience workforces</p>	<ul style="list-style-type: none"> • Establish a lived experience advisory function and co-production competency within the Implementation Office to create: <ul style="list-style-type: none"> – standardised educational and training options for lived experience workforces – learning and development pathways, including optional qualification opportunities – practice support structures, including supervision frameworks – an organisational readiness program for senior leaders and induction materials, applicable to area mental health services and identified non-government organisations, in support of lived experience workforces – accountability mechanisms for measuring organisational attitudes including establishing a benchmark in 2020
<p>Workforce readiness</p>	<ul style="list-style-type: none"> • Establish an expression of interest process for new graduate placements for nurses, allied health workers and other professionals • Plan for and distribute additional postgraduate mental health nurse scholarships in coordination with universities and mental health services • Working with The Royal Australian and New Zealand College of Psychiatrists and the Postgraduate Medical Council of Victoria, plan for the increase in junior medical officers undertaking a psychiatry rotation • Working with leadership academics from the public, not-for-profit and private sectors, establish a 'mental health leadership network' • Work with mental health services to provide relevant supports to facilitate overseas recruitment campaigns • Procure workforce data and intelligence capabilities—including ICT and data infrastructure and data-sharing arrangements—to enable workforce planning • Secure expertise in workforce strategy and professional learning and leadership development

21.4.2 Collaboration with key partners and the Commission

A consistent theme in submissions to the Commission was the need for collaboration and the collective expertise of a broad range of partners. As discussed throughout this report, approaches to the design and implementation of mental health services and programs must include people with lived experience as key partners.

The mental health workforce and service providers are also central to creating a new approach to mental health. Transforming the system cannot be achieved without their commitment. They will be called on to do much of the actual implementation of the Commission's recommendations, within already pressured working environments. The Implementation Office must set out to engage and involve the workforce in its early work.

The Commission has been encouraged by the level of interest shown by federal and Victorian government departments and agencies, including the Productivity Commission, the National Mental Health Commission and the Hospital Pricing Authority in its work. The Implementation Office should be positioned to inform—and be informed by—government policy agendas to ensure alignment with any developments affecting the mental health sector.

The Commission itself is another partner. It will make its time and resources freely available to ensure the Implementation Office understands its recommendations and the vision behind them.

21.4.3 Evidence-based design and implementation

Implementing some of the Commission's recommendations will require new datasets or analysis including supply and demand, workforce profiles and prevalence data. It will necessitate obtaining data from a range of government sources.

When the Implementation Office is leading the design of new services or improvements, it should use contemporary data and research to identify effective practice and assess the strength of evidence behind different options. It should also collect and review information about what is happening for different service users during implementation so that barriers to progress are dealt with quickly,³¹ evidence is shared and fed back into the design and delivery of service developments,³² and effective innovations are suitably scaled up.³³

The Implementation Office should establish from the outset evaluation measures and processes for each of the recommendations it has responsibility to deliver. Evaluation design should be part of the planning phase for each work program and should include cost–benefit analyses.

The Implementation Office should also establish mechanisms for continuing review and assessment of intermediate and longer term outcomes³⁴ for each initiative and their collective impact. Progress and success should be measured against the original objectives of the recommendations—noting that an action being completed does not guarantee that change has occurred effectively.³⁵

Ms Peake outlined the importance of establishing effective outcome measures in embedding reform and measuring success:

As well as providing shared direction for service delivery reform, an outcomes framework can provide a shared view on whether the aims of the reform are being achieved. This allows clinicians, managers and government actors to monitor when things are not working and make necessary adjustments to policy settings and service delivery as they go.³⁶

In preparation for future reform, the Implementation Office should start to develop capability in consumer outcomes measurement, which is currently lacking in the sector.³⁷

Box 21.2 provides an example of collaboration via a central data repository.

Box 21.2

An example: data and evidence in suicide prevention

Victoria has a nation-leading approach to suicide data collection with the Victorian Suicide Register, which is managed by the Coroners Court of Victoria. The register helps coroners conduct investigations into suicide deaths and produce data and evidence to support recommendations. It is also a source of information for organisations developing suicide prevention policy and initiatives and for academic research.

In 2018 the Coroners Court and the Department of Health and Human Services signed a memorandum of understanding to formalise the sharing of information on suicides in Victoria and to facilitate development of evidence-based suicide prevention policy and initiatives.

The memorandum of understanding has allowed the department to consider and analyse data about suicides over time, and by municipality, to guide pillars of its prevention strategy—place-based trial sites and the HOPE program. It has also enabled the department to provide localised information and de-identified data to area mental health services that capture patterns and trends in suicide to support quality improvement and new approaches to care.

With the rollout and expansion of HOPE statewide, the Implementation Office should establish a unit that facilitates the critical linkages between data, evidence, practice and practice improvement to ensure successful, evidence-based design and implementation of assertive outreach programs. This process should bring together multiple streams of work, including existing projects and programs of work such as linked data projects, monitoring and health service benchmarking. This work will help deliver the interim recommendations but also create the functionality for longer term suicide prevention efforts as part of the Commission's continuing work program.

21.4.4 Accountability

Implementation will stand a greater chance of success if the Implementation Office builds community confidence in reform and trust in the institutions leading it.³⁸

Building community confidence and commitment will depend in part on taking early, effective steps towards making improvements to the mental health system. This has been demonstrated in longer term projects such as the program of changes to make Melbourne a more liveable city—when people started to see the benefits of the early changes, their view of the overall initiative became far more positive.³⁹

In this context, the Commission envisages that the Implementation Office's primary purpose will be to effectively deliver on the Commission's recommendations, rather than compliance. It will not be an implementation monitor.

Early and regular public reporting is a feature of timely and effective implementation.⁴⁰ Accountability to the public can best be achieved by the Victorian Government through the Implementation Office, publicly committing to a program of work detailing milestones and specific activities for delivering on the Commission's recommendations. The Implementation Office should produce public reports on its progress and the impact of its work.

21.4.5 Recruitment

The Victorian Government should ensure the Implementation Office is established quickly and is adequately resourced to perform the functions the Commission has articulated. The Office must be able to plan and coordinate different but interrelated work programs involving many partners and participants. Recognising that this will be a highly prominent role in both the health and social service sectors, it must be led by a CEO with deep leadership expertise and experience in health and project delivery.

The program of work the Implementation Office leads will require it to engage people with specific skills and experience. The Implementation Office should co-opt and contract the requisite knowledge and skills, including from beyond government, connecting workers flexibly around changing project needs.

The specific areas of expertise that the Implementation Office will require are discussed in Box 21.3.

21.5 Going forward

The Implementation Office offers an opportunity to make the best use of time before the Commission's final report is published. It will create the capacity and focus for implementing change, start making essential improvements, and build the confidence and commitment needed to deliver the Commission's ambitious vision for the future mental health system.

The Implementation Office can help create the best possible conditions for prompt and successful reform. The evidence, expertise, momentum and early successes of the office will all be building blocks for the reform agenda and will accelerate improvements in the mental health system.

Box 21.3**Specific areas of expertise required by the Implementation Office****Lived experience**

People with lived experience should be represented in senior positions within the Implementation Office, in specific work programs, and as co-producers of new services and improvements.

Knowledge of mental health services and experience implementing change in mental health

To support rapid implementation of these interim recommendations, the Implementation Office's leadership team will benefit from including individuals with direct experience of working within Victorian mental health services. On-the-ground experience in leading change and improvement initiatives within mental health services will assist in design and implementation.

Project and program planning, coordination and monitoring

The Implementation Office should develop a comprehensive implementation plan for the Commission's recommendations and should coordinate, monitor and refine planned activities. Advanced program management skills will be required, including in relation to risk identification and management, outcome measurement, accountability and reporting.

Evaluation and data analysis

The Implementation Office should employ or commission experts in evaluation, including evidence review and sophisticated data analysis and linkage skills.

Adaptive design and innovation

The Implementation Office will need adaptive design and innovation skills, including in problem definition and solving, participatory and human-centred design, systems thinking, and synthesis of data and information to develop creative solutions.

Team and partnerships building

Senior staff of the Implementation Office should have demonstrated expertise in building and sustaining collaborative teams and effective coordination with diverse partners and stakeholders.⁴¹

- 1 Victorian Government, *Royal Commission into Victoria's Mental Health System – Terms of Reference*, 2019, p. 3.
- 2 Family Violence Reform Implementation Monitor, *Report of the Family Violence Reform Implementation Monitor as at 1 November 2017: First Report to Parliament*, November 2017, p. 6.
- 3 For example, Victorian Auditor-General's Office, *Access to Mental Health Services*, March 2019, p. 7.
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Chapter 22

Next steps

The Royal Commission has heard many accounts of how the current mental health system is failing Victorians. Despite repeated reviews and the hard work of many, a contemporary and responsive mental health system has not eventuated.

The problems facing the mental health system described in this report are systemic (see Box 22.1). The recommendations put forward by the Commission at this point are not designed to resolve all the problems that have been raised. Instead, their purpose is to begin to develop the foundations for a better mental health system and provide an initial response to the need for additional services.

Much work remains to be done. A fundamental redesign of the system is required, and people with lived experience have an invaluable contribution to make to this. The scale of the necessary change is enormous; indeed, some of the benefits of this inquiry's work are likely to be realised only in generations to come.

A long-term reform agenda is imperative to achieving lasting change. The depths of the problems besetting the system are so great that a patchwork of short-term fixes will not deliver the full benefits that people expect and that people living with mental illness, and their families and carers deserve.

This chapter describes the nature of the Commission's continuing efforts to design a contemporary and responsive mental health system, for now and for future generations. A comprehensive set of recommendations for transforming Victoria's mental health services will be presented in the Commission's final report, due for release by the end of October 2020.

Box 22.1

The present mental health system in Victoria: systemic problems

- The system is complex and difficult to navigate—for consumers, families, carers and workers alike.
- There are not enough services to respond to growing demand, and the system does not offer 'stepped care', in contrast with original intentions.
- People miss out on receiving services when it would make the greatest difference, and they are often told they are 'not sick enough' or 'not suicidal enough'.
- The bars to obtaining care are rising—service capacity is there only for people in crisis. Insufficient attention is given to early intervention and recovery.
- People report that their experiences of care are highly variable. A lack of dignity, empathy, choice and equity are commonly cited.
- The system does not support coordination and integration with other services to best respond to an individual's needs.
- The system is not inclusive, and this contributes to some individuals and communities being disproportionately affected by poor mental health and suicide.
- People living in rural and regional areas experience additional challenges when seeking mental health services. Among them the pervasive impact of stigma, limited access to local services and the 'tyranny of distance'.
- Families and carers often feel they lack information, are excluded from the treatment of their loved one and have their contributions insufficiently recognised.
- A range of structural factors associated with workforce shortages, and poor job satisfaction, impinge on the mental health workforce's ability to work well.
- Stigma and discrimination remain ever present, having detrimental effects on people living with mental illness, their families and carers.
- The structural foundations of the system have eroded. There is a lack of role clarity between the Commonwealth and the Victorian governments, inadequate system planning, weakened accountability, underinvestment and poor system leadership. Additionally, the priority assigned to investment in mental health has diminished.
- Suicide—with its profound impact on families, friends and communities—is perhaps the ultimate expression of failure on the part of the Victorian mental health system.

22.1 Redesigning the system

The Commission's highest priority has been to listen to what people have had to say about their experiences with the mental health system and their ideas for change and improvement. This contact, as well as the contributions received and the analytical work done, has led the Commission to conclude that the most productive use of an inquiry of this importance is to propose a redesigned system.

The Commission seeks to set a new path, one where people living with mental illness and their families and carers are respected and enabled to live full and contributing lives: 'We don't have a mental health system. It's not existent. We need to stop calling it a system until it's made one'.¹

In seeking to redesign the system, the Commission is motivated by a desire to leave a legacy that will allow a better future for people living with mental illness and for their families and carers. This focus is also about maximising the opportunity afforded through the Victorian Government's commitment to implement all of the Commission's recommendations.

Consistent with the ethos of the inquiry so far, the Commission will continue to involve people with lived experience in its work and the development of the final report. The Commission will base its redesign of the mental health system on the experiences and needs of people with lived experience. A redesigned mental health system can only be truly responsive if the people who turn to it for help—those with the most at stake—are involved in its creation. The Commission considers this essential to achieving a contemporary and responsive mental health system.

The Commission will work with people living with mental illness, their families and carers to fully understand what they value, what they seek and what they think are the most important features of a future mental health system. This will be the beacon that guides the Commission's work.

Future models of treatment, care and support across the continuum of the mental health system will be founded first and foremost on what will deliver the best results for people living with mental illness and for their families and carers. They will also be grounded in the available evidence and in an appreciation of future societal changes such as advances in technology and changes in help-seeking behaviour. This approach will remove the variability, inequity and rationing that characterise the present system.

The intersection between the mental health system and related service systems will also be the subject of further deliberation by the Commission. This will include examining the relationship with the justice, housing and other health and social systems to identify ways in which consumers, families and carers might be better supported across systems and how treatment, care and support can be more easily obtained and coordinated.

Fixing the architecture of the mental health system will also be a central concern. The legislative and human rights framework, roles and accountabilities between various governments and organisations that operate in the system, and the way services are funded, commissioned and delivered will continue to form part of the Commission's deliberations. In particular, the Commission will consider how these foundations can be leveraged to establish a redesigned system to deliver what people with lived experience value and seek.

22.2 The Commission's ongoing approach

Fundamentally, the Commission's ongoing work will be based on an understanding of what lies at the heart of an individual's experience when seeking and obtaining support and treatment in the mental health system.

The Commission will also continue with its policy, research and analysis work. It will continue to draw on a wide range of sources and will be guided by Australian and international research, expertise and experience. This will include ongoing review of the information received to date and of government documents and literature, as well as further data analysis and consultation.

There has been strong and constructive public interest in the Commission's work to date, and the Commission will continue to be transparent in its deliberations. There will be a second round of public hearings in late April to early May 2020. These hearings will focus on testing some of the Commission's proposals in relation to service design. The topics for and approaches to these hearings will be made public in the first few months of 2020.

The Commission will also pursue opportunities to capitalise on the renewed interest in mental health at both the Commonwealth and state government levels.

The final report will be delivered by 31 October 2020. It will set out an ambitious blueprint for transforming Victoria's mental health system and improving outcomes for people living with mental illness, families, carers and the Victorian community both now and into the future.

1 The Age, "'He Lost His Human Dignity': Mother Relives Pain as Son Slipped into Homelessness', 9 July 2019.

Appendices

Terms of Reference

**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

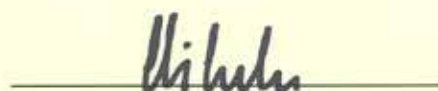
Her Excellency the Honourable
Linda Dessau, Companion of the
Order of Australia, Governor of
the State of Victoria in the
Commonwealth of Australia at
Melbourne this 22nd day of
February two thousand and
nineteen.

By Her Excellency's Command

A handwritten signature in blue ink, appearing to read 'Daniel Andrews', is written over a horizontal line.

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

A handwritten signature in black ink, appearing to read 'H. H. H.', is written over a horizontal line.

Secretary, Department of Premier and Cabinet

Appendix B

Detailed overview of Victoria's mental health system

B.1 Individuals, social supports and communities

The impact of social determinants on mental health is well understood.¹ This includes the role of: social and cultural attributes; environmental events; and neighbourhood, economic and demographic factors.² There is evidence that housing, employment, education, finance, locations, access to services (broadly considered because of Australia's geography to include transport and accommodation), ethnicity and language all have an impact on people's experiences of poor or good mental health.³

The treatment, care and support people receive for their mental health therefore go well beyond formal health care settings. For many people living with mental illness, their source of regular support is family, friends and other close connections. Many care for and support their loved ones because of the bonds of family and friendship, because they believe they can provide better care than is otherwise available or affordable, or because comparable services are simply not available.⁴

Beyond this, many people turn for support to the wider communities in which they live, work and play. Increasingly, communities across Victoria are coming together to foster social connections, raise awareness of mental illness and promote good mental health. Activities of this nature can engender a sense of place and belonging while creating the space for people to discuss their mental health.

