Annual Report 2024-25

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Mental Health and Wellbeing Commission

Mental Health and Wellbeing Commission

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Mental Health and Wellbeing Commission

31 October 2025
Ingrid Stitt, MP
Minister for Mental Health
50 Lonsdale Street
Naarm / Melbourne VIC 3000

Dear Minister,

I am pleased to present the Mental Health and Wellbeing Commission's Annual Report for the 2024-25 financial year.

In accordance with section 427 of the *Mental Health and Wellbeing Act 2022*, this report outlines the Commission's performance in delivering its statutory functions over the past year and acquits the additional reporting obligations required of the Commission under section 427(2)(d)-(f) of the Act.

We hope this Annual Report provides meaningful insight into our work to elevate lived experience, to upholding rights and oversee system performance.

The report reflects our ongoing commitment to supporting consumers, families, carers, supporters and kin, service providers, and all other stakeholders across Victoria's mental health and wellbeing system.

Yours sincerely

Treasure Jennings
Chair Commissioner,
Mental Health and Wellbeing Commission

Level 13, 2 Lonsdale 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 devastating 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 and living experience of mental ill health and psychological distress, as well as people of all backgrounds, genders, sexualities, cultures, bodies and abilities.

We also recognise the important role of families, carers, supporters and kin. We honour and respect this in all our work and we thank you for working in partnership to achieve system transformation.

Language in this report

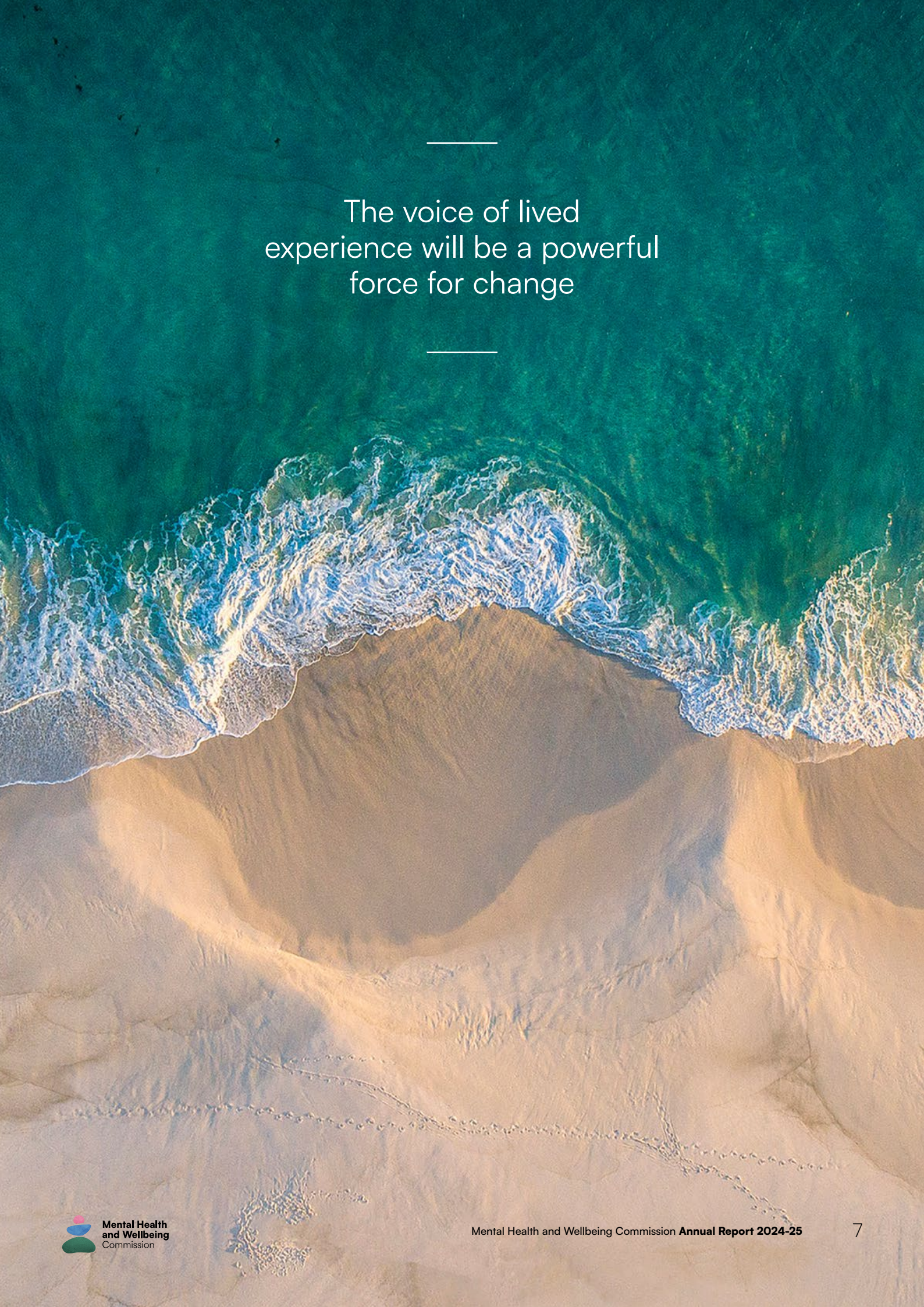
The language used in this report is guided by the words and language of the Royal Commission into Victoria's Mental Health System. Please refer to the glossary table from the Royal Commission's final report.

The Commission's approach to language is to be person-centred, clear, inclusive and respectful. The Commission prioritises the voices of people with lived experience of mental ill-health and psychological distress (consumers), their families, carers, supporters and kin. We note that their perspectives and priorities often intersect but may differ significantly. Considering this, we take our lead on language use from those with lived experience, and we do not view our preferred terminology or conventions as final or fixed. We continue to listen to lived experiences voices, and individual preferences to ensure the language we use is respectful, inclusive and fit-for-purpose.

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.

Contents



The voice of lived experience will be a powerful force for change

Section 1: Who we are

Our vision

All Victorians are socially and emotionally well and can live the life they want to live.

Our commitments

We are:

Fearlessly independent

Brave, fair, impartial and transparent in our work

A voice for inclusion, understanding and compassion

Grounded in the expertise of people with lived experience

An exemplar organisation for lived experience leadership

Focused on addressing the most important issues at the time that best serves the public interest.

Our lived experience values

01 We are genuine and put people and communities first.

02 We are committed to inclusion, representation and equity.

03 We are courageous, bold, and focused on outcomes.

04 We acknowledge and share power.

05 We are purposeful; our actions are intentional.

06 We are accountable and transparent.

07 We are committed to collaboration, co-production and evaluation.

08 We acknowledge the fact we stand on the shoulders of those who have been before us.

Our strategic ambition

We will be a driving force for change, using the Royal Commission's recommendations as the blueprint for a mental health and wellbeing system where people have the right to choose and access safe, high quality mental health and wellbeing services (services) when and where they need them.

Our role in the Victorian public mental health system

The Mental Health and Wellbeing Commission (the Commission) is an independent statutory authority established under the *Mental Health and Wellbeing Act 2022* (the Act). The Act sets out the Commission's objectives, functions and role in overseeing the performance, quality and safety of the mental health and wellbeing system.

Our legislated objectives:

Government accountability

To ensure government is accountable for:

- The performance, quality and safety of the mental health and wellbeing system, including the implementation of recommendations made by the Royal Commission.
- Ensuring the mental health and wellbeing system supports and promotes the mental health and wellbeing of consumers, families, carers and supporters, and the mental health and wellbeing workforce.

Lived experience leadership and participation

- To support and promote the leadership and participation of persons living with mental illness or psychological distress in decision making about policies and programs, including those that directly affect them.
- To promote the role, value and inclusion of families, carers and supporters of persons living with mental illness or psychological distress in the mental health and wellbeing system.

Complaints handling

- To provide a complaints handling system and promote effective complaints handling by mental health and wellbeing service providers.

Reduce stigma

- To reduce stigma related to mental illness.

Protect rights

- To promote, support and protect the rights of consumers, families, carers and supporters.

Our functions

The Mental Health and Wellbeing Commission exercises its **functions and powers** under **Section 415** of the Act, which include:

- Hold the government to account for the performance, quality and safety of Victoria's mental health and wellbeing system.
- Elevate lived experience leadership and support effective participation of people with lived experience in decision-making processes.
- Promote the role, value and inclusion of families, carers and supporters of persons living with mental illness or psychological distress in the mental health and wellbeing system.
- 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 those run and delivered by public hospitals in Victoria.
- Conduct investigations into individual complaints or on its own initiative, in relation to any matter that a person can make a complaint about.
- Initiate and conduct inquiries into any matter relevant to our objectives and functions, to support system-wide improvement and accountability.
- 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 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 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.

Commissioner Messages

Treasure Jennings
Chair Commissioner

Year in Review

The past 12 months were a period of both challenge and significant progress for the Mental Health and Wellbeing Commission. Across communities, the impacts of social and economic pressures have continued to influence the mental health landscape. While these pressures have resulted in an ongoing need for high quality and diversified services, and continue to exert pressure on the workforce, I can also confirm a continued commitment to improving mental health outcomes from services, their staff and key entities involved in supporting the aspirations of reform.

This year, the Commission deepened our engagement with lived experience communities, service providers, and government agencies, and focused on ensuring that elevating lived and living experience voices remains a cornerstone of our work. We delivered all our establishment commitments and continued to strengthen the focus on identifying areas for improvement through complaints and investigations. More information on our work regarding this can be found in the Complaints Handling and Upholding Rights Section of this annual report.

Looking Ahead

While we acknowledge the gains made, we know much remains to be done. In 2025-26, our focus will remain on ensuring that effective and accessible mental health is treated as a fundamental human right. We will continue to push for transparency, accountability, and sustained investment across the system. We are committed to building a future where everyone can access the support they need, when and where they need it.

Although the Commission will undergo changes and has seen a significant reduction to its budget, I remain hopeful that we can continue to work in a productive manner with the Government to build a sustainable and appropriately funded model that continues to support the intention of reform and maintains the independence and integrity of the Commission.

I would like to extend my deep gratitude to the staff of the Commission, our entity partners and the peak bodies Victorian Mental Illness Awareness Council (VMIAC) and Tandem as well as Mental Health Victoria (MHV) and services for their cooperation. I especially want to thank the individuals and families who have shared their stories with us. Your courage and commitment continue to shape a better future for mental health and wellbeing.

Maggie Toko
Lived Experience
Commissioner, Consumer

Kia Ora everyone,

It has been a busy and meaningful year for my portfolio. Consumers have always been my focus, and they remained my priority for the past 12 months. I had the privilege of hearing directly from many individuals about issues impacting their lives, from concerns within their local communities to broader government and global challenges. Stigma and discrimination, interactions with police, and employment-related issues featured strongly in these conversations. Their stories and experiences feed into the work of the Commission and help me prioritise my focus as commissioner.

I also had opportunities to participate in a wide range of engagement initiatives. Over the past year, I delivered speeches on topics including mental health and wellbeing, trauma in multicultural communities, leadership, Indigenous health, and supporting people with complex needs at a range of forums and events. I also continued to meet regularly with peak bodies and maintain strong ties with multicultural, multifaith, and Pasifika communities to ensure their voices are reflected in our work.

Workforce and education in lived experience leadership have also been key areas of focus. Connecting stakeholders to collectively elevate lived experience leadership continues to be an important priority for the consumer movement. One significant commitment has been to the lived and living experience Study Group, a collaboration between Yale University, SHARC, the Department of Health and the Commission.

I have been a co-sponsor of the Mental Health and Wellbeing Principles project, led by our Lived Experience Team. This project is a critical piece of work for the Commission and aims to provide practical guidance for services and clinical settings on applying the 13 mental health and wellbeing principles set out in the Act

Seeing the dedication, collaboration and expertise that has gone into the Commission's work has been an enormous point of pride for me. I would like to thank everyone at the Commission, particularly the Lived Experience Team for the incredible work they have done, and our friends and partners who have made such powerful contributions to projects, and my role.

Jacqueline Gibson
Lived Experience
Commissioner, Carer

This year, I continued to focus on ensuring that families, carers, supporters and kin are seen, heard and respected as equal partners in Victoria's mental health and wellbeing system. When I sit with people, I hear stories marked by exhaustion, resilience and love: reminding me that carers are not peripheral to the system, they are its foundation. Through the Mental Health and Wellbeing Act the Commission serves to promote their role, their value and their inclusion in shaping the way services are designed, delivered, and overseen. It is a responsibility I carry with pride and determination.

A highlight of my work has been my involvement with Mental Health and Wellbeing Connect Centres across Victoria. Led by families and carers, these centres are building communities of understanding, providing safe spaces for peer support, and offering practical resources. I have witnessed first-hand how these services are shifting culture: from carers feeling invisible, to being acknowledged as essential to recovery.

During the year I contributed to the development of the Lived and Living Experience Leadership Strategy and Plan, and ensured supporters are embedded in its design, with clear pathways into governance, workforce roles and decision-making. I also helped shape the Mental Health and Wellbeing Principles Guidance ensuring that the Family and Carers Principle is not only recognised but applied in practice.

We are already seeing services improving communication with families, creating structured involvement in treatment planning, and embedding co-designed carer education programs. Through my engagement with sector networks, I brought forward issues such as inadequate recognition of young carers, carer burnout, and the need for trauma informed family engagement.

There are significant changes ahead for the Commission and there is also uncertainty across the mental health and wellbeing system. In the face of these challenges, one thing is certain: families, carers and supporters' voices still matter. The Commission continues to take complaints, and your experiences remain essential to ensuring the system is accountable, inclusive and safe. Every story shared is not just a complaint, but a step toward systemic change.

Annabel Brebner
Commissioner

Over the past year, the Commission took significant steps forward in building the teams and establishing work plans required to discharge our functions in a strategic manner. In some areas, this meant bringing new capabilities to the Commission such as the team charged with monitoring and reporting on the performance, quality and safety of the mental health and wellbeing system.

All staff have worked tirelessly to enable the Commission to contribute positively to system reform, and I thank them sincerely for their efforts. I also acknowledge the cooperation and generosity of our sector partners for sharing their insights and knowledge to improve the quality of our work.

Our team and Commissioners worked consistently with the Department of Health to establish the processes and agreements required to share the information needed to discharge our monitoring and reporting functions. These arrangements must be established with great care, and unfortunately, they have not yet been completed. This has been a source of frustration for those who have looked to the Commission for more detailed reporting.

I have heard from consumers, their families, carers and supporters, people who work in the mental health and wellbeing system, and the broader community that providing clear, reliable information about the mental health and wellbeing system's performance is crucial. It helps build trust and confidence that the system will be available when people need to access appropriate and safe treatment and support, that services will be safe and rewarding for those who work in them, and that funds are being spent to address systemic issues identified by the Royal Commission into Victoria's Mental Health System. The Commission has worked hard to progress this much needed reporting.

I hope that over the next year the processes to enable transparent reporting are advanced across the organisations who play roles in this area. Showing the impact of the unprecedented investment in mental health and wellbeing helps justify ongoing investment, and the need for ongoing investment has never been greater.

CEO Message

It has been a privilege to lead the Commission through a year of significant progress in strengthening Victoria's mental health and wellbeing system. Focussed on building trust and championing fairness, accountability, and empathy, our dedicated staff have delivered trauma-informed responses, ensured that rights are communicated and safeguarded, and provided the checks and balances that help build public confidence in a system undergoing reform.

This work has taken place in a complex and evolving environment. Since our inception, the Commission has operated within a tight fiscal setting and periods of funding uncertainty, requiring us to prioritise carefully and plan with agility. At the time of writing, the Commission is working toward a reduced operational budget in 2025-26. Workforce planning and consultation with the Department of Health began in financial year 2024-2025 after budget announcements.

Implementing new legislative responsibilities under the Mental Health and Wellbeing Act 2022 has involved building capability while adapting to the practical realities of accessing and working with available data and information to meet our statutory oversight role.

At the same time, establishing visibility, credibility, and trusted relationships with sector partners, while putting foundational systems and processes in place, has required a sustained focus, collaboration, and resilience.

In 2024-25, we continued our establishment program and focused on embedding the new functions introduced under the Act, including enhanced compliance and oversight powers. This has required building capability, attracting skilled people, and ensuring our staff felt supported, safe, and empowered to do meaningful work.

At the heart of this has been genuine collaboration - working closely with the sector, the Commissioners, and people with lived experience to shape reforms that deliver fairer, more accountable, and more responsive services.

Key Achievements in 2024-25

Lived Experience Plan embedding lived experience leadership and insight across all aspects of our work. I was privileged to play a modest role on the Commission's steering committee in partnership on this plan co-designed with our Lived Experience Team and important lived experience and service thought leaders.

Monitoring and Reporting Plan establishing a clear framework for assessing and improving system performance.

Local complaints reporting shining a light on service-level trends to inform targeted improvement.

Approach to complaints handling and compliance monitoring ensuring fairness, transparency, and accountability in how we respond.

Approach to inquiries and systemic reviews exploring issues in depth to address root causes of systemic challenges.

Service visits gaining first-hand insight into the on-the-ground challenges and opportunities of implementing the transformational reforms outlined by the Royal Commission.

First insights report on restrictive practices complaints supporting consumers' rights through greater understanding of existing practices and areas for improvement.

Commenced our first systemic review to determine current policy and practice regarding consumers on compulsory treatment orders being charged for accommodation in secure extended treatment units.

