Annual Report 2023-24

Mental Health & Wellbeing Commission

Mental Health & Wellbeing Commission

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31 October 2024
Ingrid Stitt, MP
Minister for Mental Health
50 Lonsdale Street
Naarm / Melbourne VIC 3000

Dear Minister,

I am pleased to provide you with the Mental Health and Wellbeing Commission's (the Commission's) Annual Report.

As required under section 427 of the *Mental Health and Wellbeing Act 2022* (the Act), this document is a report on the performance of the Commission's functions under the Act during the financial year 2023 -2024. As the Commission came into effect on 1 September 2023, this report will cover the period from 1 September – 30 June 2024.

I trust this Annual Report will help to inform the Parliament, consumers and their families, carers, supporters and kin, mental health and wellbeing services and the wider Victorian community about our key safeguarding, oversight and service improvement roles under the Act.

Yours sincerely

Treasure Jennings
Chair Commissioner,
Mental Health and Wellbeing Commission

Level 26, 570 Bourke Street
Naarm / Melbourne Vic 3000

Acknowledgement of Country

The Mental Health and Wellbeing Commission acknowledges with deep respect all First Nations and Traditional Owners groups within Victoria. We recognise their enduring connections to Country, Culture and Kin, a connection that has been nurtured for over 60,000 years.

We acknowledge government's role in the devasting impacts of colonisation, the displacement and dispossession of First Nations people, and the ongoing social, emotional, biological and political consequences.

The Commission is committed to Reconciliation and Aboriginal self-determination, working towards equality of outcomes and ensuring an equitable voice.

We pay our deepest respects to Elders past and present, recognising their ongoing resilience, wisdom, and leadership. We acknowledge that this land was, is and always will be Aboriginal land.

Recognition of lived experience

We are driven by the voice, expertise and wisdom of people with lived experience of mental ill health and psychological distress and all those who care for them including family, carers, supporters and kin. We honour and respect lived experience in all our work, and we thank you for working in partnership to achieve system transformation.

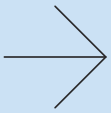
Throughout this report, we use the term lived experience to refer to people with personal experience of mental ill health and recovery or people with personal experience as a family member, carer, supporter or kin of a person living with mental ill-health and recovery.

Language used in this report

This Annual Report uses the words and language of the Mental Health and Wellbeing Act 2022 and the Royal Commission into Victoria's Mental Health System. Please consult the glossary table from the Royal Commission's final report and Section 3 of the Act for definitions of key terms.

As the Royal Commission into Victoria's Mental Health System's final report said: "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."

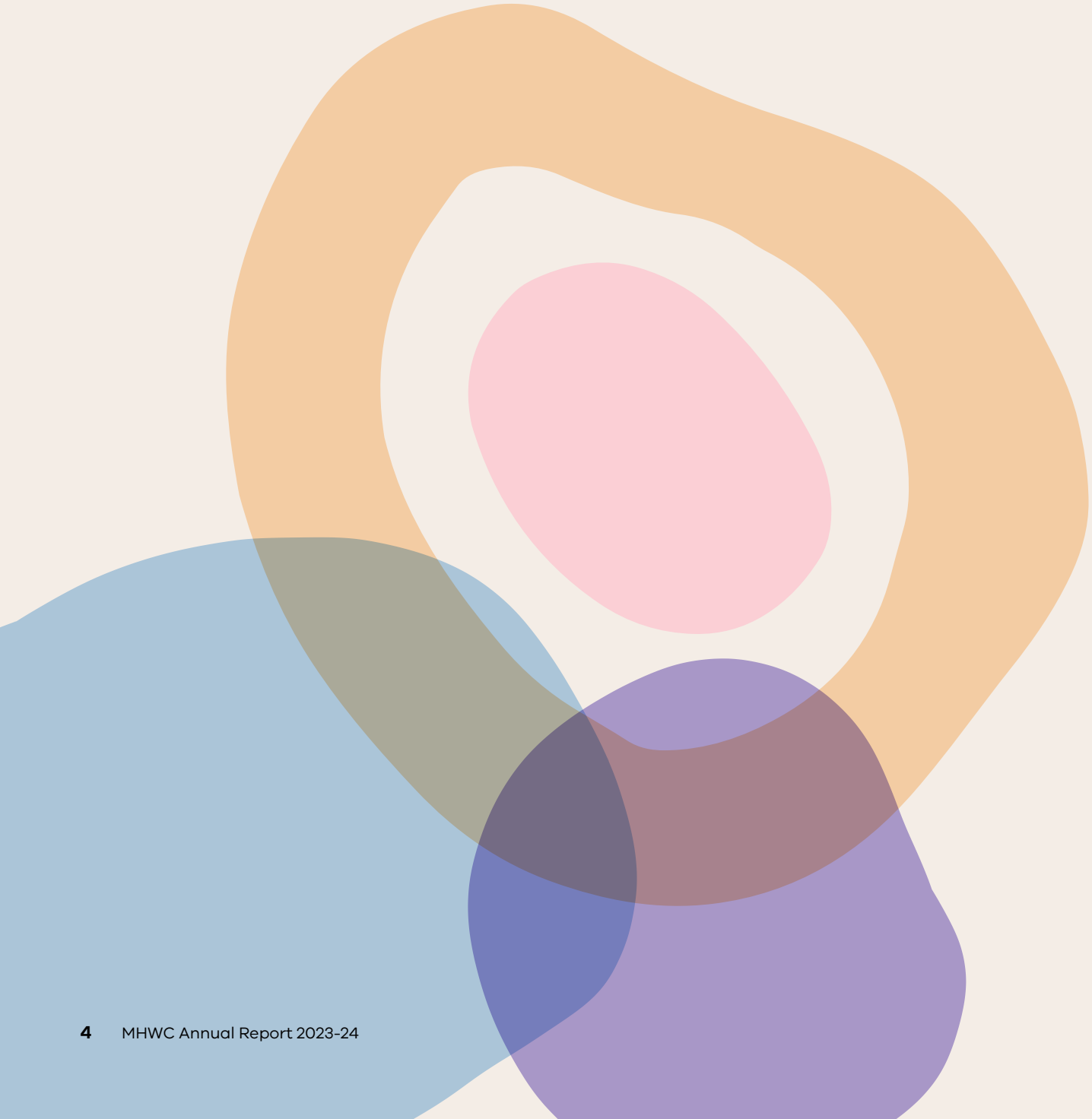
We acknowledge that the language used in this report may not reflect the views and preferences of all people. At the Commission, we have an adaptive approach to language use and preferred terminology. We regularly review and update our language use in line with community and lived experience expectations, and we consult best-practice guidance in the mental health and wellbeing sector. The language that the Commission uses will continue to change and evolve, and we always welcome feedback.



Content warning

Please note that the content in this report may be distressing to some readers. Sections of this report refer to suicide, self-harm and the use of restrictive interventions. Reader caution is advised.

About this report



The Mental Health and Wellbeing Commission was established on 1 September 2023. This report covers our first ten months of operations and has been structured to acquit against the areas outlined in s427 of the Mental Health and Wellbeing Act 2022.

As a new entity, much of the first year focussed on building our resources and capability to deliver our objectives and functions as outlined in the Act.

We developed a strategic directions document to guide us during our establishment phase and outline to the Victorian community how we will contribute to system improvement as we also grow and shape our culture.

We have been designing how we will work and what we will work on, engaging to build relationships and trust, and taking action through the implementation of our plans.

We have transitioned staff from the former Mental Health Complaints Commissioner and spent time recruiting new staff to help us fulfil our new responsibilities outlined under the Act.

We have appointed key leadership positions including CEO, General Counsel, General Manager Lived Experience, General Manager System Performance and Monitoring and General Manager Communications and Engagement.

As an establishment year there has been a strong inward focus on ensuring we have the right people with the right skills and shared values to influence and help bring about meaningful change in the mental health and wellbeing system.

This report outlines what we have achieved towards system reform while also growing our capability to contribute to further improvements in the future.

Who we are

The Mental Health and Wellbeing Commission (the Commission) is an independent statutory authority that holds government to account for the performance, quality and safety of Victoria's mental health and wellbeing system.

The Commission was established on 1 September 2023, in line with a recommendation of the Royal Commission into Victoria's Mental Health System.

The Commission promotes, supports and protects the rights of consumers and their families, carers, supporters and kin. As an independent body, the Commission has the powers necessary to perform its functions under the Act. These functions include dealing with complaints, initiating investigations, conducting inquiries, sharing data, reporting on the performance, quality, and safety of Victoria's mental health and wellbeing system, and making recommendations to the Premier, Minister, and heads of public service bodies.

The Commission is led by Chair Commissioner Treasure Jennings, Lived Experience Consumer Commissioner Maggie Toko, Lived Experience Carer Commissioner Jacqueline Gibson and Commissioner Annabel Brebner. Each of the Commissioners brings lived and or living experience to their role.

The hope of the Commission is that all Victorians are socially and emotionally well and can live the life they want to live. This means they can choose and access safe services when and where they need them.

Our purpose

To ensure our work shines a light on systemic issues in the mental health and wellbeing system that hold back progress, as well as recognise what works well.

Our commitment:

At the Commission we have made a commitment to be:

- Fearlessly independent
- Grounded in the expertise of people with lived experience
- Brave, fair, impartial and transparent in our work
- An exemplar organisation for lived experience leadership
- A voice for inclusion, understanding and compassion
- Focused on addressing the most important issues at the time that best serve the public interest.

Our functions

Under the Act, the Mental Health and Wellbeing Commission has the following functions and powers:

- Hold the government to account for:
  I. the performance, quality and safety of the mental health and wellbeing system, including the implementation of recommendations made by the Royal Commission into Victoria's Mental Health System; and
  II. ensuring the mental health and wellbeing system supports and promotes the health and wellbeing of consumers, families, carers and supporters and the mental health and wellbeing workforce.
- Design and deliver initiatives that create awareness of people with lived experience and their unique experiences, including promoting the role of families, carers, supporters and kin of persons living with mental illness or psychological distress.
- Handle complaints about Victorian publicly funded mental health and wellbeing services, which include mental health and wellbeing services run and delivered by a public hospital in Victoria.
- Elevate lived experience leadership and support effective participation of people with lived experience in decision-making processes.
- Lead and support initiatives to prevent and address stigma related to mental illness.
- Monitor and report on the performance, quality and safety of the mental health and wellbeing system.
- Report on the use of restrictive interventions in designated public mental health and wellbeing services.
- Monitor and report on the progress to improve the mental health and wellbeing of the Victorian community.
- Monitor and report on the progress of implementing the recommendations made by the Royal Commission into Victoria's mental health system.
- Promote effective complaint handling by public mental health and wellbeing service providers.
- Make recommendations to the Premier, Minister and heads of public service bodies.
- Promote and support compliance with the Act and report significant breaches of the Act to the Health Secretary.

Commissioners' message

Since the Mental Health and Wellbeing Commission (the Commission) was established on 1 September 2023, our focus has been on listening, learning, and laying the groundwork for meaningful change.

This Annual Report reflects the insights we've gained and the actions we've taken during the Commission's first 10 months of operation. Much of our work is ongoing, and we are focused on creating the conditions necessary for meaningful and lasting change in Victoria's mental health and wellbeing system.

Over the past 10 months, we have built our capacity and capability across lived experience, data analysis, investigations, legal, and people and culture. Alongside our lived experience and resolution teams, we have engaged in rich conversations across the mental health and wellbeing sector, particularly with people with lived experience. These discussions have been foundational in gathering insights so we can effectively fulfill our legislative role and support genuine system reform.

In October 2023, we released Our Strategic Direction for year one, a document that continues our commitment to ground everything we do in lived experience.

We have committed to delivering a Lived Experience Plan, a Stakeholder Engagement Framework, a Monitoring and Performance Plan, our Approach to Complaint Handling and Compliance and an Annual Plan to address systemic issues. Each of these plans is well progressed and shaped by valuable input and feedback from voices across the mental health sector. This is to ensure our work reflects the needs and aspirations of consumers, carers, families, supporters and kin while also meeting our legislative functions.

The Lived Experience Plan outlines the core activities of our dedicated team for 2024-2025 and beyond.

This plan demonstrates how lived experience perspectives inform all aspects of the Commission's operations, from recruitment to our broader policies and processes. This work has involved deep collaboration with consumers, families, carers, supporters and kin and we look forward to launching it publicly in the coming months.

The Commission takes pride in integrating lived experience perspectives into all facets of our work, reflected in our staffing, documentation, and connections with the lived experience sector.

We fully embrace the specialised values cultivated by the consumer and carer movements, ensuring that we, as an organisation, genuinely represent the voices of those who have experience of the mental health system. This commitment has led us to ask important questions about power and decision-making and engage in challenging but necessary conversations to ensure we deliver on our responsibilities.

With the introduction of mandatory reporting of restrictive interventions on 1 April 2024 for all people receiving mental health and wellbeing services in Emergency Departments of designated mental health services, we renewed our call for expanded oversight and safeguards legislation. We are seeking the Victorian government to apply these measures to all Emergency Departments in public hospitals and not just in Designated Mental Health Services, and where a restrictive intervention is used in a public hospital outside of the Mental Health and Wellbeing Act.

In July 2024, we published our policy for Exploring issues through inquiries and systemic reviews, which includes a platform on our website where the public can share their concerns about the mental health and wellbeing system with us.

We are currently finalising Our Approach to Complaint Handling and Compliance Monitoring, which demonstrates how the Commission exercises its powers relating to compliance, as they arise from single complaints and investigations as well as broader concerns that may be systemic in nature across a service or the health care system. This approach has been developed and embedded with a lived experience perspective and takes a person-centred perspective to complaint handling and resolution.

We acknowledge that many people felt uncertain about the pace of implementing the recommendations of the Royal Commission's final report following the 2024-25 Victorian State Budget. We continue to urge the government to be transparent and specific about its revised implementation plans, and to prioritise initiatives that address workforce shortages. We are seeking the answers and direction that consumers, carers, family, supporters and the wider mental health sector need.

Since establishment, we have also continued the important work of the former Mental Health Complaints Commissioner, handling complaints, making recommendations for service improvements, and ensuring these improvements are implemented. Details of our compliance activities – including investigations and enforceable undertakings – are outlined in this report.

Our inward focus has included the appointment of key leadership roles, such as our CEO Simon McKenzie, and the creation of a dedicated Lived Experience Team led by General Manager Danilo Di Giacomo.

We acknowledge the dedication and adaptability of our team, which has formed the backbone of the Commission throughout its establishment. Our team is comprised of compassionate individuals committed to improving mental health outcomes for the Victorian community. This work is not easy, and we thank them for their tireless efforts.

In the following pages, you will find a comprehensive overview of our establishment activities and work over the past 10 months. We have structured this report to cover what we have done at the Commission over this reporting period, what we have seen through our system monitoring and oversight functions and what we have heard through our engagement and consultation activities.

Looking ahead, we remain steadfast in our commitment to shedding light on systemic issues within the mental health and wellbeing system, contributing to continuous improvement across the sector, and ensuring that all Victorians have access to, and positive experiences with, mental health and wellbeing services.

This work will be guided by our upcoming three-year strategy, which outlines the Commission's priorities and goals. Currently in development, the strategy will be released later this year.

Finally, we extend our deepest thanks to everyone who has engaged and connected with us, including mental health and wellbeing services and lived experience experts, for your insight and valuable feedback throughout the Commission's planning and establishment year.

We have an exciting future ahead, and by working together, we can drive change and ensure that all Victorian consumers, carers, families, supporters and kin have access to effective treatment, care, and support.

Chair Commissioner Treasure Jennings

Commissioner Maggie Toko

Commissioner Jacqueline Gibson and

Commissioner Annabel Brebner

Message from the CEO

The first year of the Mental Health and Wellbeing Commission has seen enormous growth, development and adaptation of our operations to meet the objectives and functions set out in the Mental Health and Wellbeing Act 2022 (the Act).

I joined the Commission's senior leadership team in September 2023. It's been a privilege to be the inaugural Chief Executive Officer (CEO) of the Commission, setting up ways of working and managing the day-to-day operations of the Commission. This work has involved close collaboration with the commissioners as they set the strategic direction for the Commission, including providing oversight of system performance and insight into system improvement.

A priority for me has been on building the capacity of our team. The new Act has introduced new functions that the Commission must acquit, and new skill sets were required to administer and deliver these functions, including revised compliance and system oversight powers. Attracting great people, and ensuring that staff feel supported, safe and empowered to do meaningful, important work in the context of Victoria's mental health reforms is a key driver of our operations.

Our success hinges on our ability to form genuine working partnerships across the mental health and wellbeing sector. Meaningful collaboration and engagement have informed so much of our establishment work, and I was proud to be a part of the steering committee developing the Commission's first Lived Experience Plan. This plan sets out how we will elevate lived experience leadership and participation in system reform. We were intentional in how we created senior designated lived experience roles, and worked with our Lived Experience Team to ensure lived experience expertise is genuinely embedded in decision-making across the Commission. Leading by example in elevating lived experience leadership is a key strategic pillar of the Commission.

As a new, independent statutory entity, the Commission has been particularly concerned with establishing systems, processes and structures to support meeting our legislative and regulatory obligations aimed at good public administration, risk management, financial responsibility, records management and data security. I am proud of the work we have done in this space, establishing policies and protocols that ensure we operate efficiently and with best practices always in mind. The Commission accurately managed its budgeted funding in its first year of operation, remaining vigilant of the need to balance financial responsibility and constraints with capacity building.

There is much to be proud of in our first 10 months, and I would like to thank the staff of the Commission for their unrelenting commitment and focus on the objectives of the Act.

I would also like to sincerely thank everyone who has worked with us, contributed to our engagement and consultation processes, provided feedback and met with us in our establishment year. System reform is a challenging process, but your contributions, and commitment to improving the system for all those who use it, are what make system transformation possible.

Simon McKenzie
CEO

Our leadership team

Chair Commissioner – Treasure Jennings

Treasure Jennings has over 20 years of experience in management and senior leadership roles, notably as the joint Mental Health Complaints Commissioner and Disability Services Commissioner. She is also a former Public Transport Ombudsman.

Treasure is passionate about improving Victoria's mental health system and in particular elevating the rights of consumers, carers, families, supporters and kin. Her experiences as a supporter and carer have shaped and informed her commitment to systemic reform and building a more inclusive and compassionate mental health system.

Treasure has focused this year on listening and learning about the community's views of the priorities of the Commission as well as providing expert advice on a range of initiatives aimed at supporting the reforms, particularly in the areas of safety and quality. Treasure is particularly focused on how the Commission will use its powers to drive the cultural shifts needed to ensure a safe system that delivers on the aspirations of the Royal Commission.

"Throughout my life and career I have seen first-hand how stigma and discrimination is a barrier to having a better life for many people I'm driven to see the work of the Commission change that – so that all Victorians can have better experiences and lives."

Lived Experience Commissioner, Consumer – Maggie Toko

Maggie Toko brings a powerful blend of lived experience and professional expertise to her role. With a background ranging from consumer consulting to not-for-profit leadership, Maggie has served as the CEO of the Victorian Mental Illness Awareness Council and the Assistant Commissioner of the Mental Health Complaints Commission.

Her deep understanding of the consumer movement, combined with her work in homelessness, sexual assault, and youth advocacy, fuels her drive for system reform. She is passionate about reducing the stigma that surrounds mental health. As an indigenous person of Ngāpuhi – Ngāti Whātua descent and someone with lived experience of mental illness, Maggie is a passionate human rights advocate dedicated to amplifying the voices of those often unheard.

As Lived Experience, Consumer Commissioner, Maggie's work in the Commission's first year has been focused on engaging with consumer groups, service providers and community across the system as well as leading the development of guidance on the mental health and wellbeing principles from the Act so that everyone can understand and follow them. Maggie has taken a particular interest in education, and this year, she has focused on inducting lawyers working in the pro bono space to ensure they are aware of the Commission's role and consumer rights.

"The Commission's remit is to raise the efficacy and the voice of lived experience – and this is a once-in-a-lifetime chance."

Our leadership model

The Mental Health and Wellbeing Commission is led by four commissioners who work via a collaborative leadership model. Each commissioner brings their individual perspective, diverse experiences, skills, and expertise and commits to mutual respect, trust and information sharing. All decision-making at the Commission is shared, which allows the Commission to be adaptable, leaning into each commissioner's strengths to solve problems, innovate, and achieve common goals.

Lived Experience Commissioner, Carer – Jacqueline Gibson

Jacqueline's primary identity is that of a mental health carer and supporter. Her personal experiences in this role have not only shaped her understanding of the field but also allowed her to actively participate in governance and decision-making within the health sector on a national level.