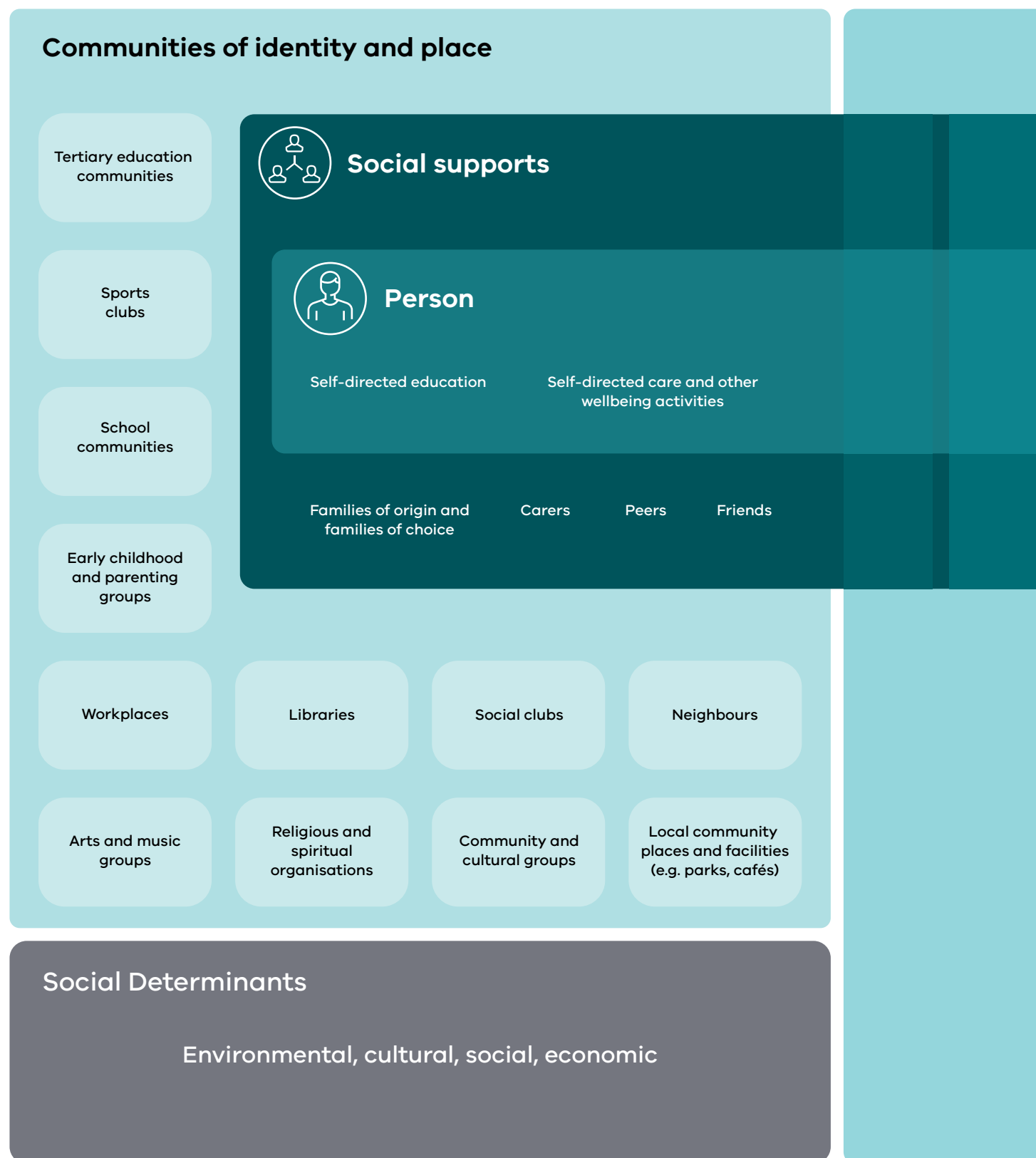
For example, the Commission has been told about local groups that are promoting mental health through community activities such as local football and netball clubs and community golf days.⁵ The LGBTIQ+ community has established community events and festivals as a means of celebrating diversity and promoting self-care and resilience. These events are providing opportunities for people to come together, connect, celebrate and be proud of who they are.⁶

Local governments are involved too, giving increased priority to the mental health and wellbeing of their communities. This includes implementing local strategies for engaging older people who are lonely and delivering training in mental health awareness.⁷

Employers are also recognising the need to support the mental health of their staff. These kinds of workplaces are driving innovation and productivity while at the same time fostering an environment that is a positive and supportive place for people to work.⁸

Sometimes, however, a person may find that personal, social and community supports are not sufficient to address their poor mental health. In those instances people can turn to the services in Victoria's mental health system, which form part of the broader health, social and community services landscape as set out in Figure B.1A.

Figure B.1A: Mental health treatment, care and support in Victoria



Health, social and community services

Services in Victoria's mental health system



Primary care and
general counselling
services



Clinical treatment
and psychosocial
support services



Public specialist
mental health
services



Emergency and
crisis services

Different services are available across different geographic areas

Different services are available for different age cohorts

Services are operated by and/or work with general health services (e.g. hospitals)

Education
services

Justice services
(e.g. prisons,
corrections,
youth justice)

Health services
provided in justice
and corrections
settings

Aged care
services

Disability
services

Income support and
financial counselling
services

Child and family
services

Police and
emergency
services

Workplace
support services

Family violence
and sexual
assault services

Mental health
promotion and
prevention

Legal and
court services

Employment
services

Housing and
homelessness
services

Advocacy
services

Guardianship
services

Alcohol and
other drug
services

Figure B.1B: Services in Victoria's Mental Health System



A holistic response to poor mental health recognises and works with an individual's personal strengths and support networks. The National Mental Health Commission recommended a person-centred approach in its 2014 Contributing Lives review:

A person-centred mental health system is one where services are designed around the needs of people, rather than people having to organise themselves to find their way around what the system provides.

It shifts the locus of control away from providers and towards meeting the needs of users. That does not mean that people make all the decisions about their care and support, but rather that they are involved in decision-making at all levels of planning, designing and delivering services.⁹

B.2 Services in Victoria's mental health system

The services that are more directly involved in providing mental health treatment, care and support can be grouped—for the purpose of description—into four categories as set out in Figure B.1B: primary care services and general counselling services; clinical treatment and psychosocial support services; public specialist mental health services; and emergency and crisis services.

This approach to categorising services in the system is based on increasing acuity; that is, the services are classified according to the support provided for people with increasingly acute, severe or prolonged mental illness. A person who is severely affected by mental illness might receive support from all categories or different combinations of categories at different times in their lives—for example, from their GP throughout their life, from a private psychologist for a specific amount of time, from a community clinical mental health service for a specific amount of time, and from emergency phone services during a crisis.

Mental health services are also categorised by age. For example, specialist public clinical mental health services for children and young people are available from birth to 18 years of age.¹⁰ In addition, the availability of many services is restricted by geography, meaning that a person's place of residence determines which services they can have access to.

B.2.1 Primary care and general counselling services

Primary care services can be the first point of contact for people experiencing psychological distress or mental illness. These services include GPs and general counselling services in schools and workplaces. Primary mental health services play an important role in early intervention, prevention, diagnosis and treatment of mental illness. This includes coordination of care and facilitating referrals to other services where necessary.

General practitioners

The first place most Victorians seek medical support for their mental health is through their GP. In 2017–18, 578,576 Victorians gained access to mental health–related services through their GP. (This figure has risen by about 8 per cent a year since 2013–14.)¹¹ As at June 2019 Victoria had 6,468 GPs. A 2019 national survey of GPs found that mental health is the most common problem that people present with: 61 per cent of patients saw their GP for that reason in 2017; the figure was 65 per cent for 2019.¹²

The data highlight the crucial role of GPs in prevention, early intervention and ongoing support of mental health. GPs' broad scope of practice, including coordinating overall care and making referrals to relevant supports, means they play a central role in helping consumers navigate the system and obtain the supports they need to maximise their mental health.

General counselling services

General counselling services are provided in a range of settings—for example, in workplaces, schools, tertiary education settings such as universities, family violence services, housing and homelessness services, and child and family services.

All Victorian public schools offer access to mental health practitioners who provide direct counselling and other early intervention support, or soon will.¹³ Some people also obtain general counselling from one of Victoria's 86 community health services.¹⁴

Telephone support, counselling and referral services

A range of telephone and face-to-face counselling services help people to manage challenges to their mental health and wellbeing. While their functions and targeting vary, telephone 'helplines' generally provide support, advice and referral to other services where necessary. For example, Lifeline has a crisis telephone line and a nightly online Crisis Support Chat service, operated by volunteers.¹⁵ Beyond Blue operates a 24-hour support service delivered by trained mental health professionals.¹⁶

The Victorian Government's Better Health Channel website lists more than 20 different telephone helplines. Many provide advice, counselling and help for consumers, families and carers to find services appropriate to their needs.¹⁷

Community health services and integrated care services

Victoria's community health services provide primary health, human services and community-based supports to meet local community needs. There are currently 86 services that fall into two organisational types:

- 31 independently managed registered community health centres
- 55 community health services that are part of rural or metropolitan health services, including small rural health services.

Community health services provide universal access to services as well as targeted services for vulnerable population groups. They sit alongside general practice and privately funded services to make up Victoria's primary health sector. Some are also major providers of a range of health and human services including drug and alcohol, disability, dental, post-acute care, home and community care, mental health services and community rehabilitation.¹⁸

Integrated care services also provide a range of services and supports including primary care and mental health care. One example of an integrated care service is headspace, which is a service for children and young people aged between 12 and 25 years. There are 27 headspace centres in Victoria.¹⁹ The centres provide multidisciplinary care structured around four core service streams: mental health (with a focus on mild to moderate mental illness and early intervention); alcohol and other drug services; primary care (general and sexual health); and vocational support.²⁰

Primary Health Networks

Primary health services in local areas can be coordinated by Primary Health Networks. These networks were originally established to plan and commission a range of primary health services to meet the needs of specific populations, to increase the efficiency and effectiveness of medical services for patients, and to improve coordination of care.²¹

The networks commission a variety of services including: referral and support services; primary and specialist consultation services; capacity-building activities; prevention and early intervention services; and services to reduce the harm associated with alcohol and other drugs.²²

Victoria has six Primary Health Networks—North Western Melbourne, Eastern Melbourne, South Eastern Melbourne, Gippsland, Murray and Western Victoria.²³ The healthcare providers deliver a wide range of services, which are generally funded through the Medicare Benefits Scheme, although all levels of government as well as private and non-government organisations contribute to funding.²⁴

B.2.2 Clinical treatment and psychosocial support services

The government and the private and community sectors provide clinical services and psychosocial supports to people of all ages and at all levels of need. The services offer treatment, care and support to people living with mental illness in a community setting or outpatient setting. They can also provide ongoing support in a community or outpatient setting for people with a chronic or severe mental illness.

The current range of services includes mental health clinical services provided by public and private psychologists and psychiatrists, mental health nurse practitioners, other psychologists and other allied health providers who offer clinical services such as medication, counselling and cognitive and behaviour change therapies, as well as psychosocial supports focusing on rehabilitation, wellbeing and community participation.

Private hospital mental health inpatient services

Private hospitals include acute care and psychiatric hospitals as well as private freestanding hospitals that provide day-only services.²⁵ In Victoria in 2016–17 there were 15 private hospitals offering mental health care.²⁶ These provided 575 private hospital acute mental health beds in 2016.²⁷ Private hospitals offer treatment to a wide range of people; compared with public hospitals, they attend to a higher proportion of people experiencing depression and a lower proportion of people living with psychotic illnesses such as schizophrenia.²⁸

Private hospitals in Victoria cannot provide compulsory treatment under the *Mental Health Act 2014* (Vic).²⁹ Access to private hospital acute mental health beds comes at an out-of-pocket cost to consumers, including costs for accommodation and other services provided by the hospital,³⁰ meaning these services are not accessible to all.

Psychiatrists and allied mental health practitioners

The Medicare Benefits Scheme and the associated Better Access initiative³¹ provide subsidised access to GPs and other health professionals such as psychiatrists, psychologists and other allied health practitioners.³² (Concurrently, the Pharmaceutical Benefits Scheme provides subsidised access to some medicines.)³³

Better Access is an initiative that allows people living with mental illness to receive up to 10 government-subsidised sessions with a psychologist, psychiatrist, GP or eligible social worker or occupational therapist each year.³⁴ Better Access represents the Commonwealth Government's largest investment in mental health. In 2016–17 the initiative delivered 8.6 million services at a cost of \$820 million.³⁵ There is, however, little evidence to support the effectiveness of the program,³⁶ and access to these services is not equitable in some parts of Australia, particularly for people living in rural, regional and remote areas.³⁷

Allied mental health services are 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. In 2016–17 psychologists, social workers and occupational therapists accounted for about 18 per cent of people working in Victoria's specialist mental health facilities.³⁸

In 2017–18, 2.2 per cent of Victorians used clinical psychologist services, 3.3 per cent used other psychologists' services and 0.6 per cent used other allied health services (occupational therapists and social workers).³⁹

These health professionals play a central role in assessing, treating and supporting people living with mental illness and often operate in multidisciplinary teams.⁴⁰ Among the services provided are behavioural therapy, behavioural and cognitive interventions, counselling, group therapy, and strategies to resolve psychological, social and environmental problems.⁴¹

Psychosocial support services

Psychosocial supports focus on recovery, rehabilitation, wellbeing and community participation.⁴² Examples of such services are assistance with managing daily household tasks (such as meal planning, shopping and cleaning), group recreation and leisure activities and supported independent living services.⁴³

Historically, the Victorian Government funded a range of non-government organisations to deliver psychosocial support services (known as mental health community support services).⁴⁴ A number of these supports—among them individualised client support packages, adult residential rehabilitation services and selected supported accommodation services—have been or are transitioning to the National Disability Insurance Scheme.⁴⁵

The NDIS is not, however, intended to support everyone with psychosocial disability: many people will not meet the eligibility criteria and will need supports beyond the NDIS.⁴⁶ For people who previously received support but who are ineligible for the NDIS, both the Commonwealth and Victorian governments have agreed to provide continuity of support.⁴⁷

In 2017–18 the Commonwealth Government committed \$80 million over four years to fund a National Psychosocial Support Measure to provide psychosocial support services to people who do meet the eligibility criteria for the NDIS.⁴⁸ The Commonwealth component of the measure is being implemented through specific-purpose funding to Primary Health Networks to commission new psychosocial services.⁴⁹

Additionally, in 2018–19 the Victorian Government provided interim funding for new psychosocial support services for adults who previously received support but who are not eligible for the NDIS.⁵⁰

B.2.3 Public specialist mental health services

Most public specialist mental health services are clinical mental health services delivered by area mental health services. Area mental health services are operated by 17 public health services across the state.⁵¹ The area mental health services are permitted to provide compulsory treatment under the state's *Mental Health Act 2014* (Vic).⁵²

The service framework established in the 1990s⁵³ included 13 child and adolescent area mental health services for people aged under 18,⁵⁴ 21 adult area mental health services for people aged 16–64,⁵⁵ and 17 aged persons area mental health services for people over 65.⁵⁶ These services operate within geographic boundaries and, ordinarily, a person must live within the boundary of the 'catchment' to access the service. Figures B.2–B.4 show the catchments for child and adolescent, adult and aged persons area mental health services, respectively, in the metropolitan area. Figure B.5 shows mental health service areas in rural and regional Victoria. In rural areas, the same catchments apply to child and adolescent, adult and aged persons area mental health services.