Our strengthened complaints function continues to ensure that we create a safe space for people to share their experiences, with responses that are grounded in fairness, transparency, and an understanding of trauma.

We have maintained strong governance, prudent risk management, and careful financial stewardship - balancing fiscal responsibility with the investments needed to deliver on our statutory obligations and support our people.

I thank our staff for their unwavering commitment through challenging times, and the many individuals and organisations who have engaged with us, provided feedback, and contributed to our work.

System reform requires a sustained effort, but with trust, fairness, accountability, and empathy at the core, we can help build momentum and deliver meaningful and lasting change to the system for the people who rely on it.

Our Leadership Team

Our leadership model

The 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.

Treasure Jennings, Chair Commissioner

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.

Maggie Toko, Consumer Commissioner, Lived Experience

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.

Jacqueline Gibson, Carer Commissioner, Lived Experience

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.

Annabel Brebner, Commissioner

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.

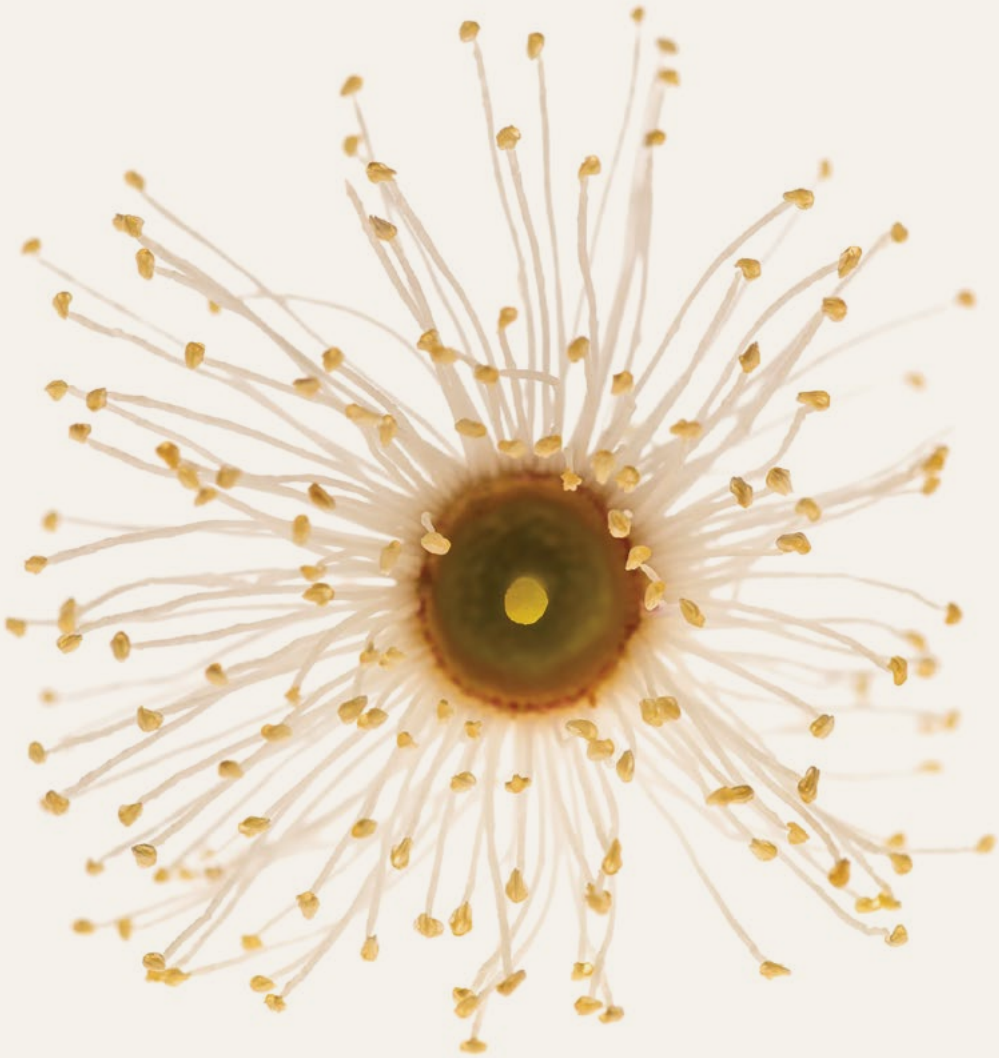
Her personal experience as a consumer and carer of those facing mental ill health drives her passion for system reform and improving access to treatment and support. Annabel is dedicated to meaningful system oversight and creating a community where everyone feels a sense of belonging.

Simon McKenzie, CEO

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.

Section 2: What we've done



Highlights

1 July 2024 - 30 June 2025	
Projects delivered	• Webinar for designated mental health services on our approach to complaint handling and compliance monitoring • Service visits roadshow • Lived Experience Plan launch • Updated website to enhance user experience • New visual branding developed with lived experience engagement and participation
Reports/submissions	• Monitoring and Reporting Plan • Lived Experience Plan • Local complaints reports • Our approach to complaints handling and compliance monitoring • Exploring issues through inquiries and systemic reviews • Supporting consumers' rights through improved understanding of complaints about restrictive practices - first insights report. • AHPRA National Prescribing Standards revision - submission
Sector wide newsletters	16 issued

Key milestones

Date	Milestone
July 2024	*Exploring issues through inquiries and systemic reviews* published
August 2024	Maggie Toko, Consumer Commissioner takes part in the working group that developed the *Heiloo Declaration* at the Global Leadership Exchange 2024, in Amsterdam. The *Heiloo Declaration* on Lived Experience promotes peer leadership and gives us an understanding of lived experience that needs to be central to the process of recovery for people experiencing mental health challenges and psychological distress.
August 2024	Commissioners receive initial briefing from Department of Health on the 2024/2025 budget for mental health and wellbeing
August 2024	*Our approach to complaint handling and compliance monitoring* published

Date	Milestone
September 2024	Chair Commissioner Treasure Jennings hosts webinars for designated mental health services on the Commission's approach to complaint handling and compliance monitoring
November 2024	*Monitoring and Reporting Plan* published
November 2024	Commissioner and staff visits with designated mental health services begin - taken to gain a deeper understanding of the challenges and successes experienced by services regarding sector reforms arising from the Royal Commission
November 2024	*2023-24 Annual Report* tabled in parliament and published
December 2024	Strategic Plan 2025-28 and Annual Plan (18 months: January 2025-June 2027) prepared
January 2025	*Supporting consumers' rights through improved understanding of complaints about restrictive practices* - first insights report published
February 2025	*Lived Experience Plan* launched and published
May 2025	Commission writes to services to protect consumers rights to vote in hospital settings
May 2025	Website updated to improve user experience
May 2025	Commissioners request Government keep mental health and wellbeing as a continued priority in the 2025-26 Budget
June 2025	Commission submits AHPRA's revised National Prescribing Competencies Framework.

Alignment with the Mental Health and Wellbeing Act objectives

Victoria's *Mental Health and Wellbeing Act 2022* 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.

Objectives

In pursuit of the highest attainable standard of mental health and wellbeing for the people of Victoria, this Act has the following objectives—

(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 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 people 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;

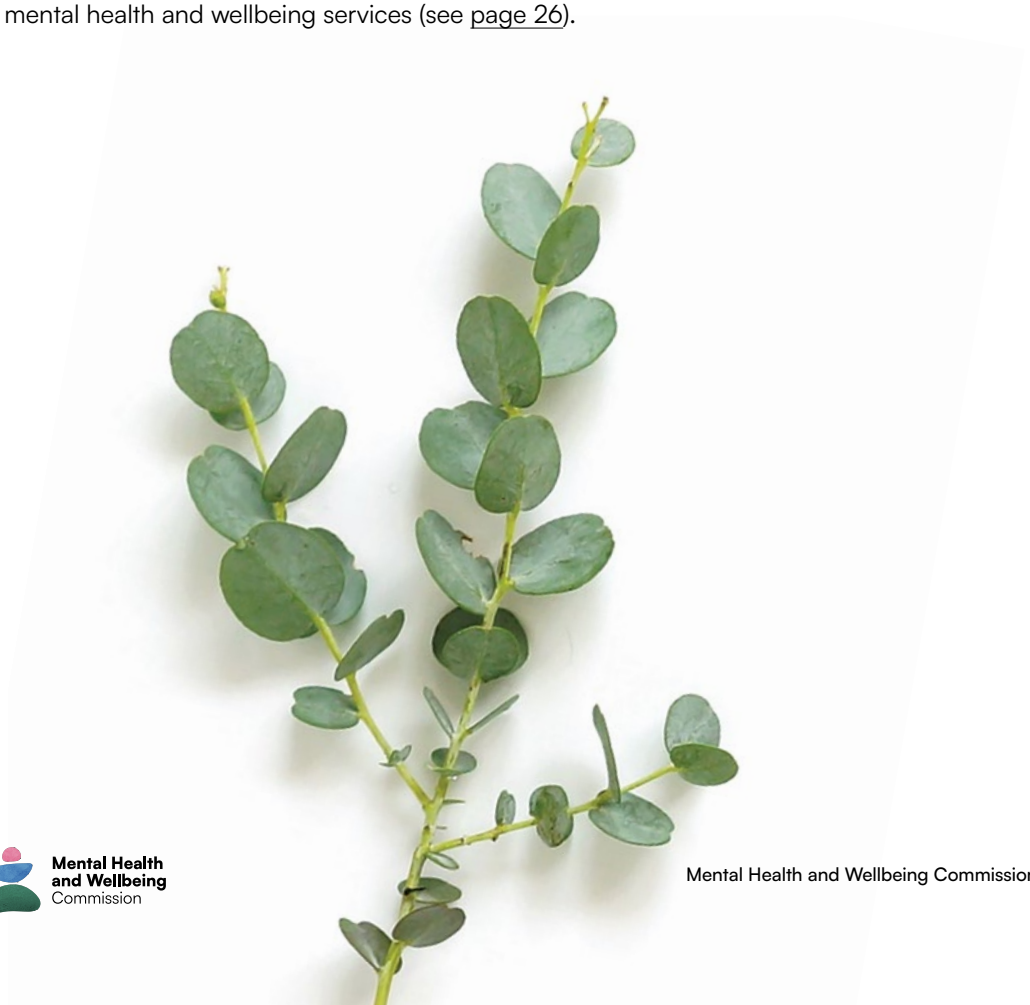
(i) to recognise and value the critical role of the clinical and non-clinical mental health and wellbeing workforce and to support and promote the health and wellbeing of members of that workforce;

(j) to promote the mental health and wellbeing principles.

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 and Investigations section on page 34) 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 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 the performance, quality and safety of mental health and wellbeing services (see page 26).
- 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 services for all individuals and ensuring fair, equitable service delivery (see reporting on page 50).
- 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 monitoring and reporting on page 50). 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.



Alignment with Mental Health and Wellbeing principles

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

Dignity and autonomy

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

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

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

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

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

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.

Health needs

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

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

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

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

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.

Cultural safety

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.

Wellbeing of dependents

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

The Commission's work to comply with the principles

The Commission is required to comply with the 13 mental health and wellbeing principles. Some principles relate to the direct provision of mental health and wellbeing treatment, care and support, which we do not directly provide. Our work, does however, intersect with each principle, particularly in our complaints and resolutions functions.

Through our resolution processes, we encourage services to consider complaints 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 supporting services to apply the mental health and wellbeing principles in their approach and practice.

Dignity and autonomy principle

- Upholding and protecting the rights, dignity and autonomy of people living with mental illness or psychological distress is central to our complaints process and this principle underpins this core function of our work.
- Our Resolutions team supports consumers, their carers, family and supporters to understand their rights under the Act and the Charter of Human Rights. The team also supports consumers and carers to understand how the mental health and wellbeing principles framework applies in practice at services.

Diversity of care principle and dignity of risk principle, supported decision making principle

- These principles are all significant in care settings. We are supporting services to ensure they provide consumers, families, carers and services a common ground of understanding to support conversations and decision-making around their care, treatment options and recovery.

Least restrictive principle

- We report on the use of restrictive interventions in Designated Mental Health Services
- When we receive a complaint about restrictive practices, we regularly ask service providers to complete a comprehensive questionnaire detailing the steps taken prior and during the use of restraint. The questionnaire is used unless it is not deemed the most appropriate way to review the use of restrictive practices due to length or number of episodes. The use of the questionnaire promotes continuous learning.

Family and carers principle

- Support for carers, family, supporters and kin is built into the leadership model of the Commission. We have a designated Carer Commissioner, Lived Experience Advisor and Policy officer to ensure that carer perspectives are incorporated into our work.

Lived experience principle

- Lived experience is embedded in all our work and at all levels of the organisation.

Health needs principle

- Our resolutions process promotes services to be considerate of the other health needs of people receiving care.

Wellbeing of young people principle

- We work across the sector to support young people. This has included engaging with Orygen Youth Services and our Commissioners meeting with youth advocates. For example, we supported Melbourne City Mission in launching their report on the challenges faced by homeless young people in accessing services.

Diversity principle

- Using intersectionality as a foundational framework in our Lived Experience Plan allows us to make meaning of diverse perspectives and examine how societal constructs impact individuals' representation, voice, and validation within systems of power and privilege

Cultural safety principle

- We meet regularly with diverse groups to gain perspective on the needs and views of different communities.

Wellbeing of dependents principle

- Our resolutions process promotes services to be considerate of the needs and safety of children and other dependents of people receiving care

Section 2a: Elevating Lived Experience

Our approach to lived experience

The Mental Health and Wellbeing Commission's approach to lived experience is centred on key legislated functions in the *Mental Health and Wellbeing Act 2022*, including:

- To elevate the leadership, and support the full and effective participation in decision-making processes
- To develop and support the leadership capabilities
- To design and deliver initiatives to develop awareness and understanding of the experiences
- To promote the role, value and inclusion of families, carers, supporters and kin.

Our Lived Experience Team

The Commission's Lived Experience Team is led by the General Manager who is part of the Commission's executive leadership team and supported by a manager, two Senior Lived Experience Advisors and two Senior Policy Officers.

The Lived Experience Team is an integral part of the Commission. Its impact is reflected throughout the operational functions from developing and prioritising strategic goals to driving key projects.

Lived Experience Plan

In February 2025, we launched our *Lived Experience Plan 2025 - 2028* (the Plan) which was co-designed with consumers, carers, families and kin, alongside sector leaders with lived and living experience.

Grounded in the belief that every person receiving mental health care has the inherent right to lead their own recovery, the Plan calls for the government and the sector to embed lived experience expertise across every space, setting and piece of work in the mental health and wellbeing system.

The Plan is a roadmap to ensure the right goals, functions and actions are in place to create genuine and lasting change.

It covers all 32 legislated functions of the Commission and ensures that lived experience drives all the Commission's work.

The Plan aims to strengthen the lived experience workforce, support leadership in the sector, track and report on the system performance and ensure government accountability for its commitments.

Our Lived Experience Plan sets out five goals:

01 People's diverse lived experiences, and the role of the Commission, are understood

02 The Commission has listened to, heard and responded to the stories of people with lived experience

03 Lived experience leadership and pathways across the sector and communities are defined

04 Lived experience is integrated in and across the governance and performance management of the mental health and wellbeing system and services, with shared power and increased accountability

05 Lived experience values are at the heart of the Commission's culture, which is seen as an exemplar organisation for lived experience and inclusion

The Plan was sponsored by the Lived Experience Consumer and Carer Commissioners. It was 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.

To read our Lived Experience Plan, visit our website.

Figure 1: Lived Experience Plan - Elevating lived experience leadership model

Group	Sponsoring Group	Steering Group	Project Team	Internal partners (staff)	External engagement
Who	4 MHWC Commissioners, including 2 Lived Experience Commissioners, CEO.	2 Lived Experience Commissioners, GM Lived Experience, CEO, **5 independent experts/external representatives**	GM Lived Experience, other MHWC Executives (or delegates), Project Officer, **6 consumer and carer representatives**	The Commission's staff - Designated Roles and all other staff	Relevant external stakeholders - agencies and experts
Chair	2 Lived Experience Commissioners	GM Lived Experience/ Lived Experience Commissioner	GM Lived Experience/ Independent Facilitator		
Role played	Overall accountability for the plan, providing authorisation to the Steering Group to lead the work.	Leads the delivery of the project, providing strategic oversight, directions and insights. The Steering Group will make decisions on the form and content of the Lived Experience Plan.	Undertakes the day to day delivery of the project, including coordinating engagement and developing material to support Steering Group decision making.	As required, the Commission's staff will support the Project Team in developing content and information to support the plan's development. Staff will also provide insights from their work and experience within the organisation.	On a targeted basis provide feedback on relevant parts of the work in progress.
Decision making	Approve overall project development framework/ governance and sign off on final Plan as drafted by Steering Group.	Decision making authority on form and content of the Plan based on inputs from the project team, as well as inputs and feedback from internal partners and external stakeholders.	Develops draft material to support Steering Group decision making, including synthesising inputs and feedback from internal and external stakeholders.	Provides individual and group level insights and feedback, including on key issues and draft material approved by the Steering Group.	Provides individual and organisational insights and feedback on draft material approved by the Steering Group.

Graphic Illustration from the Lived Experience Launch regarding how the plan will contribute to change in the system.

The Lived Experience Plan launch.

Developing Mental Health and Wellbeing Principles Guidance

Under section 415(g) of the Act, the Commission is required to issue guidance materials about how the mental health and wellbeing principles should be applied in relation to actions and decisions.