Jacqueline's unwavering commitment to protecting the rights and dignity of persons with mental illness is a cornerstone of her work. This commitment is evident in her past work at the Mental Health Tribunal as a community tribunal member. Her dedication to safeguarding individuals in the public mental health and wellbeing system is not just a job, but a driving force in her work today as a Lived Experience Commissioner.

This year, Jacqueline has made it a priority to listen and learn about the perspectives of families, carers, supporters, and communities.

Her inclusive approach and unwavering commitment to community engagement not only involves these communities but also make them feel valued and integral to these efforts.

"I am committed to working closely with the lived experience workforce, consumers, families, carers, supporters and kin. Together, we will implement our strategic plan and the Commission's Lived Experience Plan, turning them into tangible actions that will bring about real change in our mental system."

Commissioner – Annabel Brebner

Annabel Brebner has extensive expertise as an executive, economist, and public policy consultant with over 17 years advising governments on social policy, including health and mental health. Annabel brings valuable insight from her roles as Director of Performance Audit at the Victorian Auditor-General's Office, consulting on the National Mental Health Workforce Strategy Taskforce and evaluating initiatives related to the Royal Commission into Victoria's Mental Health System.

Her personal experience as a consumer and carer of those facing mental ill health drives her passion for system reform and improving access to treatment and support. Annabel is dedicated to meaningful system oversight and creating a community where everyone feels a sense of belonging.

Annabel's focus in the Commission's establishment year has been the design and development of the Commission's reporting and monitoring framework and approach to systemic reviews.

"I really want the Commission to be a trusted place – we do what we say we're going to do and look to improve the information we have, so we get a really accurate view of how the system is performing."

Chief Executive Officer (CEO) – Simon McKenzie

Simon McKenzie is an admitted lawyer with over 20 years of operational, senior management and executive-level experience in the private and not-for-profit sectors.

He also has experience in consumer rights, including at the Telecommunications Industry Ombudsman and Public Transport Ombudsman. Simon's work has contributed towards system and service improvement. Simon is driven by his work, engaging with consumer complaints, people with lived experience, and advocates of those who face barriers to accessing services, education, work and social connection. Simon has experience with the mental health system as a family member and supporter of someone experiencing mental illness.

"The Mental Health and Wellbeing Commission needs to reflect the community it serves; it should be diverse, in terms of the people that inform it and work in it, it needs to execute the functions of the Act and be a learning environment where we listen to the people who are experts – whether they are consumers, carers, advocates or other mental health sector leaders."

The Commission's leadership team completed the Centre for Mental Health Learning's training program 'Understanding & Supporting Lived Experience Workforces'.

Ongoing training in this area will continue to be a focus as we grow and mature as an organisation. In this way, we can ensure our work is grounded not only in the values of the lived experience workforces, but to the consumer and carer movements and their long-standing advocacy.

Lived experience at the Commission

The Royal Commission into Victoria's Mental Health System reflected a new approach and commitment to working with lived experience. A key observation of the Royal Commission's final report was that the system will only be safe and effective – and will only lead to genuinely improved outcomes – if the system is designed, delivered and overseen in partnership with people who have a lived experience of that system.

This underpins the leadership design of the Mental Health and Wellbeing Commission, which has appointed designated Lived Experience Consumer and Carer commissioners. The Commission has designated lived experience functions:

- to elevate the leadership, and support the full and effective participation, of consumers and carers in decision-making processes
- to develop and support the leadership capabilities of lived experience
- to design and deliver initiatives to develop awareness and understanding of people's experiences of mental illness and distress
- to promote the role, value and inclusion of families, carers, supporters and kin.

Our Lived Experience Team

In response to the Royal Commission recommendation 28 'Developing system-wide roles for the full and effective participation of people with lived experience of mental illness or psychological distress', the Commission has developed a specific lived experience stream within the organisation.

Led by the two Lived Experience Commissioners, Maggie Toko (Consumer Commissioner) and Jacqueline Gibson (Carer Commissioner), the Lived Experience Team now includes a range of designated roles, including a General Manager who is part of the Commission's Executive team, a manager and two Senior Lived Experience Advisors. Further roles within the team, including policy roles, will be recruited to support consumer and carer project and policy development.

The Lived Experience Team provides critical internal consultancy across the full range of the Commission's functions and is also building a portfolio of work through a range of projects related to functions as set out in the Act.

> "The foundation of my work lies not in abstract policy or distant directives but in the voices and lived experiences of families, carers, and supporters – those who often find themselves unheard, lost in the vast machinery of Victoria's public mental health and wellbeing system. It is their stories, their quiet struggles, that inform every focus, every direction, every priority that guides the Mental Health and Wellbeing Commission."
>
> **Jacqueline Gibson, Lived Experience, Carer Commissioner**

Embedding lived experience

The Lived Experience Team is building the foundations, policies and structures for a growing lived experience program through targeted activities. These include projects like developing inclusive internal recruitment policies, reviewing all internal policies and protocols, and working alongside colleagues to develop meaningful and effective approaches to working with services.

The Lived Experience Team is an integral part of the Commission. The team ensures that the perspectives and expertise of consumers, families, carers, supporters and kin are fully integrated, by working collaboratively across the organisation, including Resolutions, Communications and Engagement and Performance Management. The team's influence extends throughout the organisation, shaping strategic direction and enhancing operational efficiency. At the same time, the team also has its own portfolio of projects, and receives organisational resources and support to achieve its objectives. This dynamic interplay between contributing to the broader organisational goals and advocating for its own needs exemplifies the team's critical role in both driving and supporting the work and objectives of the Commission.

The Lived Experience Plan

Critical in guiding the strategic work of the Lived Experience Team is the Lived Experience Plan, a foundational document of the Commission that covers all 32 functions of the Commission that are in its legislation. It looks to ensure that the Commission is driven by lived experience across all its work and functions.

The Lived Experience Plan is sponsored by the Lived Experience Consumer and Carer commissioners and is being developed through targeted engagement with subject matter experts from the lived experience sector including, consumer and carer peak bodies, previous lived experience commissioners (from other jurisdictions), academic experts and current and former service users and their carers.

> "My highlight since joining the Commission has been developing the LE Plan. It brings together long-standing advocacy from the sector, fused with the key lived experience recommendations from the Royal Commission's reports. It's progressive, enabling and provides clear direction for how we want to improve the system."
>
> **Danilo Di Giacomo, General Manager, Lived Experience**

The Lived Experience Plan will be launched in the second half of 2024, and considers metropolitan and regional perspectives, and is built on the following five goals:

1
- Embed lived experience values in the culture of the Commission and be an exemplar organisation for lived experience and inclusion

2
- Define lived experience leadership and facilitate pathways across the sector and communities

3
- Integrate lived experience in and across the governance and performance measurement of mental health and wellbeing system and services, with shared power and increased accountability

4
- Listen to the voices and meet the diverse needs of people engaging with the Commission and the wider mental health system

5
- Strengthen understanding of people's diverse lived experience and the role of the MHWC through collaborations, partnerships and community engagement

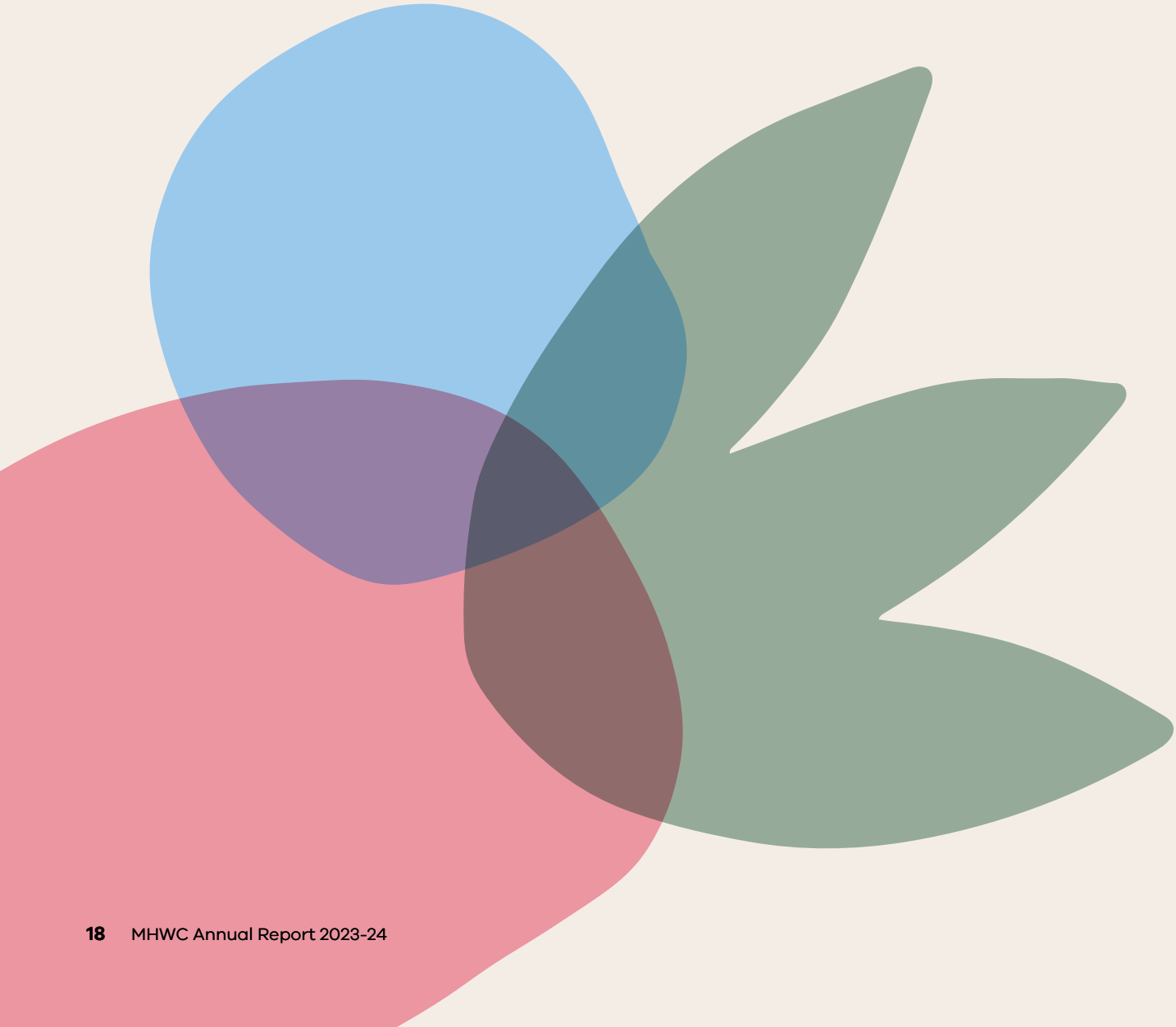
Advisory mechanism for the Commission

The work of the Lived Experience Team has included developing a comprehensive lived experience engagement strategy and mechanisms through which the Commission will seek strategic advice and expertise into the monitoring of both the Lived Experience Plan and broader strategic priorities of the Commission over time. Establishing a Lived Experience Advisory Group mechanism is included in the Lived Experience Plan and will be established in the next financial year.

Lived experience is embedded in everything we do at the Commission. Throughout this report, you will notice that we have flagged some lived experience highlights. These highlights demonstrate how our lived experience goals are reflected across every aspect of our work.

What we've done

The first 10 months of the Commission have been largely focused on establishment; laying the foundations and plans for how we will execute our new functions.



Establishment

The Mental Health and Wellbeing Commission was established on 1 September 2023. The new Commission is publishing its inaugural annual report to cover the period from 1 September 2023 – 30 June 2024.

The first 10 months of the Commission have been largely focused on establishment; laying the foundations and plans for how we will execute our new functions. This work has hinged on extensive consultation and engagement across the mental health and wellbeing sector. As you will see throughout this report, we have consulted widely in our first 10 months. The section 'What we've heard' from p65 provides a summary of these activities.

Year one priorities

Engage with consumers, carers, carers groups and peak bodies and with service providers across the system.

Develop guidance on the mental health and wellbeing principles from the Act so that everyone can understand and follow them.

Design and develop our approach to compliance and report the baseline of service performance, quality and safety.

Build and nurture the Commission team and shape our culture.

"Our journey over the first ten months has been fantastic; collectively we have had to reach beyond our comfort zone in some matters while holding strong to the developing values and principles of the Commission. I have no doubt that we will enrich the reform process for the betterment of consumers and carers."

Maggie Toko, Lived Experience Consumer Commissioner

Strategic directions: establishing the Commission

We released our Strategic Directions document in November 2023. This document set out the ways that we would go about establishing the Commission in its first year and how we will contribute to system improvement.

While this document outlines the strategic direction of the Commission in year one, a longer-term Strategic Plan is also being developed and will be released later this year.

We committed to delivering a number of significant documents. How we're tracking:

Our commitment	Progress in year one
A Lived Experience Plan that articulates how the Commission will elevate lived experience leadership and participation.	Our Lived Experience Plan is being developed and is due to be published in 2024.
A Monitoring and Reporting Plan that describes how the Commission will monitor and report on the mental health and wellbeing system's safety and quality, and the government's implementation of Royal Commission recommendations.	A Monitoring and Reporting Plan is being developed and will be published in 2024.
A Stakeholder Engagement Plan that supports the Commission's activities including the development of other plans.	An Engagement Framework has been finalised and published. The framework recognises that specific engagement plans will need to be developed for projects.
An Annual Plan that describes the Commission's program of work including potential inquiries and systemic reviews.	An Annual Plan has been finalised and will be shared later this year.

We have also been developing our Approach to Complaint Handling and Compliance Monitoring which outlines how we will exercise our powers and provide rigorous system oversight as set out in the *Mental Health and Wellbeing Act 2022*.

Our Approach to Complaint Handling and Compliance Monitoring will explain how we'll exercise our compliance powers, from individual complaints to broader systemic concerns.

Shortly, we will also be publishing our Exploring Issues through Inquires and Systemic Reviews Guide.

The Guide focuses on the importance of inquiries and systemic reviews, detailing our approach to our monitoring and reporting functions. Our annual planning cycle will help determine and prioritise issues for exploration based on the diverse perspectives and the needs of those with mental illness and psychological distress, including their families, carers and supporters.

Exploring and addressing issues within the mental health and wellbeing system is a critical step toward driving improvements and ensuring that consumers, carers, families and supporters benefit from a more responsive and accountable system.

Promoting the objectives of the Act

Victoria's Mental Health and Wellbeing Act 2022 (the Act) commenced on 1 September 2023.

The objectives of the Act reflect the Royal Commission's aspirational vision for the new mental health and wellbeing system. They are framed broadly to support the pursuit of the highest attainable standard of mental health and wellbeing for all Victorians.

Promoting the objectives of the Act is at the core of our work at the Commission.

The Commission:

- Handles complaints about Victorian publicly funded mental health and wellbeing services. Through this work (see Complaints, resolutions and investigations section on page 28) we ensure that services are delivering high-quality, compassionate and safe care, providing accessible treatment and support systems for individuals to recover from mental health issues or psychological distress.
- Promotes and complies with the mental health and wellbeing principles (see page 23). This ensures that we protect and promote the human rights and dignity of those accessing mental health and wellbeing services and helps us to ensure services are providing assessment and treatment in the safest, and least restrictive way possible.
- Supports people with lived experience to lead and partner in reform and play a key role in leading actions to reduce stigma related to mental health. By embedding living and lived experience leadership, including the voices of carers, families, supporters and kin across the Commission, we promote continuous improvement in the way we handle complaints and via our complaints handling, the performance, quality and safety of mental health and wellbeing services (see page 15).
- Provides a system monitoring and oversight role, conducts investigations, and promotes effective complaint handling by mental health and wellbeing service providers in Victoria. This work will help to identify and explore systemic issues and to address disparities by improving access to mental health and wellbeing services for all individuals and ensuring fair, equitable service delivery (see Mental health and wellbeing system review from page 39).
- Will publish reports on the performance, quality and safety of the mental health and wellbeing system and progress towards improving mental health and wellbeing of Victorians. (See page 37 on our system review and approach to monitoring and reporting). This helps to create best-practice standards across the mental health and wellbeing sector, recognise and value the critical role of the clinical and non-clinical mental health and wellbeing workforce and provides Victorians with oversight on the mental health system's performance.

Objectives of the Act

In pursuit of the highest attainable standard of mental health and wellbeing for the people of Victoria, the objectives of the Act are:

a) to promote conditions in which people can
   i) experience good mental health and wellbeing; and
   ii) recover from mental illness or psychological distress

b) to reduce inequities in access to, and the delivery of, mental health and wellbeing services

c) to provide for comprehensive, compassionate, safe and high-quality mental health and wellbeing services that promote the health and wellbeing of people living with mental illness or psychological distress and that
   i. are accessible; and
   ii. respond in a timely way to the people's needs and recognise that these needs may vary over time; and
   iii. are consistent with a person's treatment, care, support and recovery preferences wherever possible; and
   iv. are available early in life, early in onset and early in episode; and
   v. recognise and respond to the diverse backgrounds and needs of the people who use them; and
   vi. provide culturally safe and responsive services to Aboriginal and Torres Strait Islander peoples in order to support and strengthen connection to culture, family, community and Country; and
   vii. connect and coordinate with other support services to respond to the broad range of circumstances that influence mental health and wellbeing including alcohol and other drug support services and treatment; and
   viii. include a broad range of treatment options with the aim of providing access to the same treatment and support irrespective of whether a person is receiving voluntary or compulsory treatment; and
   ix. include a broad and accessible range of voluntary treatment and support options–
      A) to enable a reduction in the use of compulsory assessment and treatment; and
      B) to enable a reduction in the use of seclusion and restraint with the aim of eliminating its use within 10 years

d) to promote continuous improvement in the quality and safety of mental health and wellbeing services including by ensuring that the experiences of people living with mental illness or psychological distress, and the people receiving treatment, their carers, families and supporters, are at the centre of changes in practices and service delivery and the design and evaluation of systems

e) to protect and promote the human rights and dignity of people living with mental illness by providing them with assessment and treatment in the least restrictive way possible in the circumstances

f) to recognise and respect the right of people with mental illness or psychological distress to speak and be heard in their own voices, from their own experiences and from within their own communities and cultures

g) to recognise, promote and actively support the role of families, carers and supporters in the care, support and recovery of people living with mental illness or psychological distress

h) to promote and support the health and wellbeing of families, carers and supporters of people living with mental illness or psychological distress

i) to recognise and value the critical role of the clinical and non-clinical mental health and wellbeing workforce and to support and promote the health and wellbeing of members of that workforce

j) to promote the mental health and wellbeing principles.

Complying with and enforcing the mental health and wellbeing principles

The following are the 13 mental health and wellbeing principles in full:

Dignity and autonomy principle

The rights, dignity and autonomy of a person living with mental illness or psychological distress are to be promoted and protected and the person is to be supported to exercise those rights.

Diversity of care principle

A person living with mental illness or psychological distress is to be provided with access to a diverse mix of care and support services. This is to be determined, as much as possible, by the needs and preferences of the person living with mental illness or psychological distress including their accessibility requirements, relationships, living situation, any experience of trauma, level of education, financial circumstances and employment status.

Least restrictive principle

Mental health and wellbeing services are to be provided to a person living with mental illness or psychological distress with the least possible restriction of their rights, dignity and autonomy with the aim of promoting their recovery and full participation in community life. The views and preferences of the person should be key determinants of the nature of this recovery and participation.

Supported decision-making principle

Supported decision-making practices are to be promoted. Persons receiving mental health and wellbeing services are to be supported to make decisions and to be involved in decisions about their assessment, treatment and recovery including when they are receiving compulsory treatment. The views and preferences of the person receiving mental health and wellbeing services are to be given priority.

Family and carers principle

Families, carers and supporters (including children) of a person receiving mental health and wellbeing services are to be supported in their role in decisions about the person's assessment, treatment and recovery.

Lived experience principle

The lived experience of a person with mental illness or psychological distress and their carers, families and supporters is to be recognised and valued as experience that makes them valuable leaders and active partners in the mental health and wellbeing service system.

The 13 mental health and wellbeing principles (continued)

Health needs principle

The medical and other health needs of people living with mental illness or psychological distress are to be identified and responded to, including any medical or health needs that are related to the use of alcohol or other drugs. In doing so, the ways in which a person's physical and mental health needs may intersect should be considered.