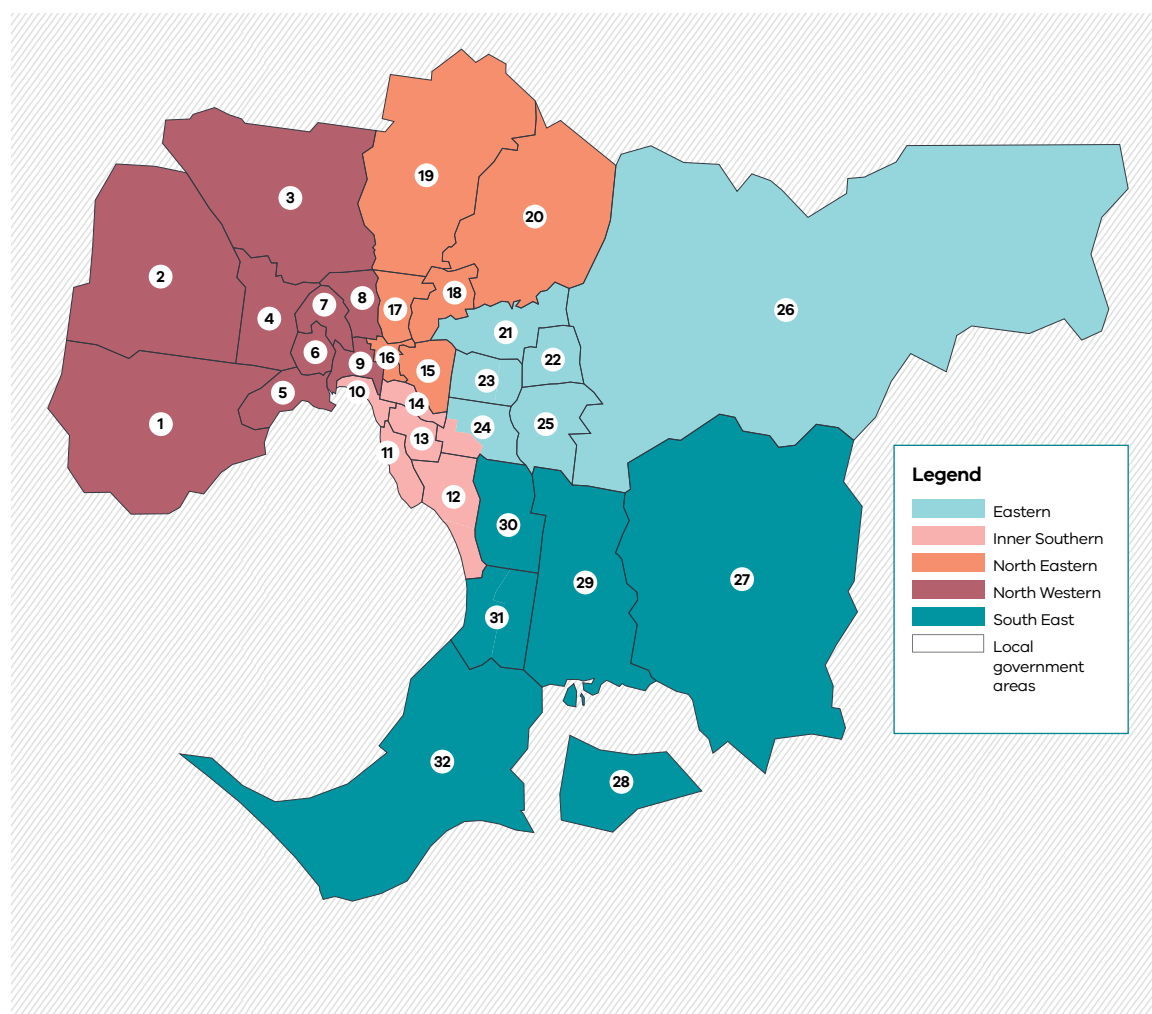
While the catchments have remained largely unchanged, age groupings now vary across the system. For example, in some areas, child and youth services extend to consumers up to the age of 25. Clinical mental health services targeting only people up to 18 years are known as 'child and adolescent mental health services'. Service models for people who are up to 25 years of age are known as 'child and youth mental health services'.⁵⁷ These services provide specialist, team-based treatment to children and young people who have highly complex needs.⁵⁸

Multiple area mental health services can operate in one catchment covering different age brackets.⁵⁹ For example, the three area mental health services in the metropolitan catchment of Peninsula are Peninsula Health, the provider of adult and aged services, Monash Health and Alfred Health, the providers of child and adolescent services.⁶⁰

There are also variations depending on providers: the Royal Children's Hospital provides services to young people aged 13–15 years and Orygen Youth Health supports people aged 15–24 years.⁶¹ There are also services available to young people aged 16–25 years; examples are youth prevention and recovery centres and early psychosis services.⁶²

A range of specialist mental health services are available to adults aged between 16 and 64 years, among them acute inpatient services, community care units and prevention and recovery centres.⁶³ Mental health community support services support people aged 16–64 years.⁶⁴ People aged over 65 years have access to a variety of specialist mental health services such as acute inpatient services and residential services.⁶⁵

Figure B.2: Catchments of Victoria's child and adolescent area mental health services, metropolitan Melbourne, 2019



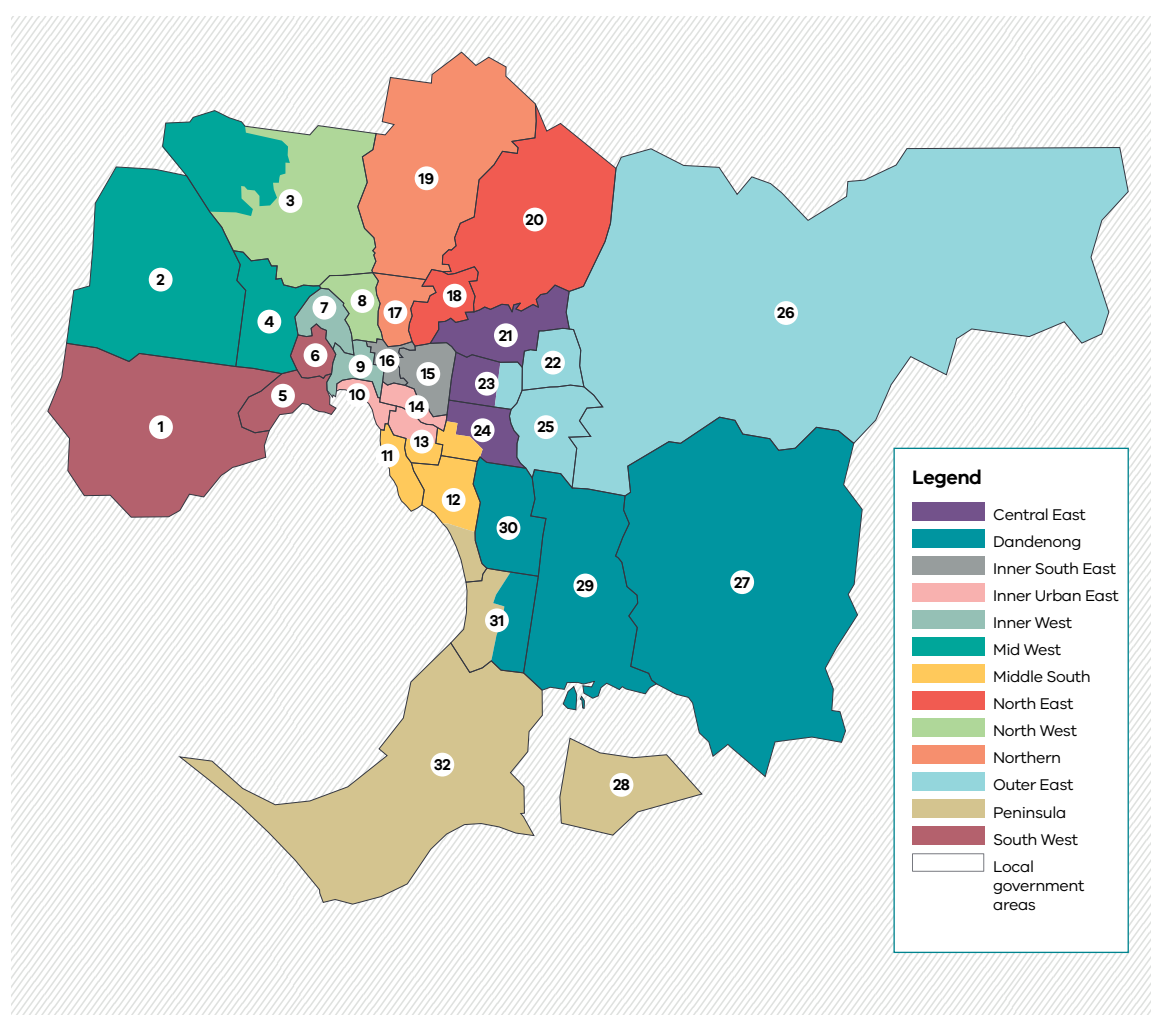
Child and adolescent mental health service areas Metropolitan Melbourne

Local government areas

1 Wyndham	12 Kingston	23 Whitehorse
2 Melton	13 Glen Eira	24 Monash
3 Hume	14 Stonnington	25 Knox
4 Brimbank	15 Boroondara	26 Yarra Ranges
5 Hobsons Bay	16 Yarra	27 Cardinia
6 Maribyrnong	17 Darebin	28 Bass Coast
7 Moonee Valley	18 Banyule	29 Casey
8 Moreland	19 Whittlesea	30 Greater Dandenong
9 Melbourne	20 Nillumbik	31 Frankston
10 Port Phillip	21 Manningham	32 Mornington Peninsula
11 Bayside	22 Maroondah	

Source: Adapted from Department of Health and Human Services. Mental Health Service Areas – Maps, 2015, <<http://www.health.vic.gov.au/mentalhealthservices/maps/index.htm>> [Accessed 27 October 2019].

Figure B.3: Catchments of Victoria's adult area mental health services, metropolitan Melbourne, 2019



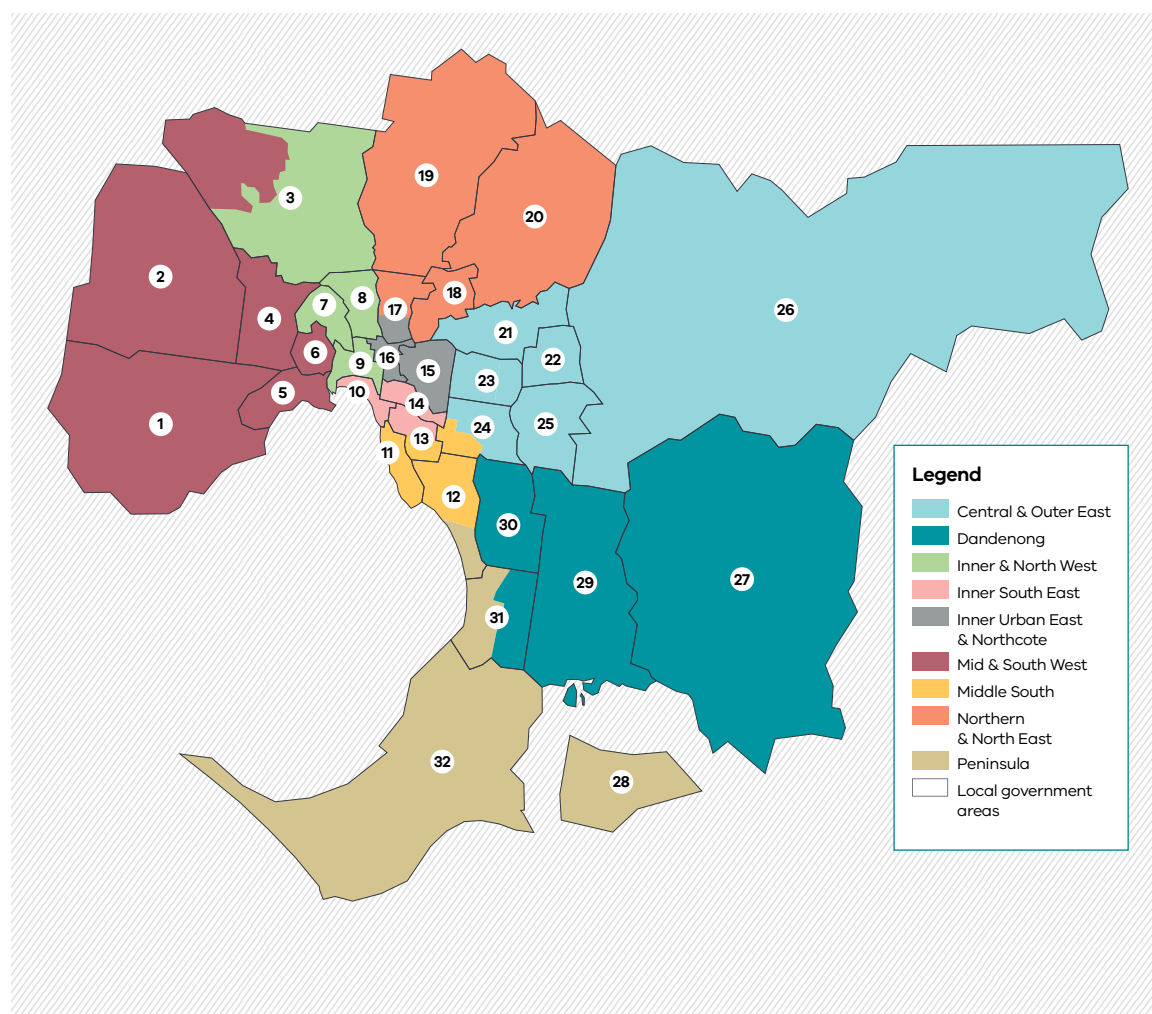
Adult mental health service areas Metropolitan Melbourne

Local government areas

1 Wyndham	12 Kingston	23 Whitehorse
2 Melton	13 Glen Eira	24 Monash
3 Hume	14 Stonnington	25 Knox
4 Brimbank	15 Boroondara	26 Yarra Ranges
5 Hobsons Bay	16 Yarra	27 Cardinia
6 Maribyrnong	17 Darebin	28 Bass Coast
7 Moonee Valley	18 Banyule	29 Casey
8 Moreland	19 Whittlesea	30 Greater Dandenong
9 Melbourne	20 Nillumbik	31 Frankston
10 Port Phillip	21 Manningham	32 Mornington Peninsula
11 Bayside	22 Maroondah	

Source: Adapted from Department of Health and Human Services. Mental Health Service Areas – Maps, 2015, <<http://www.health.vic.gov.au/mentalhealthservices/maps/index.htm>> [Accessed 27 October 2019].

Figure B.4: Catchments of Victoria's aged area mental health services, metropolitan Melbourne, 2019



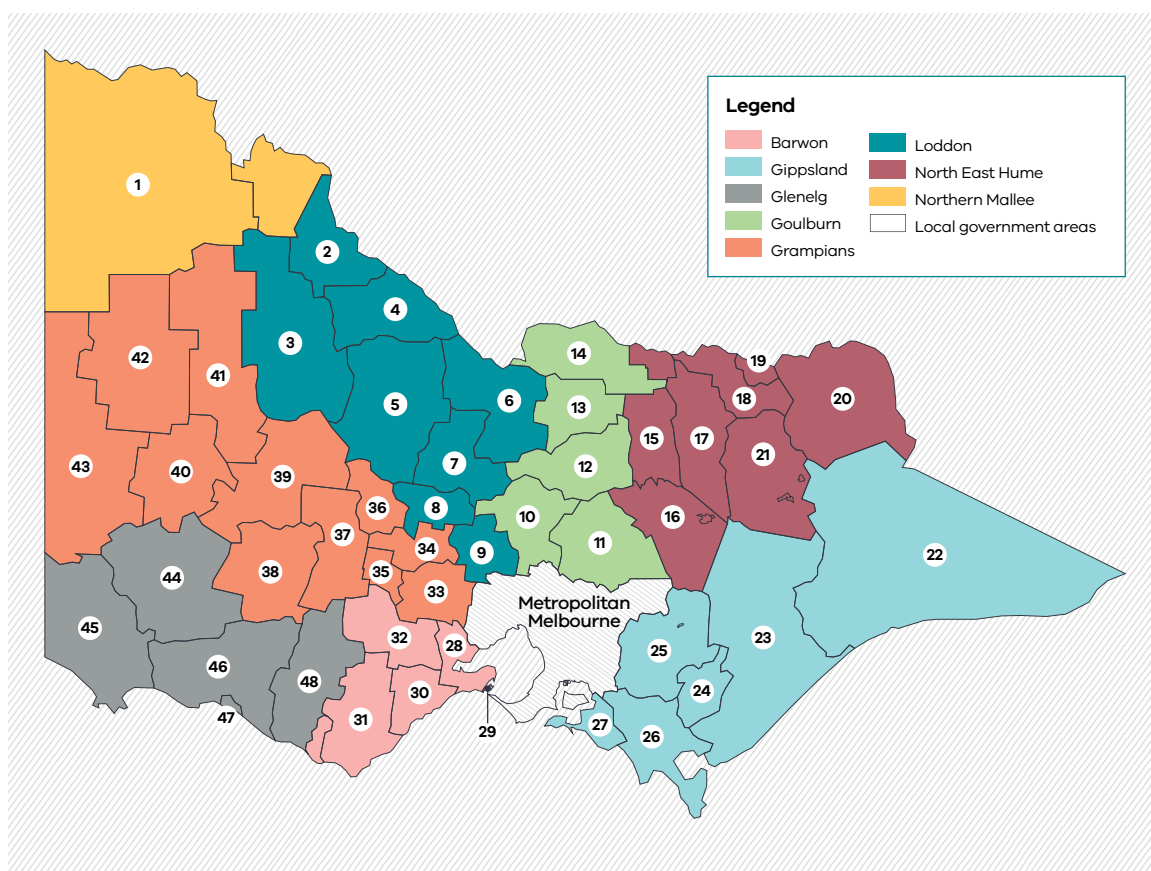
Aged persons mental health service areas Metropolitan Melbourne