To deliver this guidance the Lived Experience Team has led extensive engagement across the mental health and wellbeing sector to help inform the development of guidance on the mental health and wellbeing principles.

The guidance builds on the findings of the Royal Commission into Victoria's Mental Health System and reflects the long-standing advocacy from the consumer and carer sectors.

The guidance is intended to drive safe and high-quality care for all people who use designated mental health services.

Lived experience and clinical leaders from across designated mental health services have been engaged to develop the guidance and have provided valuable input to make sure the information is practical, useful and accessible.

We have consulted closely with the lived experience workforce, clinicians, First Nations organisations and other key stakeholders, including the Commissioner for Children and Young People, Yooralla, the LGBTIQA+ Commissioner and Family Safety Victoria.

Figure 2: Principles guidance project - Elevating lived experience leadership

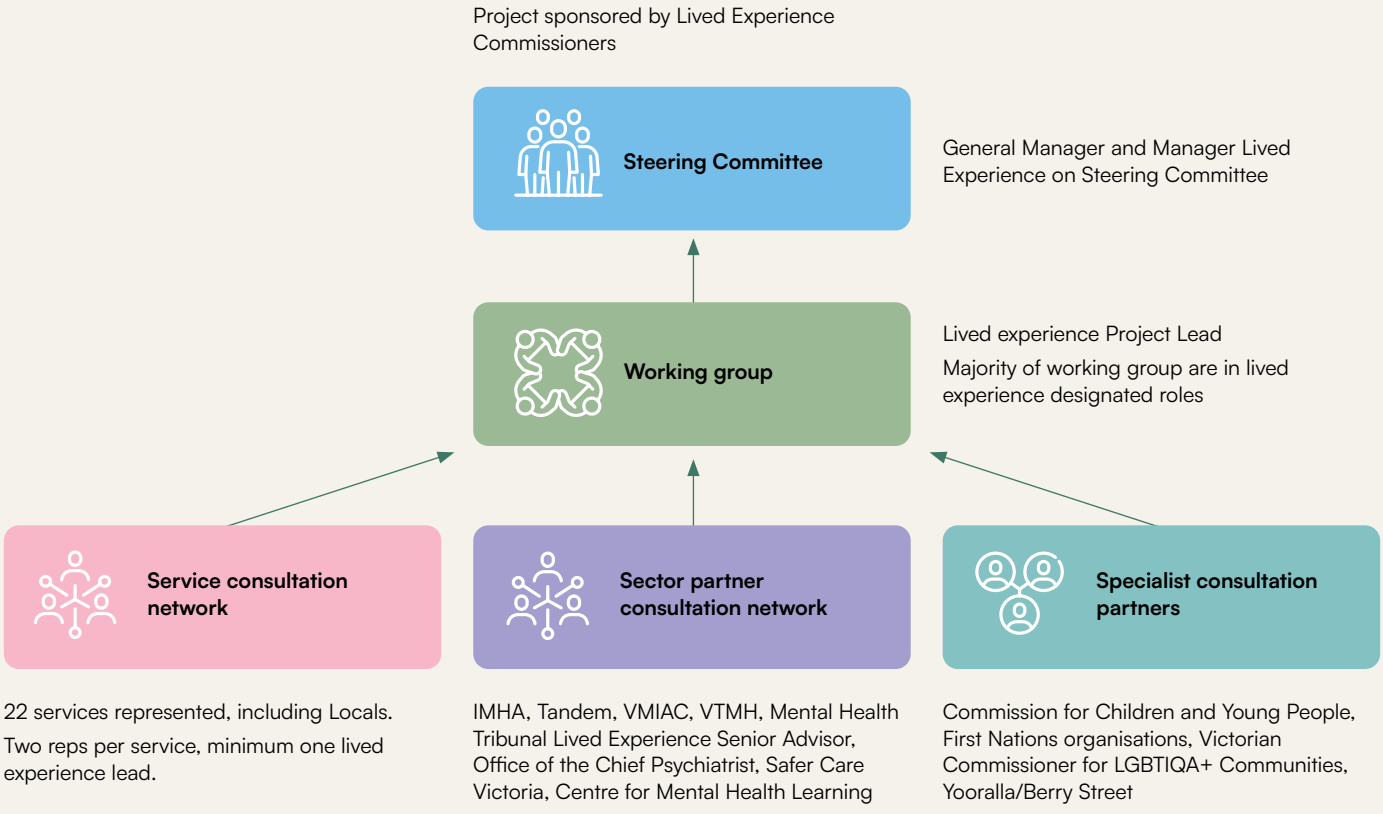
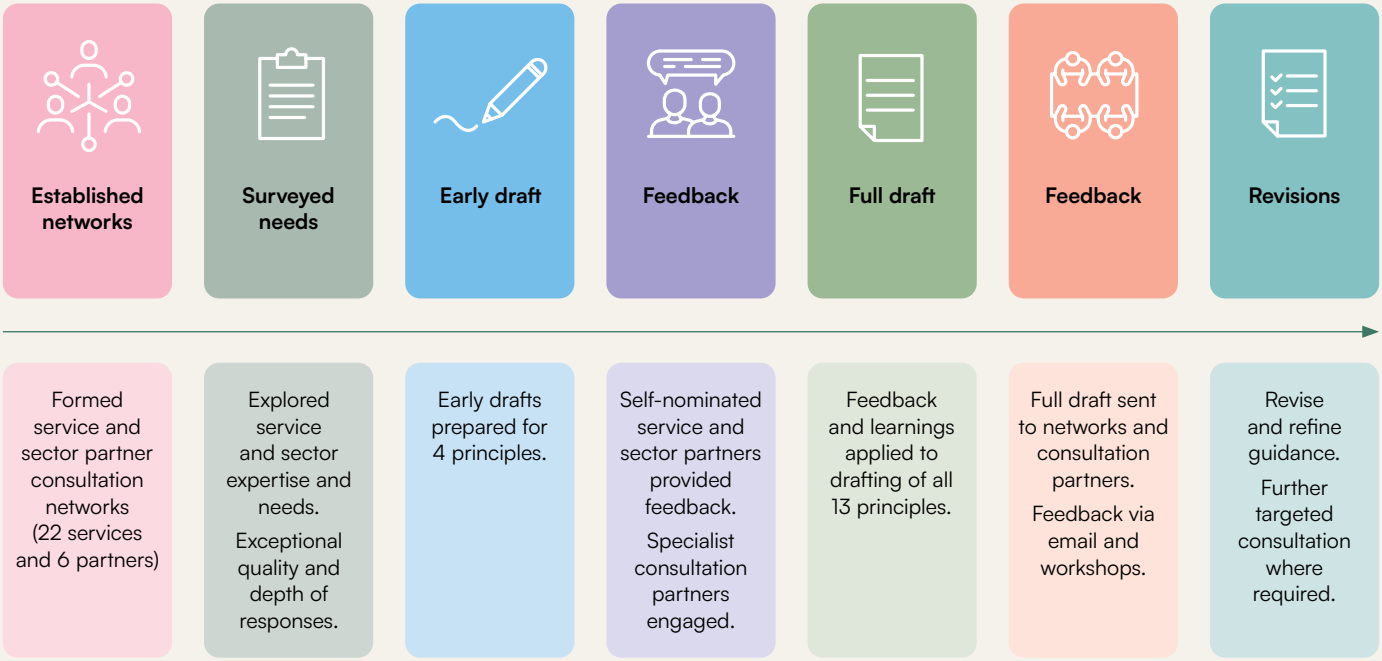


Figure 3: Principles guidance process to June 2025



The guidance provides practical steps services can apply at all levels - from leadership and governance to workforce practice. It demonstrates how services can meet the requirements for proper consideration and reasonable efforts in applying the principles when working with consumers, carers, family, kin and supporters.

For each principle, the guidance includes:

- What do the Act and relevant guidance say?
- How do human rights relate to this principle?
- How might a consumer experience this principle?
- How might carers, families and supporters experience this principle?
- How do treating teams put this into practice?
- How might services reflect on practice?

By promoting and complying with the principles guidance, services protect and uphold the human rights and dignity of those accessing mental health and wellbeing services and support the delivery of assessment and treatment in the safest and least restrictive way possible.

Lived and Living Experience Workforce Learning Collaborative

Starting in January 2025, Consumer Commissioner Maggie Toko, and members of the Lived Experience Team and Executive Services participated in monthly group sessions as part of the Lived and Living Experience Workforce Learning Collaborative (LLEWLC).

The purpose of the LLEWLC is to deliver training and technical assistance to approximately 10 government funded mental health services, as well as to the Commission.

The sessions focused on developing organisational cultures and frameworks that increase services' capacity to employ lived experience workers and expand the availability of lived experience support for people accessing services.

This 12-month Department of Health (Lived Experience Branch) funded project is delivered by a consortium with facilitators from Yale University, Self Help Addiction Resource Centre (SHARC) and Dr Louise Byrne.

Program modules include:

- Preparing organisational culture
- Developing lived-experience workforce role clarity
- Supervision and sustainability

The Commission is applying insights from the LLEWLC to advance the goals in our Lived Experience Plan and strengthen our organisational commitment to lived experience leadership, ensuring our work is grounded in the expertise of people with lived experience.

Lived experience leading change at the Commission and across the sector

Internally focused work

Throughout the reporting year, the lived experience team worked across all functional projects, ranging from reviewing progress of the Royal Commission recommendations, developing the complaints practice guidance, co-leading Ways of Working (focused on corporate and operational procedures within the Commission), providing lived experience perspective education and training for all staff, and working closely with the investigations and the communications teams. The team has been part of all recruitment panels and works closely with People and Culture.

Externally focused work

Building Consumer and Carer Connections and Networks

Our team has continued to work closely with many organisations throughout this year to strengthen our engagement with consumers, families, carers, supporters and kin.

We appreciate the opportunity to have worked closely with: VMIAC, Tandem, the Carer Lived Experience Workforce (CLEW) network, Satellite Foundation, batyr, Family and Carer Research and Advocacy Network (FaCRAN), Forensicare Consumer and Carer Advisory Groups, the Centre for Mental Health Learning (CMHL), Family and Carer Connect Centres, the Centre for Mental Health Learning, Independent Mental Health Advocacy (IMHA), Victorian Aboriginal Legal Service (VALS), Victorian Transcultural Mental Health (VTMH), Victorian Women's Mental Health Alliance, the Mental Health Tribunal (MHT), the Victorian Advocacy League for Intellectual Disability (VALiD) and the Department of Health Lived Experience Branch.

Nationally, as a member of the NDIS Quality and Safeguards Commission's Complaints sub-committee, we have provided strategic advice to ensure psychosocial disability is highlighted and encouraged trauma informed approaches into their complaint handling processes.

Additionally, the Commission also contributed to consultations on the National Carer Strategy 2024-2034, ensuring that the voices of mental health carers were reflected in policy shaping.

Team members are working with Safer Care Victoria on the Reducing Compulsory Treatment faculty. Our team attends relevant lived experience-led training and conferences and applies the learning to our work.

Connecting with Services

The Commission maintained strong service connections through quarterly virtual meetings and the annual program of on-site visits across:

- Designated mental health services
- Family and Carer Connect Centres
- Mental Health and Wellbeing Locals

These forums and visits provided valuable opportunities to monitor the development of lived experience teams and carer workforces, and to observe the rollout of new initiatives, including the launch of Family and Carer Connect Centres.

Section 2b: Complaint Handling and Upholding Rights

Our approach to complaint handling and compliance monitoring

In September 2024, the Commission published *Our approach to complaint handling and compliance monitoring* which outlines how we use our powers and provide rigorous oversight as set out in the *Mental Health and Wellbeing Act 2022*.

Our approach has been guided by the Towards best practice guide for regulators and:

- Takes a proportionate, risk-based approach to compliance monitoring
- Serves public interest
- Is designed to ensure the best use of our resources, and
- Aims to use informal processes whenever appropriate and possible.

Foundations of our approach

The Commission works within a network of entities responsible for the mental health and wellbeing system's performance, quality and safety.

We consider the perspectives of those with lived experience

We take a trauma-informed and 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.

We aim for early, informal resolution

The Commission aims for early resolution - we will attempt the least formal action that is appropriate under the circumstances. This is a requirement under the Act. We will conduct detailed reviews when informal resolution is unsuitable. Formal investigations will only be conducted for serious or systemic rights, safety or risk issues raised, or, where other complaint resolution pathways/ mechanisms are not appropriate or effective.

As outlined in the publication, we apply the following decision-making process:

Review Understand the nature of the complaint and resolution sought.

Refer If suitable, refer the matter to the service for direct resolution.

Resolve Work with the service and complainant for resolution.

Escalate Consider further action if issues remain unresolved.

The purpose of the Commission's compliance activities is to:

- Elevate rights and consumers' involvement in their treatment and recovery and where applicable elevate the rights of families and carers
- Educate services on compliance with the Act
- Ensure services take the appropriate corrective action where non-compliance with the Act has been identified, or may be an issue
- Where required, inform and advise regulators or other oversight bodies for their action
- Create both immediate and long-term systemic quality and safety improvements
- Provide transparent information on service performance
- Correctly refer to other oversight bodies for their action where they are the more appropriate body.

Webinars

In September 2024, Chair Commissioner Treasure Jennings hosted two webinars with designated mental health services and the Commission's approach to compliance under the *Mental Health and Wellbeing Act 2022*.

The webinar outlined:

- People who use services or make a complaint should be able to see what compliance actions the Commission takes, why they are taken and what changes they lead to. Wherever possible, we will publish the outcomes.
- We will explain to complainants and services about when and how we step up our compliance actions, and how we use our powers. The Act expects us to be a strong driver of compliance and improve service delivery.
- Our compliance actions depend on two things: the level of risk and how cooperative the service is. This is consistent with the Better Regulatory Practice Framework.
- We act case by case, escalating when needed and being guided by the purpose of the actions.

Our decision-making steps

Our approach to complaint handling and compliance monitoring outlines our decision-making steps as outlined below.

The Commission must consider the mental health and wellbeing principles and make sure our decision-making processes are transparent, systemic 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 using any means it considers appropriate.

When we are dealing with a complaint, we can use any appropriate method to resolve the complaint, including informal dispute resolution, conciliation or conducting an investigation.

The 4 As

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

01 **Acknowledgement** of a person's experience.

02 **Answers** or explanations about the complaint issues.

03 **Actions** taken because of the complaint.

04 **Apology** for the person's experience.

We refer to this as the 4 As of complaint resolution.

Complaints and resolutions

Taking and resolving complaints

The Commission takes complaints about any matter arising from the provision, or failure to provide, publicly funded mental health and wellbeing services under the *Mental Health and Wellbeing Act 2022* (the Act).

Examples include:

- not making all reasonable efforts to comply with the Act's principles and duties
- communication issues, including with nominated families or carers
- how a service provider handled a complaint it received

Complaints can be made by consumers, by others on a consumer's behalf, and by carers, family members or supporters about their own experiences. We consider complaints about the experiences of consumers, carers and families as defined in the Act.

Confidentiality and information sharing

Complaints to the Commission are confidential. We do not publish identifying details. We may share non-identifying, usually aggregated, information to be transparent about our work and system performance.

The Act limits what we can disclose. We cannot publish information obtained during an investigation, complaint data review, complaint resolution process or a conciliation. Disclosure is permitted only in limited circumstances - for example, with written consent, to avoid a serious risk to someone's life, health, safety or welfare, or where necessary to perform the Commission's functions (noting conciliation has additional protections).

Who contacted us

During 2024-25, the Commission received **2,747** new complaints, enquiries and referrals. This included referrals from the Australian Health Practitioner Regulation Agency (AHPRA). Complaints accounted for approximately **74%** of all matters received by the Commission over the reporting period (**2,040** complaints). **1,684** (approx. 83%) of total complaints received, were assessed to be in-jurisdiction to be progressed by the MHWC through the different resolution pathways.

Complaints we handle

In-jurisdiction complaints are made by people about their experiences in Victorian public mental health and wellbeing services.

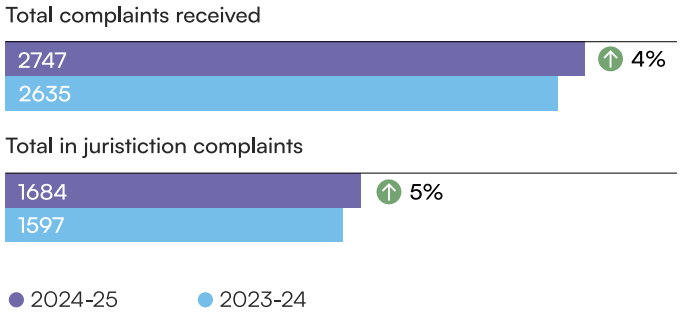
How we receive complaints

Complaints are received either verbally through our phone line or in writing through emails 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 356 complaints that were assessed to be out of jurisdiction. They were commonly about general health services, private mental health practitioners, or mental health services in other jurisdictions.