Dignity of risk principle

A person receiving mental health and wellbeing services has the right to take reasonable risks in order to achieve personal growth, self-esteem and overall quality of life. Respecting this right in providing mental health and wellbeing services involves balancing the duty of care owed to all people experiencing mental illness or psychological distress with actions to afford each person the dignity of risk.

Wellbeing of young people principle

The health, wellbeing and autonomy of children and young people receiving mental health and wellbeing services are to be promoted and supported, including by providing treatment and support in age and developmentally appropriate settings and ways. It is recognised that their lived experience makes them valuable leaders and active partners in the mental health and wellbeing service system.

Diversity principle

The diverse needs and experiences of a person receiving mental health and wellbeing services are to be actively considered noting that such diversity may be due to a variety of attributes including any of the following:

- gender identity
- sexual orientation
- sex
- ethnicity
- language
- race
- religion, faith or spirituality
- class
- socioeconomic status
- age
- disability
- neurodiversity
- culture
- residency status
- geographic disadvantage.

Mental health and wellbeing services are to be provided in a manner that:

- is safe, sensitive and responsive to the diverse abilities, needs and experiences of the person including any experience of trauma; and
- considers how those needs and experiences intersect with each other and with the person's mental health.

Gender safety principle

People receiving mental health and wellbeing services may have specific safety needs or concerns based on their gender. Consideration is therefore to be given to these needs and concerns and access is to be provided to services that:

- are safe; and
- are responsive to any current experience of family violence and trauma or any history of family violence and trauma; and
- recognise and respond to the ways gender dynamics may affect service delivery, treatment and recovery; and
- recognise and respond to the ways in which gender intersects with other types of discrimination and disadvantage.

Wellbeing of dependents principle

The needs, wellbeing and safety of children, young people and other dependents of people receiving mental health and wellbeing services are to be protected.

Cultural safety principle

Mental health and wellbeing services are to be culturally safe and responsive to people of all racial, ethnic, faith-based and cultural backgrounds.

Treatment and care is to be appropriate for, and consistent with, the cultural and spiritual beliefs and practices of a person living with mental illness or psychological distress. Regard is to be given to the views of the person's family and, to the extent that it is practicable and appropriate to do so, the views of significant members of the person's community. Regard is to be given to Aboriginal and Torres Strait Islander people's unique culture and identity, including connections to family and kinship, community, Country and waters.

Treatment and care for Aboriginal and Torres Strait Islander peoples is, to the extent that it is practicable and appropriate to do so, to be decided and given having regard to the views of elders, traditional healers and Aboriginal and Torres Strait Islander mental health workers.

Consumers, carers, families, supporters and kin may make complaints to the Mental Health and Wellbeing Commission on the basis that they are dissatisfied with the service they, or their loved one, has received. The principles in the Act provide a framework for assessing whether a service is delivering safe and high-quality care in line with the Royal Commission's aspirations for a reformed mental health system.

The Act requires mental health and wellbeing services to:

- make all reasonable efforts to comply with the mental health and wellbeing principles when exercising a function under the Act
- give proper consideration to the mental health and wellbeing principles when making a decision under the Act
- provide safe, person-centred mental health and wellbeing services
- foster continuous improvement in the quality and safety of the care and mental health and wellbeing services they provide.

How we have complied with the principles

The Commission developed interim practice guidance on applying the principles. The guidance is designed to help Mental Health and Wellbeing Commission staff understand how common complaint themes align with the mental health and wellbeing principles and other principles in the Act, and use this to increase the longer-term impact of our engagement with consumers, carers and services, through:

- supporting consumers and carers, family and supporters to understand their rights within the framework of the mental health and wellbeing and other principles, and expectations for practice in services.
- encouraging services to consider complaint issues in relation to the relevant mental health and wellbeing principles, to maximise the outcome for individual complainants, and also to increase the likelihood of systemic change by encouraging services to apply the mental health and wellbeing principles in their approach and practice.

The guidance suggests questions to guide discussions between our Resolutions and/or Investigations Officers and consumers, carers or services. These questions are framed around each of the mental health and wellbeing principles contained in Part 1.5. of the Act, and we have developed questions both for complainants and services

The questions are informed by lived experience and are framed to be as easy as possible to answer, for both people making a complaint, and services.

Examples from our guidance

Here are some examples from our interim guidance on how we apply the principles.

The questions included here are a guide only. Our resolutions staff use discretion and judgement to ask questions that are most relevant to the person's concerns and are most likely in the circumstances of the complaint to achieve a meaningful response from the service.

Figure 1: Sample guidance; Diversity of care principle

	Questions for complainant	Questions for service
Questions people want to be asked	• What kinds of care and support services do you want to access? • Has anyone told you what services might be available to you? • What has worked for you in the past? What would you like to be different in the future?	• How have you worked with <name> to identify the care and support services they would like to access? • How have <name's> preferences about the services they would like to access guided their care and treatment?
Questions the Commission needs to know	• How has <service> talked to you about services you want to access? • Has <service> told you about anything they've tried to do to help you access the services you would like? • Were you asked if you have any issues you'd like to address with different services (see list in text above)?	• Are there any barriers to <name> accessing these services? How have you talked to <name> about those barriers? • Are there interim solutions, or is there a plan to help <name> access those services in future? How has <name> been involved in developing that plan?

This guidance supports our work to always have the mental health and wellbeing principles at the forefront of our interactions with consumers and services.

Mental health and wellbeing principles, collaborative approaches to implementation

The Commission has a function under s 415 (g) of the Act to issue guidance materials about how to apply the mental health and wellbeing principles in relation to actions and decisions made under the Act.

We are currently developing this guidance (see the lived experience section below/adjacent for more detail on this project). The project includes working with consumers, families, carers and services to develop clear guidance about what it means in practice.

This guidance will provide Victorian consumers, families, carers and services a common ground of understanding to support conversations and decision-making around treatment options and approaches.

Our guidance will also help outline to service providers and decision-makers practical ways that they can make better decisions that recognise and promote the principles. The guidance will encourage service providers to take action and improve their processes in a manner that is consistent with the values and expectations set out in the principles.

In our work developing guidance, we have taken a particular focus on the Cultural Safety Principle, and looking specifically at how mental health services support Aboriginal consumers to access culturally appropriate care. We understand the need to prioritise the cultural safety of Aboriginal Victorians accessing mental health and wellbeing support and care and we are engaging with Aboriginal Victorians to understand their lived experience and specific issues of Cultural safety within Victoria's Mental Health and Wellbeing system.

Our project to develop guidance on the mental health and wellbeing principles is being led by the Lived Experience Team.

This key organisational project has been informed by extensive engagement, with its initial phase of scoping including the initiation of two virtual networks for services and other interested parties.

Phase One focused on seeking feedback via a questionnaire from mental health services about the principles to ensure the guidance includes clear explanation and scenarios for applying or using the principles. Services and other interested parties will be sent early draft guidance to ensure the guidance is clear and practical. The guidance will include key messages for consumers and their families, carers and supporters. The Guidance will be published in 2025. Phase Two will include developing products that enhance understanding of the principles, which may include translated materials, animations and posters.

"As commissioners, we have a responsibility to know the mental health and wellbeing system and have a deep understanding of that system in all its complexity. I know that the Commission can achieve positive outcomes and do really good work in the community, but only if we are doing work that is grounded in lived experience and knowledge."

Treasure Jennings, Chair Commissioner

Complaints, resolutions and investigations

This section should be read alongside the final Annual Report of the Mental Health Complaints Commissioner (which covers the period from 1 July – 31 August 2023) to understand the full financial year of public mental health service complaints, resolutions and investigations registered in the 23-24 reporting period.

Taking and resolving complaints

The Commission can take complaints relating to any matter arising out of the provision, or failure to provide, a publicly funded mental health and wellbeing service by a mental health and publicly funded wellbeing service provider.

This includes such things as:

- failure to make all reasonable efforts to comply with the mental health and wellbeing principles and other principles and duties in the Act;
- communication including to nominated families or carers; or
- the way a service provider handled a complaint it received.

These complaints can come from consumers, from other people on behalf of consumers, or from carers, family members or supporters about their own experiences.

The Commission deals with complaints about the experience of consumers, carers or families, as defined in the Act. The Act also specifies the Commission must resolve complaints using the least formal action that is appropriate in the circumstances (section 451(2)).

Our Lived Experience Team works closely with the Resolutions Team at the Commission to ensure our complaints and resolutions processes are sensitive, trauma-informed, inclusive and clear.

Most importantly, it works to ensure complaints lead to meaningful and positive change. We regularly review our practice guidance through a lived experience lens to support continuous improvement.

We take a person-centred approach to complaint resolution. This includes keeping the complainant informed at every step of our process and seeking their views before closing a complaint on the basis that the resolution must comply with the principles of the Act.

Disclosure and information sharing

Complaints made to the Commission are confidential and no identifying details are made public. That said, the Commission shares non-identifying details, usually in an aggregated format, for the purposes of transparency about our work and service or system performance.

There are specific parts of the Act that restrict the type of information the Commission can make public or share.

We are not allowed to disclose any information obtained during an investigation, a complaint data review, or a complaint resolution process, or during a conciliation.

Disclosure is only permitted in very limited circumstances, for example where there is written consent from the person to whom the information relates, or if it is necessary to avoid a serious risk to the life, health, safety or welfare of a person. It is also permitted – except in relation to conciliation – if it is necessary for the performance of the Commission's functions.

Who contacted us

Between 1 September 2023 and 30 June 2024, the Commission received **2,195** new enquiries, complaints and referrals (including referrals from the Australian Health Practitioner Regulation Agency).

Of the **1,719** complaints received, **1,339** (approx. 78%) were assessed to be in-jurisdiction to be progressed by the Commission through the different resolution pathways.

In-jurisdiction complaints are made by people about their experiences in Victorian public mental health and wellbeing services. Complaints are received either verbally through our phone line or in writing through e-mails and our web form (a very small fraction is received via letters).

When the Commission receives complaints that are out of jurisdiction (including those that are about services that are not Victorian public mental health and wellbeing services), our team continues to support people to contact the most appropriate body to help them with their complaints, where appropriate/relevant.

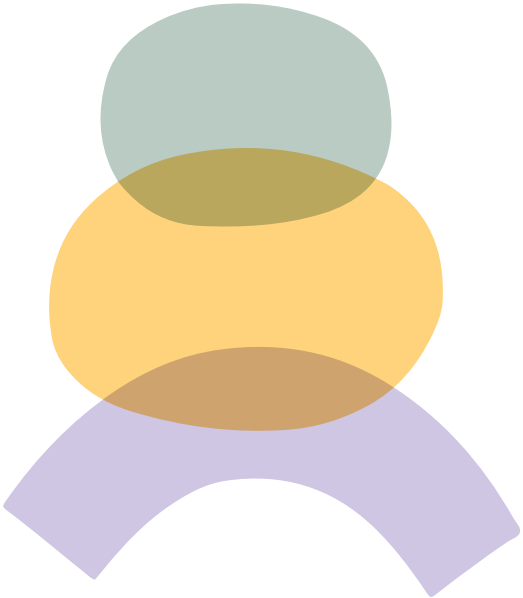
Over the reporting period, the Commission received 380 complaints that were assessed to be out of jurisdiction. These complaints were most frequently in reference to general health services, private mental health practitioners, or mental health services in other jurisdictions. The Commission assists people to reach the relevant complaints bodies and/or support services to assist with any complaints not within our jurisdiction.

Complainants

Over the reporting period, the Commission received **987 (73.7%)** in-jurisdiction complaints from people accessing services themselves (consumers).

303 (22.6%) in-jurisdiction complaints were made by family members and carers. Complaints from carers can be made on behalf of a consumer or about their own experiences with the services.

49 (3.7%) in-jurisdiction complaints were made by others, including advocates, lawyers and service staff.



Mental health and wellbeing services

1,278 (95%) of the in-jurisdiction complaints received by the Commission were made about designated mental health and wellbeing services (DMHWS), including hospital-based, community, residential, specialist and forensic services.

A lower proportion of complaints were received about mental health and wellbeing community support services (MHWCSS) and the newly established local services (the Locals). Only **12 (less than 1%)** complaints received were about these services. This could be attributed to the lower number of people who access these services.

49 (9%) of in-jurisdiction complaints received by the Commission did not identify a service provider. This can occur is situations where the Commission is unable to contact the complainant for further information, either because the complainant does not wish to disclose this information, or because the complainant chooses not to progress their complaint.

Approximately **79%** of complaints (where the service was known) were made about designated **metropolitan** mental health and wellbeing services and about **21%** were made about **regional** designated mental health and wellbeing services.

Figure 2: Distribution of complaints about designated mental health and wellbeing services across metropolitan and regional areas in Victoria

Service	Number of complaints
Metro mental health services	
Alfred Health	86
Austin Health	54
Eastern Health	161
Forensicare	108
Melbourne Health	73
Northern Health	122
Mercy Public Hospitals Incorporated	68
Monash Health	138
Peninsula Health	52
Royal Children's Hospital	11
South West Health Care	20
St Vincent's Hospital	45
Western Health	59
Orygen Health & Orygen Specialist Program	16
Total Metro	**1013**
Regional mental health services	
Albury Wodonga	24
Grampians Health Services (Ballarat Health)	40
Barwon Health	58
Bendigo Health	59
Goulburn Valley Health	20
Latrobe Regional Hospital	50
Mildura Base Hospital	11
Total Regional	**262**
Total DMHS*	**1275**
Unknown	**57**

This data reflects the status of a complaint at a specific point in time. Figures vary slightly over time as the status of a complaint changes in the system. For this reason, the number of complaints reported in the table below will not align with the overall figures reported above.

A calculation of the percentage of complaints about an individual service provider, per 1,000 consumers that access each service, was not possible to provide for this reporting period due to it being less than 12 months.

* This figure excludes services with low numbers of complaints to avoid the identification of individuals.

Complaints received

Complaints made to the Commission often involve more than one issue. In this annual report, the number and percentage of complaints about each issue are recorded for all in-jurisdiction complaints received.

The Commission uses a three-level system to classify the issues raised in complaints. This classification of issues broadly aligns with the Victorian Health Incident Management System (VHIMS) issues categories. Each level has an increasing specificity to describe what the complaint was about.

- level 1 issues capture the broad themes behind complaints
- level 2 breaks these issues down into more specific groups
- level 3 issues provide more detailed information about the complaint

See figures 3 and 4 – three-level system of classification, complaint classification.

- **Level 1 issues:** treatment, communication, conduct and behaviour, medication, access, diagnosis, facilities, complaint management and records
- **Level 2 issues:** break down Level 1 issues into more specific categories. E.g. the Level 1 category Medication includes the following Level 2 issue: Disagreement with medication
- **Level 3 issues:** further breakdown Level 2 issues. E.g. Level 2 category of Disagreement with medication includes the Level 3 issue: Dissatisfaction with the prescribed medication

Figure 3: The Commission's three-level system to classify issues raised in complaints

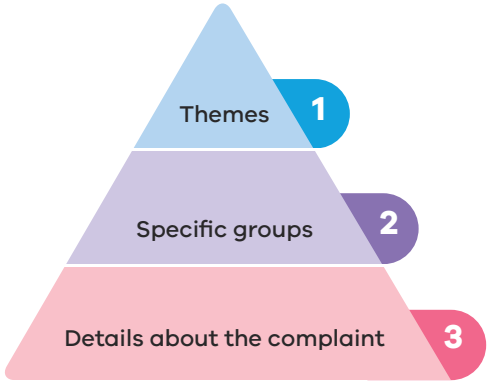
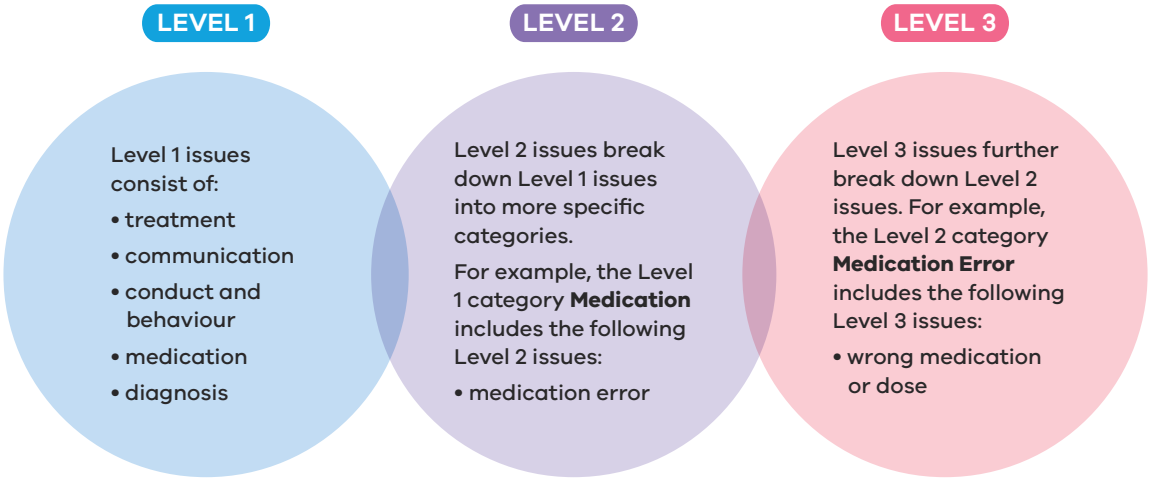


Figure 4: Complaint classification



Frequently raised issues in complaints

- percentages for Level 1 and Level 3 issues are calculated based on the number of occurrences of the issue in in-jurisdiction complaints during the reporting period
- complainants usually raise more than one issue in a complaint that is made to the Commission
- The top two Level 2 issues for the top five Level 1 issues as received in in-jurisdiction complaints made to the Commission
- The top Level 3 issues are calculated as a percentage of the total number of Level 1 issues category they fall under.

Figure 5: Issues raised in complaints

Level 1 Issues	Level 2 Issues (top2)	Level 3 Issues- top 1st	Level 3 Issues – top 2nd
Treatment (51%)	Suboptimal Treatment Responsiveness of Staff	Lack of care or attention (e.g. people feeling listened to or believed) (15%)	Disagreement with the treatment order (13%)
Communication (31%)	Inadequate communication with consumers/carers and other providers	Incomplete or confusing information provided to consumer (34%)	Incomplete or confusing information provided to carer, family member or nominated person (15%)
Medication (23%)	Disagreement with medication Oversedation & side effects	Dissatisfaction with prescribed medication (39%)	Side effects from medication (22%)
Conduct & behaviour (18%)	Rudeness/lack of empathy Alleged threats, bullying or harassment by staff	Rudeness, lack of respect or discourtesy (25%)	Threats/intimidation or bullying by staff – clinical (5%)
Access (11%)	Refusal to access or treat Insufficient access	Refusal to admit or treat (32%)	Lack or insufficient access to service (26%)
Diagnosis (10%)			
Facilities (6.5%)			
Complaint management (3.5%)			
Records (3%)			

Closure of complaints

During the reporting period, **1,305** complaints were closed by the Commission that were within its jurisdiction.

Of the complaints that were closed, **626** were either **fully or partially resolved** to the satisfaction of the complainant; **60** were **not resolved**, and **619** did not have a resolution applicable/reported.

For those complaints with no resolution reported, this was typically in instances where we were unable to contact the complainant after initial contact, where we could not obtain the consumer's consent to access further information necessary to progress the complaint or where resolution was not required to be reported to the Commission by the service.

Over **90%** of complaints where outcomes were reported to the Commission were resolved to a level of satisfaction (either fully or partially) for the complainant.

The Commission continues to implement an assisted referral process where suitable and with agreement from the complainant. This is when the matter may be referred to the service for resolution directly with the complainant.

We assist the complainant to know their rights and what to expect through the process, noting a complainant may return to the Commission if they remain dissatisfied. In some cases, our assessment means referring to a more appropriate entity, such as the Health Complaints Commissioner or the Victorian Equal Opportunity and Human Rights Commission.

Over this reporting period, almost **49%** of the closed in-jurisdiction complaints were progressed through the assisted referral process with a high percentage or resolution reported back to the Commission. This has highlighted better and faster outcomes for complainants than previously reported.

The Commission complaints process has resulted in **56%** of the complaints that were closed during that period to be finalised within the first month of receipt **(732 complaints); 87%** were finalised within three months of receipt **(1,140 complaints)**; and **94%** were finalised within six months of receipt **(1,221 complaints)**.