Local government areas

1 Wyndham	12 Kingston	23 Whitehorse
2 Melton	13 Glen Eira	24 Monash
3 Hume	14 Stonnington	25 Knox
4 Brimbank	15 Boroondara	26 Yarra Ranges
5 Hobsons Bay	16 Yarra	27 Cardinia
6 Maribyrnong	17 Darebin	28 Bass Coast
7 Moonee Valley	18 Banyule	29 Casey
8 Moreland	19 Whittlesea	30 Greater Dandenong
9 Melbourne	20 Nillumbik	31 Frankston
10 Port Phillip	21 Manningham	32 Mornington Peninsula
11 Bayside	22 Maroondah	

Source: Adapted from Department of Health and Human Services. Mental Health Service Areas – Maps, 2015, <<http://www.health.vic.gov.au/mentalhealthservices/maps/index.htm>> [Accessed 27 October 2019]

Figure B.5: Catchments of Victoria's child and adolescent, adult and aged area mental health services, rural Victoria, 2019



Mental health service areas Rural Victoria

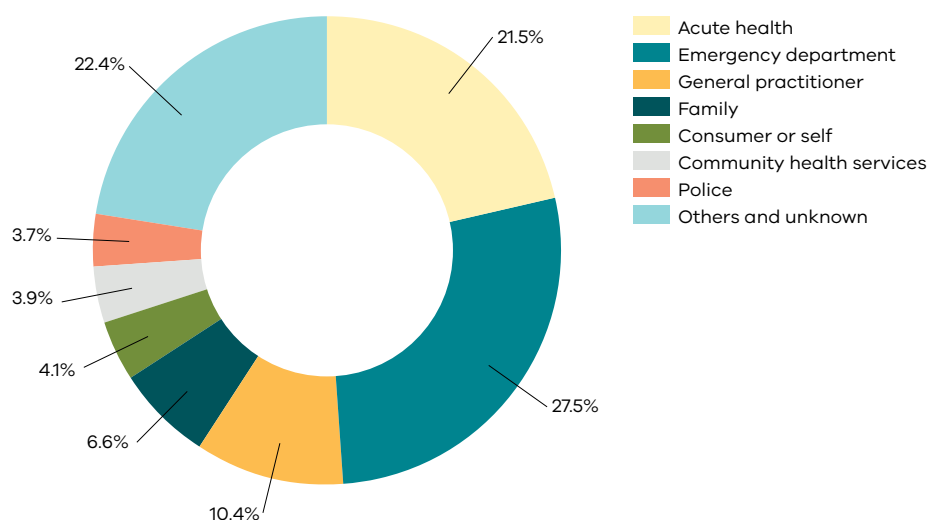
Local government areas

1 Mildura	17 Wangaratta	33 Moorabool
2 Swan Hill	18 Indigo	34 Hepburn
3 Buloke	19 Wodonga	35 Ballarat
4 Gannawarra	20 Towong	36 Central Goldfields
5 Loddon	21 Alpine	37 Pyrenees
6 Campaspe	22 East Gippsland	38 Ararat
7 Greater Bendigo	23 Wellington	39 Northern Grampians
8 Mount Alexander	24 Latrobe	40 Horsham
9 Macedon Ranges	25 Baw Baw	41 Yarriambiack
10 Mitchell	26 South Gippsland	42 Hindmarsh
11 Murrindindi	27 Bass Coast	43 West Wimmera
12 Strathbogie	28 Greater Geelong	44 Southern Grampians
13 Greater Shepparton	29 Queenscliff	45 Glenelg
14 Moira	30 Surf Coast	46 Moyne
15 Benalla	31 Colac–Otway	47 Warrnambool
16 Mansfield	32 Golden Plains	48 Corangamite

Source: Adapted from Department of Health and Human Services. Mental Health Service Areas – Maps, 2015, <<http://www.health.vic.gov.au/mentalhealthservices/maps/index.htm>> [Accessed 27 October 2019]

As Figure B.6 shows, people are referred to Victorian clinical mental health services from a wide range of places.⁶⁶ Most commonly, they are referred to services through hospital emergency departments (27.5 per cent), from acute (general) health (21.5 per cent) and from a GP (10.4 per cent).⁶⁷

Figure B.6: How people were referred to Victorian public clinical mental health services in 2018–19



Source: Department of Health and Human Services. Victoria's Mental Health Services Annual Report 2018–19, p. 60.

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. The services provide both voluntary and compulsory inpatient support and treatment for people who are experiencing a crisis or are in the acute phase of mental illness.⁶⁸ In 2018–19, 49.7 per cent of all admissions to Victorian public health services were compulsory admissions.⁶⁹

Acute inpatient units exist for young people, adults and aged people; a small number of acute beds are available for children (see Table B.1). In 2018–19 there were 31,244 admissions to acute adult mental health beds.⁷⁰

Psychiatric assessment and planning units offer assessment and treatment for people experiencing an acute episode of mental illness and minimise the need for an extended hospital stay in an inpatient unit. Short-stay units aim to provide access to short-term bed-based treatment for up to 72 hours.⁷¹

Several Victorian child and adolescent mental health services provide inpatient care, but most mental health services for children and young people are provided through outpatient clinics at hospitals or outreach programs at other community locations. These programs account for 74.4 per cent of annual funding for child and youth mental health services.⁷² In 2017–18 clinical mental health services in Victoria treated 11,945 children and young people up to the age of 18 years and admitted 2,014 to inpatient care.⁷³

Table B.1: Acute inpatient mental health beds and funding Victoria

Acute care bed type	Estimated open beds at 30 June 2019	2018–19 State government output funding
Adult acute inpatient mental health beds (includes beds in psychiatric assessment and planning units)	757	\$233m
Aged acute inpatient mental health beds	237	\$70m
Child and adolescent acute inpatient mental health beds	80	\$25m
Secure Extended Care Beds	148	\$30m
Transition support unit beds	20	\$4m

Source: Calculation by the Commission using Department of Health and Human Services. Policy and Funding Guidelines 2018–19; Department of Environment, Land, Water and Planning. Victoria into the Future 2019.

Bed numbers as per the Department of Health and Human Services. Policy and Funding Guidelines 2018–19.

Adult beds excludes 20 veterans' beds and 10 brain disorders beds at Austin Health

Excludes two adult beds funded at Barwon Health and nine adult beds at Eastern Health in 2018–19.

Includes 24 beds purchased from private providers in 2018–19.

Adult beds includes Orygen youth beds.

Adult bed output funding includes 20 veterans' beds and 10 brain disorders beds at Austin Health; Two adult beds funded at Barwon Health; nine adult beds at Eastern Health but excludes 24 beds purchased from private providers and Orygen youth beds.

In 2017–18 there were 2,494 hospitalisations of people aged 65 years or older in acute mental health inpatient services. The average length of stay was 15.5 days⁷⁴—much longer than the adult length of stay of 9.1 days.⁷⁵ Aged persons mental health services also provide specialist residential care for older people with a mental illness who cannot live at home or be managed in mainstream aged care residential services (see 'Community-based and extended care mental health beds' below.)

Area mental health services make their own arrangements for delivering services to consumers following an inpatient stay. Some services have established post-discharge programs; for example, Mercy Mental Health has established a Post Admission Support Team to provide follow-up for consumers for up to four weeks following a discharge from an acute inpatient unit.⁷⁶

Additionally, the Expanding Post Discharge Support initiative provides post-discharge supports to people following an inpatient admission. The program is delivered by peer support workers and includes at least three contacts within the first 28 days following discharge.⁷⁷ The purpose of the program is to assist consumers in their transition to the community and reduce the risk of readmission.⁷⁸

Community-based and extended care mental health beds

Some bed-based mental health services are delivered in the community. These include prevention and recovery care units, community care units and public sector residential aged care services.

Prevention and recovery care unit services are generally short term (up to 28 days) and provide recovery-focused treatment services in community-based residential settings.⁷⁹ A few services provide more extended care (up to six months). Prevention and recovery services operate in a homelike setting and provide early intervention for people who are becoming unwell; the aim is to prevent acute admission into hospital by acting as a 'step up' in support.⁸⁰ They can also act as a 'step down' for consumers following a hospital admission before they return home.⁸¹ Prevention and recovery services provide psychosocial rehabilitation programs and clinical care intended to assist recovery.⁸²

There are various prevention and recovery care unit models in Victoria. These include services for adults, youth-specific services for people aged 16–24 years, women-only units and intensive clinical prevention and recovery units. These services are generally unable to accept consumers with insecure housing and no fixed address, with suicidal ideation or with substance use disorders.⁸³ Victoria has 23 prevention and recovery care units⁸⁴ providing 250 beds. In 2017–18 the occupancy rate for the beds was 77.9 per cent.⁸⁵

Youth prevention and recovery centres offer voluntary short-term, subacute, intervention and recovery-focused clinical treatment services in residential settings designed for young people aged 16–25 years.⁸⁶ There are currently three such centres operating in Victoria (in Bendigo, Frankston and Dandenong), each with 10 inpatient beds. A fourth youth prevention and recovery centre with 20 beds is due to open in the Melbourne suburb of Parkville in 2021.⁸⁷

Community care units provide longer term (up to two years) residential clinical treatment and non-clinical supports to help people living with severe mental illness to recover.⁸⁸ The units offer a homelike environment: people share a unit and are given the opportunity to learn or relearn the everyday skills required for living successfully in the community while receiving treatment to assist with recovery.⁸⁹ Victoria had 348 beds in community care units in 2018–19 at a cost of \$51 million.⁹⁰

Secure extended care units are secure services on general hospital sites for people who need a high level of secure and intensive clinical treatment for severe mental illness.⁹¹ The units provide long-term compulsory management and treatment at three metropolitan and three regional hospitals, and there is limited non-secure extended care bed capacity at two further hospitals.⁹² In 2017–18 there were 222 'separations' from these units, with occupancy remaining high at 89.5 per cent.⁹³

In 2018–19 there were 495 beds in aged persons mental health public sector residential aged care services, at a cost of \$23 million.⁹⁴ These beds are for older Victorians whose needs cannot be met in mainstream aged care facilities, including older people who have 'high levels of persistent cognitive, emotional or behavioural disturbance'.⁹⁵ They provide long-term accommodation in a homelike environment, with assessment, treatment, rehabilitation and a range of activities available. For these services, there were 237 'separations' in 2017–18.⁹⁶

Community-based clinical services

Community-based clinical mental health services are services that are made available to people outside hospital settings—often in their own homes, in community facilities or by phone.⁹⁷

In 2018–19 there were more than 2.4 million ‘contacts’ by community clinical mental health services.⁹⁸ Among these services are acute community intervention services, which provide urgent community-based assessment, referral and treatment to people who are in psychological distress. The services assess all potential inpatient admissions and assist in determining the most appropriate support.⁹⁹

Community clinical-based services provide continuing care services, offering assessment, treatment, case management, support and continuing services in the community.¹⁰⁰ Continuing care services are delivered by discrete or integrated teams; examples are mobile support and treatment services and homeless outreach psychiatric services.¹⁰¹

Further, there are five statewide intensive mobile youth outreach services in Victoria. These teams provide intensive case management and support to young people ‘who display substantial and prolonged psychological distress and have complex needs that can include challenging, at-risk and suicidal behaviours’.¹⁰²

Additionally, aged persons mental health community teams provide community-based assessment, treatment, rehabilitation and case management for people aged 65 years or older.¹⁰³ Aged persons mental health intensive community treatment is also available in a person’s home during an acute phase of mental illness as an alternative to an inpatient admission.¹⁰⁴

Statewide and regional specialist services

Several specialist mental health services provide highly specialised treatment and care to Victorians with severe and complex mental illnesses.¹⁰⁵ Health services deliver these services on a statewide or regional basis.

Among these services are the Koori statewide inpatient service at St Vincent’s Mental Health Service, the Brain Disorders Unit at Mary Guthrie House at Royal Talbot Rehabilitation Centre, the Victorian Dual Disability Service run by St Vincent’s Mental Health and NorthWestern Mental Health, the Mood and Eating Disorders Unit at Austin Health, the Mother and Baby Unit at Austin Health, the Monash Health Gender Clinic, the Psychiatric Intensive Care Unit at Alfred Psychiatry, neuropsychiatry at the neuropsychiatric unit at the Royal Melbourne Hospital, personality disorder services run through Spectrum and services for Victorian Transcultural Mental Health.¹⁰⁶

Overall, there are 92 specialist beds in Victoria.¹⁰⁷ In 2017–18 the number of people accessing statewide specialist mental health services increased by almost 20 per cent.¹⁰⁸

In addition, the Multiple and Complex Needs Initiative is a statewide specialist service for people aged 16 years or older who have identified as having multiple and complex needs.¹⁰⁹ The program is underpinned by the state’s *Human Services (Complex Needs) Act 2009* (Vic) and aims to coordinate supports and services to stabilise safety issues, pursue therapeutic individual goals, and provide a platform for long-term engagement with the system.¹¹⁰

Forensic mental health services

Forensic mental health services provide treatment, care and support services to people living with mental illness who have come into contact with the criminal justice system.¹¹¹ These services are delivered by Forensicare (the Victorian Institute of Forensic Mental Health), a statutory authority created under Victoria's *Mental Health Act 2014*.¹¹²

Forensic mental health services include assessment, early intervention and prevention, inpatient care, rehabilitation and community transition support and are delivered by:

- Thomas Embling Hospital, a forensic mental health hospital that provides 136 secure beds and delivers acute and continuing care
- prison mental health services—specialised forensic mental health services that provide 141 beds, with programs and outpatient services located across metropolitan Melbourne and rural and regional Victoria
- the Community Forensic Mental Health Service, providing outpatient and community-based programs that assess, treat and support high-risk consumers.¹¹³

Thomas Embling Hospital opened in Fairfield in 2000. It was the first purpose-built secure hospital in Victoria and the first 'modern' secure hospital in Australia. It initially had 116 beds for psychiatric assessment, treatment and care. While the hospital now has 136 beds, its current capacity is 128 due to challenges recruiting mental health nurses.¹¹⁴

From its inception, Thomas Embling Hospital's target population included three cohorts:

- security patients—individuals transferred from the criminal justice system for psychiatric assessment, treatment and care under the Mental Health Act
- forensic patients admitted under the *Crimes (Mental Impairment Unfitness to be Tried) Act 1997*
- compulsory patients under the Mental Health Act (ss.45, 52), including patients transferred from other area mental health services for treatment.

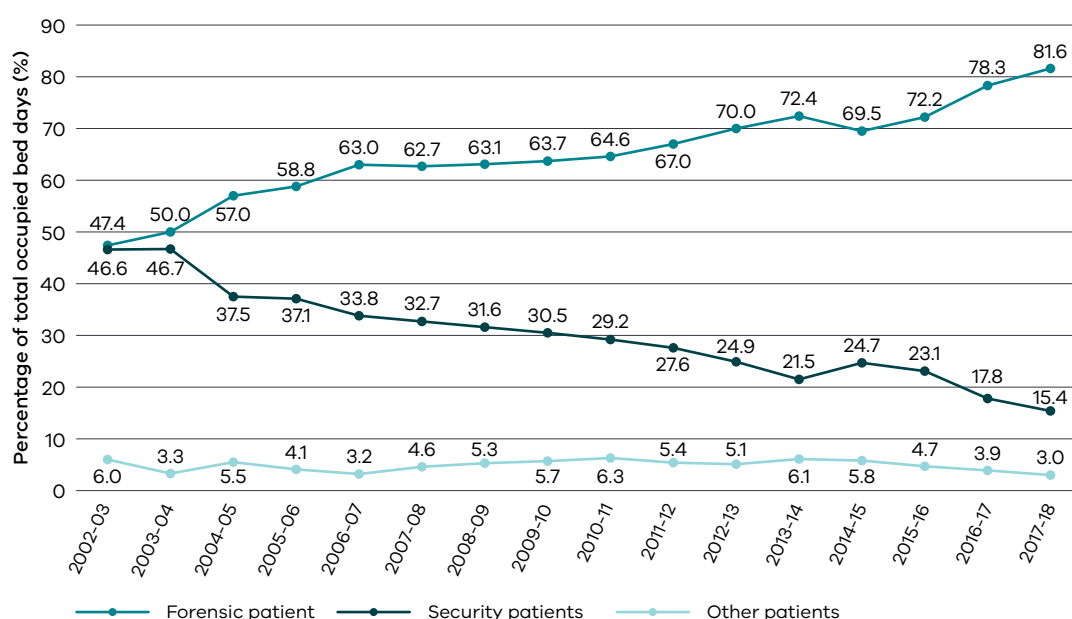
This allows Forensicare to accommodate people who are at risk of self-harm or harm to the others, including staff and the community, but who are not under forensic or sentencing orders.¹¹⁵

Most admissions to Thomas Embling Hospital are security patients who have a relatively short length of stay. However, a large proportion of people at Thomas Embling Hospital (82 per cent) have been found not guilty or unfit to plead on the grounds of 'mental impairment' and ordered by a court to be detained for treatment.¹¹⁶ Figure B.7 shows the proportion of total occupied bed days by each patient cohort, from 2002–03 through to 2017–18.