Figure 4: Complaints received

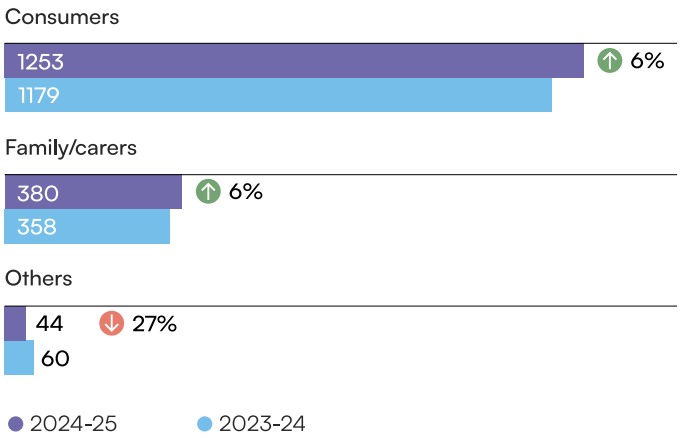


Complainants

Over the reporting period, we received **1,684** complaints that were in-jurisdiction:

- **1,253 (74%)** were made by people who received services themselves (consumers)
- **380 (23%)** from family members or carers of consumers, and
- **51 (3%)** from others including advocates, lawyers, carers making complaints about their own experiences and staff who worked for the mental health and wellbeing services.

Figure 5: Who made complaints



Mental Health and Wellbeing Services

1,592 (95%) of the in-jurisdiction complaints we received were made about designated mental health and wellbeing services, including hospital-based, community, residential, specialist and forensic services. Meanwhile only **10 (less than 1%)** of complaints received were about mental health and wellbeing community support services and the newly established local services (the Locals).

For **82 (5%)** of the in-jurisdiction complaints received we did not have sufficient information to identify the service provider. This happens when a complaint may be in-jurisdiction, but we were unable to contact the complainant for further information, because the complainant wished not to report where the issue had occurred, or because the complainant chooses not to continue with the complaints process.

Note: The data show that trends in complaints made to the Commission, and directly to services may vary across services, and caution should be used while making conclusions about relative rates of complaints.

Higher rates of complaints may reflect higher numbers of issues experienced by people accessing those services; however, they may also reflect the services' efforts to make consumers aware of their right to make a complaint.

Similarly, higher rates of complaints reported by services may represent effective complaints reporting processes and/or a positive complaints culture. They may also demonstrate higher numbers of issues experienced by people who use those services.'

Figure 6: Distribution of in-jurisdiction complaints about designated mental health and wellbeing services designated mental health and wellbeing services in Victoria

Metro Mental Health services	Number of complaints
Alfred Health	79
Austin Health	73
Eastern Health	217
Forensicare	118
Melbourne Health	95
Northern Health	147
Mercy Public Hospitals Incorporated	83
Monash Health	194
Peninsula Health	70
Royal Children's Hospital	less than 10
South West Health Care	16
St Vincents Hospital	66
Western Health	72
Orygen Health	less than 10
Regional Mental Health services	**Number of complaints**
Albury Wodonga	24
Grampians Health Services (Ballarat Health)	69
Barwon Health	51
Bendigo Health	99
Goulburn Valley Health	28
LaTrobe Regional Hospital	54
Mildura Base Hospital	less than 10
Total	**334**
Complaints about unknown DMHS	**16**

Note: 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 this table above will not align with the overall figures reported in the previous section.

A calculation of the percentage of complaint about an individual service provider, per 1,000 consumers that access each service over the reporting period, was not possible due to the data not being available at the time this report was written.

Approximately **74%** of complaints (where the service was known) were made about designated **metropolitan** mental health and wellbeing services and about **20%** were made about **regional** designated mental health and wellbeing services.

Local Complaints Reports 2023-24

Local Complaints Reporting Under the Act, all public mental health and wellbeing services in Victoria are required to share (upon request) 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 followed a more in-depth 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 2023-24 period, which were collected and developed under the *Victorian Mental Health Act 2014*, and the *Mental Health and Wellbeing Act 2022*, are now published on the Commission's website. Additionally, a Statewide report on complaints and compliments that includes comparative data charts and narratives was also made publicly available on the Commission's website.

Complaints received

Complaints raised with 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 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

Figure 7: The Commission's three-level system to classify issues raised in complaints

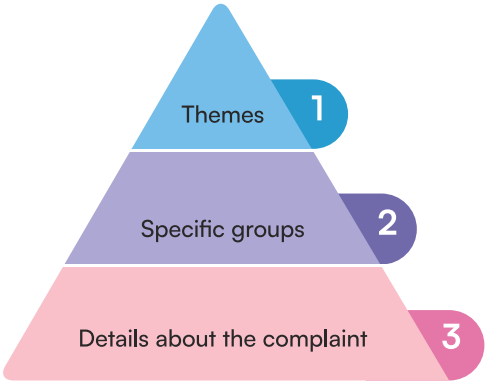
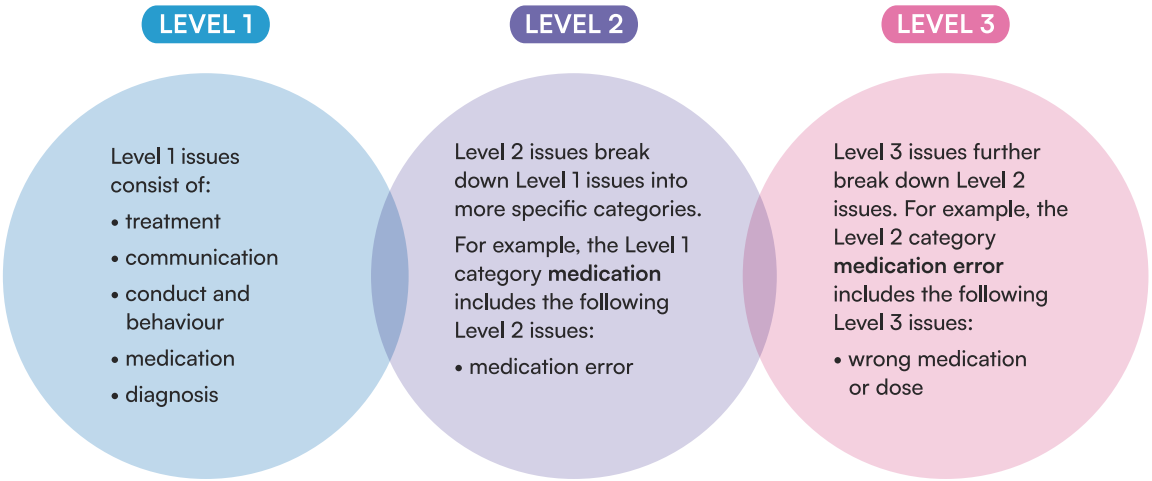


Figure 8: Complaint classification



Level 1 issues include: 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

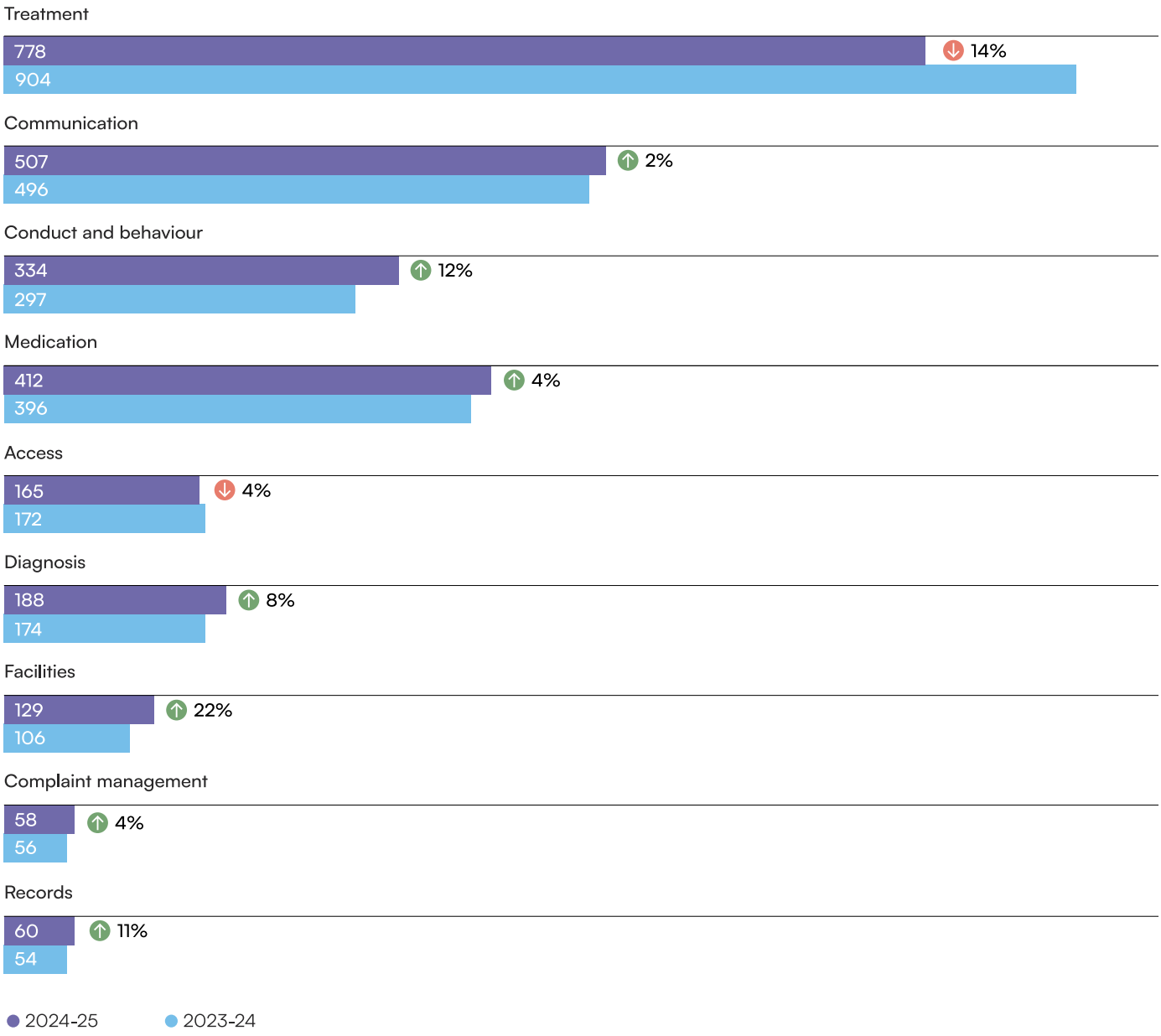
Level 3 issues: further breakdown level 2 issues. e.g. level 2 category of disagreement with medication includes the level 3 issue: dissatisfaction with the prescribed medication

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 to the Commission
- Top two level 2 issues for the top five Level 1 issues as received in in-jurisdiction complaints made
- Top level 3 issues are calculated as a percentage of the total number of level 1 issues category they fall under.

Level One Issues	Level Two Issues (top 2)		Level Three Issues - top 1st L2	Level Three Issues - top 2nd L2
Treatment (46%)	Suboptimal treatment Responsiveness of staff		Disagreement with the treatment order (7%)	Lack of care or attention (e.g. people feeling listened to or believed) (20%)
Communication (30%)	Inadequate Communication with Consumer Inadequate Communication with Family / Carer / Other Provider		Incomplete or confusing information provided to consumer (40%)	Incomplete or confusing information provided to carer, family member or nominated person (20%)
Medication (24%)	Disagreement with medication Oversedation and side effects		Dissatisfaction with prescribed medication (32%)	Side effects from medication (26%)
Conduct and behaviour (20%)	Rudeness/lack of empathy Alleged threats, bullying or harassment by staff		Rudeness, Lack of Respect or Discourtesy (31%)	Threats/intimidation or bullying by staff - clinical (5%)
Access (10%)	Refusal to access or treatment Insufficient access		Refusal to admit or treat (34%)	Lack or insufficient access to service (27%)
Diagnosis (10%)	Incorrect Diagnosis, Inadequate or Inappropriate Assessment	Incorrect / Disputed Diagnosis	Inadequate Assessment Process	
Facilities (8%)	Security, Accommodation	General Unsafe Environment (e.g. Feeling Physically, Emotionally Unsafe)	Quality of Food / Meals	
Complaint Management (3%)	Inadequate or No Response, Retaliation as a Result of Complaint	Local Complaints Process - Inadequate / No Response	Reprisal / Fear of - Against Consumer	
Records (3%)	Record Keeping, Access to Record	Inaccurate / Incomplete Records	Lack of Access to Records	

Figure 9: Frequently raised level 1 issues



Closure of complaints

In total, **1,617** in-jurisdiction complaints were closed between 1 July 2024 - 30 June 2025:

- **792** that were either **fully or partially resolved** to the satisfaction of the complainant
- **77** were **not resolved**
- **748** complaints, a resolution was not applicable / reported.

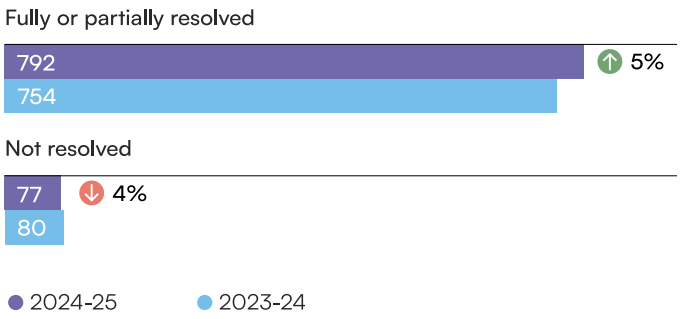
A number of complaints were not progressed (approximately **46%**) because:

- it wasn't possible to contact the complainant again after making a number of attempts following the initial contact
- the consumer consent was not obtained where information about them was material to the complaint
- the resolution was not required to be reported by the service when following a direct resolution approach, where the Commission does not seek information about the outcome of complaint.

Where complaints were progressed through the process and outcomes reported to the Commission, over **91%** were resolved to a level of satisfaction (either fully or partially) for the complainant.

The Commission continues to implement the assisted referral process, that has been receiving positive feedback from services and encouraging them to report back to us on the outcomes achieved, responding to the complaints directly to the consumers and complainants.

Figure 10: Complaints resolved



Over this reporting period, almost **46%** of the closed complaints were progressed through the Assisted Referral process with a high percentage of resolution reported back to the MHWC. This has highlighted better and faster outcomes for complainants than previously reported.

Our complaints process resulted in:

- **51%** of the complaints that were closed during that period to be finalised within the first month of receipt **(831 complaints)**
- **86%** were finalised within three months of receipt **(1,391 complaints)**, and
- **94%** were finalised within six months of receipt **(1,526 complaints)**.

Figure 11: How long it took to finalise complaints (within 1 month, within 3 months, within 6 months)

51%
(831 complaints)
finalised within
1 month

86%
(1,391 complaints)
finalised within
3 months

94%
(1,526 complaints)
finalised within
6 months

Outcomes from complaints

As outlined earlier in this report, the Commission records the outcomes of complaints using the 4 As model, noting that complaints may have more than one outcome.

These include

- Acknowledgement
- Action
- Answer
- Apology.

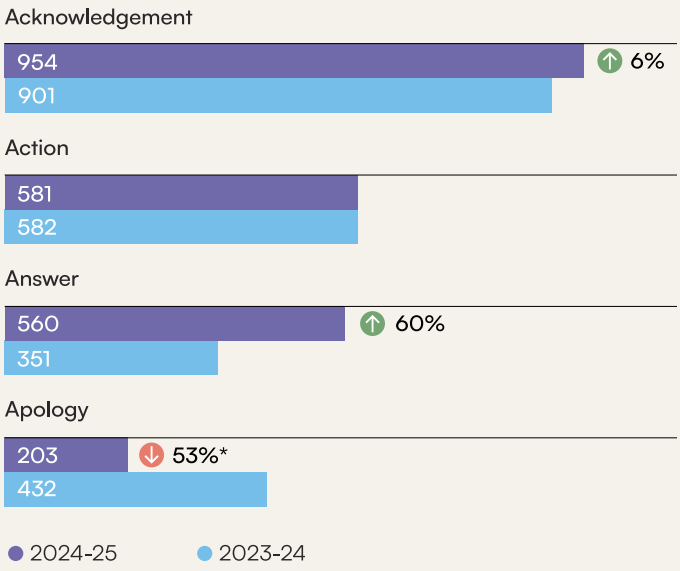
The Commission acknowledges all complaints we receive and aim to support consumers, their families, supporters, carers and kin in raising concerns with services and achieving meaningful outcomes.

Although not all complaints outcomes are reported to the Commission, the most common outcomes reported by mental health service providers for the reporting period were:

- Acknowledgement of the concerns raised were made in 954 complaints
- Actions addressing concerns raised were taken in 581 complaints
- Answers and explanations to concerns raised were provided in 560 complaints
- Meaningful apologies were provided as part of a response to 203 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.

Figure 12: Service response to complaints



* While this year has shown a significant decrease in reporting from services on providing apologies to complainants, this may have been a result of the increase of complaints that went through the Assisted Referral process where Services are not required to report on resolution outcomes.

Service improvements

Over this reporting period, the Commission has made a number of recommendations to services. Services have also initiated service improvements as a result of dealing with 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 207 service improvements that were made in response to individual complaints, some because of recommendations made by the Commission, and others were initiated by the services as part of the resolution of complaints. Recommendations and service improvements focused on changes to policies, procedures and practices of service provision, followed by training and providing feedback to staff. Services have also undertaken internal audits and investigations to matters that were raised by consumers and carers in their complaints to the Commission.

Themes of service improvements were predominantly about reducing the use of restrictive interventions, changes in clinical governance and enhancing communication about treatment, care and support.