Figure 6: How long it took to finalise complaints (within 1 month, within 3 months, within 6 months)

56%
(732 complaints)
finalised within
1 month

87%
(1,140 complaints)
finalised within
3 months

94%
(1,221 complaints)
finalised within
6 months

Outcomes from complaints

When resolving complaints, the Commission seeks to deliver outcomes that broadly result in achieving at least one of the following:

- Acknowledgement,
- Action,
- Answer, and
- Apology.

This is referred to as the 4 As of complaint resolution.

The Commission acknowledges every complaint that we receive and supports consumers, families, carers and supporters to raise concerns with services and achieve meaningful outcomes, guided by the 4 As model.

Not all complaints outcomes are reported to the Commission, however the most common outcomes reported by mental health service providers were:

- Acknowledgement of the concerns raised – 770 complaints.
- Actions addressing concerns raised – 491 complaints.
- Answers and explanations to concerns raised – 331 complaints.
- Apologies – 129 complaints.

The most common actions taken by services to address individual concerns were addressing communication issues between the complainant and the service, responding to the complaint directly, offering and/or providing a service, making changes in the service provided to the consumer and providing feedback to the relevant staff at the service.

Service improvements

Over the reporting period, complaints received by the Commission resulted in **100 recommendations**. All of these recommendations were made in the process of resolving individual complaints. Recommendations made by the Commission are based on information obtained during the complaints resolution process and are not indicative of findings of non-compliance of the Act.

Services reported **255 service improvements** back to us that were made in response to complaints; some of these improvements were a result of recommendations made by the Commission.

Recommendations and service improvements often focused on:

- changes to policies, procedures and practices of service provision;
- training and providing feedback to staff.

Themes of service improvements were predominantly about reducing the use of restrictive interventions including the use of seclusion, bodily restraint or chemical restraint as well as changes in clinical governance and enhancing communication about treatment, care and support.

Figure 7: Service improvements themes*

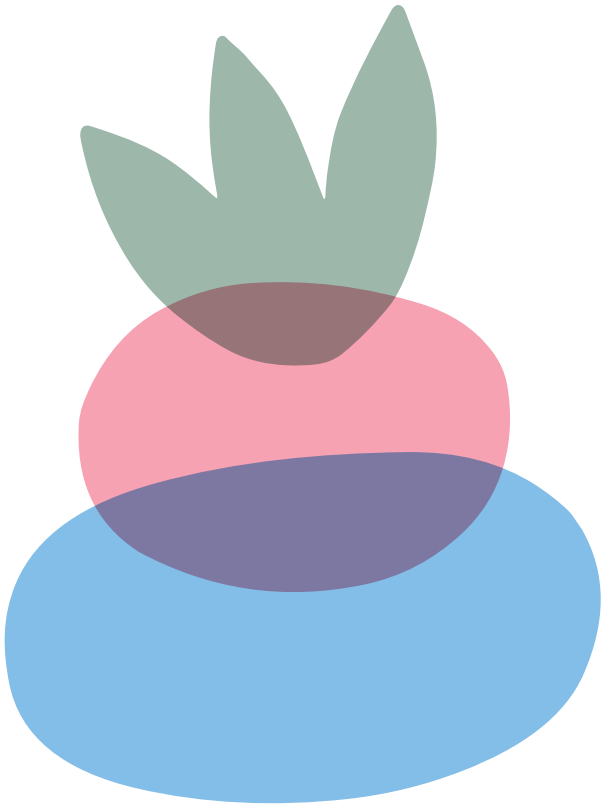
a. Communication	50
b. Clinical governance	55
c. Restrictive intervention	75
d. Alleged staff misconduct	24
e. Risk assessment and management	29
f. Safety	24

Figure 8: Service improvements actions by services

a. Policy/procedure/practice	159
b. Training/input to staff	88
c. Undertake an audit/ investigation	4
d. Other systemic change	1
e. Improvements to infrastructure	2
f. Other systemic change	1

"Complaints are the backbone of the work of the Commission. The voices of people who contact us represent a lived experience of the people who use and interact with mental health and wellbeing services. It's only through hearing these experiences that we can really use our powers to shape change and drive reform. I thank each person who has contacted the Commission to share their experiences."

Treasure Jennings, Chair Commissioner



* Multiple service improvements can be reported through a single complaint and/or for more than one theme. This is why the number of themes exceeds the number of service improvements reported by services.

Resolving complaints

The Commission takes a trauma-informed and person-centred approach to complaint resolution and considers the perspectives of those with living and lived experience. This means that we adjust our process to meet an individual where they are at, and we adopt a resolution approach that is led by the complainant, considering their expectations and preferences.

In addition to this, the Commission must consider the mental health and wellbeing principles and make sure our decision-making processes are transparent and appropriate.

When taking complaints, the Commission must abide by the guiding principles in section 430 of the Act, which require us to:

- act in a fair, impartial and independent manner;
- seek to improve the quality and safety of mental health and wellbeing services;
- seek to protect the rights under this Act of persons seeking or receiving services from mental health and wellbeing service providers; and
- act in an efficient, effective and flexible manner that avoids unnecessary formality.

The Act says the Commission may attempt early resolution of a complaint in any manner and using any means it considers appropriate. When we deal with a complaint, we can use any appropriate method to resolve the complaint, including informal dispute resolution, conciliation or conducting an investigation.

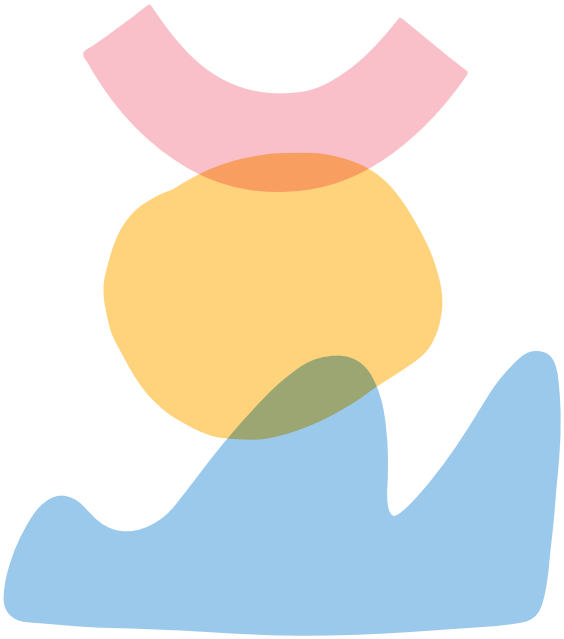
Our staff work with the complainant to determine the best approach to progress the complaint. Where possible we encourage the service to resolve the issues directly with the complainant and focus on rebuilding trust and communication. We also support services to implement service-led improvements based on the experience of consumers, carers, families and supporters.

Local Complaints Reporting

Under the Act, all public mental health and wellbeing services in Victoria are required to share their data about complaints made directly to them (local complaints) with the Commission. The Commission uses these data, together with data about complaints received by the Commission, to create an overall assessment and provide advice to services on areas where they can improve, where they are doing well and how to progress further improvements.

The Commission is developing a new approach to ensure these data are used to support individual service learning and shine a light on systemic matters across the sector.

Individual Service Provider reports for the 2022-23 period, which were collected and developed under the *Victorian Mental Health Act 2014*, are now published on the Commission's website, in addition to a state wide report on complaints and compliments that includes comparative data charts and narratives.



Investigations

Our approach to complaint resolution is consistent with the Act which is to act in an efficient, effective and flexible manner that avoids unnecessary formality. Formal Investigations are only conducted for serious or systemic rights, safety or risk issues raised through complaints, where other complaint resolution pathways or mechanisms are ineffective or inappropriate.

Investigations are a formal process (section 476 of the Act) undertaken when we believe that the full extent of the issues can only be confirmed, and a conclusion reached, through formal investigation.

In instances where an investigation arises out of an individual complaint as it is part of the individual complaint resolution process, our staff work with the complainant to determine the best approach to progress a complaint.

The Commission can also launch own initiative investigations or investigate a matter referred to it by the Minister, which do not require an individual consumer or complainant to be involved, only that the investigation be in relation to any matter that a person can make a complaint about under Sections 431-433 of the Act. The Commission did not open an own initiative investigation in this reporting year. However, our annual planning process will identify issues for which it may be appropriate for the Commission to initiate own initiative investigations. The Minister has not referred any matters to the Commission for investigation.

Our staff work with the complainant to determine the best approach to progress a complaint taking into consideration the least formal way to resolve the complaint. Over this reporting period, we opened one new investigation and progressed two existing investigations opened by the former Mental Health and Wellbeing Commissioner. Of these investigations, two concern the use of restrictive interventions and practices and one concerns the making of compulsory treatment orders.

Inquiries

The Commission has the authority to conduct inquiries in relation to any matter relating to our objectives and functions on our own initiative or as referred by a House of Parliament, a Parliamentary Committee, a Minister, the Health Secretary or the Chief Officer.

We will conduct inquiries when a structured approach is required to explore a systemic issue. Inquiries are a significant undertaking, which may include conducting public hearings. We estimate that any inquiry would take between 12 and 18 months to complete.

We have not initiated any inquiries since September 1, 2023; however, we have developed our guide to, 'Exploring issues through inquiries and systemic reviews', which sets out our approach to undertaking an inquiry.

This will be something that will form part of our annual planning cycle. The annual planning cycle identifies potential issues for exploration by incorporating a broad range of perspectives, prioritising the issues that matter to people with mental illness and psychological distress and their carers, families, supporters and kin.

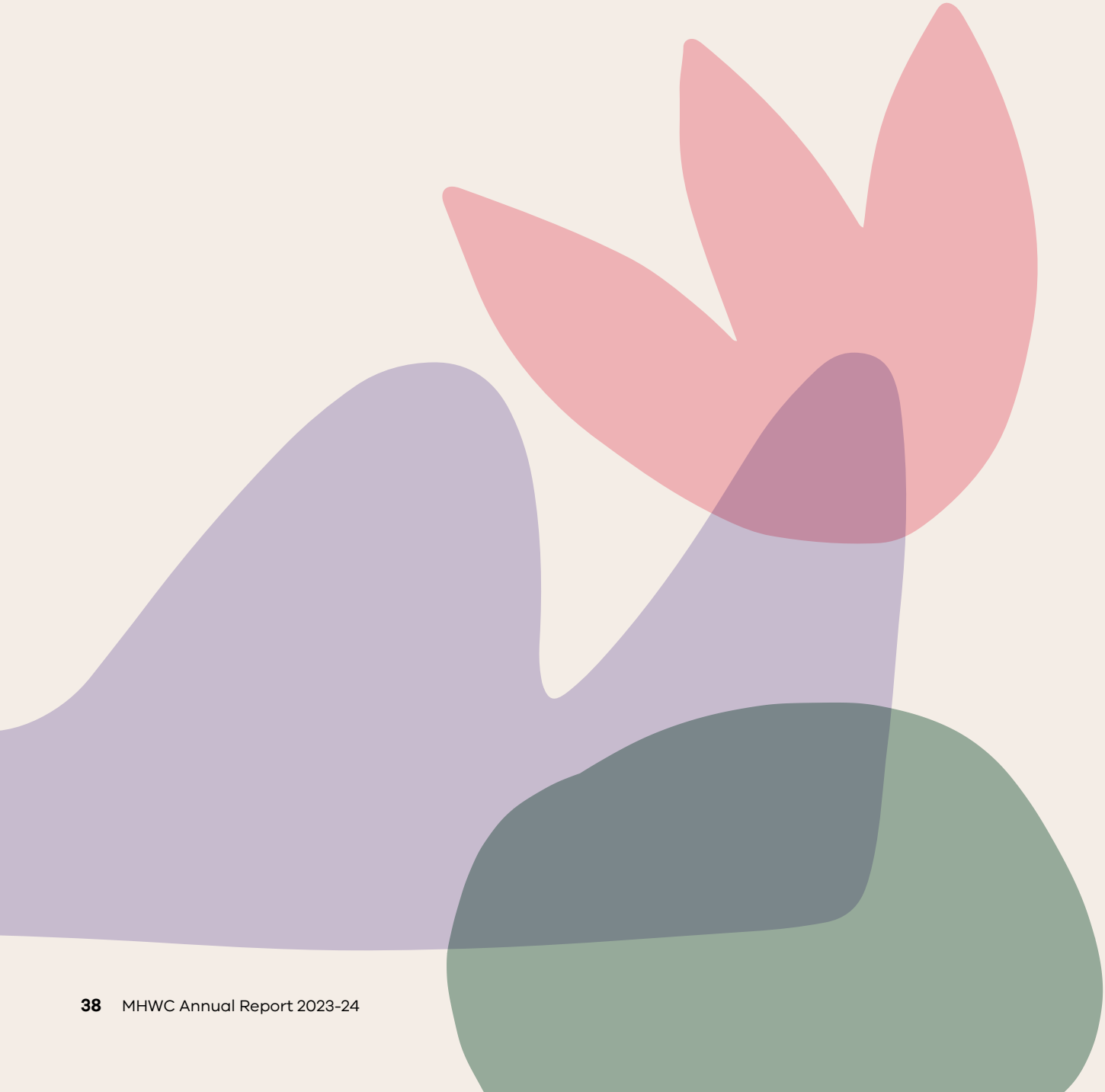
Reports

The Commission has not published any reports in its first ten months of operation, these will be an important output of the Commission.

We have written a report, on 'The Use of Restrictive Interventions in Designated Mental Health Services', which we look forward to sharing in 2024. This report looks at processes and data collection for complaints concerning the use of bodily restraint in designated mental health services. It particularly evaluates the use of a questionnaire as part of this complaint resolution process. The report also looks to identify trends and insights about the use of restrictive intervention practices in services and considers how the Commission can better oversee and reduce the use of these harmful practices.

What we've seen

The Commission is required to report on the safety, quality, and performance of the system, as well as progress towards improving mental health and wellbeing outcomes in the Victorian community.



Mental health and wellbeing system review

The Mental Health and Wellbeing Commission (the Commission) has a wide range of statutory objectives and functions. These include contributing to system governance via monitoring and reporting, as well as functions to promote the improvement, awareness and understanding of mental health and wellbeing across government, business and the wider community.

The Commission is required to report on the safety, quality, and performance of the system, as well as progress towards improving mental health and wellbeing outcomes in the Victorian community. This Annual Report represents the first round of system reporting undertaken by the Commission, and it is intended to provide an analysis of the current state and recent trends in mental health and wellbeing in Victoria.

The Commission is required to report on the incidence of gender-based violence at bed-based mental health and wellbeing services in each Annual Report. In the 2023-24 reporting year, we requested access to relevant sources of data but have not been provided with these data. The Commission understands that there are definitional issues that are being examined by the Department of Health. These issues must be resolved so the Commission can meet its legislative reporting requirements in future annual reports.

Our approach to system review and reporting

As outlined in the Commission's Monitoring and Reporting Plan (to be published in 2024), the Commission's approach to reviewing mental health and wellbeing outcomes in the community includes examination of several factors, ranging from social determinants of mental health, through to psychological distress, service outcomes, and suicide and self-harm. These are dimensions broadly used in other mental health and wellbeing outcomes frameworks, for example, the Productivity Commission's Report on Government Services.

Some of the factors explored in this report are beyond the control of the Victorian government, but they help provide important context in which the Victorian system operates. For example, social determinants of mental health and psychological distress contribute to the underlying level of need for mental health supports.

Where the Commission feels there is sufficient evidence to make commentary in the form of a hypothesis or view, we have done so. However, we note that many of the issues outlined are complex and we will seek to understand these in greater detail over time.

The work here provides both a starting point for meeting our reporting obligations for how mental health and wellbeing is tracking within the community and informs our future work and plans as outlined in our Monitoring and Reporting Plan.

It is also important to recognise that state-funded services are not the only services accessible to consumers. This necessitates consideration of non-state government-funded supports, such as services via the Medicare Benefits Schedule or medications on the Pharmaceutical Benefits Scheme.

The reporting is organised as follows:

1. **Mental health and wellbeing in the Victorian community –** including social determinants and prevalence of mental ill-health to assess the extent of community need for service delivery
2. **System performance, quality and safety –** including levels of access and investment, as well as whether the quality and safety of the system is improving in aggregate
3. **System and broader outcomes –** to examine whether the system is helping consumers, families, carers and supporters to recover, and the overall outcomes for community.

The Commission intends to supplement this analysis with a deep-dive report into the safety, quality, and performance of the system, drawing on detailed data from the Victorian Department of Health. We aim to provide a more detailed examination of the performance, quality and safety of the system by location and for specific cohorts, with key measures to be incorporated into future annual reports. This report will be released prior to the 2024-25 Annual Report.

The following section provides a brief summary of our assessment of the state of the Victorian community's mental health, as well as the Commission's view of the performance, quality, and safety of the mental health system. More information is provided in the subsequent sections.

Some notes on data used in this report

At the time of writing the Victorian government has not released its Outcomes and Performance Framework (the OPF). The Commission will continue to scan and review emerging trends and issues affecting the wellbeing of the Victorian community. We will review our approach following release of the framework. At present the analysis is focused on public data, including from the Department of Health's Mental Health Services Annual Report, the Productivity Commission's Report on Government Services and associated data sources, the Australian Institute of Health and Welfare, the Australian Bureau of Statistics, and several other sources.

Over time we will work with government to assist in addressing any gaps in the measures available, and ensuring the OPF is measuring what matters most to consumers, their families, carers and supporters in the broader Victorian community.

The Commission has not been able to report as comprehensively as we would like in relation to some aspects of system performance, quality and safety. We will continue to work with the Department of Health to address data issues. These include definitional issues, matters of timing, and data that enables a finer granularity of analysis or reporting than is included in this report.

The Act requires the Commission to report on the incidence of gender-based violence at bed-based mental health and wellbeing services in each annual report. We endeavoured to fulfil this requirement. The Commission understands that there are definitional issues around these measures that are being examined by the Department and will continue to work with them to ensure the issues are resolved so we can meet our obligations in future annual reports.

The Commission is confident the data issues will be resolved and therefore intends to augment this annual report by undertaking a deep dive analysis of data relating to restrictive practices and compulsory treatment across consumer groups in different services in 2024-25.

Summary of the Commission's analysis

Available data shows that the Victorian community has experienced increasing levels of psychological distress in recent years. Rates of high or very high psychological distress reported in the Victorian Public Health Survey were increasing prior to the pandemic, from 15 per cent in 2018 to 18 per cent of adults in 2019. In 2020, rates of high or very high psychological distress increased to 23.5 per cent and have remained at these levels to 2022. Our review of mental health determinants in recent years suggests the community is still experiencing significant challenges.

This reinforces the need for continued investment in the mental health and wellbeing system as well as a need to address the factors contributing to mental illness and psychological distress in the community.

The number of people accessing mental health and wellbeing services has increased in recent years. This has been supported by substantial funding by the Victorian government but also affected by the withdrawal of other supports, such as the additional funded psychology services made available by the Australian government during the COVID-19 pandemic under the Better Access initiative. National data shows there has been an increase in the use of medication to treat mental illness, reinforcing that the community is requiring additional support.

In Victoria, there has been a growth in Victorian government-funded clinical mental health services delivered in the community since the reform commenced, while the number of consumers accessing bed-based services has remained steady. This may be indicative of the successful targeted investment in earlier intervention by government. However, further work is needed to confirm whether additional bed-based service delivery is needed, and whether there has been a net increase in service accessibility in the community.

There appears to be improvement in some elements of safety in bed-based service settings. The rate of seclusion has decreased, and stronger targets for further reductions in the use of seclusion have been set by government for 2024-25. The use of compulsory treatment appears to be steady.

Outcomes reported from mental health and wellbeing services also appear to be stable. These are measures of mental health on exit from a service, as assessed by consumers and clinicians. Noting that these are direct measures of service impact, further data and analysis are required to monitor improvements in the outcomes produced by the system as a whole.

The rate of Victorians taking their own lives is increasing, with data from the Victorian Coroner's Court indicating 11.7 deaths by suicide per 100,000 population at the end of 2023 (801 deaths). This trend has continued into 2024, with 453 deaths to July, compared to 434 at the same time in 2023. The Commission notes the multi-factorial nature of suicide, and the need for coordinated and comprehensive work by government to address the drivers alongside improving the performance, quality, and safety of services.

This difficult outcome reflects the scale of the challenge facing the Victorian government at a time where there is increased budgetary pressure. While we note there are workforce constraints factored into recent budgetary decisions regarding the pace of reform, the data indicate that there are significant challenges facing the Victorian community, reflected by increased rates of distress in recent years, additional demand for support, and increased levels of suicide.

Figure 9: Summary data from our analysis of the mental health and wellbeing system

1. Community mental health and wellbeing

What are the long and short-term trends in mental illness and distress?