From the late 2000s, capacity at the hospital became very limited. For example, Forensicare told the Commission that it no longer has the capacity to provide treatment, care and support to people with complex needs and challenging behaviours who are unable to access services through an area mental health service.¹¹⁷

Forensicare submitted that an increase in the number of forensic consumers is linked to the current lack of capacity in the public mental health system, which 'escalates the severity of mental illness, forensic (offending) risk and in turn community safety'.¹¹⁸

Figure B.7 Proportion of total occupied bed days by patient type, Thomas Embling, 2002–03 to 2017–18



Source: Department of Health and Human Services. Integrated Data Resource, Client Management Interface / Operational Data Store 2002–03 to 2017–18.

Classification of patient legal status for the purposes of calculating the percentage of total occupied bed days by patient legal status is as follows:

- Forensic patients included anyone on a forensic order at any time during their episode
- Security patients included anyone who was not on a forensic order, but on a security order at any time during their episode
- Other patients included all other patients not listed above

As the Victorian prison population continues to grow, so does pressure on forensic mental health services. In 2017–18 the number of people accessing such services increased by 16.2 per cent from the previous year.¹¹⁹ Pressure on inpatient beds is particularly high, with a bed occupancy rate of 96.6 per cent in 2017–18.¹²⁰ Mental health consumers in Thomas Embling Hospital have an increasingly long duration of stay and a lack of alternative options for their treatment.¹²¹

Consultation-liaison psychiatry

Consultation and liaison psychiatry teams provide mental health services to people who have been admitted to a general hospital setting and may require services and supports related to mental illness.¹²² These services work with other practitioners to treat people living with mental illness in general hospitals, as well as providing direct support to people.¹²³

Mental health community support services

In addition to clinical services, the Victorian Government has traditionally funded psychosocial support services, known as mental health community support services.

As noted above, many mental health community support services have transitioned to the NDIS, leaving the Victorian Government with responsibility for a relatively small range of psychosocial support services.¹²⁴ In 2018–19 the Victorian Government provided interim funding for new psychosocial support services for adults who previously received support but who are not eligible for the NDIS.¹²⁵

B.2.4 Emergency and crisis services

There are a number of services in Victoria that provide crisis support and responses to people living with mental illness.

Ambulances

Each year, approximately 11 per cent of emergency calls relate to mental health presentations.¹²⁶ About 18 per cent of mental health cases involving an Ambulance Victoria dispatch do not result in consumers being transported to hospital. In these cases, consumers might instead receive treatment at the scene, be referred to other services or decline assistance.¹²⁷

As a first responder to people experiencing mental illness or psychological distress, Ambulance Victoria plays a role in providing immediate support and linking consumers to other forms of treatment, care and support. It also provides a safety net for people who are unable to get help from other mental health services.¹²⁸

In addition to sending an ambulance and transporting people to emergency departments, where required, Ambulance Victoria provides a secondary triage service.¹²⁹ Secondary triage is used for calls to triple zero that are not deemed time-critical emergencies. They generally involve paramedics and registered nurses providing patients with a referral to appropriate services or advice on self-care.¹³⁰

The Commission estimates that in 2018–19 the Victorian Government spent about \$54 million on ambulance-related mental health services.¹³¹

Emergency departments

Emergency departments are an initial point of contact for many people when seeking treatment for the first time. For others, they act as an alternative point of care for after-hours support.¹³²

Among the mental health services provided by emergency departments are triaging, assessment, treatment, admission to hospital and facilitating arrangements for follow-up care.¹³³ In 2018–19, 27.5 per cent of referrals to public clinical mental health services were made from emergency departments; the proportion has been steadily increasing over time.¹³⁴

Some emergency departments have emergency crisis and assessment teams that provide triaging and support. These teams generally include mental health-trained nurses, psychologists, social workers, occupational therapists, psychiatrists and registrars.¹³⁵ Some emergency departments also provide short-term bed-based services.¹³⁶

In May 2018 the Victorian Government announced funding of \$100.5 million to roll out six new mental health and crisis hubs.¹³⁷ The hubs will be in a dedicated area of emergency departments at the Royal Melbourne Hospital, Barwon Health, Monash Medical Centre and Sunshine and Frankston hospitals.¹³⁸

They will be staffed by a multidisciplinary team of workers including psychiatrists, psychiatric registrars, social workers, mental health nurses, peer support workers, alcohol and other drug specialists and nurse practitioners.¹³⁹ Services provided will include assessment, therapeutic interventions and referrals to other services (including community-based services, inpatient units and assertive outreach services following discharge).¹⁴⁰

In 2017–18, 23 per cent of mental health–related emergency department presentations had a primary diagnosis relating to alcohol and other drugs, and 13.8 per cent had a principal emergency department diagnosis relating to anxiety disorders.¹⁴¹

In 2017–18 the number of mental health–related emergency department presentations was 102,038, representing 5.8 per cent of all presentations.¹⁴² In the 10 years to 2017–18 the number of mental health–related emergency department presentations increased at about 7.0 per cent annually.¹⁴³

Joined-up mental health responses with police and ambulance

Victoria also has a number of joint mental health and emergency services teams. These services include the Police Ambulance Clinical Early Response (PACER), jointly run by Victoria Police and adult area mental health services.¹⁴⁴ PACER is an intervention program that aims to provide targeted and timely responses for people who have come into contact with Victoria Police and require an urgent response.¹⁴⁵ Ambulance Victoria can request the attendance of a PACER team, where available. Nineteen of these programs currently operate throughout Victoria, each tailored to local community need.¹⁴⁶

Mental health triage

Responding to people experiencing mental health crises is also a function of mental health triage services, which are a component of public specialist mental health services. Most triage in mental health services is conducted over the telephone.

All area-based public specialist clinical mental health services in Victoria are required to have a telephone number providing access to a triage clinician 24 hours a day, seven days a week. The purpose of these services is to provide a clinical assessment of the person's needs, determine the urgency of the response required by mental health or other services, and to facilitate that response.¹⁴⁷

Decisions made by the triage clinician determine whether the person requires further assessment and treatment and, if so, the type and urgency of the response required.¹⁴⁸

The Statewide Mental Health Triage Scale is used to record the decision, which can include mobilising a response from police or ambulance or a referral to an emergency department or a mental health crisis assessment and treatment team in the community.¹⁴⁹

B.3 Broader health, social and community services

Victoria's mental health system operates in the context of Victoria's general health system and other health, social and community services that have a role in supporting mental health. Social determinants have a role in shaping people's mental health, and these determinants can influence what services people need, use and whether they can gain access to them when and where they need to.¹⁵⁰

As outlined below, these services can promote good mental health, prevent poor mental health, facilitate early intervention and provide ongoing treatment, care and support. They include services provided by governments, not-for-profit organisations and individual practitioners.

B.3.1 Mental health promotion

Mental health promotion works by empowering people and communities, imparting the knowledge they need to change behaviour and create environments that support mental health and wellbeing.

A small number of organisations in Victoria receive dedicated funding from governments to run mental health promotion programs. In 1999 VicHealth became one of the first organisations in the world to develop and implement a specific framework for promoting mental health and wellbeing.¹⁵¹ Today VicHealth works in five main areas to promote mental health and wellbeing: workplaces, digital and online environments, sports and physical activity, schools, and the arts.¹⁵²

The Better Health Channel runs dedicated campaigns and programs for mental health promotion.¹⁵³ In workplaces, the state's statutory authority in charge of workplace compensation and safety, WorkSafe Victoria, runs WorkWell, a five-year \$50 million program to deliver research, information, tools and funding opportunities for workplace mental health promotion.¹⁵⁴

While there is no single overarching framework for mental health promotion in Victoria, the Victorian Government funds a range of programs that include mental health promotion as a primary or secondary aim, including:

- men's sheds¹⁵⁵ and neighbourhood houses,¹⁵⁶ which can respond to social determinants of mental health by building social networks and community connections
- Safe Schools¹⁵⁷ and the Healthy Equal Youth program,¹⁵⁸ which support mental health promotion and community engagement activities focused on LGBTIQ+ young people.

At the national level, the Commonwealth funds mental health promotion activities through headspace for young people, Beyond Blue and other mental health initiatives commissioned by Primary Health Networks.¹⁵⁹

B.3.2 Mental illness prevention

Mental illness prevention targets the direct causes of mental illness, in contrast to the broader range of factors that mental health promotion seeks to cover.¹⁶⁰

There is evidence that specific prevention initiatives, such as parenting programs and school-based programs, are both clinically effective and cost-effective.¹⁶¹

Prevention can be 'universal' (targeted to the whole population), selective (designed to reach specific groups of people that can be disproportionately affected by mental illness) or indicated (for people showing minimal but detectable signs of poor mental health).¹⁶²

An example of selective prevention is the Enhanced Maternal Child Health program. This program is offered to selected vulnerable families and provides flexible services, actions and interventions for women and their infants who are living with family violence and/or are identified as vulnerable.¹⁶³ Programs such as this, supporting specific groups, are typically delivered outside of health services.

An example of indicated prevention is the Youth Early Psychosis Program at The Alfred.¹⁶⁴ Accessed by about 700 young Victorians each year, the program is designed for people who are experiencing their first episode of psychosis (or are at risk of developing psychosis) and are aged between 12 and 25 years. The aim of the program is to prevent disruptions in a young person's life and minimise the duration of untreated psychosis.¹⁶⁵

B.3.3 General health services

People who experience mental illness are also at higher risk of poorer physical health. For example, the 2007 National Survey of Mental Health and Wellbeing found that 11.7 per cent of adults with a 12-month mental disorder also reported a physical disorder.¹⁶⁶

Mainstream health services play a role in the support, referral and treatment of people experiencing mental illness and psychological distress. In 2018–19, 21.5 per cent of all referrals to public clinical mental health services were from acute health services. This includes people who were admitted with a physical illness or injury who were subsequently referred for mental health treatment.¹⁶⁷

B.3.4 Other health, social and community services

Many people experiencing mental illness or psychological distress also receive support from general health services, aged care, housing services, income support services, financial counselling services, advocacy services, child and family services and alcohol and other drug services (see Figure B.1A).

Compared with the general population, people using specialist mental health services are 14 times more likely to use alcohol and other drug services.¹⁶⁸ Alcohol and other drug services include, for example, counselling, residential and community-based rehabilitation services and residential withdrawal services, alongside prevention and harm-reduction services delivered through community-based providers.¹⁶⁹

In 2017–18 about 17 per cent of adults using Victoria's specialist mental health services were also using specialist homeless services.¹⁷⁰ Services for people who are experiencing mental illness and who are homeless or at risk of homelessness include a range of accommodation and non-accommodation support services delivered by a mix of government and non-government organisations.¹⁷¹

The justice interface

Compared with the general population, people making use of specialist mental health facilities are 10 times more likely to be known to Victoria Police.¹⁷²

Victoria Police also play a role in crisis response, connecting people to assessment, treatment, care and support, responding to requests for assistance from mental health services, and engaging with consumers who are involved in various parts of the criminal justice system.¹⁷³ The Commission estimates that in 2018–19 the Victorian Government spent \$151.3 million on mental health-related responses and functions delivered by Victoria Police.¹⁷⁴

In situations where Victoria Police is satisfied that a person appears to have a mental illness and is at risk of harming themselves or another person, the person can be apprehended, as specified under s. 351 of the state's *Mental Health Act 2014*.¹⁷⁵ Victoria Police can then arrange referrals for further assistance.¹⁷⁶ Averaged across the year, Victoria Police in 2017–18 responded to events coded as 'psychiatric crisis' or 'suicide attempt or threat' every 12 minutes.¹⁷⁷

Some services within the justice system are aimed at helping people gain access to early treatment, care and support. For example, the Court Mental Health and Response Service (formerly the Mental Health Court Liaison Service) is available in some magistrates' courts in Victoria and aims to divert offenders experiencing mental illness from the criminal justice system into appropriate mental health services.¹⁷⁸

Justice Health is responsible for delivering health services to prisoners, the services being contracted out to several organisations. A private company called Correct Care Australasia delivers primary health care services, including mental health services.¹⁷⁹ Prisoners do not have access to the Medical Benefits Scheme, meaning they cannot use the subsidised services of private psychologists or psychiatrists.¹⁸⁰ Forensicare is contracted to provide specialist mental health services to prisoners.

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Appendix C

Background to economic analysis

This appendix provides an overview of the approach taken to the economic analysis presented in Chapters 12 and 20. It includes information on the calculations, assumptions and the data sources used.

The Commission also notes the personal costs of poor mental health. People living with mental illness incur a variety of personal costs, including emotional distress and pain, social isolation, discrimination, and lack of the freedom and rights enjoyed by others. Families and carers also experience emotional and psychological costs. These costs are considered elsewhere in the report.

C.1 Economic analysis advice

The Commission formed an Advisory Committee to provide advice on its economic analysis. The members of the Committee included:

- Professor Allan Fels – Commissioner and Chair of the Advisory Committee
- Dr Henry Cutler – Director of the Macquarie University Centre for the Health Economy
- Professor Cathy Mihalopoulos – Chair and Head of Deakin Health Economics
- Mr Tim Marney – Principal at Nous Group.

The teams at the Macquarie University Centre for the Health Economy and Deakin Health Economics provided analytical and advisory support.

Table C.1 The Commission's economic analysis: costs considered for different parties and perspectives

	Economic cost: direct costs + opportunity costs and no transfers between different parties		
	Victorian society	Consumers	Carers
Out-of-pocket costs for services and medicines	Y	Y	
Lower workforce participation	Y	Y	
Unpaid care	Y		Y
Welfare payments		Deduction	Deduction
Workplace injury and illness	Y		
Discretionary employee support programs	Y		
Productivity losses	Y		
Funding to provide mental health services	Y		

C.2 Cost estimates

The Commission has used a 'top-down' approach (state- or system-level data) to estimate the economic costs of poor mental health in Victoria, as outlined in Chapter 12.

C.2.1 Aggregate estimates

The costs of poor mental health have been calculated from a range of perspectives. These are outlined in Table C.1, with the corresponding costs covered and type of analysis (economic versus financial) used under each perspective. Figures and estimates use June 2018 for population and labour-force data, are adjusted to be in 2018–19 dollars, and use Victoria-specific data wherever possible, supplemented with Australian data when unavailable.

Financial cost: direct costs for each actor			
Employers	Victorian Government	Commonwealth Government	Private health insurers
		Y	
Y			
Y			
Y			
	Y	Y	Y

It is important to note that, because of the limited availability of high-quality data, this analysis does not consider:

- tax revenue forgone as a result of lower workforce participation and productivity
- out-of-pocket costs for consumers from related services – for example, a higher likelihood of having physical health comorbidities and consequent use of other health services
- out-of-pocket costs to carers for carer supports
- donations from the broader community to mental health services
- higher use and costs of related services as a result of poor mental health outcomes that are covered by private health insurers.

It is also worth noting that although the costs of mental health services are listed according to the party that administers them (for example, the Victorian Government and private health insurers), individual Victorians ultimately pay these costs in the form of taxes and insurance premiums.

C.2.2 Individual cost estimates

Table C.2 shows the individual estimates made to calculate a total cost of poor mental health to Victoria.

Table C.2 Estimates for total cost of poor mental health

Actor/measure	Data sources
Individuals—out-of-pocket costs (Medicare Benefits Schedule - MBS)	Commonwealth Department of Health, <i>MBS mental health data by Primary Health Network by Mental Health Service type 2011–12 to 2016–17</i> , 2017
Individuals—out-of-pocket costs (Pharmaceutical Benefits Scheme - PBS)	Australian Department of Health, <i>MBS mental health data by Primary Health Network by Mental Health Service type 2011–12 to 2016–17</i>
Individuals—forgone wages due to inability to work (can also be characterised as a productivity loss due to lower participation)	<p>Australian Bureau of Statistics, <i>Labour force status by sex, Victoria –Trend, seasonally adjusted and original</i>, Table 5, 2019</p> <p>Australian Bureau of Statistics, <i>National Health Survey: first results, 2017–2018 Australia</i>, 2018, p. 40</p> <p>Australian Bureau of Statistics, <i>National Health Survey: first results, 2017–18 Australia, Table 21: Victoria</i>, 2019, Table 3.1</p> <p>Australian Bureau of Statistics, <i>Average weekly earnings, Victoria (dollars) – original</i>, Table 13B, 2019</p>

Calculation notes

Estimate (2018–19)

- This figure was obtained by calculating out-of-pocket costs for Victorians.
- This figure includes out-of-pocket costs for mental health–related MBS services only.