Figure 13: Service improvements themes

Themes	Number
Communication	49
Clinical governance	39
Restrictive intervention	20
Mental Health and Wellbeing Act - Support family/carers' role in decision making (s20)	21
Mental Health and Wellbeing Act - Supported to make decisions about assessment/treatment/recovery (s19)	12
Safety	10

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

Figure 14: Service improvements actions by services

Actions	Number
Policy/procedure/practice	108
Training/input to staff	71
Undertake an audit/investigation	18
Improvements to infrastructure	7
Other systemic change	1

Investigations

Our approach to complaint resolution is consistent with the Act which is to respond in an efficient, effective and flexible manner through the least formal processes. Investigations are a formal process (section 476 of the Act) undertaken when the risks identified through our enquiries are significant and lead us to believe that the full extent of the issues can only be confirmed, and a conclusion reached, through formal investigation.

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.

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.

Over this reporting period, the Commission finalised two investigation reports into complaints which had been originally received by the Mental Health Complaints Commissioner.

One investigation concerned the experiences of a young person who was secluded for several days. The Commission's final investigation report made findings and included recommendations for service improvement to the mental health and wellbeing provider. The recommendations focused on risk assessment processes, staff training about restrictive interventions and the right to communicate, trauma informed care, cultural safety and internal review processes. The Commission has worked with the provider on the implementation of the recommendations. There have been a range of improvements implemented which we expect will improve the experiences of young people accessing care with this provider in the future. We anticipate the investigation will be closed once further information is received from the provider on its service improvements. The investigation also led to the Commission making recommendations to the Department of Health and consulting with the Chief Psychiatrist to inform their ongoing work and projects.

The second investigation concerned the making and revocation of compulsory treatment orders for a consumer admitted to a mental health inpatient unit. The final report made findings and recommendations for service improvement to the mental health and wellbeing provider. The recommendations focused on reviewing compulsory treatment documentation and staff training about compulsory treatment. In response, the provider offered an undertaking to the Commission in addition to implementing other service improvements. The Commission issued a compliance notice to the provider on the basis that the provider has not complied with the terms of the undertaking. The provider has applied to the Victorian Civil and Administrative Tribunal for review of the decision to issue a compliance notice.

The Commission is currently completing an investigation into a complaint concerning a person's experiences of restrictive interventions during an admission to an emergency department and later, a mental health unit.

Exploring systemic issues

Exploring issues through inquiries and systemic reviews guide.

Published in July 2024, the guide provides information about the Commission's approach to exploring systemic issues associated with the performance, quality and safety of Victoria's mental health and wellbeing system and the mental health and wellbeing of the Victorian community, through inquiries and systemic reviews.

The Act sets out the Commission's objectives and functions and provides the authority to explore issues, including those that are systemic. We have achieved this through our work in complaints resolution, investigations and systemic reviews.

We identify potential topics through:

- engagement activities
- referrals (including website form)
- complaints
- mental health and wellbeing system performance data
- literature scanning
- investigations.

As an outcome of our complaints resolution and investigations work, we have:

- Made recommendations to the Department of Health to:
  - ensure rectification of building defects at a mental health unit following several incidents which led to the unit being damaged and unable to admit consumers
  - assess the processes around commissioning building projects and ensuring mental health units are fit for purpose and safe for use
  - liaise with the Department of Justice and Community Safety in relation to access to secure mental health units for young persons in custody requiring mental health care.
- Consulted with the Chief Psychiatrist in relation to a range of issues, including:
  - their transfer of care project, with regard to the experiences of young people being transferred to and from custodial settings
  - environmental issues at a mental health unit which was closed due to incidents resulting in significant damage
  - the documentation requirements for compulsory orders, including the responsibilities of Authorised Psychiatrists and their delegates
  - the criteria for placing a person on a compulsory order
  - the criteria for charging secure extended care unit patients for accommodation and the inconsistency in practice across services
  - unsafe / premature discharge of consumers where various risks are identified
  - clinical practice issues when identified through complaints, seeking guidance to services.
- Accepted an undertaking from a mental health and wellbeing service to complete an audit of compulsory treatment documentation to determine whether the documentation and information requirements of the *Mental Health and Wellbeing Act 2022* have been routinely met at the service.
- Made a referral to the Chief Quality and Safety Officer within Safer Care Victoria (SCV) in conjunction with the Chief Psychiatrist to raise issues of compliance and reporting of the use of restrictive interventions in Emergency Departments. SCV responded with a range of actions we will monitor.
- Published an insight report on the use of restrictive interventions with the intention of improved care to consumers (see page 48).

Through our annual planning process for systemic reviews for exploring potential systemic reviews and inquiries, our resolution team identified that some consumers in secure extended care units were being billed accommodation fees. We consulted with stakeholders to gain a better understanding of the issue, including IMHA, who confirmed that practices varied between services. We considered this to be inequitable. We escalated the issue to the Department of Health, and the Secretary has now written to services requiring these billing practices to stop (see page 49).

The Supporting consumers' rights through improved understanding of complaints about restrictive practices - first insights report

The report examines the questionnaire that is completed by services when we receive complaints about restrictive practices.

The questionnaire provides important insights about the use of restrictive practices that inform our activities in supporting the rights of consumers.

The goal of eliminating the use of restrictive practices is a priority area of Victoria's mental health reform and for the Mental Health and Wellbeing Commission.

This is our first report of analysing data from complaints about the restrictive interventions using insights from complaints made to the former Mental Health Complaints Commissioner and the Mental health and Wellbeing Commission.

This is an example of how we will use our expanded functions under the *Mental Health and Wellbeing Act 2022* and how our *Approach to Complaints Handling and Compliance Monitoring* (September 2024) is used in practice.

We gain insights into areas for improvement through our complaints function. The report examines a sample of complaints about restrictive practices in designated mental health facilities throughout the past two reporting years (2022-23 and 2023-24) to gain a deeper understanding of the issues involving the use of these practices.

The availability of reliable, robust information about the use of restrictive practices is very important as Victoria moves towards the reduction and elimination of these practices.

While the report does not make findings of non-compliance, it does highlight areas for improvement, and we will continue to monitor and report on this.

In the report, we examined whether less restrictive practices were attempted and what efforts have been used to reduce the likelihood of restraint or seclusion being used, as well as whether practices are being adequately documented and reported.

This report has been provided to designated mental health and wellbeing services with the intention of improving their approach to the use of restrictive practices and supporting a better service provided to consumers.

The report outlines a pattern of emerging issues including gaps in reporting multiple types of restraint used in one incident, and unclear authorisation for the use of restraint, which is a requirement under legislation.

We believe this report examines complaints over a sufficient period to reveal potential systemic issues, and its findings align with concerns brought to our attention through other channels.

In response to the findings in the report, four recommendations are made to services, including:

- the consistent use of post-restrictive intervention debriefing and experience of care reviews
- the provision and use of advance statements of preferences for all consumers
- fulsome completion of reporting obligations, including reporting to the OCP and Independent Mental Health Advocacy (IMHA) and
- continued training for EDs in now to meet their legislative requirements.

Consumers on compulsory treatment orders should no longer be charged accommodation fees in secure extended care units (SECUs)

Consumers on compulsory treatment orders receiving treatment as public patients should no longer be charged for their accommodation in secure extended care units with the Mental Health and Wellbeing Commission receiving confirmation that imposing fees may breach the 2020-25 National Health Reform Agreement and people's human rights.

Consumers on compulsory treatment orders told us through our complaints process, that they faced different charging practices for SECU accommodation, depending on the service they used. Our resolution team raised the issue of services charging consumers on compulsory treatment orders for unwanted accommodation and treatment. This was brought up as part of the Commission's annual planning process for exploring potential systemic reviews and inquiries.

The issue of fees being charged to consumers on compulsory treatment orders had also been raised with us by Independent Mental Health Advocacy and Victoria Legal Aid.

The Department of Health has confirmed that charging SECU consumers is not permitted under the 2020-25 National Health Reform Agreement except in limited cases. Charges may only apply when consumers are deemed suitable for discharge after 35 days but either have no alternative accommodation or, they refuse to leave.

We raised this issue with the Department of Health and were pleased to hear that the Secretary had written to public designated mental health services requiring that these billing practices stop immediately. We have also been advised that voluntary consumers should not be charged for accommodation in SECUs and all charging practices have ceased across the board.

The Commission was not aware of the extent to which charges were being applied, however, we challenge the notion of charging consumers on compulsory treatment orders for SECU accommodation and treatment they do not want, given the additional burden this represents.

Section 2c: System Performance and Monitoring

The Commission is required to monitor and 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.

The Commission has a broad range of statutory objectives and functions, including contributing to system governance through monitoring and reporting, and promoting greater understanding of mental health and wellbeing across government, business, and the wider community.

Figures reported on quality, safety, and performance of the mental health and wellbeing system have been updated in this annual report where data are available. As with the 2023-24 Annual Report, this largely reflects the information published in the appendix of the Chief Mental Health and Wellbeing Officer report 2024-25. The Commission hopes to obtain more comprehensive information in the future to expand on its ability to fulfil its monitoring and reporting function.

The Commission acknowledges the longstanding challenges identified by the Royal Commission regarding the quality, consistency, and accessibility of mental health data. The Commission will continue to work with the Department of Health to realise the Royal Commission's vision for a transparent, outcomes-focused system. This collaboration will focus on strengthening reporting and the further development of measures that provide meaningful insights into consumer outcomes, service performance, and system accountability, enabling evidence-based decision-making and continuous improvement across the sector.

As part of these efforts, the Commission and the Department of Health are working to develop an information sharing agreement with a view to expanding on the level of analysis in future periods.

Our commitments and achievements

Our first review, in the 2023-24 Annual Report, resulted in the Commission committing to a series of actions that support our continued monitoring of the system. The following table outlines our progress against those commitments. We then present the Commission's review of the system for 2024-25.

Commitment	Progress
Review whether psychological distress in the community changes significantly in the latest Victorian Population Health Survey (VPHS).	This is included within the Commission's review of outcomes for the Victorian community.
Consider whether to adjust our monitoring of community outcomes and determinants, based on a review of government's Outcomes and Performance Framework (OPF).	The government's OPF was released in late 2024. The framework includes indicators but is yet to specify measures. The Commission will consider how to incorporate the OPF into future annual reports once the complete framework and baseline report against measures is released.
Develop a framework to monitor lived experience leadership and representation across the mental health and wellbeing system	The Commission released its Lived Experience Plan in February 2025 which provides the basis for this framework. Subsequent work will be undertaken to develop a framework.
Continue to monitor government's investment in mental health and wellbeing and ensure mental health is a priority for government	The Commission has monitored initiative and output spending on mental health in 2024-25, as shown in the Mental Health Investment by State Budget figure on page 59.
Seek evidence on whether there is a net increase in access to services accessible to the community	The data required to support this commitment was unavailable. The Commission continues to work with the Department of Health to determine the data required and available to report on this commitment. Consultation with service providers continues to raise the question of net changes in service delivery as a concern, along with concerns around the consistency in services funded to be delivered across the state.
Undertake a deep dive into measures of quality, safety, and performance of the system	This is reliant on finalisation of an information sharing agreement between the Department of Health and the Commission.
Review government's revised implementation plan for the Royal Commission recommendations [and consider workforce impacts and prioritisation].	Our approach to monitoring the Royal Commission Recommendations is described in that section.

Outcomes for the Victorian Population

The Department of Health released the Outcomes and Performance Framework (OPF) in December 2024. This annual report represents the first cycle of system reporting undertaken by the Commission since publication of the framework.

The framework identifies 22 indicators within Domain 1 to monitor outcomes for the Victorian community. This report draws on publicly available measures identified by the Commission as an interim approach while the Department of Health is finalising the official measures to be used for monitoring outcomes for the Victorian population.

The OPF was developed in response to Recommendations 1 and 49 of the Royal Commission, with Recommendation 1 requiring an outcomes framework to establish a mechanism to drive collective responsibility and investment for improving mental health and wellbeing.

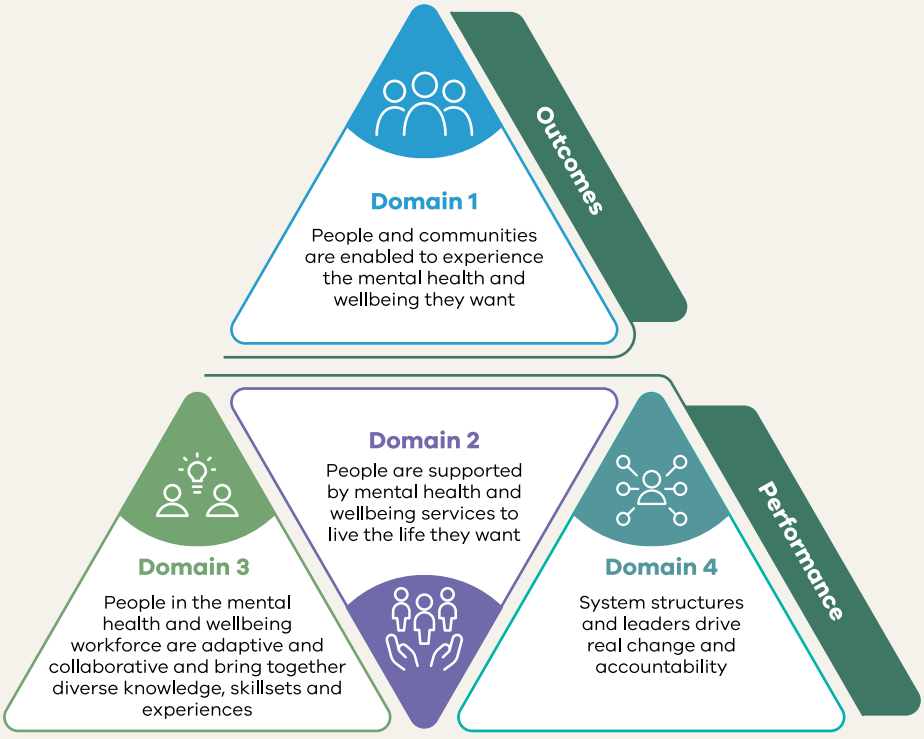
The OPF sets out four domains to track the outcomes of the reform. The first domain focuses on outcomes for the Victorian population.

Figure 15: Outcomes and Performance Framework

Source: Outcomes and Performance Framework, Department of Health

Domain 1: Victorian Population
People and communities are enabled to experience the mental health and wellbeing they want

This domain presents an overview of the factors contributing to the mental health and wellbeing of both individuals and communities. Understanding these factors means we can better support improved performance and public accountability for the performance of the system.



The reform is intended to deliver improved mental health and wellbeing across the community, with progress measured against three overarching outcomes:

Outcomes for the Victorian population:

01 People's mental health and wellbeing enable them to live a life they want.

02 Communities support and enable mental health and wellbeing.

03 People's mental health and wellbeing is supported by every aspect of their life.

These outcomes are accompanied by indicators that describe what success should look like and how progress can be measured over time.

The Department of Health is yet to publish the measures that will be used to track indicators or provide a baseline report measuring outcomes. For this report, the Commission has reported measures based on their alignment with the published OPF indicators, relevance to the indicators and capacity to provide trend data from publicly available sources. Several of the sources include both national and state-wide data (e.g. the Victorian Population Health Survey (VPHS) and Australian Bureau of Statistics) and were chosen due to the availability of a pre-reform reference period of 2021-22.

The Department of Health has stated that they will use the framework annually to publicly report on progress against outcomes, including Victorian population-level outcomes. The Commission will further refine its approach to reporting against outcomes over time, and as further information about the OPF is made available.

Insights from Population-Level Data

Cross-outcome insights

The Commission has identified key high-level trends from analysis of the data. While the overall levels of psychological distress and suicide within the Victorian community have subsided from the high levels experienced during and shortly after the Covid-19 pandemic, measures of overall life satisfaction have also fallen to move closer to pre-pandemic levels.

Measures of community support and enablement of mental health and wellbeing are relatively steady, though the Commission could not identify appropriate indicators for all of these at this time. Social determinants of mental health and wellbeing indicate a mixed picture, with measures related to violence and financial and housing insecurity increasing, while discrimination and exclusion show improvement.

Figure 16: Notable outcomes identified

'High' or 'very high' life satisfaction is 76.6% in 2023.

Psychological distress notably improved, with rates decreasing from 22.8% to 19.1%.

Rate of suicide is 11.1 per 100,000 people, it remains above the levels reported in previous years.

Decreasing rates of discrimination and racism between 2022 and 2023 (down 11% and 19% respectively).

Increasing rates of homelessness over the long-term, despite increases in social housing.

Increasing numbers of family violence incidents (up 9.1% in the latest year), assault offences (24.7%) and child protection notifications (8.7%).

Longer-term trends of decreased alcohol use (down 4.1% over four years).

Increasing illicit drug use (up 7.3%).

Outcome 1 - People's mental health and wellbeing enable them to live a life they want

The rate of people reporting high or very high distress and rates of suicide have improved over the latest year of available information, however there is a decrease in people reporting feeling satisfied and valued.

Measures identified against this outcome include the following:

- The proportion of VPHS respondents[1] reporting 'high' or 'very high' life satisfaction is 76.6% in 2023. This is below the 79.2% recorded in 2022, but similar to levels reported in 2020.
- The proportion of people who reported "definitely" feeling valued by society also dropped from the levels of around 51% recorded in 2020 and 2022, to 47.8% in 2023. This is still above the level reported in 2019.
- The proportion of people reporting psychological distress notably improved, with rates of high or very high distress decreasing from 22.8% to 19.1% in the 2023 VPHS.