Mental illness and psychological distress in Victoria are increasing over the long-term and escalated significantly during 2020-2022. The Victorian Population Health Survey (VPHS) shows distress increased by over half in two years – from 15 per cent in 2018 to 18.1 per cent in 2019 and 23.4 per cent in 2020.

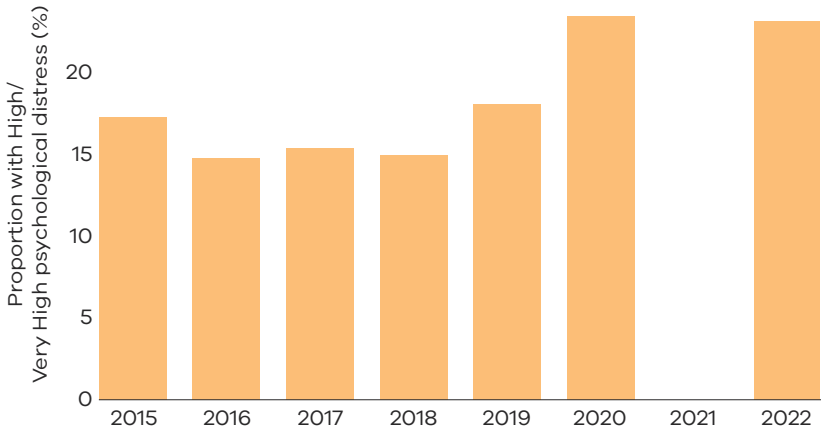
While circumstances of the pandemic are a likely explanation for the increased level of distress in 2020, the rate of distress remained persistently high in 2022, at 23.2 per cent. The primary contributor to this is unclear; it may be caused by residual issues from the pandemic or non-pandemic factors, as discussed later in this analysis.

At the time of writing the 2024 VPHS is underway. The outcomes of this survey will be important for understanding whether levels of psychological distress have since decreased back to longer-term trends or remain elevated at levels observed through the pandemic.

The VPHS data also reflect that different degrees of mental health challenges are experienced by different groups of people. For example, the data show that over 40 per cent of women under 24, and 33 per cent of women between 25 and 34 were experiencing high levels of psychological distress in 2022. In contrast, the highest rate for men is among the 25 to 34 years age group, with one in four men reporting high psychological distress.

Figure 10: Proportion of adult population with High/Very high psychological distress (K10 score≥22)

Source: VPHS and Victoria's mental health services annual reports[1]
Please note that data from 2021 is not available.



The increasing rate of psychological distress is consistent with increasing rates of mental disorders. Data from the National Study of Mental Health and Wellbeing, 2020-2022 show that the proportion of people reporting symptoms of a mental disorder in the previous 12 months rose from 19.5 per cent in 2007 to 21.5 per cent nationally in 2020-22, with similar trends in Victoria. This suggests a longer-term trend of increasing levels of mental illness in the community.

The following section explores some of the drivers of psychological distress and mental illness in more detail, to provide the Commission and the Victorian community with some understanding of what sits behind the broad increases described above.

1 https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey and https://www.health.vic.gov.au/publications/victorias-mental-health-services-annual-report

What factors may have contributed to the long-term changes in mental illness in the Victorian community?

While there is minimal causal data on what broad social, economic, and cultural changes are driving mental illness and psychological distress, the determinants of mental health more broadly are relatively well known. The Royal Commission into Victoria's Mental Health System identified many factors that may be protective or add risk across different life stages , including:

- family functioning and childhood experiences
- housing security
- financial stability and employment
- physical activity
- social support and connection
- physical health conditions
- use of drugs and alcohol.

Some of these drivers are harder to shift or may take some time to materially impact mental health at the community level. These are discussed below to provide an indication of the longer-term trend in many of these determinants. Overall, there are some key trends of concern in these drivers, although several of them have been addressed over the past decade and are moving in a positive direction or remain steady.

Figure 11: Factors that may be contributing to long term changes in mental illness in the Victorian community

Risky consumption of alcohol

Source: Alcohol, tobacco & other drugs in Australia, AIHW[3]

↓ Proportion of people engaging in risky drinking has **fallen** from around 38 per cent in the early 2000s, to around 26 per cent in 2022-23.

↑ Similar trend for tobacco smoking, although e-cigarette and illicit drug use has **increased**.

Drug and alcohol-related ambulance attendance

Source: Alcohol, tobacco & other drugs in Australia, AIHW

↓ Rates of attendances increased to 2019 but then trended **downward** to 2023.

Estimates of rates of homelessness

Source: ABS Census[4]

↑ **Increased** from 2006 to 2021, rising from 35 to 47 per 10,000 population.

Home ownership by age group

Source: Australian Institute of Health and Welfare, Home ownership and housing tenure, 2023

↓ Steady **downward** trend in home ownership over time across all age groups.[5]

Family violence

Source: Crime Statistics Victoria[6]

↑ **Increase** in family violence incidents from 1,265 per 100,000 population in 2018-19 to 1,378 in 2022-23.

Youth resilience

Source: Victorian public health and wellbeing outcomes dashboard[7]

↓ **Reduction** in resilience from 2014 (70.1 per cent resilient) to 2018 (67.3 per cent).

Family functioning

Source: Victorian public health and wellbeing outcomes dashboard

↓ **Decrease** in children living in families with unhealthy functioning from 2013 (7.6 per cent) to 2021 (6.7 per cent).

Developmentally vulnerable children

Source: Australian Early Childhood Census[8]

→ The proportion of developmentally vulnerable children has remained relatively **steady**, with around 20 per cent of Victorian children vulnerable on at least one domain in 2021; similar proportions to 2009.

Physical health

Source: Report on Government Services, Mental Health Services – Productivity Commission[9]

↑ People with a mental illness are estimated to be 86 per cent **more** likely to have asthma, 76 per cent **more** likely to have cardiovascular disease, and 69 per cent **more** likely to have arthritis. They are also 65 per cent **more** likely to be daily smokers, although they are marginally less likely to be overweight or obese, or at risk of long-term harm from alcohol.

2 RCVMHS Volume 1, pages 158, 159

3 https://www.aihw.gov.au/reports/illicit-use-of-drugs/state-alcohol-drug-use

4 Table 3. Rates(a) of people experiencing homelessness by state/territory, 2006 to 2021, https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/latest-release#state-and-territories

5 For detail, see https://www.aihw.gov.au/reports/australias-welfare/home-ownership-and-housing-tenure#ownership

6 https://www.crimestatistics.vic.gov.au/family-violence-data/family-violence-data-tables, Victoria Police Data Tables (2024).xlsx

7 https://www.health.vic.gov.au/victorian-public-health-and-wellbeing-outcomes-dashboard

8 https://www.aedc.gov.au/data-explorer/

9 Data tables 13A.58 and 13A.59, accessed via https://www.pc.gov.au/ongoing/report-on-government-services/2023/health/services-for-mental-health

Causality is difficult to assess in some of these longer-term measures. For example, poor mental health may limit physical recovery, and vice versa, or there may be external factors that influence both mental and physical health. In addition, changes in reported rates of family violence may be due to changing rates of reporting, rather than changes in the underlying level of violence. The important finding is that over the longer-term many of the factors that are protective of mental health and wellbeing appear to be deteriorating.

There are additional factors that are more difficult to measure and may be examined by the Commission in the coming years. Use of technology, changing methods of connecting with others, social cohesion, and global events such as wars and terrorism are broad issues that are noted in the media and within research and policy releases as impacting mental health.

What about the factors affecting mental health and wellbeing more recently?

At the time of writing, most of the evidence on levels of psychological distress in the Victorian community is available until around 2022. As noted above, the prevalence of mental illness and distress at that time may have been affected by factors related to COVID-19 as well as other issues.

The 2024 VPHS is being collected at the time of writing, and the Commission views this as a critical piece to understanding whether some of the psychological distress observed over 2020 to 2022 has subsided.

In the meantime, the Commission has sought to understand several of the key drivers that may be influencing community distress at present. Some of the themes and drivers identified by the Commission at this time include:

- Workplace mental health – there have been increases in the rates of mental health Workcover claims up to 2022-23[10]
- School refusal – estimated to be up by 50 per cent to 2021[11]
- Wellbeing of Aboriginal and Torres Strait Islander peoples – particularly following the unsuccessful referendum on the national voice to parliament.

Transitioning away from the supports and approaches that underpinned government and the community's response to the pandemic have also raised challenges. These include:

- the withdrawal of programs developed through the pandemic such as the Homeless to Home program[12]
- withdrawal of financial supports developed to support people through lockdowns
- the use of working from home arrangements, and current discourse around in what form this continues.

In parallel to these issues is a particularly tough economic environment, with substantial cost-of-living challenges, and restraint in Victorian government spending. The VPHS shows 57 per cent of respondents that experienced food insecurity also experienced high or very high levels of distress, indicating that access to such essentials is correlated with psychological distress. Noting this, consumer price index data for Melbourne shows that some of the fastest growing prices from December 2021 to June 2024 were for essential household items such as oils (42 per cent), gas and household fuels (36 per cent), beverages and drinks (around 28 per cent), bread (25 per cent), eggs (25 per cent), and milk (23 per cent).[13]

The evidence above, while not comprehensive by any means, suggests a continuing need for the Victorian government to prioritise the mental health and wellbeing of the community, despite the difficult budgetary environment. Over the coming year, the Commission expects to be informed of and to review, the government's approach to ensuring a coordinated and outcomes-focused approach across government to address community determinants of mental health, as envisioned by the Royal Commission into Victoria's Mental Health System.

These trends in distress and illness impact the demand for mental health and wellbeing services. These impacts as well as the safety, quality, and performance of the Victorian mental health and wellbeing system are described below.

10 Worker's compensation claims data on https://data.safeworkaustralia.gov.au/interactive-data/topic/workers-compensation (accessed 25 September 2024) shows an increase in mental health claims in Victoria from 2,195 in 2017-18 to 3,844 in 2022-23.

11 https://www.orygen.org.au/About/News-And-Events/2024/Orygen-launches-new-toolkit-to-address-rising-rate

12 https://www.homes.vic.gov.au/sites/default/files/documents/202407/05246%20H2H%20Outcomes%20Evaluation%20Snapshot%20Report%20REV%205-7-24_accessible.pdf The Homeless to Home program was developed in the pandemic using and saw 72 per cent of clients report improvements in their mental health.

13 ABS catalogue 6401.0 Consumer Price Index, Australia, TABLE 9. CPI: Group, Sub-group and Expenditure Class, Index Numbers by Capital City

2. System performance, quality and safety

The increased levels of distress in the Victorian community outlined above have several flow-on effects on demand for mental health and wellbeing services. While the focus of the Commission's work is on Victorian publicly funded services, which are within the scope of the Act, it is important to note that these are often not the first support sought by members of the community. As outlined by the Royal Commission into Victoria's Mental Health System; Services – including Local, Area, and Statewide services – sit on a scale of responses, which start with informal supports, and include non mental health services, as well as primary and secondary service that may be funded by others, such as the Commonwealth.

As such, we have reviewed trends in the level of support provided by General Practitioners (GPs) and private psychologists as context for Victorian service use and may consider measures of other early interventions in future reporting.

Primary and secondary mental health access

The Medicare Benefits Schedule data below show that there has been increased usage of GPs and psychologists, including private psychological services subsidised by Medicare, over the past decade.

There was a substantial jump in service delivery in 2020-21, in line with COVID-19 and a doubling of the number of Medicare-subsidised psychological sessions available to people to 20, although this eased back to 2022-23.

Figure 12: Six levels in a responsive and integrated system

Source: Royal Commission into Victoria's Mental Health System, Volume 1, page 226

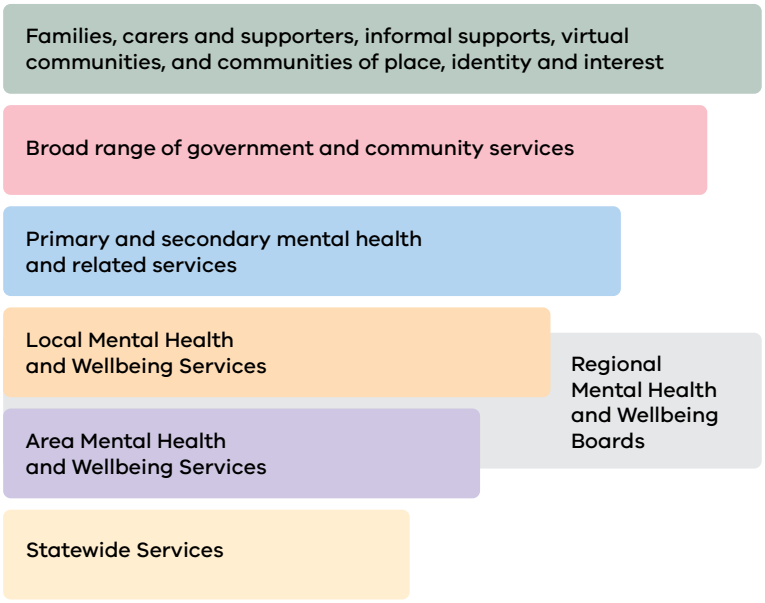
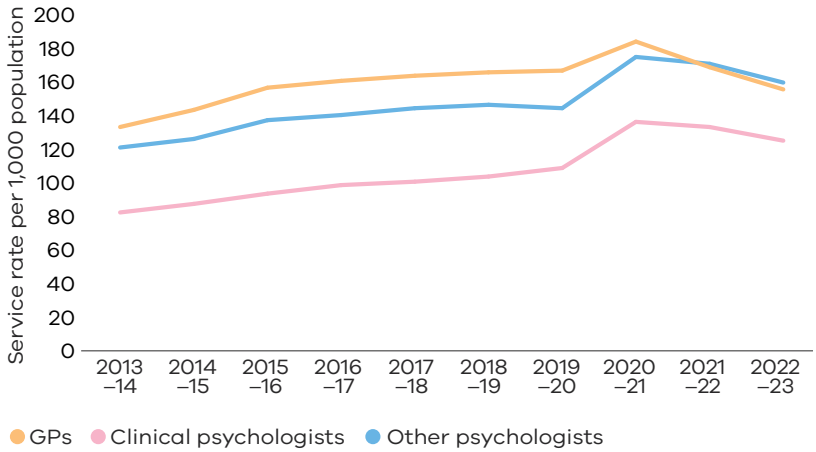


Figure 13: MH service rates per 1,000 persons – GPs and psychologists



In contrast, the rate of prescriptions to treat mental health conditions increased substantially during 2020-21 and 2021-22 and continued to be high in 2022-23. These trends indicate that while direct access to GPs and psychologists may have subsided to reflect longer-term trends, there remains a residual level of mental illness that is being treated by medication at a significantly higher rate than previously.

Access to the Victorian mental health system

Data from the Victorian Department of Health shows that the delivery of funded mental health services has increased. From 2019-20 to 2023-24:

- the number of consumers accessing clinical mental health services increased by 21 per cent
- growth was highest in specialist (71 per cent) and child and adolescent mental health services (41 per cent), and lowest in aged mental health services (12.3 per cent)
- forensic mental health service access spiked in 2021-22 but fell again in 2022-23
- adult mental health services strongly reflect the overall trend in access, with 80 per cent of mental health consumers accessing an adult mental health service in 2023-24.

In addition, the number of consumers who are 'new', or have not accessed services in the previous five years, increased by 32.6 per cent over this period. The Commission will seek to understand whether this reflects increases in psychological distress in the community, or greater access for people who previously were not able to access services.

Figure 14: Prescription rate per 1,000 persons – all MH prescriptions, Victoria

Source: Medicare mental health services 2022–23 data tables and Data tables: Mental health-related prescriptions 2022–23, Australian Institute of Health and Welfare

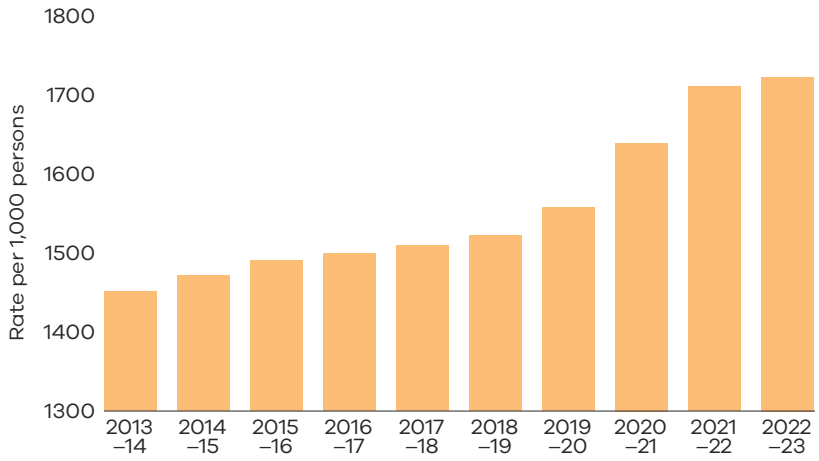
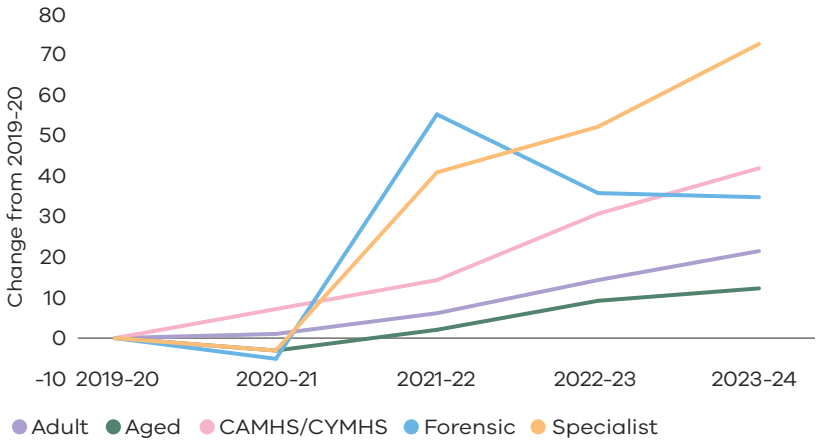


Figure 15: Change in consumers accessing clinical services from 2019-20 by cohort

Source: Service data provided by the Department of Health



The growth in access has been primarily in community-based clinical services, while bed-based service activity has remained stable over time. Key trends include that:

- the number of acute admitted patient separations (discharge) has changed from 26,660 in 2019-20 to 26,108 in 2023-24
- total bed-based separations increased only from 31,073 to 31,315
- clinical community service contacts increased from 2.6 million to 3.1 million over the same period
- mental health presentations at emergency departments increased from 101,049 in 2019-20 to 108,696 in 2023-24, (although they dropped to 95,245 in 2022-23, there was then a particular increase to 108,696 in 2023-24). Overall, this suggests a possible rise in the numbers of people in crisis.
- the number of consumers accessing mental health community support services (which are affected by service delivery transferring to the National Disability Insurance Scheme (NDIS)) declined from 5,818 in 2019-20 to 2,535 by 2021-22. Since then, the number of consumers accessing these services has increased to 3,658 in 2023-24.

These trends indicate that increased access to services has come predominantly from community-based clinical service delivery. While this may indicate an increase in earlier intervention, and more appropriate service usage and availability, the Commission has been unable to confirm whether this reflects a net increase in access, or whether it primarily reflects substitution from other community-based services into funded services.

Systemic impacts of the implementation of mental health and wellbeing Locals, and whether funding for community services is delivering a net increase in service access are factors that the Commission will be seeking to understand over the coming years as new Locals are funded.

The Commission has also considered complaints in its review of system access. The rate of complaints made to the Commission regarding access, including refusal to assess or treat consumers, has increased in 2023-24, indicating that some consumers are still facing barriers to accessing services even with increased non-admission service delivery.

Insights from complaints – access issues

The Commission received 140 in-scope complaints relating to accessing services over this reporting period. Of these, 57 were related to refusal [of services] to assess or treat consumers, which represents an increase of two complaints per month on the previous 14 months (from July 2022 to August 2023).

How has funding aligned with service delivery?

The level of funding for clinical and community mental health services has increased substantially over the past five years.

Figure 16 shows total investment documented in State Budget papers. Mental Health Clinical Care and Mental Health Community Care increased from around $1.5 billion prior to the Royal Commission, to a budgeted amount of almost $3 billion in 2024-25.