\$88.4 million
(direct cost)

- This figure was obtained by calculating out-of-pocket costs for mental health-related PBS-subsidised medications for Victorians.
- All Anatomical Therapeutic Chemical Level 2 Code N05 and N06 data were considered as relating to mental health.
- Because medication data were available at the Level 2 Code only, rather than for individual medicines, this estimate:
 - includes one prescription that is not mental health specific (Prochlorperazine, used for nausea)
 - does not include select prescriptions in other categories relevant to mental health (for example, two N03 category prescriptions that are used as mood stabilisers).
- Prescriptions relevant to mental health, but not exclusively so (for example, N07 categories, which have many items related to substance use), have also not been included in the estimate.

\$93.8 million
(direct cost)

- This estimate is based on the counterfactual that a person's ability to work is not affected by their mental illness.
- This estimate assumes that people living with mental illness experience the same labour force participation rate as Victorians without a mental illness and, once looking for work, experience an improved employment rate. However, given common confounding factors such as physical comorbidities that impact on the ability of people living with mental illness to gain employment, a mid-point between the current employment rate of people living with mental illness and those without has been used.
- As well as variations in the labour force participation and employment rates that are considered achievable, the annual wage people would receive is also speculative. The Commission has therefore estimated a number of scenarios to account for this, based on those entering work receiving:
 - average wages, across full-time and part-time wages to reflect variation in how people return to work
 - a mid-point between the average and minimum wage
 - the minimum wage.
- These different wage rates were multiplied by Victorians who could work due to improved mental health.
- Note:
 - the term 'mental illness' is used in this context to refer to 'mental and behavioural conditions' as used in the National Health Survey
 - this estimate does not empirically account for other factors, such as comorbidities, which might not allow a person to return to work. However, the mid-point employment rate used tries to partially account for this
 - the estimate assumes the economy is at full employment (that is, those who enter the workforce will be able to find a job at a similar success rate as currently occurs).

\$4,778.0 million, with a range
of \$3,598.4–\$5,957.5 million
(opportunity cost)

Actor/measure	Data sources
Individuals/Commonwealth Government—welfare payments	Commonwealth Department of Social Services, <i>Annual Report 2017–18</i> , 2018, p. 44 Commonwealth Department of Social Services, <i>Payment demographic data</i> < https://data.gov.au/dataset/ds-dga-cff2ae8a-55e4-47db-a66d-e177fe0ac6a0/details > [accessed 25 October 2019]. December 2019, Table: DSP by medical condition
Carers—number	Sandra Diminic and others, <i>The economic value of informal mental health caring in Australia: Summary report</i> (commissioned by Mind, March 2017), p. 135. Australian Bureau of Statistics, <i>Estimated resident population by single year of age, Victoria</i> , Table 52, 2019
Carers—provision of unpaid care	Diminic and others, p. 135
Commonwealth Government/carers—welfare payments	Commonwealth Department of Social Services, <i>Payment demographic data</i> . December 2019, Table: Care receivers by medical condition
Employers—workplace injury and illness	Whole of Victorian Government, <i>Submission to Productivity Commission inquiry into mental health</i> , 2019, p. 31. WorkSafe, <i>Annual Report 2018</i> , 2018
Employers—employee support programs	Medibank and Nous Group, <i>The case for mental health reform in Australia: A review of expenditure and system design – detailed expenditure calculations</i> , 2013, p. 23

Calculation notes

Estimate (2018–19)

- This figure was calculated using the total 2017–18 Disability Support Pension payments paid and the proportion of total Disability Support Pension recipients who have a medical condition of psychological or psychiatric disability (36%).
- A Victorian proportion of this national total is derived based on the state's share of the national population.
- It is possible that people living with mental illness receive other social security payments. The number of people is difficult to calculate and so has not been included. Conversely, while people receive a payment based on a psychological or psychiatric disability being their main disability, they may also have other disabilities, so the need for social security payments may not be wholly attributable to mental illness.

\$1,554.2 million
(direct cost to Commonwealth,
deduction for consumers from
forgone wages, transfer from
Victorian society perspective)

- This figure was calculated using estimates published by Mind Australia on the proportion (based on the Survey of Disability, Ageing and Caring) of the population that provides informal care for someone with a mental illness.
- This proportion was applied to Victoria's total population aged 15 years or older.

Primary mental health
carers—13,064
Other mental health
carers—45,000

- This figure was calculated by estimating the cost of replacing an informal carer with a paid carer.
- Mind Australia's estimates of average annual replacement costs for informal care were used. Estimates of average annual replacement costs included the activities generally involved in caring—the time spent on each activity and the corresponding cost of a paid worker performing this role.
- The annual replacement cost per mental health carer (primary versus other) was multiplied by the estimated number of Victorian informal mental health carers.

\$3,672.0 million
(opportunity cost)

- This figure was calculated using the total 2017–18 Carer Allowance payments and Carer Payments paid and the proportion of recipients of each payment who were caring for someone with a psychiatric disability.
- A Victorian proportion of this national total is derived based on the state's share of the national population.
- There are many people with a mental illness or people caring for someone with a mental illness who receive other social security payments. This is difficult to calculate and has not been included. Conversely, while people receive a payment based on their care recipient having a psychological or psychiatric disability as their main disability, the recipient may also have other disabilities, so the need for social security payments may not be wholly attributed to poor mental health.

\$560.5 million
(direct cost to Commonwealth,
deduction for carers from forgone
wages, transfer from Victorian
society perspective)

- This figure is based on the estimated \$400.0 million in workers compensation insurance premiums paid each year by Victorian businesses for mental injury claims.
- To avoid double-counting wages forgone (as these are captured under lost productivity), the proportion of total WorkSafe Victoria payments for weekly benefits in 2018–19 was deducted from the total using the WorkSafe 2017–18 annual report.

\$263.4 million
(direct cost)

- This figure is based on the Medibank/Nous estimate of total spending on employee support programs related to mental health in Australia.
- A Victorian proportion of this national total is derived based on the state's share of the national population.

\$34.5 million
(direct cost)

Actor/measure	Data sources
Employers—productivity loss due to people needing to be away from work when they are unwell	Australian Bureau of Statistics, <i>National Survey of Mental Health and Wellbeing 2007</i> , 2008
Victorian Government—clinical mental health services	Victorian Government, <i>Submission to the RCMHS: SUB.5000.0001.0001</i> , July 2019, p. 9
Victorian Government—community mental health support services	Victorian Government, p. 9
Victorian Government—ambulance service activity related to mental health	Information provided to the Commission in response to Commissioner Fels' question taken on notice regarding the dollar cost of mental health for Ambulance Victoria, <i>Evidence of Simon Thomson</i> , 11 July 2019, p. 776
Victorian Government—emergency department activity related to mental health	Department of Health and Human Services, <i>Victoria's Mental Health Services Annual Report 2017–18</i> , October 2018, p. 64 <i>Productivity Commission, Report on Government Services 2019: Public hospitals – Attachment, Part E, Chapter 12</i> , Tables 12A.1 – 12A.61, 2019, Table 12A.59

Calculation notes

Estimate (2018–19)

<ul style="list-style-type: none"> This estimate is based on the counterfactual that a person's ability to engage with their work is not affected by their mental illness. This estimate is based on unit record-level data from the Australian Bureau of Statistics 2007 National Survey of Mental Health and Wellbeing that asked Australians with high-prevalence mental health disorders the estimated total number of days they were absent from work due to mental illness. It provided an average number of days absent by diagnosis and level of need. A total number of days absent from work due to mental illness was calculated for Victoria using the survey's mental illness prevalence data applied to Victoria's population. The Commission estimated the value of this time away from work based on people receiving: <ul style="list-style-type: none"> average wages, across full-time and part-time wages to reflect variation in how people return to work a mid-point between the average and minimum wage minimum wage. Note: <ul style="list-style-type: none"> the survey data avoid double-counting as a result of comorbid mental health diagnoses this methodology underestimates actual productivity because the survey does not capture all mental illnesses, such as low-prevalence disorders. 	<p>\$1,597.9 million, with a range of \$1,203.4 to \$1,992.4 million (opportunity cost)</p>
<ul style="list-style-type: none"> Total Victorian Government 2018–19 spending on specialist mental health services is taken from the Victorian Government's submission to the Royal Commission into Victoria's Mental Health System. Note: <ul style="list-style-type: none"> this includes transfer payments from the Commonwealth to Victoria as per the National Health Agreement this does not include Victorian Government expenditure on alcohol and other drug services, which are dealt with separately in this analysis. 	<p>\$1,506.0 million (direct cost)</p>
<ul style="list-style-type: none"> Total Victorian Government 2018–19 spending on community mental health support services is taken from the Victorian Government's submission to the Royal Commission into Victoria's Mental Health System. 	<p>\$98.9 million (direct cost)</p>
<ul style="list-style-type: none"> This estimate was provided by Ambulance Victoria, based on its assessment of costs related to 'responding to and managing patients with a primary mental health condition' in 2017–18. It notes that this should be considered a minimum cost estimate. Estimated costs are based on: <ul style="list-style-type: none"> relevant service activity—where a 'mental health' case is considered to be where a) the cause of the presenting problem is mental health related and/or b) specific mental health management is required and/or c) psychiatric services were present at the scene average costs—including direct costs (such as staff and medical consumables) and overhead costs (such as administration and depreciation of assets). This estimate does not include activity that involves a mental health issue, where it is not the primary presentation. 	<p>\$63.8 million (direct cost)</p>
<ul style="list-style-type: none"> Expenditure per acute emergency department presentation is calculated based on the average cost across admitted and non-admitted presentations in Victoria. Expenditure per presentation is multiplied by the number of presentations specific to mental health, as recorded by the Department of Health and Human Services. 	<p>\$64.3 million (direct cost)</p>

Actor/measure	Data sources
Commonwealth Government—MBS mental health services	Australian Institute of Health and Welfare, <i>Mental Health Services in Australia: Expenditure on Mental Health Services 2016–17</i> , Table EXP.18
Commonwealth Government—PBS-covered mental health pharmaceuticals	Australian Institute of Health and Welfare, <i>Mental Health Services in Australia: Expenditure on Mental Health Services 2016–17</i> , Table EXP.27
Commonwealth Government—national mental health programs and other expenditure	Australian Institute of Health and Welfare, <i>Mental Health Services in Australia: Expenditure on Mental Health Services 2016–17</i> , Table EXP.31 Australian Bureau of Statistics, <i>Estimated Resident Population by Single Year of Age, Victoria</i> , Table 52
Commonwealth Government—psychosocial supports under the National Disability Insurance Scheme (NDIS)	NDIS, <i>Participant numbers and plan budgets data</i> , < https://www.ndis.gov.au/about-us/data-and-insights/data/participant-data/participant-data-downloads > [accessed 28 October 2019]
Private health insurers—benefits paid for mental health services	Australian Institute of Health and Welfare, <i>Mental Health Services in Australia: Expenditure on Mental Health Services 2016–17</i> , Table EXP.34 Australian Bureau of Statistics, <i>Estimated Resident Population by Single Year of Age, December 2018 Victoria</i> , Table 52

Calculation notes

Estimate (2018–19)

- | | |
|--|----------------------------------|
| <ul style="list-style-type: none"> This figure is from the Australian Institute of Health and Welfare's 2016–17 total Commonwealth Government expenditure on MBS-subsidised mental health-related services provided for Victorians. | \$371.0 million
(direct cost) |
| <ul style="list-style-type: none"> This figure is from the Australian Institute of Health and Welfare's 2016–17 total Commonwealth Government expenditure on mental health-related medications subsidised under the PBS and Repatriation Pharmaceutical Benefits Scheme for Victoria. | \$134.1 million
(direct cost) |
| <ul style="list-style-type: none"> This figure is based on the Australian Institute of Health and Welfare's 2016–17 total Commonwealth Government expenditure on mental health programs, including: <ul style="list-style-type: none"> – national programs and initiatives (Department of Health, Department of Social Services and Department of Veterans' Affairs managed) – Department of Defence-funded programs – Indigenous social and emotional wellbeing programs – National Mental Health Commission – National Suicide Prevention Program – private health insurance premium rebates – research. A Victorian proportion of this national total is derived based on the state's share of the national population. | \$357.6 million
(direct cost) |
| <ul style="list-style-type: none"> This figure is based on National Disability Insurance Agency's published total funds committed to Victorian NDIS participants with a psychosocial disability, as at the end of June 2019. This includes some transfer payments from the Victorian Government to the Commonwealth Government, as per the Bilateral Agreement on the NDIS. These are committed supports, not actual expenditure. Actual expenditure is estimated to be about 65 per cent of this, according to plan utilisation rates for Victorians in 2018–19. Actual plan budgets in future years could be higher than this, as more Victorian participants enter the scheme. | \$425.3 million
(direct cost) |
| <ul style="list-style-type: none"> This figure is based on the Australian Institute of Health and Welfare's 2016–17 total private health funds expenditure on mental health-related services. A Victorian proportion of this national total is derived based on the state's share of the national population. | \$136.8 million
(direct cost) |

C.2.3 Payments across levels of government

The foregoing estimates allocate service costs against the level of government that has the relevant lead service delivery and financial responsibility. This does not, however, show payments that occur across levels of government and contribute to covering these costs.

Under the National Health Reform Agreement, the Commonwealth Government funds growth in hospital activity, including clinical mental health services. Additional services provided each year are funded at 45 per cent of the National Efficient Price¹, published annually by the Independent Hospital Pricing Authority, up to a total annual cap of 6.5 per cent.²

In 2018–19, the Commonwealth contributed just over \$5 billion (44 per cent) to hospital services in Victoria; the Victorian Government contributed the remaining 56 per cent (\$6.3 billion).³

The Victorian Government also provides funding for psychosocial supports through the National Disability Insurance Scheme. Victoria has a fixed annual contribution to the NDIS of \$2,586 million in 2019–20, escalated by 4 per cent a year.⁴ This funding is for participants' individual support packages and Information, Linkages and Capacity Building grants. The Commonwealth contributes the balance of scheme costs, including the National Disability Insurance Agency's administrative costs.⁵

C.2.4 Estimates of related government service use

Mental illness can increase the need for, or use of, many other services delivered by government, and failure in these aligned services systems can increase demands on the mental health system.

The true cost of poor mental health outcomes for related government services is the additional service use and costs that are a direct result of a person's mental health needs not being met. It is difficult with current data and academic research to isolate these costs and address confounding factors that might otherwise explain a person's need for related services.

In the context of these limitations, the Commission has taken the following general approach:

- Estimates are based on service use patterns (for example, the additional use of homelessness services with an unmet need for mental health services), rather than service cost patterns (for example, the additional costs of providing homelessness services to a person with poor mental health, compared with someone without). This is because there is very limited Australian information on the latter.
- The approach has concentrated on the service areas with the largest crossover. As a result, this does not include all the possible related services that a person experiencing poor mental health might need to access.
- The best available data are used. This means the calculations use a mix of estimation approaches, depending on what data are available.

As a result of these factors, the estimates fall into three main categories, as shown in Table C.3.

It is worth noting that welfare payments could also be considered a related government service. Under economic analysis, however, this is considered a transfer, rather than a separate cost.

Table C.4 shows the data sources used for each related service.

C.3 Benefit estimates

The Commission has used a 'cost-of-illness study' approach to analyse the economic costs and potential benefits of an improved mental health system.

This analysis is additional to the cost estimates outlined in Section C.2, which estimate the economic cost of poor mental health from a 'top-down' perspective using data reported at the system or statewide levels.

In contrast, the cost-of-illness analysis uses individual-level reporting (via survey data) of service use and costs. This 'bottom-up' approach allows analysis of the costs of poor mental health per person, for different diagnoses and levels of need. It has also allowed the Commission to model 'benefit scenarios' from changing mental health outcomes at the system level, rather than modelling the impact of specific mental health interventions.

The following section outlines the analytical approach and data sources used.

C.3.1 Cost-of-illness approach

The cost-of-illness analysis is based on mental illness prevalence rather than incidence. This means the analysis can specify the costs of poor mental health for each year, but not the lifetime impact of poor mental health on a person or the cumulative impact on Victoria.⁶

There are three dimensions to the analysis, including:

- the prevalence of most common mental health diagnoses in Victoria
- the level of need (high, medium, low) by diagnosis in Victoria—this is based on survey data⁷ relating to the intensity of a person's symptoms and capacity to engage in day-to-day activities as they would like (by specific mental health diagnosis), which is assumed to translate into varying levels of need for ongoing mental health care, support and treatment
- the types of costs incurred by a person experiencing mental illness.

The analysis had to rely on a variety of data sources, because no single survey in Australia covers the most common mental health diagnoses.

