

“

Changes since the Royal Commission:  
perspectives on responding to mental  
health crises in the community

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## Issues paper #2

March 2026



**Mental Health  
and Wellbeing**  
Commission

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# 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.

## Appreciation

We sincerely thank all those who found time in their busy days to share their expertise and experiences with us. This work cannot proceed without such generosity.

## 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. Reader caution is advised.

# Introduction

## About this project

The Mental Health and Wellbeing Commission (MHWC, the Commission) is a statutory authority established under the Mental Health and Wellbeing Act, 2022 (Vic) (the Act). One of the Commission's functions is to monitor and report on the Victorian Government's progress in implementing the recommendations of the Royal Commission into Victoria's Mental Health System (the Royal Commission).<sup>1</sup>

One way the Commission is doing this is by presenting issues papers that address specific areas of reform and inform the community including consumers of mental health and wellbeing services, their families, carers, supporters and kin, people who work in the mental health and wellbeing system and government about progress.

This is the Commission's second issues paper, and the first exploring issues raised by the Royal Commission. It explores perspectives on how things have changed when someone experiences a mental health crisis in the community (not when admitted to a bed-based facility) since the Royal Commission concluded.

This issues paper reports what we have heard about crisis responses. The work is illustrative rather than comprehensive in nature, due to the limited time and resources available to the Commission.

We recognise and regret the limitation that our approach presents, and the small stakeholder samples we had available to us. Hence, we acknowledge that this work is not sufficient to draw robust findings or make conclusions about the success of implementation.

Regardless, we believe it contains interesting and valuable insights for those working to improve what happens when someone experiences a mental health crisis in the community.

## Purpose

The purpose of this paper is to explore perspectives on the immediate responses that support someone who experiences a mental health crisis in the community and relevant changes since the Royal Commission was completed.

The topic was selected due to its importance to consumers and the critical role that crisis response plays in preventing harm, reducing trauma, and connecting people with the right care at the right time. It is important to families, carers, supporters and kin for the same reasons.

## Background

Demand for crisis and emergency mental health services remains extremely high and requires significant attention and resourcing. Over the last decade, mental-health emergency department presentations grew from 82 to 97 per 10,000 population, an increase of 18 percent,<sup>2</sup> with 79 percent of mental-health presentations in 2023-24 triaged as urgent or higher and one in four classified as emergency.<sup>3</sup>

Population-level indicators confirm high levels of psychological distress within the community. The 2023 Victorian Population Health Survey shows that the proportion of adults reporting very high psychological distress increased from 18.1 percent in 2019 to 23.4 percent in 2020, remaining high post COVID-19 at 19.1 percent in 2023.<sup>4</sup> This survey indicates that many Victorians reported positive life satisfaction and social

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<sup>1</sup> The Mental Health and Wellbeing Act, 2022 (Vic) section 415(j)(ii)

<sup>2</sup> <https://www.aihw.gov.au/mental-health/topic-areas/hospital-based-services/emergency-departments/state-and-territory-data>

<sup>3</sup> <https://www.aihw.gov.au/mental-health/topic-areas/hospital-based-services/emergency-departments/state-and-territory-data>

<sup>4</sup> <https://vahi.vic.gov.au/reports/victorian-population-health-survey-2023>

support, however, younger people, people experiencing socio-economic disadvantage, and those with co-existing substance use issues reported disproportionately high levels of distress.

Ambulance Victoria reflected that mental health calls represent approximately 11 percent of their caseload and is their fastest growing call group.

The Royal Commission acknowledged the important role that responding to and supporting people when they experience a mental health crisis in the community plays in the mental health and wellbeing system and made several recommendations about it.

## Scope

This project sought to identify changes in what happens when someone experiences a mental health crisis in the community since the Royal Commission concluded. The paper does not reflect all the significant work not seen by consumers, their families, carers, supporters and kin, or frontline mental health staff and first responders.

The paper does not seek to acquit each element of the relevant recommendations made by the Royal Commission. The table in Appendix 1 sets out the recommendations that directly link to responding to mental health crises in the community, which provide an indication of elements of the mental health and wellbeing system that the Royal Commission deemed important to a well-functioning system.

We recognise that many other recommendations play a role in supporting crisis response, such as those that seek to prevent such crises occurring by supporting wellbeing, preventing mental ill-health or intervening earlier. These important aspects of the system are beyond the scope of this paper.

## Objectives

Our work sought to understand:

- what has changed in terms of the immediate responses when someone experiences a mental health crisis in the community
- what is working well
- priority actions to address the gaps and challenges that remain.

## Approach

This work was undertaken by a team of the Commission's staff that included members of the Lived Experience and Performance Monitoring and Reporting teams. Commissioner Brebner was the project sponsor, and the Commission's Accountability Portfolio served as the project governance group.

The Commission's team adopted a mixed methods approach utilising individual and group semi structured interviews, short surveys, written responses to discussion questions and information gathered from published sources. Discussion guides and surveys addressed the objectives, using the same or similarly worded questions which were tailored for each stakeholder group.

Unfortunately, constraints facing the Commission meant we were unable to engage directly with consumers, their families, carers, supporters and kin in the manner we would have preferred. We approached the peak bodies VMIAC and Tandem for input, however, they were unable to contribute due to their own resource constraints. We have drawn on our conversations with consumers and stakeholders that the Commission carries out routinely to augment what we have heard about crisis responses.