The increase in funding reflects recurrent funding in mental health and wellbeing services, as well as budget initiatives in each year, which are announced with a four-year budget horizon. Page 28 (and elsewhere) in the 2024-25 Budget Overview references the $6 billion of investment that government has made into Victoria's mental health system to deliver on the recommendations of the Royal Commission. This amount appears to refer to budget initiatives linked to the reforms relating to the Royal Commission, mental health, and (in some years) alcohol and other drugs.

The Commission has reviewed budget paper initiatives from 2016-17 and onwards related to mental health and wellbeing as well as others linked to the Royal Commission. Figure 17 shows the expenditure announced through initiatives in previous budgets, mapped to the years that the expenditure was budgeted to occur.[14] This analysis shows that a significant portion of government funding of mental health and wellbeing initiatives ($3.8 billion) was announced in 2021-22, responding to the final report of the Royal Commission. Budget paper initiatives typically provide for a four-year horizon, therefore the funding included in the forward estimates for initiatives announced in the 2021-22 budget extends to 2024-25.

Figure 16: Total output funding – mental health

Source: Budget Paper 3 total output funding tables.

Notes: 2023-24 is the revised estimate and 2024-25 is the budgeted value in the 2024-25 budget papers. Other values are 'actual' amounts from previous years in each budget. Values include MH Clinical Care, and MH Community Care line items.

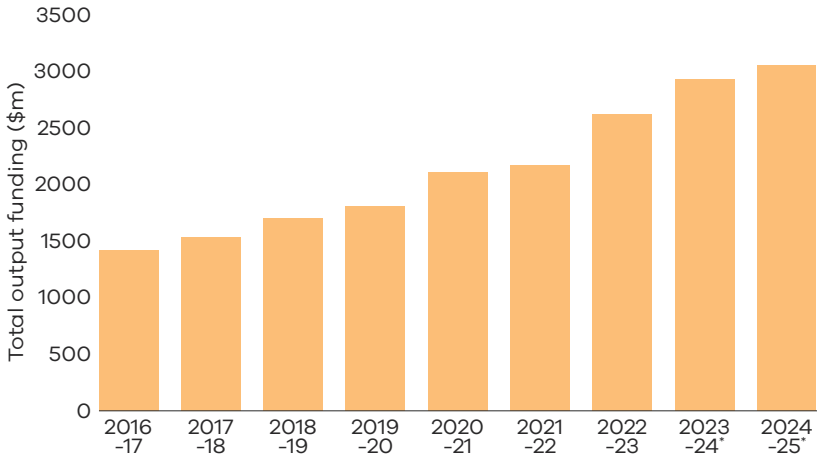
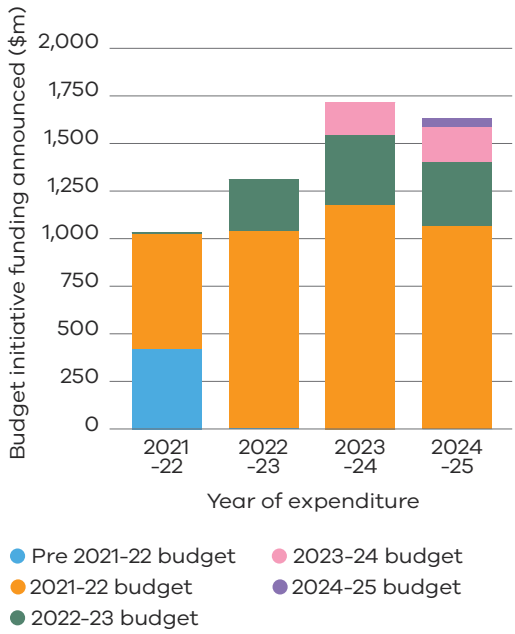


Figure 17: Previously announced mental health initiatives by budget and planned expenditure year (excludes recurrent funding)[15]



It's important to note that some budgeted initiatives might be reasonably expected to continue, however, budgets from 2025-2026 are not yet announced. We strongly encourage government to announce a revised implementation plan and associated funding to reduce any impact uncertainty might have.

14 These include output initiatives, which are initiatives intended to achieve particular outputs, as well as capital investments, for example in health infrastructure.

15 Includes all budget initiatives recorded under clinical or community mental health, or in other areas but noted as being linked to the implementation of recommendations from the Royal Commission into Victoria's Mental Health System.

How safe is the system?

As mentioned previously, our first year of monitoring is limited primarily to publicly available information, including the appendices of Victoria's mental health services annual report 2023-24. The tables underpinning the following safety, quality, and performance information are available in the appendix of that report.

Overall, there are positive signs of improvements in safety, with rates of seclusion and restraint decreasing. However, the use of compulsory treatment continues to be relatively consistent, with little change from 2021-22. Key trends include:

- The proportion of open cases in community-based clinical services where consumers are on treatment orders remained steady at 11.2 per cent
- The proportion of inpatient consumers admitted on compulsory treatment orders dropped slightly from 47.9 per cent in 2021-22 to 47.5 per cent in 2023-24.
- There has been a relatively steady decrease in the use of compulsory treatment for specialist and aged services, but other settings are somewhat more variable over time.
- The duration of compulsory treatment increased, from 87.1 days on average in 2021-22 to 102.6 days in 2023-24.

Insights from complaints – compulsory treatment

The Commission received 91 complaints relating to consumers disagreeing with treatment orders in the current reporting period. The rate of complaints received in relation to these issues fell from 13.6 per month in July 2022 to August 2023 to 9.1 per month from September 2023 to June 2024.

Some of the factors raised in consumer complaints about compulsory treatment include the financial impacts of compulsory treatment, and disagreement about the clinical diagnosis of their mental illness.

Complaints related to communication about compulsory status increased in this reporting period, with 4.6 complaints received per month, up from 2.9 per month from July 2022 to August 2023.

Restrictive practices including seclusion and restraint, are reported by services via the Client Management Interface/Operational Data Store (CMI/ODS). Key trends from those data on the use of seclusion are as follows:

- Use of seclusion has decreased, from 9.8 episodes per 1,000 days in 2021-22 to 6.3 episodes per 1,000 occupied bed days in 2023-24.
  - This is below the target for adult and forensic services (8 episodes per 1,000 days), but above the target for child, youth, and aged care services (5 episodes per 1,000 days).
- Seclusion is being used for longer on average per episode, rising from 18.6 hours in 2021-22 to 21.8 hours in 2023-24.

There are positive signs of improvement with changes to targets set by government. The target for seclusion has been revised downwards for 2024-25: 6 per 1,000 days for adult and forensic, 3 per 1,000 days for other services.

Reported bodily restraint episodes are also decreasing.

- Bodily restraint is down from 19.8 episodes per 1,000 occupied bed days in 2021-22 to 15.2 episodes in 2023-24.
- The average duration of restraint is at the lowest it has been over the past five years, lasting 0.1 hours per episode on average. Given the low average duration and variability in restraint duration from previous years, it is unclear whether this constitutes a trend.

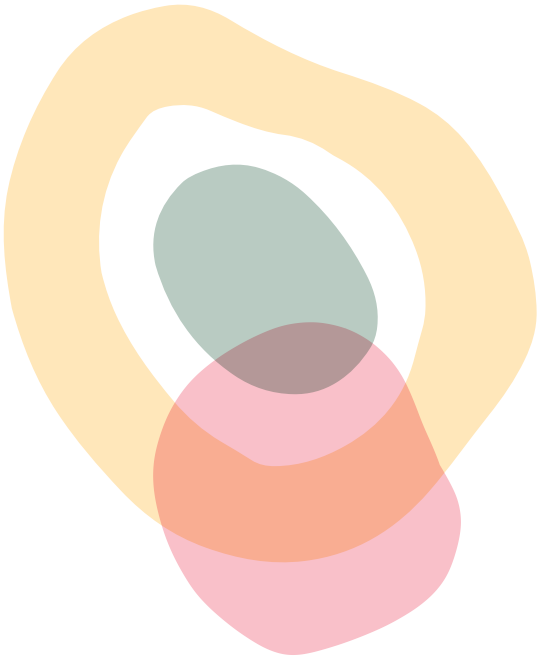
The Commission has been informed that there have been two suspected suicides on the premises of mental health inpatient units in 2023-24.

Insights from complaints – restrictive practices

The Commission received 57 complaints from consumers involving possible use of restrictive practices in the current reporting period. This reflects an increase of 1.9 complaints per month from the previous 14 months, from July 2022.

The use of security guards was a theme identified in some of the complaints received by the Commission over the past year. In addition, several complainants indicated they would like to see more personal support being offered to consumers after removal of restrictive practices, and to be involved in experience of care reviews.

The Commission also started receiving complaints related to possible chemical restraint for the first time in this reporting period, with a total of 12 complaints received.



Involvement and experiences of carers, families and supporters

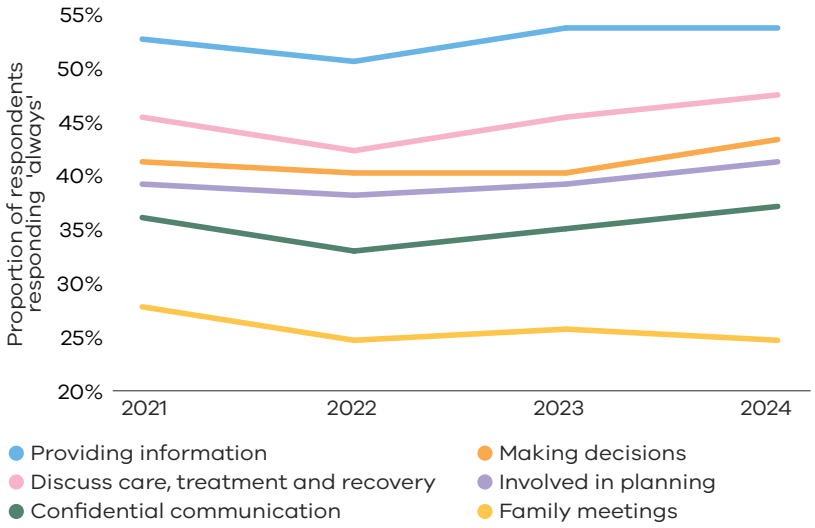
Data from the Department of Health's Carer Experience Survey indicate that there has been improvement in the experiences of carers from 2021-22 to 2023-24, following a drop from 2020-21 to 2021-22. However, the overall level of respondents reporting that they 'always' had positive involvement and experiences remains relatively low, with less than half of respondents reporting this way for all but one question.

Questions asked of respondents to the Carer Experience Survey included questions related to active participation. These included:

- In the last six months, how often did the following occur?
  - You were given the opportunity to provide relevant information about your family member, partner or friend
  - You were involved in decisions affecting your family member, partner or friend
  - You were given opportunities to discuss the care, treatment and recovery of your family member, partner or friend (even, if for reasons of confidentiality, you could not be told specific information)
  - You were involved in planning for the ongoing care, treatment and recovery of your family member, partner or friend
  - You had opportunities to communicate confidentially with the treating doctor if you needed (such as by phone, email or in person)
- In the last six months how often were you invited to a family meeting with the treating team? This includes face-to-face, telephone or video meetings.

Involvement in family meetings is the only of these elements that has not shown improvement over that period.

Figure 18: Proportion of CES respondents reporting opportunities to actively participate in treatment decisions



The Commission recognises that the inclusion and involvement in decision-making of the lived experience workforce are real measures of the quality, safety, and performance of the mental health and wellbeing system.

In establishment year, the Commission has been developing a framework for understanding how lived experience workforces operate across the mental health and wellbeing system. In addition to understanding how these staff operate in clinical settings, for example as peer workers, there is also a strong focus on system roles. These include lived experience managers and executive officers. It also includes understanding how these staff are involved in all organisational processes such as planning, evaluation, recruitment, quality and safety and community engagement.

We intend to conduct a deep-dive report into measures of quality, safety, and performance of the system which will be used in future annual reports. As part of this report, we will consider measures relating to lived experience involvement within services and across the system.

This is something that is difficult to quantify, but we intend to share best-practice examples where lived experience has been embedded in organisations in an inclusive and systemic manner, across all roles, levels and teams.

3. System and broader outcomes

Is the system helping people recover?

Measures of good system performance and the recovery of consumers should be carefully considered and not limited to clinical measures of mental health on exit from a tertiary service. The Commission expects that, within a system context, consumer outcomes should reflect measures that are important to consumers, which are often non-clinical outcomes. This includes whether consumers receive appropriate support following service access, and in subsequent mental health episodes are able to access services to intervene earlier and in settings that maximise their wellbeing, enabling them to live the lives they want to live.

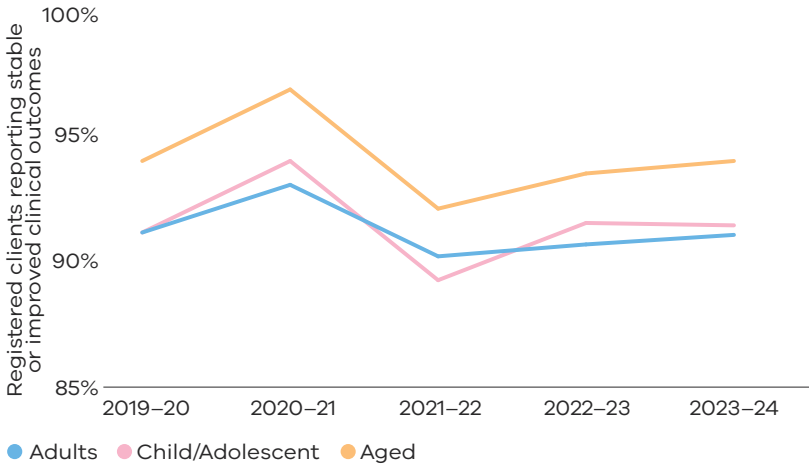
While this is the aspiration, service outcomes data at present are primarily related to experiences and impacts of clinical services. These data indicate relatively similar outcomes over time. Clinician-reported rates of improvement in community mental health cases at closure were at 53.5 per cent in 2023-24. This was up from 52.0 per cent in 2021-22, but similar to the 53.4 per cent recorded in 2019-20.

Assessments of outcomes from consumers have shown similar trends to clinical assessments. The proportion of registered clients experiencing stable or improved clinical outcomes in adult, child and adolescent, or aged mental health services increased slightly from 2021-22 to 2023-24, but these 2023-24 outcomes were similar to 2019-20.

Rates of follow-up after discharge are relatively high, with 90.9 per cent of inpatient consumers experiencing follow-up within seven days. Rates are lower in Forensic and Specialist services, at around 80 per cent, while aged consumers have the highest rates of follow-up, at 94.3 per cent.

Figure 19: Proportion of consumers reporting improved clinical outcomes from services

Source: Your Experience Survey (YES) data provided by the Department of Health



Are suicides and self-harm changing?

Suicides and self-harm are tragic outcomes that are a multifactorial issue. In considering the data on these elements, we are mindful that the mental health and wellbeing system plays only a part in this picture. For example, disconnection from culture and Country, intergenerational trauma, relationship breakdown and family violence are important factors, as are other mental health determinants, psychological distress and illness, access, quality and safety of all parts of the mental health system (including those not funded by the Victorian Government) and the effectiveness of those supports in helping people. Within the system it's also important to balance avoidance of potential self-harm or suicide with dignity of risk.

Suicide remained the leading cause of death in Victoria for people aged 18 to 44 in 2022, and the second leading cause of death behind heart disease for people aged 45-54. It accounted for 10 per cent of life-years lost to all causes.

Data from the Victorian Suicide Register (VSR), established by the Victorian Coroner's Court, were examined to identify recent trends in suicide. It is important to note that Victoria's suicide frequency can vary substantially from month to month and annually. This is not unique to Victoria – it is a feature of suicide data around Australia and the world. The deaths included in the Victorian Suicide Register (VSR) are regularly reviewed as coroners' investigations progress and more is learned about the circumstances in which they occurred.

Deaths may be removed from the VSR if investigation establishes they are likely not to be suicides; likewise, deaths initially missed may be added to the VSR as new evidence consistent with suicide is gathered. This is why some data reported here may be different to what was reported in other places. The majority of deaths that occurred in 2023 are currently under investigation by coroners to determine the circumstances. For these reasons, it is important to note that conclusions regarding trends in suicide may change as the data are updated.

Data from the Victorian Coroner's Court to the end of 2023 show:

- There was an increase in the number of suicides from below 700 in 2019 to 2021, to 761 in 2022, and 801 in 2023.
  - This rate of growth (around 15 per cent over the five years) is over three times the rate of population growth (around 4.3 per cent from 2019 to 2023).
- From 2019 to 2021 three times as many men died from suicide than women.
- In 2022 and 2023, women accounted for a higher proportion of suicides, with the ratio falling to 2.6 men dying from suicide per woman.
- One third of suicides occur in regional locations.

Figure 20: Annual suicides in Victoria

Source: Coroners Court 2023 Annual Suicide Data Report

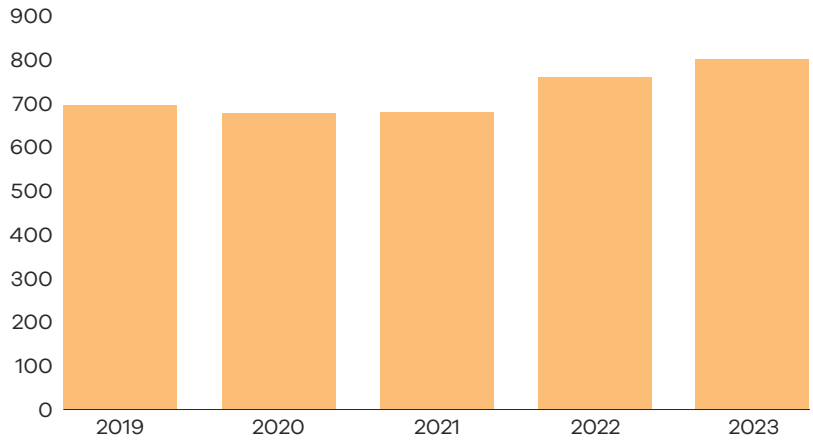
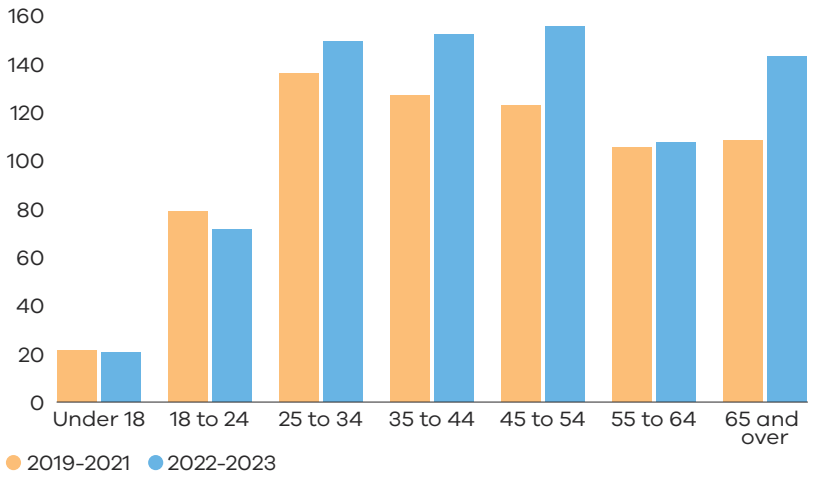


Figure 21: Average annual suicides by age group

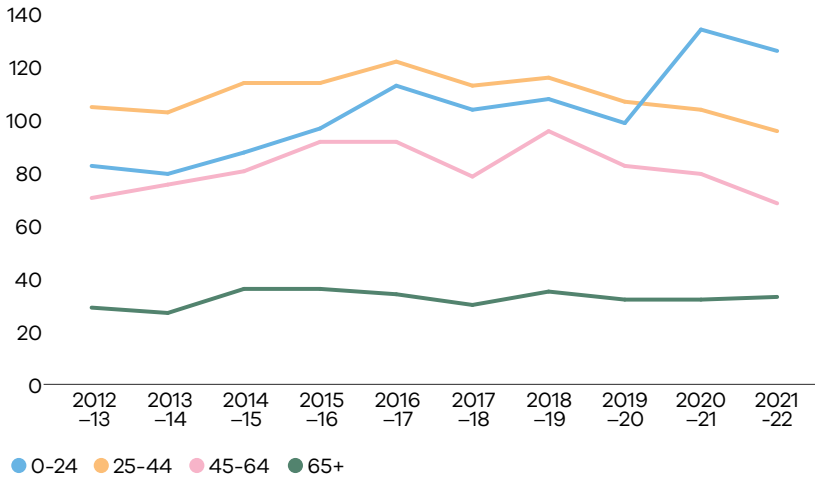
Source: Coroners Court 2023 Annual Suicide Data Report



A key factor in the increase in suicides in 2022 and 2023 reported by the Victorian Coroner's Court is an increase in suicides for those aged 35-54, and those aged 65 and over. The chart above compared the profile of annual average suicides by age group, over the periods 2019 to 2021 and 2022 to 2023.