Table C.5 shows the types of costs included in the analysis. Table C.6 shows the diagnosis groupings and how prevalence, levels of need and average cost estimates were derived.

Table C.3 Estimates of related government service use

Estimation technique	Service areas applied to
<p>Provided by service agency based on response to mental health events</p> <p>This estimate was provided by Victoria Police⁸ based on front line service responses to:</p> <ul style="list-style-type: none"> • 43,262 mental health–related events • 6,674 referrals to mental health treatment services • 20 Police, Ambulance and Clinical Early Response (PACER) units • The Victoria Police Fixated Threat Assessment Centre <p><i>multiplied by</i></p> <p>an estimated cost for each service activity based on a) the base salary rate of police members b) a 15 per cent loading for additional costs (e.g. payroll tax, superannuation, Work Cover, leave loadings). Victoria Police provided a range of costs based on different salaries of police who attend these events; the Commission has used an average across this range and indexed them to be in 2018–19 dollars.</p>	<ul style="list-style-type: none"> • Police
<p>Common clients</p> <p>Uses a population attributable fraction that is calculated as:</p> <ul style="list-style-type: none"> • proportion of clients who use a related service in the same year that they are also an active Victorian mental health client <p><i>multiplied by</i></p> <ul style="list-style-type: none"> • (proportion of clients who use a related service in the same year that they are also an active Victorian mental health client <i>minus</i> the proportion of the Victorian population who use a related service in a year) / (proportion of clients that utilise related service in the same year that they are also an active Victorian mental health client) <p><i>multiplied by</i></p> <ul style="list-style-type: none"> • total service expenditure 	<ul style="list-style-type: none"> • Alcohol and other drug services • Hospital services—admitted • Homelessness services • Social housing • Child protection • Corrections
<p>Self-reported use</p> <p>This is calculated as:</p> <ul style="list-style-type: none"> • the per person number of general practitioner visits for a non-mental health issue reported by people with a mental disorder⁹ <i>minus</i> the per person number of visits for a non-mental health issue reported by people with no mental disorder or mental health symptoms <p><i>multiplied by</i></p> <ul style="list-style-type: none"> • population of Victorians with a mental illness <p><i>multiplied by</i></p> <ul style="list-style-type: none"> • estimated government subsidy per service visit 	<ul style="list-style-type: none"> • GPs—non-mental health service use

Limitations

- This calculation does not account for dispatch events:
 - where mental health was a contributing cause but not the main cause listed in service records
 - initially classified as non-mental health related, but turned out to be mental health related
 - mental health-related events broader than the definition of 'psychiatric patient' or 'threat/attempt suicide'.
- These estimates are based on number of clients, rather than service use. Service use may have a different distribution; for example, if mental health consumers use a higher volume of services, on average, compared with other clients, this approach may underestimate the actual cost.
- Only services used in related service systems *in the same year* that the person is an active mental health client are included. The acute mental health system is highly rationed, so there is a much higher number of people whose mental illness may increase their use of related services that are not captured. As a result, this approach may underestimate the actual cost.
- Note:
 - For Corrections, the common client figure is based on people who were in custody, not necessarily in prison.
 - For Child Protection, the common client figure is based on children only and the total population used to calculate the attributable fraction was the Victorian population aged under 18 years.
- The total number of visits to the GP, and the related cost estimate, is likely to be an underestimate because it was derived indirectly.
- The non-mental health GP visits that can be attributed to poor mental health were estimated as the difference between service use for physical illness by people with a mental illness compared with people without a mental illness in the preceding 12 months.
- Both of these estimates were based on censored reporting:
 - Consultations for physical or mental health were originally coded to allow people to report up to 20 visits and then the last category was 21 or more. The last category was recoded to be 21 visits.
 - Consultations for mental health were originally coded to allow people to report up to six visits and then the last category was seven or more. The last category was recoded to be seventh visit.

Table C.4 Data sources for related services

Service area	Data for service event or common client estimate	Data for expenditure
Police	Information provided to the Commission in response to Commissioner Fels' question taken on notice regarding the dollar cost of mental health for Victoria Police, <i>Evidence of Glenn Weir</i> , 11 July 2019, p. 746	Information provided to the Commission in response to Commissioner Fels' question taken on notice regarding the dollar cost of mental health for Victoria Police, <i>Evidence of Glenn Weir</i> , 11 July 2019, p. 745–6
Alcohol and other drug services	Department of Health and Human Services (Victoria), <i>Integrated Data Resource</i> , Client Management Interface/Operational Data Store, Victorian Alcohol and Drug Collection 2015–16 to 2017–18	Victorian Government, p. 9
Hospital services—admitted	Department of Health and Human Services (Victoria), <i>Integrated Data Resource</i> , Client Management Interface/Operational Data Store, Victorian Admitted Episodes Dataset, 2015–16 to 2017–18	Productivity Commission, <i>Report on Government Services 2019: Public Hospitals – Attachment, Part E, Chapter 12: Tables 12A.1–12A.61</i> , 2019, Table 12A.57
Homelessness services	Department of Health and Human Services (Victoria), <i>Integrated Data Resource</i> , Client Management Interface/Operational Data Store, Victorian Homelessness Service Collection, 2015–16 to 2017–18	Productivity Commission, <i>Report on Government Services 2019: Homelessness Services – Attachment, Part G, Chapter 19: Tables 19A.1–19A.38</i> , 2019, Table 19A.1
Social housing	Department of Health and Human Services (Victoria), <i>Integrated Data Resource</i> , Client Management Interface/Operational Data Store, Victorian Housing Register, 2015–16 to 2017–18	Productivity Commission, <i>Report on Government Services 2019: Housing – Attachment, Part G, Chapter 18: Tables 18A.1–18A.52</i> , 2019, Table 18A.1
Child protection	Department of Health and Human Services (Victoria), <i>Integrated Data Resource</i> , Client Management Interface/Operational Data Store, Child Protection—Case Management 2015–16 to 2017–18	Productivity Commission, <i>Report on Government Services 2019: Child Protection Services – Attachment, Part F, Chapter 16: Tables 16A.1–16A.39</i> , 2019, Table 16A.7
Corrections	Department of Health and Human Services (Victoria), <i>Integrated Data Resource</i> , Client Management Interface/Operational Data Store, E-Justice 2015–16 to 2017–18	Productivity Commission, <i>Report on Government Services 2019: Corrective Services – Attachment, Part C, Chapter 8: Tables 8A.1–8A.21</i> , 2019, Table 8A.1
General practitioners	<i>Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing</i> , 2007	Commonwealth Department of Health, <i>Annual Medicare Statistics</i> < https://www1.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics > [accessed 21 October 2019]. Table 1.1

Table C.5 Cost categories in cost-of-illness analysis

Type of cost	Indicative basis ¹⁰	Split of costs by perspective
Hospital costs	<ul style="list-style-type: none"> Overall costs of hospital services were for mental or physical health conditions used by people with a mental health diagnosis. These were costed using the Australian-refined Diagnosis Related Groups, Independent Hospital Pricing Authority National Weighted Activity Unit and the National Efficient Price. Public hospital cost was used for both public and private hospital admissions, since many cost items arising in the public sector, such as medical salaries, pathology, pharmacy, imaging or allied health services, were not accounted for in private hospitals' unit costs. 	Costs to government Costs to individuals (out-of-pocket costs) and private services
Other health services	<ul style="list-style-type: none"> Costs of other health services were for mental or physical health conditions used by people with a mental health diagnosis. This includes GPs, psychiatrists, psychologists and other health professionals (for example, allied health). Other health service visits funded through public sources were costed using the MBS fees for 2013–14. For visits funded through private health insurance, unit costs from the Private Health Insurance Administration Council (2015) were applied. 	Costs to government Costs to individuals (out-of-pocket costs) and private services
Pharmaceuticals	<ul style="list-style-type: none"> Mental health-related medications were defined by five selected medication groups, as classified in the Anatomical Therapeutic Chemical (ATC) Classification System by WHO—namely, anti-psychotics (code N05A), anxiolytics (code N05B), hypnotics and sedatives (code N05C), anti-depressants (code N06A), and psychostimulants and nootropics (code N06B). These were costed using a weighted average cost of all forms and strengths for each medication listed in the 2013–14 PBS item reports. 	Costs to government Costs to individuals (out-of-pocket costs) and private services
Productivity loss	<ul style="list-style-type: none"> A human capital approach was used to value the self-reported total lost working days in the preceding 12 months attributed to mental health diagnoses. A daily wage rate was applied for people who reported their status as employed. 	Costs to individuals

Table C.6 Inputs and method for cost-of-illness analysis: a summary

Diagnoses	Prevalence	Level of need
Affective disorders, anxiety-related disorders, substance use disorder	<i>Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing 2007</i> uses two classification systems to define a mental health diagnosis—the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and the World Health Organization (WHO) International Classification of Diseases, Tenth Revision (ICD-10).	<ul style="list-style-type: none"> The three levels—low, medium and high—were defined using an Australian-refined ICD-10 version of the World Mental Health-CIDI 3.0 Survey Initiative severity measure applied to particular questions from <i>Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing 2007</i>. The measure considered the severity of symptoms (for example, experience of mania or attempted suicide) and the role of impairment according to the Sheehan Disability Scales.¹¹
Schizophrenia and other psychosis	The <i>Survey of High Impact Psychosis</i> (2010), as published in Amanda L Neil and others, 'Costs of Psychosis in 2010: Findings from the Second Australian National Survey of Psychosis', 2014, <i>Australian & New Zealand Journal of Psychiatry</i> , no. 48.2, pp. 169–82	<ul style="list-style-type: none"> The Commission derived this based on analysis of the Department of Health and Human Services, Client Management Interface/Operational Data Store. The data indicate receipt of public mental health services by people with a diagnosis of schizophrenia and other psychosis diagnosis. Level of need is then derived based on the following service use patterns: <ul style="list-style-type: none"> severe: 6+ admissions in a year, or any type of restraint, seclusion or order moderate: 1–5 admissions in a year or more than 12 contacts in a year mild: all others.
Eating disorders	The Commission estimated prevalence as 7 per cent, a conservative estimate. As published in the Australian Institute of Health and Welfare, <i>Australia's Health 2018, Australian Health Series No. 16. AUS 221</i> , 2018, p. 83, the prevalence of eating disorders for Australians aged 15 years or older is 4–16 per cent	<ul style="list-style-type: none"> The Commission derived this based on analysis of the Department of Health and Human Services, Client Management Interface/Operational Data Store. The data indicate receipt of public mental health services by people with an eating disorder diagnosis. Level of need is then derived based on the following service use patterns: <ul style="list-style-type: none"> severe: 6+ admissions in a year or any type of restraint, seclusion or order moderate: 1–5 admissions in a year, or more than 12 contacts in a year mild: all others.

Average cost and average health status

- Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing 2007*
 - Average health status by diagnosis and by impairment level, published in Catherine Mihalopoulos and others, 'Health state utility values of high prevalence mental disorders in Australia: Results from the National Survey of Mental Health and Wellbeing', 2018, *Quality of Life Research*, no. 27.7, pp. 1815–25.
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- The Commission derived this based on the average cost reported in the *Survey of High Impact Psychosis* (2010), as published in Amanda L Neil and others.
 - This study provides an average cost for all schizophrenia and other psychosis diagnoses. This was then differentiated across severity levels based on the cost distribution seen for affective disorders (given source data are available on this). The distribution is as follows:
 - severe: average cost as listed in Neil study
 - moderate: 55 per cent of severe average cost
 - mild: 35 per cent of severe average cost.
 - Average health status for people with schizophrenia was published in Amanda L. Neil and others, 'Health-related quality of life in people living with psychotic illness and factors associated with its variation', 2018, *Value in Health*, no. 21.8, pp. 1002–9. The Commission estimated the average health status by impairment level using this data and the differences between impairment level for other diagnoses published in the Mihalopoulos study, as cited.
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- The Commission derived this based on the average cost published in The Butterfly Foundation, *Paying the price: The economic social impact of eating disorders in Australia*, 2012.
 - This report provides an average cost for all eating disorders. This was then differentiated across severity levels based on the cost distribution seen for affective disorders (given source data are available for this). The distribution is as follows:
 - severe: average cost, as listed in the Butterfly Foundation report
 - moderate: 55 per cent of severe average cost
 - mild: 35 per cent of severe average cost.
 - Average health status is published in Long Khanh-Dao Le and others (2019), 'Burden and health state utility values of eating disorders: Results from a population-based survey', *Psychological Medicine*, 2019, pp. 1–8. The estimates from this study for threshold eating disorders were used for moderate disorders and sub-threshold eating disorders for mild disorders. Average health status for severe eating disorders was estimated using the differences between impairment levels for other diagnoses published in the Mihalopoulos study, as cited.
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Diagnoses	Prevalence	Level of need
Personality disorders	<p>Estimates from H. J. Jackson and P. M. Burgess (2000), 'Personality disorders in the community: A report from the Australian National Survey of Mental Health and Wellbeing', 2000, <i>Social Psychiatry and Psychiatric Epidemiology</i>, no. 35.12, pp. 531–38</p> <p>Six per cent has been taken as a conservative estimate</p>	<ul style="list-style-type: none"> The Commission derived this based on analysis of the Department of Health and Human Services, Client Management Interface/Operational Data Store. The data indicate receipt of public mental health services by people with diagnosis of a personality disorder (as defined in the ICD-10). Level of need is then derived based on the following service use pattern: <ul style="list-style-type: none"> severe: 6+ admissions in a year or any type of restraint, seclusion or order moderate: 1–5 admissions in a year, or more than 12 contacts in a year mild: all others.
Other disorders	<p><i>Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results 2007, 2008, p. 28</i></p>	<ul style="list-style-type: none"> The Commission derived this based on analysis of the Department of Health and Human Services, Client Management Interface/Operational Data Store. The data show if someone has been in the acute or mental health system to receive care for a disorder not listed in the table above. Level of need is then derived based on the following service use pattern: <ul style="list-style-type: none"> severe: 6+ admissions in a year or any type of restraint, seclusion or order moderate: 1–5 admissions in a year, or more than 12 contacts in a year mild: all others.

Note 'disorder' is not the Commission's preferred term, because it frames the impact as a deficit and adds to the stigma associated with people living with mental illness. The term is, however, used in this context to make it clear what data have been used for the economic analysis. The analysis uses this term as per the International Statistical Classification of Diseases and Related Health Problems.

C.3.2 Benefit scenarios and estimates

The Commission has not sought to analyse the costs and benefits of specific interventions or practices for this report. Instead, its aim was to consider the potential returns from a system that would deliver better mental health outcomes. Such a system would mean fewer people experiencing poor mental health because they received evidence-based care when they needed it.

Benefit scenarios

The Commission considered two 'benefit scenarios' that would follow logically from a more effective mental health system:

- Lower levels of need.* An improved mental health system would result in more effective support for people living with a mental health diagnosis and so reduce the intensity of their symptoms, improve their capacity to engage in day-to-day life as they would like, and in turn reduce their level of need for ongoing mental health care, support and treatment.

Average cost and average health status

- The Commission derived this based on the average cost for consumers with severe affective, anxiety and substance use disorders (given source data are available on this).
- This is then differentiated across severity levels based on the cost distribution seen for affective disorders (given source data are available on this). The distribution is as follows:
 - severe: average cost for severe illness across high-prevalence conditions
 - moderate: 55 per cent of severe average cost
 - mild: 35 per cent of severe average cost.

-
- The Commission derived this based on the average cost for consumers with severe affective, anxiety and substance use disorders (given source data are available on this).
 - This was then differentiated across severity levels based on the cost distribution seen for affective disorders (given source data are available on this). The distribution is as follows:
 - severe: average cost for severe illness across high-prevalence conditions
 - moderate: 55 per cent of severe average cost
 - mild: 35 per cent of severe average cost.
-

- *Lower prevalence levels.* People at risk of poor mental health are being supported to delay the onset of, or avoid developing, a diagnosable illness or to recover from an experience of poor mental health.

In keeping with similar public policy reform analysis, the Commission also considered a third scenario based directly on productivity and participation:

- *Lower productivity loss.* People who are living with a mental health diagnosis are being supported to work and to be less impeded while at work. This scenario drew on rates of labour force participation and productivity in comparable countries (described in Chapter 12).

Benefit estimates

The three hypothetical benefit scenarios were designed as follows:

- Lower levels of need – 15 per cent of those experiencing a high level of need were assumed to instead experience a medium level of need and 15 per cent of those experiencing a medium level of need were assumed to instead experience a low level of need.

- Lower prevalence levels – this is the same as for lower levels of need, but it was also assumed that 15 per cent of the low-level group went on to have no ongoing mental health diagnosis.
- Lower productivity loss – it was assumed that productivity costs could be reduced by 15 per cent with improved support for participation and absenteeism.