It is worth noting that the changes over the latest year of available data report largely reflect a shift back to pre-Covid-19 pandemic levels. The Commission expects that future iterations of reporting may provide greater insight into consistency with longer-term trends. We anticipate that over time the framework will help to understand the impacts of reform and cross-government efforts to improve wellbeing.

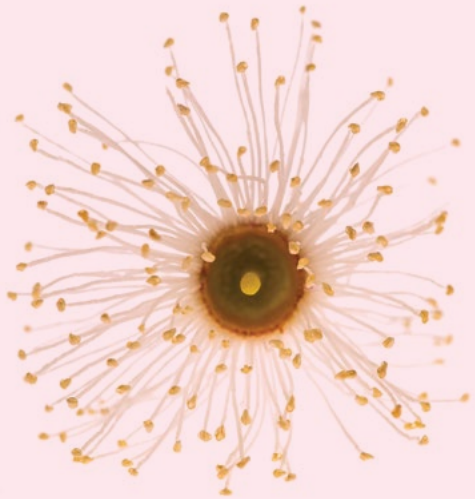
The rate of Victorians who died by suicide in 2024, as reported by the Coroner's Court, indicate a rate of 11.1 per 100,000 people. Although this is less than the rate in 2023 (11.7) and 2022 (11.6) it remains above the levels reported in previous years (e.g. 2019 to 2021).

Outcome 2 - Communities support and enable mental health and wellbeing

Indicators of community connection show some progress as well as ongoing challenges. Key measures include the following:

- Loneliness is reported in the VPHS by 23.7% of Victorians.
- The proportion of VPHS respondents reporting that multiculturalism has made life in their area better was 66.8% in 2023, continuing a long-term trend upwards from rates of around 50% in 2016.
- Local liveability held steady at high levels, with the liveability index almost unchanged (98.64 to 98.62), while the proportion of the Victorian population living within 400m of green space improved modestly 33.3% to 35.6% (up 2.3%).[2]
- Indicators of supportive relationships remain strong. In 2023, 94.1% of Victorians reported in the VPHS they could access get help from friends, family, neighbours or colleagues when needed.

Some areas within this outcome's domain are more challenging to measure at present, including changes to levels of community conversation about emotional wellbeing. The Commission looks forward to future baseline or other reporting that identifies or develops measures and provides data for these areas.



1 The VPHS survey population comprises respondents aged 18 years and over.

2 Australian Urban Observatory, RMIT University, viewed 12/09/2025, auo.org.au. DOI: 10.25956/5dcb85fa3bdfc.

Outcome 3 - People's mental health and wellbeing is supported by every aspect of their life

This outcome examines how social determinants of mental health and wellbeing are shifting. The table in Appendix 1 outlines measures identified by the Commission against each of the indicators in the OPF. Measures with longer time series, or reflecting counts, rather than survey data, are preferred in the approach below. Time periods have been selected to reflect trends based on the time series and nature of data. For example, longer-term trends are shown where available for survey data, to limit reporting changes that are due to sampling variability rather than underlying shifts in determinants.

The data present a mixed picture of how mental health and wellbeing determinants are shifting. Indicators moving in an undesirable direction, or not substantially improving over time include:

- Increasing numbers of family violence incidents (up 9.1% in the latest year), assault offences (24.7%) and child protection notifications (8.7%).
- Food and financial insecurity increasing from the late 2010s to 2022 and 2023.
- Increasing rates of homelessness over the long-term, despite increases in social housing.

Indicators moving in positive direction include:

- Decreasing reported rates of discrimination and racism in the VPHS between 2022 and 2023 (rate down 11% and 19% respectively).
- Longer-term trends of decreased alcohol use (down 4.1% over four years), but increasing illicit drug use (up 7.3%)
- Decreasing rates of persons with both mental illness and physical health conditions
- Increasing proportions of people in employment or study.

Measures for some indicators will also need to be identified, including around support for people and communities experiencing trauma, optimal family functioning and support, and decreasing discrimination and stigma.

System performance, quality and safety

This section examines the performance, quality and safety of the mental health and wellbeing system. As outlined in the Commission's 2023-24 Annual Report, publicly funded services are not always the first point of support for people experiencing distress. Consistent with the Royal Commission's findings, supports exist along a continuum. This begins with informal and community-based supports, and extends to non-mental health services, including primary and secondary care often funded by the Commonwealth Government. Community, clinical, statewide, and specialist care exist at the higher end of the continuum.

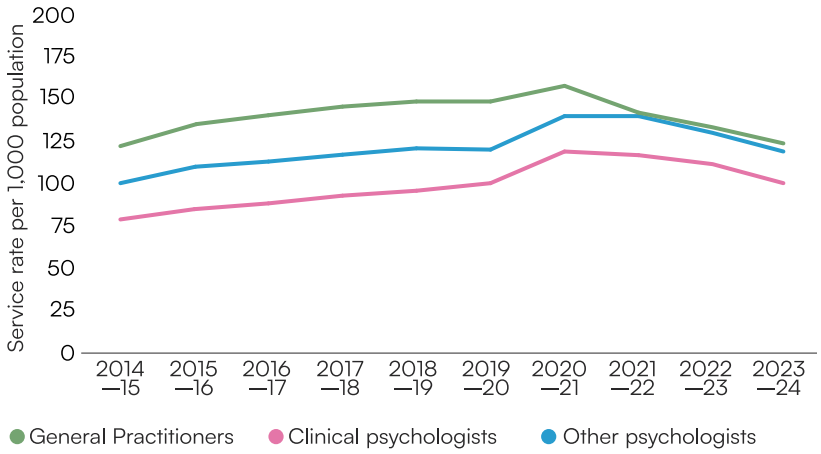
This report reviews trends in the use of general practitioners (GPs) and private psychologists alongside publicly funded services which provides meaningful context for service demand and system performance.

Primary and secondary mental health access

Rates of usage of GP and psychologist services to gain access to mental health and wellbeing have continued to decrease from the peak in 2020-21, in line with a scaling back of access to psychological services funded by Medicare. Service rates per 1,000 population for GP visits have now fallen back to levels last seen in 2014-15. The decrease in the rate of psychologist services delivery is despite an increase in the availability of psychologists available.

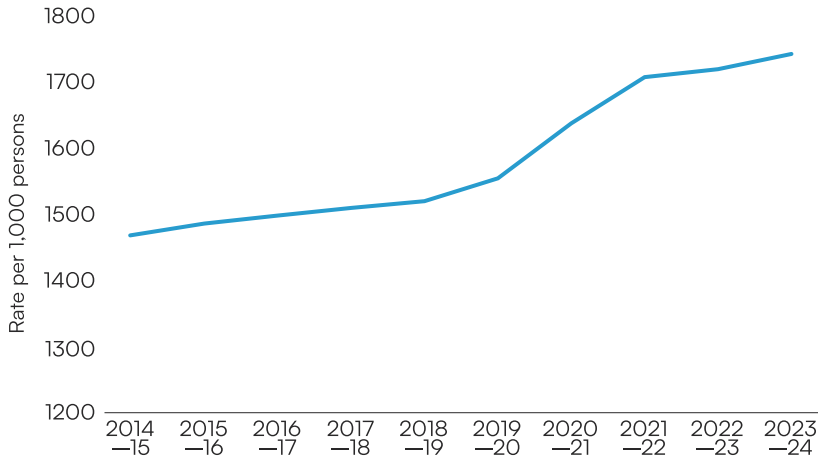
The rate of prescriptions to treat mental health conditions continued to increase in 2023-24. This reflects a continued longer-term trend of increasing rates of mental illness treated by medication, with 2021-22 now appearing to be an outlier. This is underpinned by sustained rates of antidepressant use, and rapidly increasing usage of psychostimulants (used to treat conditions such as Attention Deficit Hyperactivity Disorder). These trends indicate that while access to GP and psychologist consultations is lower, the underpinning level of mental illness in the community treated with pharmaceuticals continues to grow according to longer-term trends.

Figure 17: MH service rate per 1,000 persons - GPs and psychologists



Source: Medicare mental health services 2023—24 data tables

Figure 18: Prescription rate per 1,000 persons - all MH prescriptions, Victoria



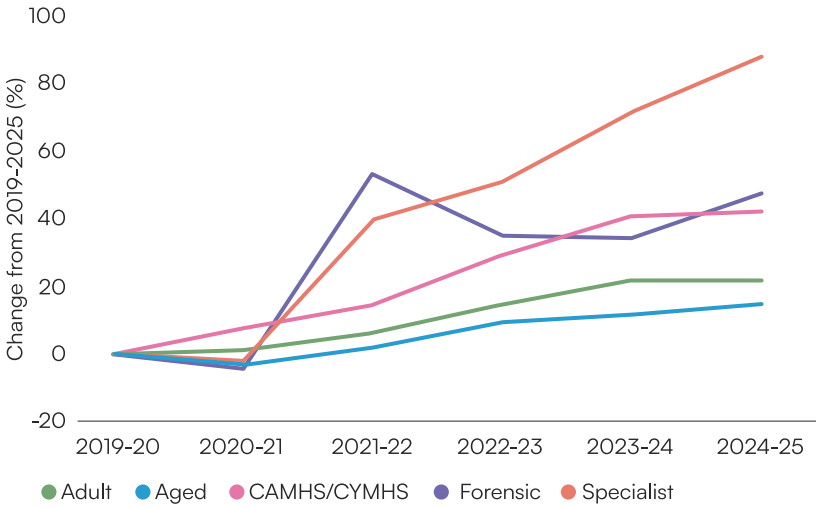
Source: Mental health-related prescriptions 2023—24 data tables, Australian Institute of Health and Welfare (AIHW).

Access to the Victorian mental health system

Data from the Victorian Department of Health shows that some of the trends in the delivery of funded mental health services appear to have changed in the last financial year. It is noted that industrial action in 2024-25 is likely to have affected these results, along with other service activity data reported throughout this section. Consequently, the following comments should be interpreted with caution and seen as indicative only with further analysis warranted when more fulsome data are available. Based on the information currently available to the Commission:

- the number of consumers reported to be accessing clinical mental health services increased by 0.6%. This steady rate of service delivery contrasts with annual growth rates of five to seven per cent in the preceding three years
- high rates of growth in forensic (9.8%) and specialist services (9.7%) was reported over the last year
- clinical delivery in adult services grew by 0.2%, while Child and Adolescent Mental Health Services grew by 1.0%
- despite the slowdown in reported mental health clinical service delivery, demand as indicated by emergency department presentations continued to increase. There was a 4.3% increase in presentations in 2024-25, building on the 14% increase reported in 2023-24
- clinical delivery is also reaching fewer 'new' consumers (those who have not accessed services in the previous five years). The number of these consumers decreased by around 3.3% in the last year
- community-based clinical delivery reported for 2024-25 is less than that reported for 2023-24 (reported service contacts down 10.9%), but this largely reflects the industrial action noted above
- bed-based delivery remained relatively similar to previous years, with 2.2% more consumer separations than in 2023-24, and bed utilisation remaining at 78%

Figure 19: Change in consumers accessing clinical services from 2019-20 by cohort



Source: Service data provided by the Department of Health

- the data regarding the number of consumers accessing mental health community support services are affected by service delivery transferring to the National Disability Insurance Scheme (NDIS) causing a break in the comparability of data over time. The number of consumers accessing these services increased from 2,535 in 2021-22 to 4,052 in 2024-25. Prior to the transfer, in 2019-20 5,818 consumers accessed these services.

The impact of industrial action on recording of data makes it difficult to draw sound conclusions about overall changes in access to services.

As noted in the Commission's 2023-24 annual report, the extent to which investment in community-based service delivery has helped to shift the performance of the system and remains a key area of interest to the Commission. The Commission anticipates providing analysis of this in future reports.

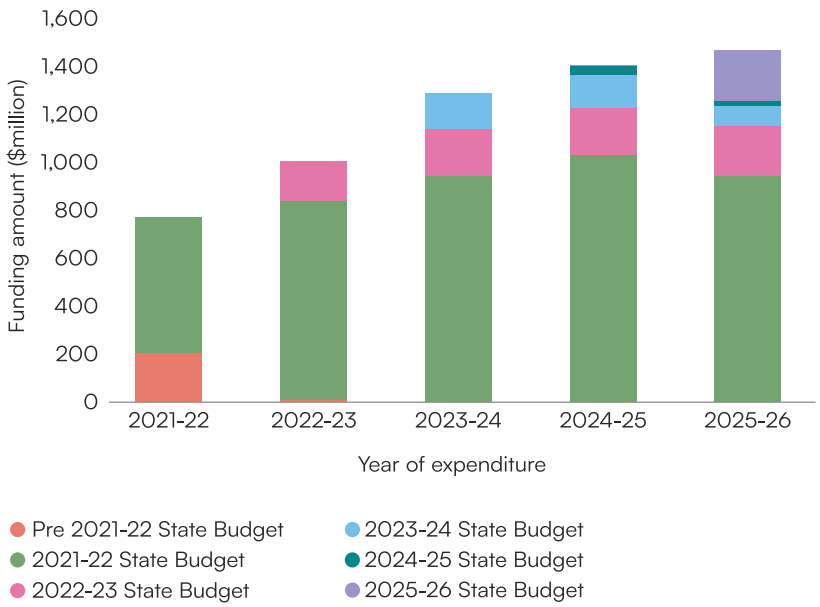
How has funding aligned with service delivery?

Funding for mental health and wellbeing has increased substantially from 2021-22 to 2024-25, in line with the initial wave of investment responding to the Royal Commission.

Funding has increased broadly in line with the Mental Health and Wellbeing Levy (with output funding up $945 million from 2020-21, compared to $1,147 million in additional funds expected to be collected in 2025-26). The Commission recommends that government provide greater detail around whether and when investments regarding key recommendations will continue to be made to realise the Royal Commission's vision for system reform.

Figure 20 shows investment flows from budgets 2021-22 through to what is expected in the 2025-26 financial year, the information showing investment flows from successive budgets (2021-22 to 2025-26) has been validated by the Department of Health.

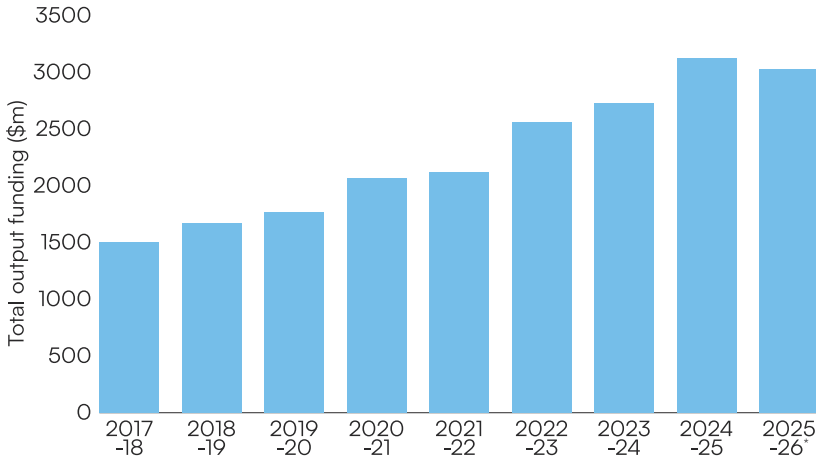
Figure 20: Mental Health Investment by State Budget



Source: Provided by the Department of Health on October 24th, 2025.

Note: The amount reflected in the figure does not include the Victorian Mental Health and Wellbeing Levy charged by the government.

Figure 21: Total output funding - Mental Health Clinical and Community Care



***Note: 2025-26 is estimated output expenditure. 2024-25 is a revised estimate as at the 2025-26 budget**

Source: Budget Paper 3 total output funding tables. Notes: 2024-25 is the revised estimate and 2025-26 is the budgeted value in the 2025-26 budget papers. Other values are 'actual' amounts from previous years in each budget. Values include MH Clinical Care, and MH Community Care line items.

1 Note that updated rates of seclusion reported in previous years are available due to changes in data reported through CMI/ODS since that reporting.

How safe is the system?

The number of suicides on the premises of mental health and wellbeing service providers was zero for 2024-25.

Information on the number of sexual safety incidents was not available in time for inclusion in this report. This is partly due to upgrades to the systems used to record these incidents.

Compulsory orders and the use of restraints

There have been several concerning trends regarding the safe use of compulsory treatment and restrictive practices of the mental health and wellbeing system in 2024-25.

- Open cases in community-based clinical services where consumers are on treatment orders increased sharply in 2024-25 to 11.8%. This is the highest level in the past five years.
- The proportion of inpatient consumers admitted on compulsory treatment orders increased to 48.9%, up from 47.5% in 2023-24. This is in the normal range from the previous five years but shows no significant downward movement on rates of compulsory treatment to date.
- The average duration of compulsory treatment episodes decreased from a high of 102.9 days in 2023-24 to 96.9 days in 2024-25 but is higher than in any of the previous years.

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:

- Rates of seclusion have increased in 2024-25 to 8.9 episodes per 1,000 bed days. This is above both the 2023-24 rate (6.8[1]), and all established targets (8 per 1,000 bed days for adults, and 5 per 1,000 bed days for other consumers.
- Directly comparable data on the rates of seclusion and restraint was unavailable, however key performance indicator reports indicate that the rate of seclusion was 8.8 episodes per 1,000 bed days for adult services, 0.4 for aged services, and 10.5 across metropolitan child and youth services.
- The average length of seclusion decreased to 17.6 hours in 2024-25, down from 21.8 hours in 2023-24 but still within the standard historical range.
- Rates of bodily restraint continues to decrease and are now at 14.4 episodes per 1,000 bed days, down from 15.4 in 2023-24. The Commission looks forward to more detailed reporting and setting of targets on restraint.