Figure 22: Intentional self-harm hospitalisations per 100,000 population

Source: Admitted Patient Care National Minimum Dataset



While suicides among young people have remained relatively stable, intentional self-harm among young people in Victoria surged in 2020-21 and 2021-22. Data from the Australian Institute of Health and Welfare based on the Admitted Patient Care National Minimum Dataset shows:

- the rate of intentional self-harm hospitalisations per 100,000 people increased from around 100 in 2019-20 to 120 in 2021-22
- rates of intentional self-harm among people aged 25 to 64 have been falling over the past five years, after rising from 2012-13 to 2016-17
- rates among those over 65 have remained relatively stable and are the lowest across the age cohorts.

Next steps

Following this review, the Commission has identified the following key actions to inform our approach for the next year.

We will:

- review whether psychological distress in the community changes significantly in the 2024 VPHS
- consider whether to adjust our monitoring of community outcomes and determinants, based on a review of government's Outcomes and Performance Framework
- develop a framework to monitor lived experience leadership and representation across the mental health and wellbeing system
- continue to monitor government's investment in mental health and wellbeing and ensure mental health is a priority for government
- seek evidence on whether there is a net increase in access to services accessible to the community
- undertake a deep dive into measures of quality, safety, and performance of the system, which will:
  - examine trends across locations, providers, and cohorts
  - seek to explore the reasons behind aggregate changes (e.g. the increase in the average length of compulsory treatment)
  - potentially identify additional measures for reporting in future annual reports
- review government's revised implementation plan for the Royal Commission recommendations, including to seek input from government on:
  - assessment of whether initiatives put in place to address workforce constraints are having an effect
  - whether reform work that is less dependent on workforce is being considered and commenced where it is appropriate to do so.

"We need to lay solid foundations if we are to perform our role effectively. This means getting the right people, having a clear understanding of how we contribute to change, and feasible plans that don't duplicate the work of others. This can be painstaking work, but it is an essential part of being impactful."

Commissioner Annabel Brebner

Progress on the Royal Commission recommendations

The final report of the Royal Commission into Victoria's Mental Health System was tabled in a special sitting of the Victorian Parliament on 2 March 2021.

The final report included 65 recommendations in addition to the nine interim report recommendations. The recommendations set out a 10-year vision for a future mental health system where people can access treatment close to their homes and in their communities.

The Victorian government committed to implementing all recommendations.

Our role

The Commission is charged with monitoring and reporting on the progress of implementing the recommendations made by the Royal Commission.

As outlined in the Commission's Monitoring and Reporting Plan, our role includes:

- Independent oversight of the implementation of the Royal Commission recommendations.
- to identify concerns with implementation progress and approach to alert government, the sector, and the community to any emerging risks and problems.
- to elevate the status of mental health across government, to ensure the recommendations remain a priority.

Our approach

The Commission remains committed to understanding progress towards achieving the outcomes of the recommendations.

Our initial approach is focused on understanding government's approach to date, including prioritisation, implementation planning, and timelines.

While we understand that implementation may be impacted by many factors, and changing circumstances may necessitate changes in how the recommendations are implemented, what we seek to understand is whether any changes are ultimately in pursuit of the objectives and outcomes set out by of the Royal Commission.

We are currently in a dialogue with government to better understand progress on the recommendations. The Department of Health has provided a summary of recommendation progress as at 30 June, which updates a previous update provided to the Public Accounts and Estimates Committee (PAEC) on 31 May, 2024.

The summary includes the implementation progress status of each of the recommendations, as well as the implementation completion date as outlined by the Royal Commission. We note that government has indicated it has reviewed and recast the implementation of the reform program through its Phase 2 Reform Plan, which is set to be released in late 2024. As a result, the Commission understands that both the acquittal approach and the associated timeframes for the Royal Commission recommendations will be updated throughout the course of 2024-25.

The Commission has committed, through its Monitoring and Reporting Plan, to an independent program of consultative work to validate the implementation of recommendations and identify key issues. This will help to inform the Commission's approach to reporting progress against the recommendations in future years.

Through 2023-24, the Commission has also been made aware of community concerns around the timing and funding for recommendations and put questions to the Victorian government about the future of mental health reforms. We look forward to the release of the Phase 2 Reform Plan, and to being informed of how government will seek to address those issues through that plan.

Figure 23: Royal Commission recommendation progress and original timelines outlined by the Royal Commission on Victoria's Mental Health System as 30 June 2024

Source: Victorian Department of Health

Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
1	Supporting good mental health and wellbeing	1.1 End 2022 1.2-1.4 End 2031	In progress
2	Governance arrangements for promoting good mental health and preventing mental illness	End 2022	In progress
3	Establishing a responsive and integrated mental health and wellbeing system	3.1 & 3.2a End 2026 3.2b. & 3.2c End 2022 3.2d. End 2026 3.3 End 2022 3.4 & 3.5 End 2024	In progress
4	Towards integrated regional governance	4.1 Mid 2021 4.2 End 2023 4.3 End 2026 4.4 End 2023 4.5 End 2022	In progress
5	Core functions of community mental health and wellbeing services	End 2026	In progress
6	Helping people find and access treatment, care and support	6.1 & 6.2 End 2026 6.3-6.5 End 2022	In progress
7	Identifying needs and providing initial support in mental health and wellbeing services	End 2026	In progress
8	Responding to mental health crises	End 2024 8.3.c End 2022	In progress
9	Developing 'safe spaces' and crisis respite facilities	End 2026	In progress
10	Supporting responses from emergency services to mental health crises	10.1 End 2024 10.2 End 2022 10.3 End 2024	In progress

Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
11	New models of care for bed based services	11.1 End 2026 11.2 End 2022 11.3 End 2026 11.4 End 2031	In progress
12	Developing new bed-based rehabilitation services	12.1 & 12.2 End 2026 12.3 End 2031	To be commenced
13	Addressing gender-based violence in mental health facilities	13.1 End 2031 13.2 Mid 2022 13.3 End 2026 13.4 End 2031	In progress
14	Supporting mental health consultation liaison services	End 2024	In progress
15	Supporting good mental health and wellbeing in local communities	15.1 & 15.2 End 2024 15.3 End 2026 15.4 End 2022	In progress
16	Establishing mentally healthy workplaces	16.1 End 2022 16.2 End 2023	In progress
17	Supporting social and emotional wellbeing in schools	17.1 End 2031 17.2 End 2022 17.3 End 2031	In progress
18	Supporting the mental health and wellbeing of prospective and new parents	18.1 End 2026 18.2 End 2022	In progress
19	Supporting infant, child and family mental health and wellbeing	19.1-19.4 End 2022 19.5 End 2026	In progress
20	Supporting the mental health and wellbeing of young people	20.1 End 2022 20.2 End 2024 20.3 End 2026 20.4 End 2022	In progress

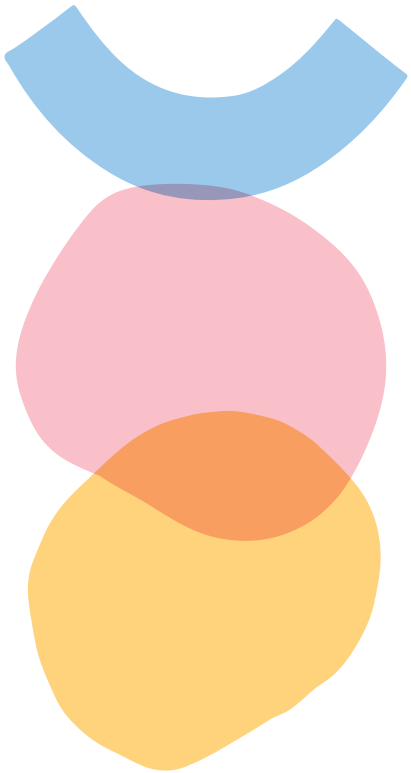
Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
21	Redesigning bed-based services for young people	21.1 & 21.2 End 2026 21.3 End 2022	In progress
22	Supporting the mental health and wellbeing of older Victorians	22.1 End 2022 22.2 & 22.3 End 2024	To be commenced
23	Establishing a new Statewide Trauma Service	End 2022	In progress
24	A new approach to addressing trauma	End 2026	In progress
25	Supported housing for adults and young people living with mental illness	25.1 End 2031 25.2 End 2022 25.3 End 2024 25.4 End 2026 25.5 End 2022 25.6 End 2031	In progress
26	Governance arrangements for suicide prevention and response efforts	26.1 End 2022 26.2 End 2031	In progress
27	Facilitating suicide prevention and response initiatives	27.1 & 27.2 End 2024 27.3 End 2022	In progress
28	Developing system-wide roles for the full and effective participation of people with lived experience of mental illness or psychological distress	End 2031	In progress
29	A new agency led by people with lived experience of mental illness or psychological distress	End 2024	In progress
30	Developing system wide involvement of family members and carers	End 2031	In progress
31	Supporting families, carers and supporters	31.1 & 31.2 End 2022 31.3 End 2024	In progress
32	Supporting young carers	End 2022	In progress
33	Supporting Aboriginal social and emotional wellbeing	33.1-33.3 End 2022 33.4 End 2024	In progress

Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
34	Working in partnership with and improving accessibility for diverse communities	34.1 End 2031 34.2 End 2022 34.3 End 2031 34.4 End 2021 34.5 End 2024	In progress
35	Improving outcomes for people living with mental illness and substance use or addiction	End 2022	In progress
36	A new statewide service for people living with mental illness and substance use or addiction	36.1 End 2024 36.2 End 2026 36.3 End 2022	In progress
37	Supporting the mental health and wellbeing of people in contact with, or at risk of coming into contact with, the criminal and youth justice systems	37.1 End 2026 37.2 & 37.3 End 2022 37.4 End 2024	In progress
38	Providing safe and appropriate mental health treatment, care and support at Thomas Embling Hospital	38.1 End 2026 38.2 End 2031	In progress
39	Supporting the mental health and wellbeing of people in rural and regional Victoria	39.1.a. End 2026 39.1.b. End 2022	In progress
40	Providing incentives for the mental health and wellbeing workforce in rural and regional areas	End 2031	In progress
41	Addressing stigma and discrimination	41.1 End 2031 41.2 End 2024 41.3 End 2031 41.4 End 2031	In progress
42	A new Mental Health and Wellbeing Act	Mid 2022	Completed
43	Future review of mental health laws	End 2031	To be commenced
44	A new Mental Health and Wellbeing Commission	44.1 & 44.2 Mid 2022 44.3 End 2031	In progress

Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
45	Effective leadership of and accountability for the mental health and wellbeing system	45.1 Mid 2022 45.2 End 2031 45.3 Mid 2021 45.4 End 2031	Completed
46	Facilitating government wide efforts	Mid 2022	Completed
47	Planning the new mental health and wellbeing system	47.1 End 2022 47.2 End 2023 47.3 End 2031 47.4 End 2026	In progress
48	Selecting providers and resourcing services	48.1 & 48.2 End 2031 48.3 End 2022	In progress
49	Monitoring and improving mental health and wellbeing service provision	End 2022	In progress
50	Encouraging national partnerships	End 2022	Completed
51	Commissioning for integration	End 2031	To be commenced
52	Improving the quality and safety of mental health and wellbeing services	52.1 End 2021 52.2 End 2031	In progress
53	Strong oversight of the quality and safety of mental health and wellbeing services	End 2031	Completed
54	Towards the elimination of seclusion and restraint	54.1 End 2031 54.2 End 2022 54.3 & 54.4 End 2031	In progress
55	Ensuring compulsory treatment is only used as a last resort	55.1 End 2031 55.2 End 2022 55.3 & 55.4 End 2031	In progress
56	Supporting consumers to exercise their rights	56.1 End 2031 56.2 End 2022 56.3 End 2024 56.4 End 2031	In progress

Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
57	Workforce strategy, planning and structural reform	57.1 End 2031 57.2 End 2023 57.3 End 2021	In progress
58	Workforce capabilities and professional development	58.1 End 2021 58.2 & 58.3 End 2022 58.4 End 2031	In progress
59	Workforce safety and wellbeing	59.1 End 2021 59.2 End 2026 59.3 End 2021	In progress
60	Building a contemporary system through digital technology	60.1 End 2022 60.2 End 2026 60.3 End 2024	To be commenced
61	Sharing mental health and wellbeing information	End 2022	In progress
62	Contemporary information architecture	End 2024	In progress
63	Facilitating translational research and its dissemination	63.1 End 2023 63.2 End 2024	In progress
64	Driving innovation in mental health treatment, care and support	End 2031	To be commenced
65	Evaluating mental health and wellbeing programs, initiatives and innovations	65.1 End 2022 65.2 End 2026 65.3 End 2031	In progress
IR1	Victorian Collaborative Centre for Mental Health and Wellbeing	Not specified	Completed
IR2	Targeted acute mental health service expansion	Mid 2022	Completed
IR3	Suicide prevention	Not specified	Completed
IR4	Aboriginal social and emotional wellbeing	End 2026	Completed

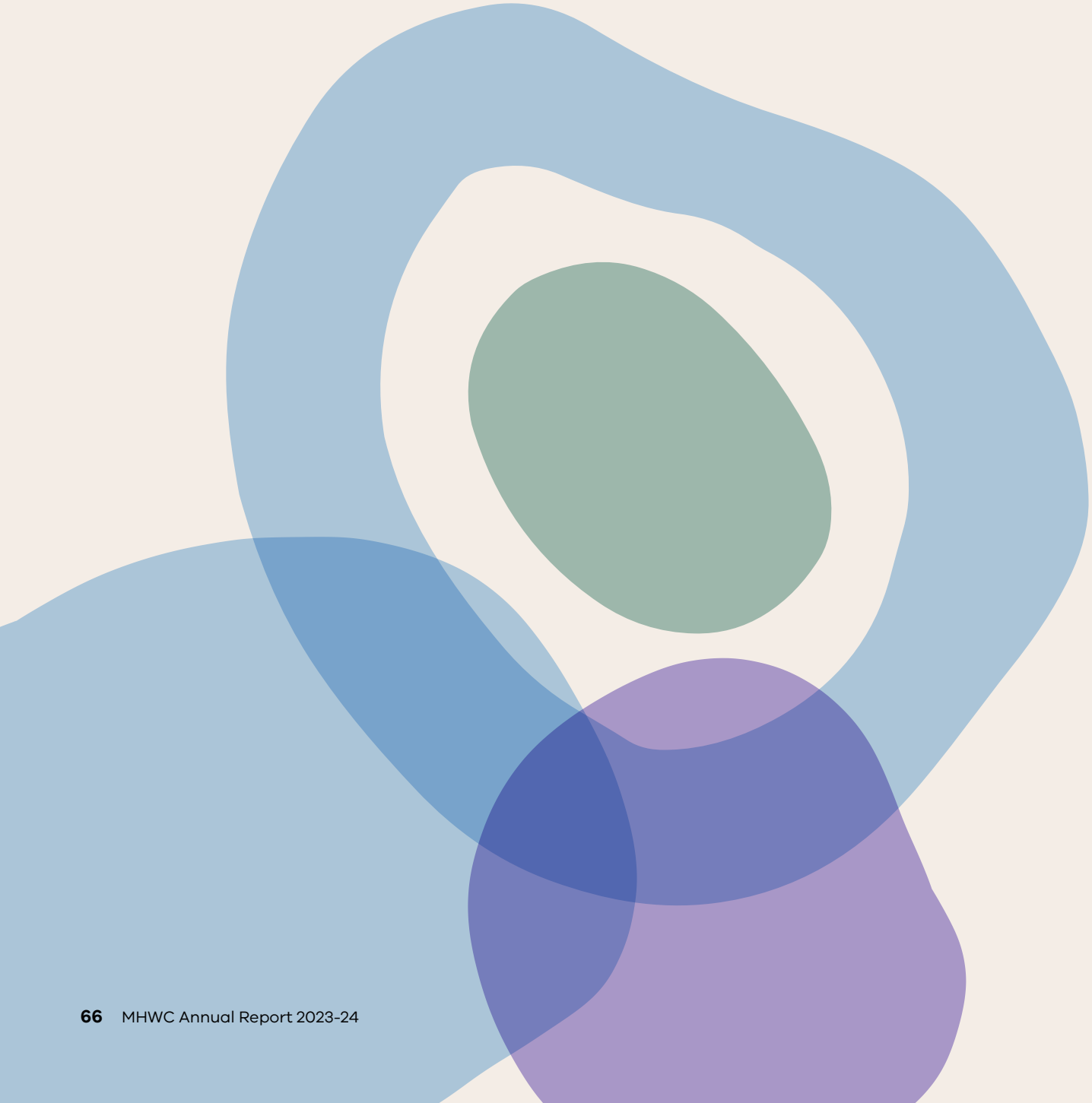
Rec	Title	Implementation to be completed by (as set by Royal Commission)	Implementation progress
IR5	A service designed and delivered by people with lived experience	Not specified	In progress
IR6	Lived experience workforces	Not specified	In progress
IR7	Workforce readiness	Junior Medical Officers by End 2023, otherwise not specified	In progress
IR8	New approach to mental health investment	Not specified	Completed
IR9	The Mental Health Implementation Office	Not specified	Completed



> “My aspiration for the future of the Commission is that we will prove to be effective; to truly progress the vision of the Royal Commission’s Final Report; to carry meaning for people with lived experience; and to be enabling and supportive to services.”
>
> **Danilo Di Giacomo, General Manager, Lived Experience**

What we've heard

Over the past 10 months, we have engaged with a wide range of individuals and organisations across the mental health and wellbeing sector.



Engagement and partnerships

Our team of four commissioners, including two with lived experience–both consumer and carer–brings valuable diversity and insight to our work. This diversity is a strength of the Commission and highlights our commitment to being an exemplar for lived experience leadership. Further, the leadership and active involvement of our commissioners highlight the importance of lived experience for effective and compassionate reform.

Our focus has been on understanding the needs and aspirations of those working in and using public mental health and wellbeing services. These conversations help us determine how the Commission can contribute to meaningful and collaborative pathways to reform. We are committed to being person-centred and trauma-informed, prioritising individuals' experiences, providing culturally safe environments and being sensitive to the effects of trauma.

Throughout the establishment year, we have focused on connecting with services, system oversight organisations, community support organisations and service users across Victoria, including regional and metropolitan areas. This has involved visiting newly established Mental Health and Wellbeing Locals and Connect Centres to gain firsthand insight into their operations. These services play a vital role in addressing the 'missing middle' of mental health and wellbeing care, providing welcoming environments for those experiencing psychological distress, and offering safe spaces for carers to connect, access respite, and focus on self-care. We had enriching and often frank conversations about the pace of reform and the need for these centres to be a continued priority in any reform plan changes.

Commissioners Maggie Toko and Annabel Brebner along with other staff from the Commission, visited the Brimbank Mental Health and Wellbeing Local in April 2024.

Our outreach has been extensive and impactful, involving participation in various events and engagements to hear diverse voices, raise the profile of the Commission, and identify ways to support and drive transformation in the mental health and wellbeing system.

Highlights of our engagement activities include:

- meeting with patients and lived experience staff at services such as Thomas Embling
- attending carers' lived experience workshops
- collaborating with universities to share information with students who will form part of future workforces
- presenting at forums like the Social and Emotional Wellbeing Forum and the TheMHS Carer Conference
- involvement in panel discussions, such as at the Equally Well Forum
- sharing our work through presentations to organisations like Wellways and Co-health
- voicing our concerns and raising awareness about the need for better reporting on mental health treatment and restrictive interventions in emergency departments
- participating in the Monash Mental Health Art Awards
- acting as a sector expert on various advisory and working groups including Psychological Safety in the Workplace.

Our Chair Commissioner Treasure Jennings participated in the following committees and advisory groups:

- Mentally Healthy Workplaces Ministerial Advisory Group
- Quality and Safety Advisory Committee
- Mental Health Workforce Safety and Wellbeing Committee
- Safer Care Victoria Mental Health Improvement Program Advisory Group

Our commissioners and senior staff regularly meet with a range of sector bodies, including the Department of Health's Mental Health Division, Forensicare, the Victoria Collaborative Centre (VCC), Office of the Chief Psychiatrist (OCP), the Mental Health Tribunal (MHT), Independent Mental Health Advocacy (IMHA), Victoria Legal Aid (VLA), Safer Care Victoria (SCV), Health Complaints Commissioner (HCC), and Mental Health Victoria (MHV).