The estimated 'benefit' of each of the scenarios (shown in Table C.7) was then calculated for:

- economic benefit—estimating the percentage change in costs compared with the base-case cost of illness analysis under each scenario and applying this percentage change to the top-down costs related to lower labour force participation (due to forgone wages and unpaid care) and lost productivity among those already in the labour force
- health benefit—estimating the change in quality-adjusted life-years by diagnosis and level of need. Because of the limited data, this is based only on a subset of diagnoses (it does not account for personality or other disorders).

Table C.7 Summary of benefit estimates across three scenarios

Type of benefit	Scenarios		
	Level of need reduction	Prevalence reduction	Productivity loss reduction
Economic benefit	\$1,062.6 million	\$1,743.3 million	\$1,743.3 million
Health benefit	23,505 quality-adjusted life-years gained	121,460 quality-adjusted life-years gained	Not applicable

C.4 Relationship to the Productivity Commission's mental health economic analysis

On 31 October 2019, the Productivity Commission released its draft report on mental health, which contained a number of estimates similar to those provided in Chapter 12.

C.4.1 Differences across all types of estimates

The Productivity Commission's approach differs from this report in three respects:

- It has a national perspective, with collective estimates for all state and territory governments, so the estimates are not specific to Victoria.
- It adopts a different scope for analysing 'mental illness', and separately analyses the cost of suicide.
- It uses different data sets for its economic analysis, focusing on a more general measure of mental wellbeing,¹² whereas the Royal Commission has focused on data based on mental health diagnoses.¹³

C.4.2 The economic costs of poor mental health

The two reports provide very similar estimates of the economic costs of poor mental health. This includes comparable estimates of out-of-pocket costs for individuals, the value of unpaid care provided by families and other carers, and the costs of delivering mental health services funded by the Commonwealth Government, the Victorian Government and private health insurers.

They differ in two respects:

- Productivity loss estimates – both reports estimate productivity losses based on the counterfactual that a person's ability to find a job and participate in work is not inhibited by mental illness. They do, however, use different underlying source data and a different methodological approach, making comparisons difficult.
- Related (non-mental health) government services – when estimating the costs of poor mental health to broader government services, the Productivity Commission uses a similar methodology, but generally analyses 'common clients' based on people using other services where they reported experiencing a mental illness. The Royal Commission's analysis uses a more conservative definition of common clients, requiring people to be clients in the acute mental health system (not just experiencing mental illness) within the same year as using the other service.

C.4.3 Quality-of-life costs

The Productivity Commission provides an estimate of the cost of disability and premature death due to mental illness (\$130 billion), and of suicide and suicide attempts (\$16 billion and \$34 billion).¹⁴ The Royal Commission has not estimated these costs.

C.4.4 Benefits of reform

The two reports adopt notably different approaches to estimating the benefits for reforming the mental health system:

- The Productivity Commission estimates the benefits for individual recommendations and combines these to provide a total benefit, whereas the Royal Commission estimates benefits based on a change in outcomes at the system level (given it is yet to determine the suite of interventions needed in Victoria's future mental health system to deliver these improved outcomes).
- The scope of the Productivity Commission's benefit estimates is much broader—for example, improved social and emotional learning in early childhood and school education is estimated to benefit more than 6.3 million people¹⁵—whereas the Royal Commission's benefit estimates focus on the experience of people currently living with a mental health diagnosis.

The benefit estimates are therefore not directly comparable.

C.5 Explanation of economic and investment terms

The following terms are used in Chapters 12 and 20.

Annual indexation	Also referred to as an escalation factor, being the overall factor or percentage that is applied to base funding to account for price inflation, service-specific cost drivers and productivity improvements. ¹⁶
Base funding	The existing funding level provided to deliver an output in a given year, at a price based on agreed levels of quantity, quality, price per unit and timeliness. ¹⁷
Capital funding	Money from the Victorian Government that is used to produce or buy physical infrastructure and other assets. ¹⁸
Economic activity	The goods and services bought and sold in Victoria. The collective value of this activity is measured via Victoria's gross state product. This does not account for all goods and services provided (for example, those provided unpaid in the home).
Economic benefits	Used in the Commission's economic analysis to capture improvements in labour force participation rates and productivity among those in work. These changes are understood to generate higher economic activity.
Economic costs	The combination of: <ul style="list-style-type: none"> • direct costs due to poor mental health that are currently paid (for example, fees to see a doctor) • opportunity costs that consider the alternative potential uses of a person or organisation's time and resources with improved mental health.
Existing funding commitments	Used by the Commission to refer to: <ul style="list-style-type: none"> • operational funding currently provided for mental health services under the output funding model, including base funding, annual indexation and currently time-limited (lapsing) funding commitments relevant to ongoing service delivery and <ul style="list-style-type: none"> • capital funding currently provided to build, improve or maintain infrastructure in the mental health system.
General revenue	The pool of revenue, accessed via the Consolidated Fund, allocated as part of the Victorian State Budget (as annual appropriations). ¹⁹
Health inflation	The rise in the price of goods and services in the health sector.
Hospital private health insurance cover	Private insurance cover for the cost of in-hospital treatment by medical practitioners, and hospital costs such as accommodation and theatre fees.

Investment	All money from the Victorian Government that is provided to deliver mental health services.
Level of need	Used in the Commission's economic analysis to consider the intensity of a person's symptoms and capacity to engage in day-to-day activities as they would like, by specific mental health diagnosis.
Quality-adjusted life-year	A measure used in economic evaluations of health interventions. States of health are assigned a health state preference of 'utility' value on a scale of 1.0 (full health) and 0 (death). The amount of time an individual spends in a given health state is multiplied by the health state preference value to calculate the quality-adjusted life-years, or QALYs, gained.
Operational funding	Money from the Victorian Government that is used to deliver services, including wages, the purchase of goods and interest on borrowings. ²⁰
Output funding	Money from the Victorian Government that is used to produce or buy goods and services. This is referred to as a combination of 'base funding' (for example, the current level of funding provided each year for the mental health output) and 'annual growth' (for example, indexation to account for price inflation and typical efficiency expectations, and additional allocations to account for changes in demand). ²¹
Output performance measures	Measures that specify a government department's expected service delivery performance for a given output. ²² The measures are expressed in terms of quantity, quality, timeliness and cost. ²³
Personal costs	Costs of poor mental health that do not have a monetary value, including poorer health, shorter life expectancy, and social detriments such as discrimination and isolation.
Productivity	The efficiency with which inputs (such as labour) are converted into outputs (such as goods and services). Growth in productivity can lead to improvements in living standards.
Recurrent expenditure	Spending (expenditure) on goods and services that are used during the year (for example, salaries). In contrast with capital expenditure, recurrent expenditure does not result in the acquisition or enhancement of an asset. Examples of recurrent expenditure are salary and wages expenditure, and non-salary expenditure, such as payments to visiting medical officers.
Revenue mechanism	A way in which governments raise and collect money.

- 1 Council of Australian Governments, 'Schedule 1 – Addendum to the National Health Reform Agreement: Revised Public Hospital Arrangements', 2017, p. 8.
- 2 Council of Australian Governments, 'Schedule 1 – Addendum to the National Health Reform Agreement: Revised Public Hospital Arrangements', p. 5.
- 3 National Health Funding Body, *National Report: Public Hospital Funding – June 2019* <<https://reports.publichospitalfunding.gov.au/Reports/national?month=jun2019>> [accessed 21 October 2019].
- 4 Council of Australian Governments, 2019 *Bilateral Agreement between the Commonwealth of Australia and Victoria on the National Disability Insurance Scheme*, Schedule A, para. 4.
- 5 Council of Australian Governments, 2019 *Bilateral Agreement between the Commonwealth of Australia and Victoria on the National Disability Insurance Scheme*, Schedule A, paras. 8 and 9.
- 6 Rosanna Tarricone, 2006 'Cost-of-Illness Analysis. What Room in Health Economics?', *Health Policy*, no. 77, pp. 51–63 (p. 53).
- 7 Tim Slade and others, 2009 *The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing* (Commonwealth Department of Health and Ageing, May 2009), p. 59.
- 8 Information provided to the Commission in response to Commissioner Fels' question taken on notice regarding the dollar cost of mental health for Victoria Police, *Evidence of Glenn Weir*, 11 July 2019, p. 745–6.
- 9 This is terminology used in the underlying data source, Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results 2007: Tables 1–15*, 2008.
- 10 The descriptions in this table apply to the main data source used, the 2007 *National Survey of Mental Health and Wellbeing*.
- 11 Slade and others, p. 59.
- 12 The Productivity Commission analysis uses the *Household, Income and Labour Dynamics in Australia* (HILDA) survey and its *Mental Health Inventory* survey (MHI-5) and the Kessler Psychological Distress Scale (K-10) to measure mental health prevalence.
Productivity Commission, 2019 *Draft Report on Mental Health: Volume 2 – Appendix F: Economic Benefits*, October 2019, p. 8; Productivity Commission, *Draft Report on Mental Health*, vol. 2, October 2019, p. 1144.
- 13 Using sources such as the *National Survey of Mental Health and Wellbeing* and the *Survey of High Impact Psychosis*, which are more likely to capture severe or low-prevalence mental illnesses and focus on people who have received a diagnosis for their mental illness.
Australian Bureau of Statistics, 2008 *National Survey of Mental Health and Wellbeing: Summary of Results 2007*, p. 5; Amanda L Neil and others, 2014 'Costs of Psychosis in 2010: Findings from the Second Australian National Survey of Psychosis', *Australian & New Zealand Journal of Psychiatry*, vol. 48.2, pp. 169–82 (p. 170).
- 14 Productivity Commission, 2019 *Draft Report on Mental Health*, vol 1, October 2019, p. 171.
- 15 Productivity Commission, 2019 *Draft Report on Mental Health*, vol 2, October 2019, p. 1044.
- 16 Department of Treasury and Finance, 2018 *Treasury and Finance Glossary for Budget and Financial Reports*, pp. 9 and 14.
- 17 Department of Treasury and Finance, p. 4.
- 18 See 'capital investment' definition in Department of Treasury and Finance, p. 5.
- 19 For further details, see definitions of 'Appropriation' and 'Consolidated Fund' in Department of the Treasury and Finance, 2017 *Budget Operations Framework: For Victorian Government Departments*, February 2017, p. 4.
- 20 See 'recurrent/operating expenses' in Department of Treasury and Finance, p. 26.
- 21 See definitions for 'base funding', 'indexation' and 'output' in Department of Treasury and Finance, pp. 4, 14 and 22.
- 22 Department of Treasury and Finance, p. 22.
- 23 Department of Treasury and Finance, p. 23.

Appendix D

Data quality statement

D.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 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.

D.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.

D.3 Sources

Most of the data sources are Victorian collections managed by Victorian Government departments or agencies.

Two 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, Client Management Interface/ Operational Data Store 2007–08 to 2017–18 (extracted 11 August 2019) and 2018–2019 (extracted 11 October 2019).

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.

D.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.

D.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.

D.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 31 December.
- 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.

D.7 Annual rates of change

Annual rates of change or growth rates have been calculated as geometric rates:

$$\text{Compound annual growth rate} = ((P_n/P_o)^{(1/n)} - 1) \times 100$$

where P_n = value in later time period

P_o = 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.

D.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.

Glossary

The Commission notes that several of the definitions within this glossary differ from 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 will inquire into all matters as per the expectations set in the Letters Patent.

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 2018–2023.¹

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.²

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 people. Refer to Appendix B for more information.

Area mental health service

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. Refer to Appendix B for more information.

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. Refer to Appendix B for more information.

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 is also used to refer to care provided to patients of community-based (non-hospital) health-care services. ³
Assertive outreach	<p>'Assertive outreach' is a term that can apply to a broad range of models of care that are delivered in different service contexts. Generally, assertive outreach recognises that some people may require services to be more proactive in engaging or following up with them.</p> <p>Traditionally, assertive outreach models have included low caseloads, a multidisciplinary team, availability outside business hours, team autonomy and psychiatrist input.</p> <p>A variety of assertive outreach models are now in operation in Australia and internationally.</p>
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. This definition is consistent with the Commission's Letters Patent.
Community care unit	Units that provide clinical care and rehabilitation services in a homelike environment.
Community health services and integrated care services	Victoria's community health services provide primary health, human services and community-based supports to meet local community needs. Refer to Appendix B for more information.
Comorbidity	A situation where a person has two or more health problems at the same time. Also known as multimorbidity.
Compulsory patient	Under s. 3 of Victoria's <i>Mental Health Act 2014</i> a compulsory patient means a person who is subject to an assessment order, a court assessment order, a temporary treatment order or a treatment order.
Compulsory treatment	The treatment of a person for their mental illness without their consent under Victoria's <i>Mental Health Act 2014</i> . To be provided with compulsory treatment a person must be a compulsory patient under the Act.

Consumer	'People who identify as having a living or lived experience of mental illness, irrespective of whether they have a formal diagnosis, who have accessed mental health services and/or received treatment.' ⁴
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.' ⁵ 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 that may provide compulsory assessment and treatment to people in accordance with Victoria's <i>Mental Health Act 2014</i> .
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).
Family	Refers to either family of origin or family of choice. This definition is consistent with the Commission's Letters Patent.
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. Refer to Appendix B for more information.
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.

Integrated care service	A service that provides a range of services and supports, including primary care and mental health care. Refer to Appendix B for more information.
Lived experience (mental illness)	<p>People with lived experience identify either as someone who is living with (or has lived with) mental illness or someone who is caring for or otherwise supporting (or has cared for or otherwise supported, including family) a person who is living with (or has lived with) mental illness.</p> <p>People with lived experience are sometimes referred to as 'consumers' and 'carers'. The Commission acknowledges that the experiences of consumers and carers are different.</p>
Lived experience (suicide)	People who think about suicide, people who have attempted suicide, people who care for someone with suicidal behaviour, people who are bereaved by suicide, and people who are affected by suicide in some other way such as a workplace incident.
Medicare-subsidised mental health-specific service	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. Refer to Appendix B for more information.
Mental illness	Under s. 4 of Victoria's <i>Mental Health Act 2014</i> mental illness is defined as a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.
Mental health system	An 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. Refer to Appendix B for more information.
Poor mental health	Combined term for referring to mental illness and psychological distress.
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. Refer to Appendix B for more information.

Primary care services	Services delivered in many settings—such as general practices, community health centres, Aboriginal health services and allied health practices (for example, physiotherapy, dietetic and chiropractic practices)—and coming under numerous funding arrangements. Refer to Appendix B for more information about primary care and other services that provide a first or early point of contact for people experiencing poor mental health.
Private hospital	Includes acute care and psychiatric hospitals, as well as private freestanding hospitals that provide day-only services. Fifteen private hospitals offered mental health care in Victoria in 2018–19. Refer to Appendix B for more information.
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. Refer to Appendix B for more information.
Psychological distress	‘One measure of poor mental health, which can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness.’ ⁶
Psychosocial support service	Psychosocial supports focus on recovery, rehabilitation, wellbeing and community participation. These services offer treatment, care and support to people living with mental illness in a community setting or outpatient setting, and can also provide ongoing support in a community or outpatient setting for people with a chronic or severe mental illness. Refer to Appendix B for more information.
Public specialist mental health service	Public specialist mental health services 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.
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. Refer to Appendix B for more information.
Self-determination	‘The ability of Aboriginal peoples to freely determine their own political, economic, social and cultural development as an essential approach to overcoming Indigenous disadvantage.’ ⁷

Social and emotional wellbeing	Being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life.
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Statewide and regional specialist services	Specialist mental health services that provide highly specialised treatment and care to Victorians with severe and complex mental illnesses. These services are delivered by health services on a statewide or regional basis. Refer to Appendix B for more information.
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- 1 Victorian Government, *Victorian Aboriginal Affairs Framework; 2018-2023*, 2018, p. 1.
 - 2 National Aboriginal Community Controlled Health Organisation, *Submission to Productivity Commission: Inquiry into Human Services: Identifying Sectors for Reform*, July 2016, p. 4.
 - 3 Australian Institute of Health and Welfare 2007. Mental health services in Australia 2004–05. AIHW cat. no. HSE 47. Canberra: AIHW (Mental Health Series no. 9).
 - 4 National Mental Health Commission, *Monitoring Mental Health and Suicide Prevention Reform: National Report 2019*, 2019, p. 86.
 - 5 P Dudgeon, H Milroy and R Walker (eds.), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, (Canberra: Commonwealth, 2014), p. 544.
 - 6 National Mental Health Commission, p. 88.
 - 7 Dudgeon, Milroy, and Walker, p. 548.