The Commission cannot report on the rates of chemical restraint as the data was unavailable. As mentioned previously, the Commission continues to work with the Department of Health to address the challenges identified by the Royal Commission with respect to the quality, consistency, and accessibility of mental health data.

Involvement and experiences of carers, families and supporters

Other than via our complaints data, the Commission is unable to report on the involvement and experiences of carers, families, and supporters in this Annual Report. The Department of Health has been working with health services over the past year to improve the collection of experience of service data in mental health services. As a result, 2024-25 data are not yet available for the YES and CES surveys, but these are expected to become available in subsequent months.

The Commission acknowledges that the meaningful inclusion of carers, families, supporters, and the lived experience workforce are real measures of the quality, safety and performance of the mental health and wellbeing system.

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 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.

Over the past year the Commission has continued to seek clear information on the progress towards the recommendations from the government. We have heard the importance of more detailed reporting, including at the sub-recommendation level, from the community, as well as through the Parliament's Public Accounts and Estimates Committee, which explicitly requested this level of reporting from the Department of Health or the Commission[1].

The Commission believes that reporting at this more detailed level benefits everybody. Greater and more transparent reporting ensures that progress can be more accurately reflected and builds community trust that government remains committed to the reform process. Where changes from the original plans outlined in the Royal Commission are made, these can be reflected and explained, so that the sector and broader community understand what is intended.

The Department of Health has confirmed that it will continue to report progress on implementing the Royal Commission at the recommendation level.

The Commission committed to undertaking a program of work based on public information to understand what has been achieved, reporting at a sub-recommendation level. This work is described below.

The Department of Health's reporting on the recommendations

As described in the Commission's 2023-24 annual report, the Department of Health has been progressing a revised approach to reporting on recommendation acquittal. The Commission provided advice to support the new approach, including recommending reporting be at the sub-recommendation level.

The Department of Health and the Commission have agreed to omit the table presented in 2023-24, as a new approach is being developed, and is intended to be released throughout 2025-26.

1 Public Accounts and Estimates Committee, 2023-24 financial and performance outcomes Report April 2025, Recommendation 8, https://www.parliament.vic.gov.au/4a6653/contentassets/9c901becc6e04a42ae59e52a710d9852/paec-60-11-2023-24-financial-and-performance-outcomes.pdf

The Commission's review of recommendation progress

The Commission has undertaken a program of work to understand the progress in implementing the Royal Commission's recommendations at a sub-recommendation level, based on public information. This was done through carrying out a desktop review of information in the public domain, which consumers, their family, carers, and supporters, and the public, can access to understand the progress taken in implementing the Royal Commission's recommendations. As such, the information in this report may not reflect the full extent of progress against each of the recommendations, as there will be progress that is not communicated publicly. Public reporting does not typically map back to specific sub-recommendations, so it is possible there may also be information in the public domain that was not identified by the Commission.

Regardless, this provides an initial view of progress at the sub-recommendation level that can be further developed and enhanced as the Commission continues its work.

The table below outlines progress by sub-recommendation identified by the Commission. The Commission intends to publish more detailed reporting of progress identified during 2025-26. This will include brief discussions of what has been found against each sub-recommendation. Sub-recommendations may be updated as more information becomes available.

Each sub-recommendation is assigned a category based on what information was identified. These categories are:

1. Commencement not evidenced from publicly available information: the Commission did not find publicly available evidence that work has commenced, or government has confirmed that work towards the sub recommendation has not commenced (noting this does not necessarily mean that no work has been undertaken).

2. Limited evidence of progress available publicly: the Commission found public information that work has been scheduled but did not find publicly available evidence that the work has taken place.

3. Partial progress evidenced from publicly available information: the Commission found publicly available, reliable evidence that the work has taken place, but not of all aspects of the sub recommendation being in place.

4. In place: the Commission found publicly available information that the core or primary element of the sub recommendation are in place (eg a new entity had been established) or that all work has been completed. This does not include assessment of the effectiveness of the work. An ongoing monitoring or watching brief may be appropriate.

5. To be assessed later: the Commission considers assessment of progress is not meaningful or feasible at this time, such as whether a newly established entity is performing all the functions that the Royal Commission intended. We suggest such assessments should be captured through evaluations and/or independent reviews after an appropriate period, usually 3 to 5 years post establishment. Such assessments should include whether entities and/or initiatives have been sufficiently funded.

Each subpoint within the interim recommendations has been considered as a separate sub-recommendation. For clarity, reporting on the interim recommendations describes which parts of the recommendations are assigned each status.

The Commission's review of progress has identified evidence of work against around three fifths of sub-recommendations. Around a third of the sub-recommendations have either no or only implied evidence that work has commenced. Commonly, these appear to be due to sequencing considerations, though this is an area for future examination.

Recommendation number	Recommendation title	Progress of each sub-recommendation
1	Supporting good mental health and wellbeing	1.1: In place
		1.2: Commencement not evidenced from publicly available information
		1.3: Commencement not evidenced from publicly available information
		1.4: Commencement not evidenced from publicly available information
2	Governance arrangements for promoting good mental health and preventing mental illness	2.1: In place
		2.2: Partial progress evidenced from publicly available information
3	Establishing a responsive and integrated mental health and wellbeing system	3.1: Partial progress evidenced from publicly available information
		3.2: Partial progress evidenced from publicly available information
		3.3: Limited evidence of progress available publicly
		3.4: Limited evidence of progress available publicly
		3.5: Commencement not evidenced from publicly available information
4	Towards integrated regional governance	4.1: In place
		4.2: Commencement not evidenced from publicly available information
		4.3: Commencement not evidenced from publicly available information
		4.4: Commencement not evidenced from publicly available information
		4.5: Limited evidence of progress available publicly
5	Core functions of community mental health and wellbeing services	5.1: Partial progress evidenced from publicly available information
		5.2: Partial progress evidenced from publicly available information
		5.3: Partial progress evidenced from publicly available information
6	Helping people find and access treatment, care and support	6.1: In place
		6.2: Partial progress evidenced from publicly available information
		6.3: Partial progress evidenced from publicly available information
		6.4: Partial progress evidenced from publicly available information
		6.5: Partial progress evidenced from publicly available information

Recommendation number	Recommendation title	Progress of each sub-recommendation
7	Identifying needs and providing initial support in mental health and wellbeing services	7.1: Partial progress evidenced from publicly available information
		7.2: Partial progress evidenced from publicly available information
8	Responding to mental health crises	8.1: Partial progress evidenced from publicly available information
		8.2: Partial progress evidenced from publicly available information
		8.3: Partial progress evidenced from publicly available information (8.3a, c)
9	Developing 'safe spaces' and crisis respite facilities	9.1: Partial progress evidenced from publicly available information
		9.2: Partial progress evidenced from publicly available information (9.2b)
		9.3: Commencement not evidenced from publicly available information
10	Supporting responses from emergency services to mental health crises	10.1: Partial progress evidenced from publicly available information
		10.2: Partial progress evidenced from publicly available information
		10.3: Partial progress evidenced from publicly available information
11	New models of care for bed-based services	11.1: Partial progress evidenced from publicly available information
		11.2: Partial progress evidenced from publicly available information (11.2a)
		11.3: Partial progress evidenced from publicly available information
		11.4: Limited evidence of progress available publicly
12	Developing new bed-based rehabilitation services	12.1: Commencement not evidenced from publicly available information
		12.2: Commencement not evidenced from publicly available information
		12.3: Commencement not evidenced from publicly available information
13	Addressing gender-based violence in mental health facilities	13.1: Limited evidence of progress available publicly
		13.2: Partial progress evidenced from publicly available information
		13.3: Limited evidence of progress available publicly
		13.4: Limited evidence of progress available publicly

Recommendation number	Recommendation title	Progress of each sub-recommendation
14	Supporting mental health consultation liaison services	14.1: Limited evidence of progress available publicly (in discussion with the Department of Health)
		14.2: Partial progress evidenced from publicly available information (14.2a, b)
15	Supporting good mental health and wellbeing in local communities	15.1: Partial progress evidenced from publicly available information
		15.2: Partial progress evidenced from publicly available information
		15.3: Partial progress evidenced from publicly available information
		15.4: In place
16	Establishing mentally healthy workplaces	16.1: In place
		16.2: In place
17	Supporting social and emotional wellbeing in schools	17.1: In place
		17.2: In place
		17.3: In place
18	Supporting the mental health and wellbeing of prospective and new parents	18.1: Partial progress evidenced from publicly available information
		18.2: Partial progress evidenced from publicly available information
19	Supporting infant, child and family mental health and wellbeing	19.1: Partial progress evidenced from publicly available information
		19.2: Partial progress evidenced from publicly available information
		19.3: In place
		19.4: Partial progress evidenced from publicly available information
		19.5: Partial progress evidenced from publicly available information
20	Supporting the mental health and wellbeing of young people	20.1: Partial progress evidenced from publicly available information
		20.2: Partial progress evidenced from publicly available information
		20.3: Partial progress evidenced from publicly available information
		20.4: Limited evidence of progress available publicly
21	Redesigning bed-based services for young people	21.1: Partial progress evidenced from publicly available information
		21.2: Partial progress evidenced from publicly available information
		21.3: In place

Recommendation number	Recommendation title	Progress of each sub-recommendation
22	Supporting the mental health and wellbeing of older Victorians	22.1: Limited evidence of progress available publicly
		22.2: Commencement not evidenced from publicly available information (in Discussion with the Department of Health)
		22.3: Limited evidence of progress available publicly
23	Establishing a new Statewide Trauma Service	23.1: Partial progress evidenced from publicly available information
		23.2: Partial progress evidenced from publicly available information
24	A new approach to addressing trauma	24.1: Commencement not evidenced from publicly available information
25	Supported housing for adults and young people living with mental illness	25.1: Partial progress evidenced from publicly available information
		25.2: Partial progress evidenced from publicly available information
		25.3: Partial progress evidenced from publicly available information
		25.4: Commencement not evidenced from publicly available information
		25.5: Partial progress evidenced from publicly available information
		25.6: Commencement not evidenced from publicly available information
26	Governance arrangements for suicide prevention and response efforts	26.1: In place
		26.2: To be assessed later
27	Facilitating suicide prevention and response initiatives	27.1: Limited evidence of progress available publicly
		27.2: Partial progress evidenced from publicly available information
		27.3: In place
28	Developing system-wide roles for the full and effective participation of people with lived experience of mental illness or psychological distress	28.1: Partial progress evidenced from publicly available information
		28.2: To be assessed later
29	A new agency led by people with lived experience of mental illness or psychological distress	29.1: Partial progress evidenced from publicly available information (ongoing assessment required)
30	Developing system wide involvement of family members and carers	30.1: Partial progress evidenced from publicly available information
		30.2: To be assessed later
		30.3: Commencement not evidenced from publicly available information
		30.4: Commencement not evidenced from publicly available information

Recommendation number	Recommendation title	Progress of each sub-recommendation
31	Supporting families, carers and supporters	31.1: In place
		31.2: Partial progress evidenced from publicly available information
		31.3: Commencement not evidenced from publicly available information
32	Supporting young carers	32.1: In place
		32.2: Partial progress evidenced from publicly available information
		32.3: Limited evidence of progress available publicly
33	Supporting Aboriginal social and emotional wellbeing	33.1: Partial progress evidenced from publicly available information
		33.2: Partial progress evidenced from publicly available information
		33.3: Partial progress evidenced from publicly available information
		33.4: Partial progress evidenced from publicly available information
34	Working in partnership with and improving accessibility for diverse communities	34.1: Partial progress evidenced from publicly available information
		34.2: Partial progress evidenced from publicly available information
		34.3 Partial progress evidenced from publicly available information (34.3b, c)
		34.4: Partial progress evidenced from publicly available information
		34.5: Limited evidence of progress available publicly
35	Improving outcomes for people living with mental illness and substance use or addiction	35.1: In place (ongoing assessment required)
36	A new statewide service for people living with mental illness and substance use or addiction	36.1: In place
		36.2: Limited evidence of progress available publicly
		36.3: Limited evidence of progress available publicly
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: Partial progress evidenced from publicly available information
		37.2: Limited evidence of progress available publicly
		37.3: Commencement not evidenced from publicly available information
		37.4: Partial progress evidenced from publicly available information

Recommendation number	Recommendation title	Progress of each sub-recommendation
38	Providing safe and appropriate mental health treatment, care and support at Thomas Embling Hospital	38.1: Partial progress evidenced from publicly available information
		38.2: Limited evidence of progress available publicly
39	Supporting the mental health and wellbeing of people in rural and regional Victoria	39.1: Partial progress evidenced from publicly available information
40	Providing incentives for the mental health and wellbeing workforce in rural and regional areas	40.1: Partial progress evidenced from publicly available information
41	Addressing stigma and discrimination	41.1: Limited evidence of progress available publicly
		41.2: Commencement not evidenced from publicly available information
		41.3: Commencement not evidenced from publicly available information
		41.4: Commencement not evidenced from publicly available information
42	A new Mental Health and Wellbeing Act	42.1: In place
		42.2: In place
43	Future review of mental health laws	43.1: Partial progress evidenced from publicly available information
		43.2: To be assessed later
		43.3: To be assessed later
44	A new Mental Health and Wellbeing Commission	44.1: In place
		44.2: Partial progress evidenced from publicly available information
		44.3: To be assessed later
45	Effective leadership of and accountability for the mental health and wellbeing system	45.1: In place
		45.2: In place
		45.3: In place
		45.4: In place
46	Facilitating government wide efforts	46.1: Limited evidence of progress available publicly
		46.2: Limited evidence of progress available publicly
47	Planning the new mental health and wellbeing system	47.1: In place
		47.2: Partial progress evidenced from publicly available information
		47.3: Limited evidence of progress available publicly
		47.4: Commencement not evidenced from publicly available information

Recommendation number	Recommendation title	Progress of each sub-recommendation
48	Selecting providers and resourcing services	48.1: Commencement not evidenced from publicly available information
		48.2: Commencement not evidenced from publicly available information
		48.3: Partial progress evidenced from publicly available information (48.3a)
49	Monitoring and improving mental health and wellbeing service provision	49.1: Partial progress evidenced from publicly available information
50	Encouraging national partnerships	50.1: Partial progress evidenced from publicly available information
51	Commissioning for integration	51.1: Commencement not evidenced from publicly available information
		51.2: Commencement not evidenced from publicly available information
52	Improving the quality and safety of mental health and wellbeing services	52.1: In place
		52.2: To be assessed later
53	Strong oversight of the quality and safety of mental health and wellbeing services	53.1: Partial progress evidenced from publicly available information
		53.2: Partial progress evidenced from publicly available information
		53.3: To be assessed later
54	Towards the elimination of seclusion and restraint	54.1: Partial progress evidenced from publicly available information
		54.2: Partial progress evidenced from publicly available information
		54.3: Limited evidence of progress available publicly
		54.4: In place
55	Ensuring compulsory treatment is only used as a last resort	55.1: Limited evidence of progress available publicly
		55.2: Commencement not evidenced from publicly available information
		55.3: Commencement not evidenced from publicly available information
		55.4: Partial progress evidenced from publicly available information
56	Supporting consumers to exercise their rights	56.1: Partial progress evidenced from publicly available information
		56.2: In place
		56.3: Partial progress evidenced from publicly available information
		56.4: To be assessed later

Recommendation number	Recommendation title	Progress of each sub-recommendation
57	Workforce strategy, planning and structural reform	57.1: Partial progress evidenced from publicly available information
		57.2: Partial progress evidenced from publicly available information
		57.3: Partial progress evidenced from publicly available information
58	Workforce capabilities and professional development	58.1: In place
		58.2: In place
		58.3: Partial progress evidenced from publicly available information
		58.4: Partial progress evidenced from publicly available information
59	Workforce safety and wellbeing	59.1: Partial progress evidenced from publicly available information
		59.2: Partial progress evidenced from publicly available information
		59.3: Partial progress evidenced from publicly available information
60	Building a contemporary system through digital technology	60.1: Commencement not evidenced from publicly available information
		60.2: Commencement not evidenced from publicly available information
		60.3: Commencement not evidenced from publicly available information
61	Sharing mental health and wellbeing information	61.1: Commencement not evidenced from publicly available information
		61.2: Commencement not evidenced from publicly available information
		61.3: Commencement not evidenced from publicly available information
62	Contemporary information architecture	62.1: Partial progress evidenced from publicly available information
63	Facilitating translational research and its dissemination	63.1: In place (ongoing assessment required)
		63.2: Limited evidence of progress available publicly
64	Driving innovation in mental health treatment, care and support	64.1: In place
		64.2: Commencement not evidenced from publicly available information

Recommendation number	Recommendation title	Progress of each sub-recommendation
65	Evaluating mental health and wellbeing programs, initiatives and innovations	65.1: Partial progress evidenced from publicly available information
		65.2: Limited evidence of progress available publicly
		65.3: Limited evidence of progress available publicly
IR1	Victorian Collaborative Centre for Mental Health and Wellbeing	VCC: In place
		VCC functions: To be assessed later
IR2	Targeted acute mental health service expansion	In place
IR3	Suicide prevention	In place, recurrent funding unclear
IR4	Aboriginal social and emotional wellbeing	In place
		Balit Durn Durn functions to be assessed later
IR5	A service designed and delivered by people with lived experience	Partial progress evidenced from publicly available information
IR6	Lived experience workforces	Partial progress evidenced from publicly available information
		Some sub-recommendations completed
IR7	Workforce readiness	Partial progress evidenced from publicly available information
		Workforce profile in place
		Limited evidence of mechanisms for continuing data collection
IR8	New approach to mental health investment	Mechanism in place
		Partial progress evidenced from publicly available information of increased funding above future expected growth
IR9	The Mental Health Implementation Office	In place

Note 1: Progress is reported against sub recommendations in disaggregated form (for example a, b, c), consistent with the methodology of the Royal Commission.