We also maintain regular and ongoing contact with peak organisations such as Tandem Carers, Victorian Mental Illness Awareness Council (VMIAC), and Self Help Addiction Resource Centre (SHARC).

These meetings ensure a collective push towards systemic reform and continuous improvement.

Our Resolutions Team engages with services to identify improvement opportunities and better understand the environments where complaints occur. This involves quarterly service meetings and an annual program of service visits. This is in addition to the day-to-day engagement that takes place regarding individual complaints.

Engagement with First Nations peoples

The Commission has had a particular focus on engaging with Aboriginal Victorians to understand their lived experience and specific issues of cultural safety within Victoria's mental health and wellbeing system.

We acknowledge the tremendous impact that events of the past year have had on Aboriginal and Torres Strait Islander Peoples, particularly in the wake of the outcome of the 2023 referendum. We also recognise that Aboriginal Victorians need improved access to culturally safe and appropriate mental health and wellbeing support and services, and that reform is needed to drive this change.

We are committed to centring Aboriginal lived experience and expertise at the heart of what we do. This past year our lived experience commissioners met with Victorian Aboriginal communities and the Aboriginal social and emotional wellbeing workforce including the Bendigo and District Aboriginal Cooperative (BDAC) and Aboriginal Advancement League (AAL) to discuss the work of the Commission and the experiences and expectations Aboriginal people have of the system.

We are committed to Aboriginal self-determination, and we approach our engagement with First Nations' peoples in a culturally respectful manner, recognising their resilience, wisdom and leadership. We understand self-determination is about deep listening, and partnering in a deeply respectful way that is more than just consultation.

Commissioner Jacqueline Gibson also attended the Yoorrook Justice Commission's hearings into the health system and heard the powerful testimony. The Commission wholeheartedly supports the Yoorrook Justice Commission and look forward to implementing the relevant recommendations that come from its inquiries.

Going forward, the Commission is prioritising the development of Indigenous data sovereignty and governance processes to ensure we can report accurately on the social and emotional wellbeing of Aboriginal Victorians. We are also developing a culturally safe complaints process. This process will ensure that Aboriginal Victorians are able to make a complaint about their experience in a manner that is free from racism, considers the impacts of colonisation and intergenerational trauma and incorporates a social and emotional wellbeing approach to recovery.

We look forward to progress on Treaty in Victoria, and the First People's Assembly. We thank Victorian Aboriginal communities for collaborating with us to achieving better mental health and wellbeing outcomes.

Lived Experience Team – engagement and connection

The Royal Commission identified the need to:

"invest in initiatives that will result in a cultural shift in the mental health system, where lived experience, diverse explanatory models and cultural perceptions of mental health are valued equally alongside the clinical knowledge and expertise of our workforce."[16]

To support this, the Commission has commenced foundational work to prioritise the importance and impact of effective engagement with all stakeholders, building upon key values and continuums of lived experience engagement.[17]

Our Lived Experience Team has ongoing engagement with a range of stakeholders across the sector and in developing the Lived Experience Plan, used a best practice approach to integrating lived experience perspectives into the steering committee, project team, and wider engagement efforts. To ensure effective and meaningful engagement occurs, the Lived Experience Plan will target future activities aimed at creating a safe environment where consumer and carer knowledge and expertise is valued and prioritised.

This approach is further evidence of the Commission's elevation of lived experience leadership and participation at all levels. More recently the team has begun work on a mental health and wellbeing principles project, which involves extensive engagement with services and the lived experience workforce. The Lived Experience Team have also provided critical advice and connection to a broader and diverse range of stakeholders in developing the Commission's Strategic Plan and Stakeholder Engagement Framework.

Consumers and carers

In the Commission's establishment year, the Lived Experience Team have built and expanded relationships with consumer groups, families, carers and supporter groups, peak bodies, government, system and community. This has included engaging directly with other lived experience teams and workforces, including but not limited to Victorian Mental Illness Awareness Council (VMIAC), Tandem Carers, Victorian Transcultural Mental Health (VTMH), Independent Mental Health Advocacy (IMHA) and the NDIS Quality & Safeguards Commission.

Our Lived Experience Team has also actively engaged with research and training organisations including the Centre for Mental Health Learning and the Victorian Collaborative Centre as we seek to contribute to, and develop our own, systemic responses to the Royal Commission recommendations.

16 Royal Commission into Victoria's Mental Health System, 2021

17 Mental health lived experience engagement framework., Department of Health & Human Services, 2019.

Lived Experience Team – Engagement and connection (continued)

Connecting with services

In conjunction with the other Commission teams (including the Resolution Team and Legal Team), the Lived Experience Team has met with 19 services through quarterly online meetings and onsite visits during 2023-2024. 12 onsite service visits were undertaken throughout Victoria, both metropolitan and regional, including with inpatient services, community outreach, and the new Locals and Connect Centres. Focus areas for the Lived Experience Team in these meetings included learning how individual services are building lived experience leadership and how we can support services to build their lived experience capability and capacity.

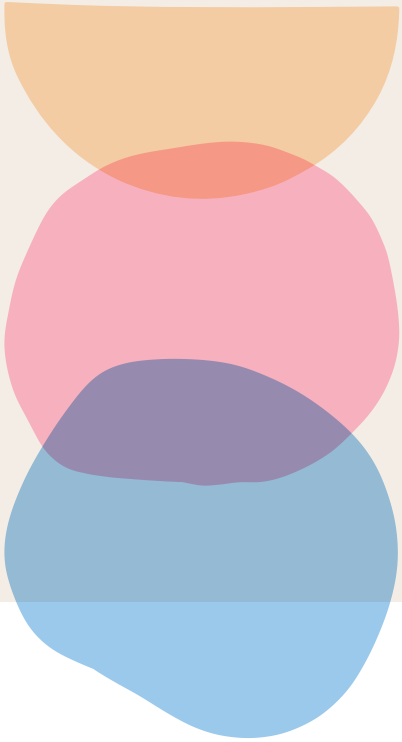
Lived experience workforce

The Commission made commitments in its Strategic Directions, to be:

- an exemplar organisation for lived experience leadership, and
- grounded in the expertise of people with lived experience.

Central to these commitments is connection with external lived experience workforce groups. The Lived Experience Team plan to stay connected and grounded in lived experience values and principles by participating in opportunities for community of practice and spaces including the Centre for Mental Health Learning Victoria's (CMHL) Consumer Workforce Reflective Circles and Tandem's Carer Lived Experience Workforce (CLEW) network.

As part of our Lived Experience Plan, the Lived Experience team are exploring other ways to engage with the lived experience workforce, including via meeting with advisory groups in services, or hosting meetings where we plan to share resources and education on supporting consumers and carers to make complaints and updates.



Communications and engagement

Our Communications and Engagement Team hold regular bi-monthly meetings with sector bodies and peak organisations to share information and learn from others about reform initiatives.

Social media, our website, and various communication materials are used to reach consumers, carers, families, and supporters. These platforms are crucial for informing individuals about their rights and encouraging feedback. Our communications must meet the needs of our end users, and we have involved lived experience perspectives in developing our website.

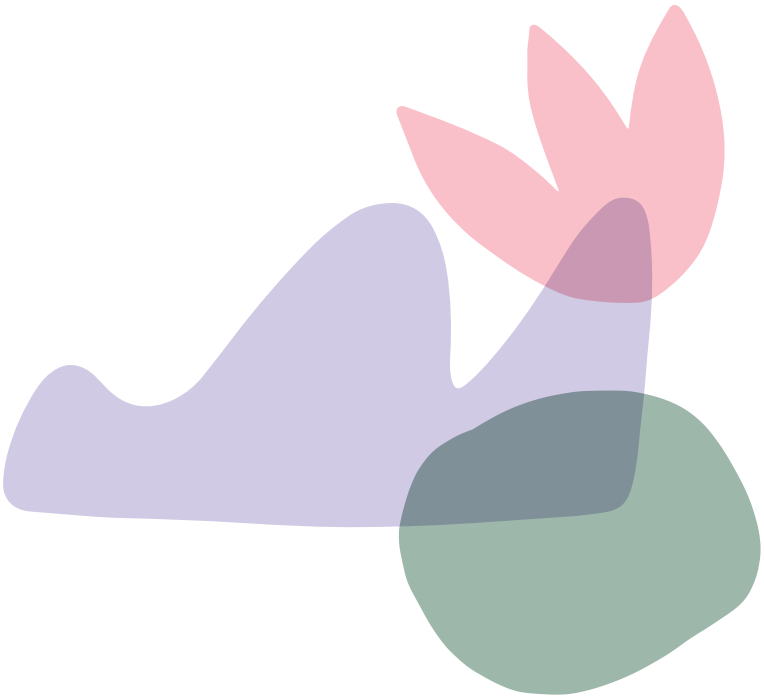
We have also developed an Engagement Framework at the Commission which outlines our commitment and approach to sector and community engagement.

We recognise that good engagement is vital to achieving our goals.

The Framework outlines the promises and expectations that guide our engagement. It demonstrates our commitment to working with others and explains how we will work with them.

While there is still much work to be done, we are committed to continuing these vital conversations and working together to enhance the system. Our goal is to ensure it is person-centred, trauma-informed, and all Victorians can choose and access services when and where they need them.

> **"The community is keen to see the Commission succeed and help drive change and reform, from its complaints process and approach to compliance through to its role in leading initiatives and participating in system improvement and design, with lived experience at the centre."**
>
> **Simon McKenzie, CEO**



Appendix 1: Operations

The Assistant Treasurer has temporarily exempt the MWHC from Standing Directions requirements in the 2023-24 financial year. The MHWC will be required to attest financial compliance as at 30 June 2025.

Financial statement for the year ended 30 June 2024

The Department of Health provides financial services to the Mental Health and Wellbeing Commission (the Commission).

The financial operations of the Commission are consolidated into those of the Department of Health and are audited as part of the department's accounts by the Victorian Auditor-General's Office. A complete financial report is therefore not provided in this annual report.

A financial summary of expenditure for 2023-24 according to Department of Health accounts is provided below. The expenditure was less than the allocated budget of $7,466,255 due to lower-than-expected operating costs for the year.

Operating statement for the year ended 30 June 2024

Expenses	
Salaries and on-costs	$ 6,386,599
Supplies and consumables	$ 902,741
Total expenses	**$ 7,289,339**

Staffing

There were 42.13 FTE (including fixed term positions) as at 30 June 2024.

Signed by: Beth Gubbins, Deputy Chief Financial Officer, Finance and Procurement, Corporate Services

02/09/2024

Appendix 2: Compliance and Accountability

Mental Health and Wellbeing Act 2022, Privacy and Data Protection Act 2014 and Health Records Act 2001

The MHWC must comply with the *Mental Health and Wellbeing Act 2022* when dealing with information provided to us, including the information sharing principles in the Act and the non-disclosure provisions that apply to information obtained in investigations, complaint data reviews, complaints resolution processes and conciliations.

The MHWC is subject to the *Privacy and Data Protection Act 2014* in relation to the collection and handling of 'personal information' about individuals. 'Personal information' is recorded information that can identify a living person.

The MHWC must also comply with the *Health Records Act 2001* when dealing with 'health information'. This is information that can identify a person, including a person who has died, about the person's physical, mental or psychological health, disability or genetic make-up.

The MHWC's privacy policy explains how we deal with personal and health information and is available on the MHWC's website at Privacy and other policies | www.mhwc.vic.gov.au.

Freedom of Information Act 1982

Requests for access to documents held by the MHWC, or the correction of documents held by the MHWC can be made under the *Freedom of Information Act 1982*.

Applications can be made in writing to the MHWC at Level 26, 570 Bourke Street, Naarm/Melbourne VIC 3000 or by email PrivacyFOI@mhwc.vic.gov.au

In 2023-2024 the MHWC made three decisions relating to freedom of information (FOI) applications. A further FOI application was withdrawn and one FOI application was ongoing at the end of the 2023-2024 FY. We also responded to an additional 3 requests for documents that were provided outside of the FOI process.

Charter of Human Rights and Responsibilities Act 2006

The *Charter of Human Rights and Responsibilities Act 2006* sets out 20 fundamental human rights for all people in Victoria, including the right to be treated equally and to have our privacy respected.

The MHWC is a public authority under the Charter and is required to act compatibly with the human rights in the Charter, and to give proper consideration to Charter rights, in dealing with complaints and doing our work.

Public Interest Disclosures Act 2012

The *Public Interest Disclosures Act 2012* encourages and assists people to report improper conduct by public officers and public bodies, and protects people from detrimental action as a result of making the disclosure.

Disclosures of improper conduct or detrimental action by the MHWC or its staff can be made to the Independent Broad-based Anti-corruption Commission (IBAC) or the Victorian Ombudsman.

Contact details are:

IBAC

Phone: 1300 735 135
Email: Info@ibac.vic.gov.au

Victorian Ombudsman

Phone: (03) 9613 6222
or 1800 806 314 (regional areas)
Email: complaints@ombudsman.vic.gov.au

More information about public interest disclosures is available on the IBAC's website at ibac.vic.gov.au and the Victorian Ombudsman's website at ombudsman.vic.gov.au/reporting-improper-conduct/.

Appendix 3 – Legislative reporting requirements for MHWC Annual Report

Section 427, Mental Health and Wellbeing Act 2022, [p342]

(1) By 31 October each year, the Mental Health and Wellbeing Commission must submit a report to the Minister on the performance of its functions under this Act during the financial year ending on the immediately preceding 30 June.

(2) An annual report must include the following–

(a) a review of the Commission's activities during the financial year;

(b) a review of the Commission's compliance with the mental health and wellbeing principles during the financial year;

(c) an overview of any actions taken during the financial year by the Commission to promote the objectives of this Act;

(d) a review of the performance, quality and safety of the mental health and wellbeing system during the financial year, including–

(i) the use of restrictive interventions in the provision of mental health and wellbeing services, including on the use of restrictive interventions compared with the targets set by the Health Secretary under section 254(h); and

(ii) the use of compulsory treatment; and

(iii) the incidence of gender-based violence at bed-based mental health and wellbeing services; and

(iv) the incidence of suicide at the premises of mental health and wellbeing service providers;

(e) a review of the State's progress during the financial year in relation to the implementation of recommendations made by the Royal Commission into Victoria's Mental Health System;

(f) a review of the progress during the financial year in relation to improving mental health and wellbeing outcomes in the Victorian community;

(g) details of any reports of the Commission that are published about the performance, quality or safety of the mental health and wellbeing system;

(h) the number and outcome of complaints made to the Commission in the financial year;

(i) the number and outcome of investigations conducted by the Commission in the financial year, including details in relation to the service of compliance notices;

(j) the number and outcome of inquiries conducted by the Commission in the financial year;

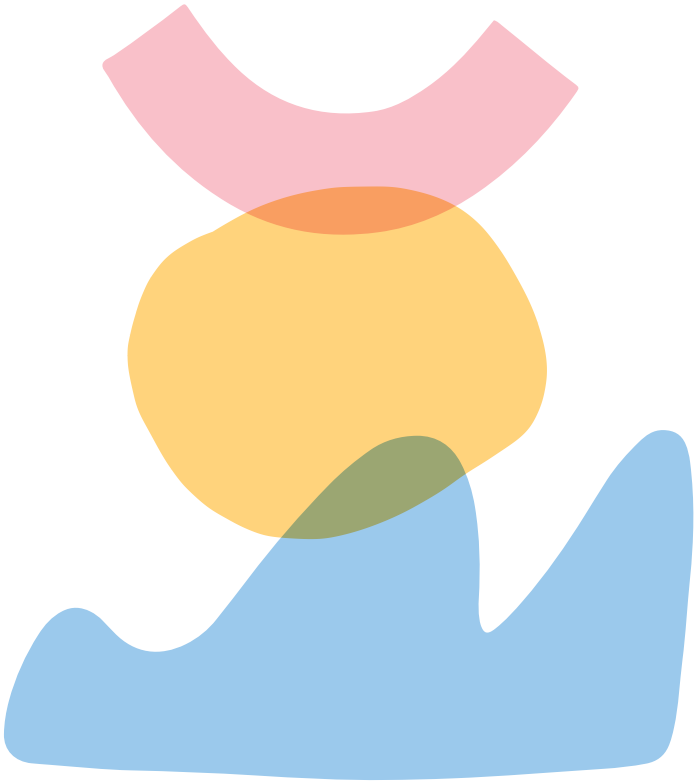
(k) a summary of actions taken that demonstrate that reasonable efforts have been made by the Commission to comply with the mental health and wellbeing principles;

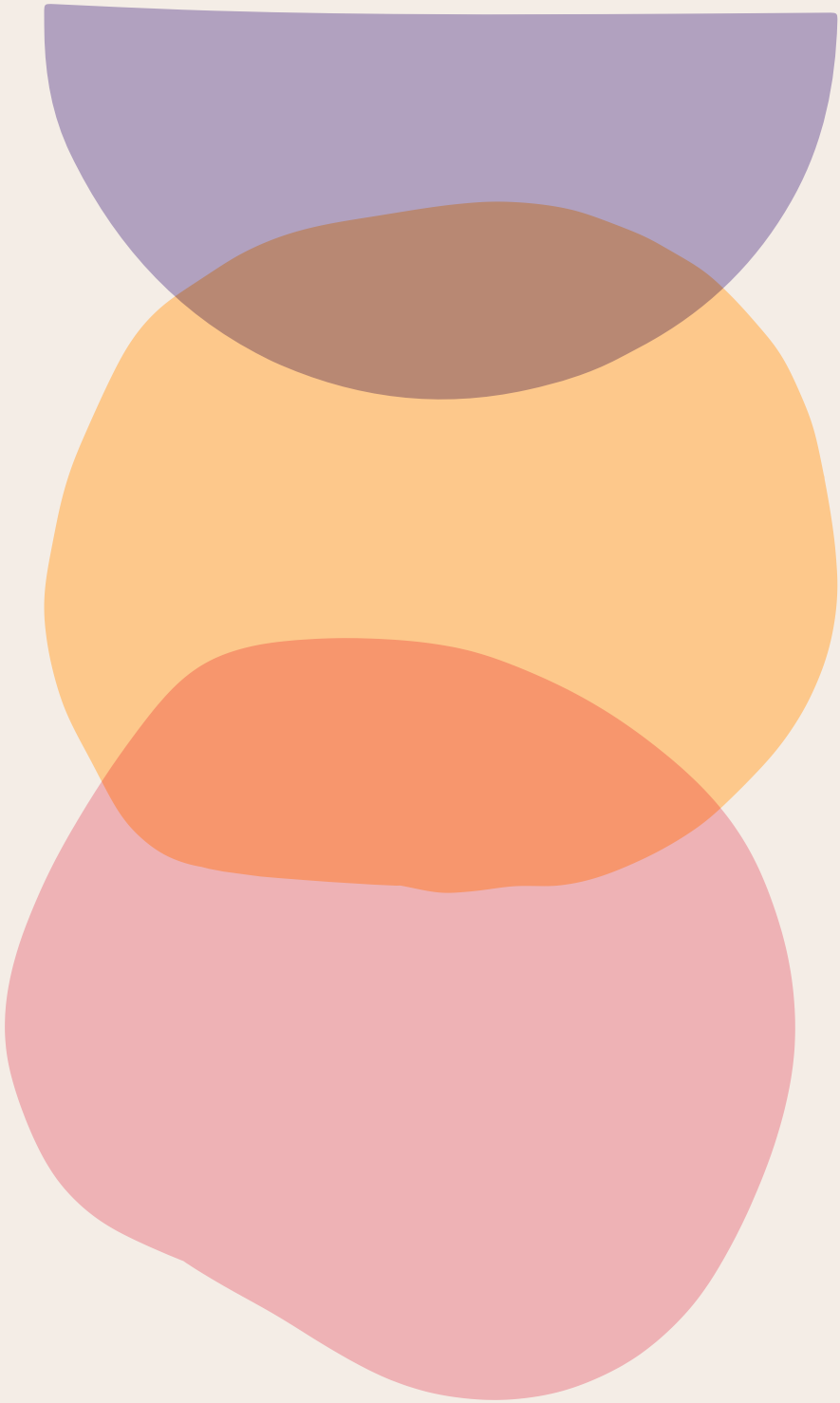
(l) any other information specified in writing by the Minister;

(m) any other information determined by the Commission.

Notes:

Notes:





Mental Health
& Wellbeing
Commission