Note 2: The Department of Health very recently provided the Commission with additional information about the progress of some recommendations. The Commission has chosen to include this information in this report, despite having insufficient time to consider the information fully. However, the Commission flags that its assessment of progress of some recommendations may change in subsequent reporting.

Information on the sources used to compile this report can be requested from the Commission by emailing info@mhwc.vic.gov.au.

Section 2d: Engagement

Sector and Community Engagement

Our Commissioners and staff have continued to build strong connections across Victoria's mental health and wellbeing system to elevate lived experience leadership, promote rights, and support system reform.

Commissioners in the Sector

Commissioners participated in a range of events including conferences, symposiums, panel discussions, and other activities to support the work of the Commission.

Highlights included:

- Presentations at the Alfred Health Lived Experience Symposium, the Collaborative Centre's Gender-Based Sexual Safety event, the TheMHS Conference - *Finding Common Ground*, the Complex Needs Conference, the Improving Mental Health Access & Quality in Emergency Departments Conference, and the Social and Emotional Wellbeing Forum (SEWB) - *Statewide Workforce Gathering*.
- Participation in key national and international discussions with Mental Health Commissions from across Australia, Mental Health First Aid International, Australian Health Practitioner Regulation Agency, and the Royal New Zealand College of General Practitioners.
- Sector leadership forums, including contributions to the National Disability Insurance Scheme Commission's Complaints Advisory Committee, the Victorian Ombudsman's Complaints Handling Standards launch, the Victorian Equal Opportunity and Human Rights Commission Race Discrimination Guidelines launch, and the National Disability Research Partnership *Evidence to Action* Collaborative Event.
- Through these contributions, Commissioners have ensured the voice of lived experience was central to policy and service reform discussions, while reinforcing the Commission's oversight role.

Elevating Lived Experience

The Commission has continued to champion the elevation of lived experience participation and decision-making. Commissioners attended and contributed to events such as the Collaborative Centre Lived Experience Strategy Workshop, the Alfred Health Lived Experience Symposium, and the TheMHS Conference.

Regular dialogue with leaders such as Vrinda Edan, CEO, VMIAC; Marie Piu, CEO, Tandem; Mary O'Hagan, formerly at the Department of Health and now at Wellways as a Lived Experience Executive Leader; and Carolyn Gillespie, Co-CEO at the Victorian Collaborative Centre for Mental Health and Wellbeing, has reinforced the centrality of lived experience in reform.

Workforce, Learning and Development

Workforce capacity remains one of the most pressing challenges in implementing the Royal Commission recommendations. The Commission contributed to lived experience workforce meetings and the Department of Health's Lived Experience Leadership and Workforce Implementation Advisory Group.

Commissioners also partnered with academic leaders including the University of Melbourne, Monash College, Auckland University, and La Trobe Law School, exploring new pathways for training, qualifications, and embedding lived experience leadership into tertiary education.

Quarterly Meetings with Services

A key feature of our oversight role has been the regular quarterly meetings with designated mental health services. These meetings provide a consistent opportunity to review complaints data, discuss systemic issues, and identify areas for improvement. By bringing together service leaders and Commission staff, these sessions foster open dialogue and accountability.

They ensure that the voices of consumers, carers, and families help inform service improvements, and that the Commission has visibility of how services are responding to concerns. The standing agenda focuses on rights, complaints, and monitoring of the Royal Commission's recommendations.

Community and Cultural Connections

The Commission engaged directly with community-based organisations and cultural networks, attending events that celebrate diversity, equity, and inclusion. This included the *Beyond Bias Festival of Women's Health and Equity* (Queen Victoria Women's Centre and Women's Health Victoria), the VACCHO Balit Durn Durn Centre anniversary, and the Rainbow Mob Gathering.

By participating in these forums, Commissioners strengthened relationships across diverse communities, building trust and ensuring the Commission's work reflects the breadth of Victoria's population.

Engagement with First Nations Communities

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

We acknowledge the continuing impact of colonisation, racism, and intergenerational trauma, and recognise that reform must prioritise culturally safe access to mental health and wellbeing support.

This year, Commissioners engaged with:

- Victorian Aboriginal Community Controlled health Organisation (VACCHO) through multiple events, including the Balit Durn Durn Centre anniversary and ongoing strategic discussions
- Victorian Aboriginal Legal Service (VALS) to discuss systemic issues, complaints processes, and cultural safety
- The Rainbow Mob Gathering 2025, celebrating Aboriginal LGBTQIA+ leadership
- Department of Health's Balit Murrup Unit where we joined the Aboriginal Mental Health Traineeship communities of practice and graduate event
- *The Social and Emotional Wellbeing Forum* (SEWB) - Statewide Workforce Gathering.

These engagements provided vital opportunities to listen deeply to Aboriginal people and communities about their experiences of reform, their expectations of the system, and the importance of Aboriginal-led solutions.

We remain committed to Aboriginal self-determination and to ensuring our oversight role is culturally respectful and responsive. The Commission is progressing work on culturally safe complaints processes and Indigenous data sovereignty, recognising the importance of reporting against Aboriginal-defined measures of wellbeing.

We acknowledge the resilience, wisdom, and leadership of Aboriginal communities, and continue to support progress towards Treaty and the work of the First Peoples' Assembly of Victoria.

Key insights from the Commission's Summary of Service Visits

Over the past year, the Mental Health and Wellbeing Commission (the Commission) conducted service visits across 14 designated mental health service providers. These visits formed part of the Commission's strategic engagement activities and were attended by Commissioners, executives, and staff from teams including Lived Experience, Communications and Engagement, Compliance, and Complaints and Resolutions.

The purpose of these visits was to build relationships, deepen understanding of service experiences, and gather insights into the opportunities and barriers to delivering high-quality, person-centred care. Through direct engagement with clinicians, executives, and the lived experience workforce, the Commission gained valuable perspectives on how reforms are being implemented and where further support is needed.

Key objectives included:

- Sharing the Commission's strategic priorities and clarifying its role under the *Mental Health and Wellbeing Act 2022*
- Learning how services are embedding lived experience leadership in practice and decision-making
- Understanding progress and challenges in implementing the Royal Commission into Victoria's Mental Health System recommendations
- Building awareness of the Commission's approach to complaints, compliance, systemic reviews, and inquiries
- Gathering feedback to improve how the Commission engages with the sector and supports reform.

Services were encouraged to speak openly about what's working well and where additional support may be needed. These visits are part of an ongoing commitment to sector engagement and continuous improvement.

Summary of Key Themes

1. Workforce and Training	Services reported critical shortages of qualified staff, particularly child psychiatrists and experienced nurses. High vacancy rates and rotational staffing models disrupt continuity of care and documentation. There is a need for clearer guidance on clinical standards, especially around chemical restraint.
2. Lived Experience Workforce	The growth of lived experience (LE) roles was widely welcomed, with many services expanding their LE teams. However, concerns remain about funding sustainability, part-time arrangements, and ongoing stigma toward LE staff. Services want more support to embed LE leadership and culture. Carer and family support roles are less common than consumer roles, and services are interested in strengthening carer involvement and leadership.
3. Funding and Systemic Constraints	Existing funding models were seen as misaligned with reform goals, favouring bed-based care and restricting innovation. The dual pressures of COVID-19 and reform implementation have stretched resources. Concerns were raised about funding transparency, sustainability, and the lack of housing options for consumers post-discharge, which delays access for others.

4. Monitoring, Reporting and Governance	There is complex compliance landscape, with overlapping obligations across oversight bodies. This duplication creates confusion and consumes significant time and resources. There is a strong call for streamlined governance and better alignment between legislative frameworks, particularly regarding restrictive practices.
5. Complaints Management and Sector Learning	Complaints are recognised as a valuable driver of improvement, however, current systems are fragmented and lack transparency. Services support the idea of a statewide forum for complaints resolution and shared learning. Carers expressed hesitation to raise complaints, fearing it could negatively affect the consumer's care. There is a need for safe, transparent, and supportive complaints processes that protect carers and encourages feedback.
6. Trauma-Informed, Least-Restrictive Care	Many services are actively working to reduce restraint and seclusion, with some reporting significant progress. There is strong commitment to trauma-informed care, supported by staff and consumer reflection sessions. However, systemic barriers - particularly in emergency departments (EDs) and outdated infrastructure - limit consistent application.
7. Stigma Reduction and Rights Awareness	Stigma remains persistent, especially for First Nations peoples and carers. Carers reported feeling stigmatised and expressed concerns about privacy breaches when providing feedback. Services called for stronger leadership, targeted education, and community engagement to promote mental health rights awareness. Advanced Statements of Preferences (ASOPs) are encouraged, but they're not consistently used or transferred across services.
8. Infrastructure Conditions and Service Improvements	Many services operate in outdated facilities that hinder the delivery of person-centred care. Shared bedrooms and bathrooms compromise dignity and privacy. In contrast, co-designed environments - including input from carers - were seen as safer, more inclusive, and welcoming. Variation in how the Act and associated guidance are interpreted has led to inconsistent practices, often shaped by the physical environment.
9. Emergency Departments' Practices	EDs face significant challenges in responding to mental health presentations. High staff turnover and limited access to community-based services place pressure on EDs and affect care quality. There is an urgent need for training in the Act to ensure compassionate, rights-based responses. Alternative triage models outside traditional ED settings were viewed positively for offering more timely and person-centred care.

Next Steps

The Commission will continue to use the insights gathered from these visits to refine its engagement strategies and strengthen its role in supporting sector reform. The feedback received highlights both the progress made and the areas where further collaboration, investment, and leadership are needed to realise the vision of a responsive, inclusive, and rights-based mental health system.

Locals and Connect Centres Visits

This year, Commissioners and staff visited a range of Locals and Connect Centres to see these community focused services in action.

Commissioners and staff travelled to mental health and wellbeing locals in Brimbank, Wangaratta, Greater Shepparton, Strathbogie, Moira, Loddon Mallee, and the Grampians, as well as Connect Centres such as the new Grampians Mental Health and Wellbeing Connect for families, carers, and supporters.

These visits enabled the Commission to hear first-hand from staff, consumers, families, and carers about how these in-community services are helping to address mental health and psychological distress.

Communications and Engagement at the Commission

Throughout the year, the Commission's Communications and Engagement team focused on building visibility, trust and practical pathways for people to engage with our work.

We met regularly with peak organisations, to share information, listen and learn from others. These helped surface emerging issues, close feedback loops, and support progress on reform.

We coordinated a statewide program of service visits and supported Commissioners' participation in conferences and events that profiled the Commission's oversight role, elevated lived experience leadership, and contributed to reducing stigma and discrimination. These activities strengthened relationships across the sector and ensured our insights were visible in public forums. We strengthened our digital front door. In partnership with lived experience, our website was refreshed to make information easier to find, with clearer pathways to make a complaint, learn about rights, and contact us. We focused on using plain language and ensuring that the layout, colours and functionality that reflect the diverse needs of our community, including people with lived experience.

We amplified our work across social channels - particularly LinkedIn and Instagram, which have become primary tools to share the work of the Commission. This approach broadened our reach to sector leaders and frontline staff on LinkedIn, while Instagram helped us connect with consumers, families and supporters in clear, human-centred ways.

We also established and strengthened relationships with media outlets. By providing timely, accurate information and context on system reform and rights, we supported balanced reporting and increased public understanding of the Commission's role as an independent oversight body.

A key priority was normalising help-seeking and making it clear that it is "OK to Complain". We developed new materials for designated mental health services including posters, wallet cards and postcards highlighting people's rights and how to contact the Commission.

Together, these efforts enhanced awareness of the Commission's role, made it easier for people to find and use our services, and deepened our connections with sector partners to support meaningful and sustained reform.

Mental Health and Wellbeing Commission

Establishing a brand people can trust and feel safe with

Our brand was developed in consultation with Lived Experience. The logo represents the significance of balance and building on progress year by year like stacking stones. The stones are shaped to look like a human figure to represent that people are at the heart of the Commission's work.

The colour palette and imagery used in the brand demonstrate how important our natural environment is to our mental health and wellbeing. The brand utilises native Victorian plants as a connection to our natural environment and place. The brand strives to build trust and give people the confidence to speak up.

Appendices

Appendix 1: Financial Operations

The Department of Health provides financial services to the Commission.

The financial operations of the Commission are consolidated into those of the Department of Health and are audited as part of their 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 2024-25 according to the Department of Health accounts is provided below. The expenditure was marginally higher than the allocated budget of $9,926,950.

Operating statement for the year ended 30 June 2025

Expenses	
Salaries and on-costs	$8,955,083
Supplies and consumables	$972,838
Total expenses	**$9,927,921**

Staffing

There were 43.9 FTE (including fixed term positions) as at 30 June 2025.

Signed by: Beth Gubbins, Deputy Chief Financial Officer,
Finance, Budget Funding and Investment

28/08/2025

Appendix 2: Compliance and Accountability

Financial Management Act 1994

The Minister for Finance has determined that, in accordance with section 53(1)(b) of the *Financial Management Act 1994* (FMA), that the report of operations and financial statements of the Commission may be consolidated with those of the Department of Health for the 2024-25 financial year and onwards.

The Minister for Finance has exempted the Commission from the requirements of the FMA Standing Directions 2018 (SDs), in particular Direction 5.1.2 for 2024-25 and full SDs for 2025-26 and 2026-27.

Notwithstanding these exemptions, the Commission continues to work with the Department of Health and Department of Treasury and Finance to focus on continuous improvement in public administration and the requirements of the FMA Act under its memorandum of understanding with the Department of Health.

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

The Commission 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 Commission 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 Commission 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 Commission'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 mhwc.vic.gov.au.

Freedom of Information Act 1982

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

Applications can be made in writing to the Commission by email PrivacyFOI@mhwc.vic.gov.au

In 2024-25 the Commission made six decisions regarding freedom of information (FOI) applications. A further FOI application was ongoing at the end of the 2024-25 FY. We also responded to an additional two requests for documents that were provided outside the FOI process.

At the end of June 2025, applications for review of two Commission FOI decisions were with the Office of the Victorian Information Commissioner and the Victorian Civil and Administrative Tribunal respectively.

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 Commission 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 Commission 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 1800 806 314 or lodge a complaint via the Ombudsman's online complaints portal by visiting 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 our annual report

Acquittal Requirements

This Annual Report had been prepared to meet the requirements as outlined in the *Mental Health and Wellbeing Act, section 427* Annual Report acquittal requirements

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.

Appendix 4: Domain 3, Commission's measures of socio-economic determinants of wellbeing

Indicator	Measure	Source	Comparison year	Current year	Change
Decrease family violence (FV), gender-based violence, gender inequality	FV incidents (number)	Crime Statistics (VIC)	93,111(2022)	98,816 (2023)	+9.1%
Decrease community and societal violence	Assault offenses (Rate per 100,000)	Crime Statistics (VIC)	7674.4 (2023)	8838.7 (2024)	+24.7%
Decrease adverse childhood experiences	Child Protection notifications	AIHW	128,412 (2022)	139,555 (2023)	+8.7%
Decrease experiences of discrimination and exclusion	Experienced racism in previous 12 months	VPHS	8.2% (2022)	7.3% (2023)	-11%
Decrease experiences of discrimination and exclusion	Experienced discrimination in previous 12 months	VPHS	19.5% (2022)	15.8% (2023)	-19%
Decrease financial insecurity	Experienced financial stress	VPHS	13.4% (2019)	15.1% (2022)	+12.7%
Decrease harmful/addictive relationships with alcohol, other drugs, gambling	Risky alcohol consumption	AIHW	32% (2019)	30.7% (2022-23)	-4.1%
Decrease harmful/addictive relationships with alcohol, other drugs, gambling	Use of any illicit drugs	AIHW	16.4% (2019)	17.6% (2022-23)	+7.3%
Increase stable, secure, and appropriate housing	Rates of homelessness	ABS	42 per 10,000 (2016)	47 per 10,000 (2021)	+11.9%
Increase stable, secure, and appropriate housing	Social housing dwellings	AIHW[1]	82,846 (2023)	84,474 (2024)	+2.0%
Increase meaningful engagement in education, employment, and other pastimes	Persons 15-74 that are fully engaged in work or study	ABS[2]	60.5 (2019)	61.2% (2024)	+1.2%
Increase physical health	Adults with both mental illness and physical health condition	ABS[3,4]	8.4% (2020-22)	8.0% (2023)	-5%

1 https://www.aihw.gov.au/reports/housing-assistance/housing-assistance-in-australia

2 https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/latest-release#state-and-territories

3 National Nutrition and Physical Activity Survey 2023 | Australian Bureau of Statistics

4 https://www.aihw.gov.au/mental-health/topic-areas/health-wellbeing/physical-health

Notes:

Notes:

mhwc.vic.gov.au

Mental Health and Wellbeing Commission