Victoria Police were also unable to engage with the Commission during the time period required.

We have used information gathered information from:

- a range of Mental Health and Wellbeing Locals (MHW Locals) and partner organisations including services located metropolitan Melbourne, regional areas and smaller rural towns
- call takers and management from Triple Zero Victoria

- front line paramedics and management from Ambulance Victoria
- general practitioners (GPs) including through a survey conducted by the Royal Australian College of General Practitioners (RACGP)
- psychiatrists through papers provided by the Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- publicly available sources such as websites, government reports and published papers
- three area mental health and wellbeing services (one located in metropolitan Melbourne, one in a large regional centre which includes rural areas, and one in rural Victoria).

Data collection was conducted between May and October 2025.

All members of the project team were involved in developing the project objectives, method, discussion guides and in stakeholder engagement activities. The information gathered was analysed thematically.

The team drew on publicly information from sources considered reliable by the Commission's System Performance and Monitoring team about progress on recommendations made by the Royal Commission.

The shorter than expected timeframe and reduced resourcing of the Commission meant the methodology was not as robust as initially intended. Consequently, this work is indicative only and robust findings and conclusion cannot be drawn from it. The work remains informative and useful to those considering progress in this key area of the mental health and wellbeing system.

Unfortunately, due to reductions in the Commission's budget, this paper is authored solely by Commissioner Brebner, and she takes full responsibility for any errors.

# From the Royal Commission

This section briefly summarises key issues associated with the responses available when people experience mental health crises in the community identified in the Royal Commission's Interim Report released in November 2018. The Royal Commission's recommendations contained in its Final Report addressed these issues.

The Interim Report described how the complexity of the mental health system, difficulties in its navigation and a lack of accessible, appropriate services can lead to 'missed opportunities to intervene early' and an increased likelihood that 'poor mental health will lead to a crisis (for example, intentional or accidental self-harm) or escalation of symptoms'.<sup>5</sup>

Reforms that reduce or eliminate these 'missed opportunities' are crucial to reducing the number of people experiencing mental health crises, the severity of crises and hence demands on crisis response services.

This paper does not explore all the services required to address these 'missed opportunities' as this is part of the system wide transformation effort. The paper focuses on the issues directly linked to the responses available when someone does experience a mental health crisis in the community rather than how it may have been prevented.

Three of the issues identified by the Royal Commission as significant when people experience a mental health crisis in the community are:

- the difficulties people in crisis, their families, carers, supporters and kin experience finding an appropriate service either because the system is hard to navigate and/or the lack of appropriate services (including choice of service type) in their area
- the increasing numbers of people in crisis presenting to emergency departments, the suitability of these spaces for people in mental health crises and the services' capacity to treat and support them person in a timely way
- the role of first responders, usually Ambulance Victoria paramedics and Victoria Police, in assessing and responding appropriately to a mental health crisis.

This paper presents perspectives on progress in addressing these issues raised with the Commission.

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<sup>5</sup> The Royal Commission into Victoria's Mental Health System, Interim Report, November 2018, p197

# What has changed since the Royal Commission?

The Royal Commission identified the need for a broader range of options to assist people when they experience a mental health crisis in the community, emphasising the importance of providing people with choice about the type of service they can access to gain the treatment, care and support they need.

Importantly, these options need to extend beyond ambulance, police and hospital emergency departments, all of which remain essential parts of the mental health and wellbeing system, but are often overstretched, and not always able to provide the most conducive environment to assist people experiencing mental health crises.

## Finding an appropriate service

### Directories

Discussions with stakeholders and anecdotal engagement with consumers, their families, carers, supporters and kin overwhelmingly reflected the ongoing confusion about what services are available to help people who are experiencing a mental health crisis. We heard that consumers, their families, carers, supporters and kin, GPs and first responders find the Department of Health online service directory resources difficult to navigate, with eligibility criteria hard to find and confusion caused by the inconsistent naming of services including frequent name changes.<sup>6</sup>

Responses from people we spoke to were consistent with our own desktop research, which was that many websites for and directories of mental health and wellbeing services direct people to call 000 or go to the nearest emergency department in case of mental health emergency or crisis. We do not suggest that this advice is inappropriate, rather that it may be incomplete and at times leads to over reliance on 000 calls and emergency department presentations. Consumers experiencing a mental health crisis for the first time, together with their families, carers, supporters and kin, may not know if what is being experienced is an emergency or crisis, and therefore if calling 000 or going to an emergency department is an appropriate response. Many consumers want choice about the type of crisis support they receive, but to exercise choice they need to know what choices are available.

The Royal Commission reported in some detail about the challenges that people experiencing mental health crises face, both when emergency services are called, and when attending emergency departments.<sup>7</sup> What we heard about progress towards improving these responses, and suitability of emergency departments for people experiencing mental health crises, are discussed later in this paper.

Department of Health websites mention that people can access assistance by phone by calling Nurse on Call (for non-urgent assistance) or the Victorian Virtual Emergency Department (for non-life-threatening emergencies). Again, people can struggle to determine which service is applicable in a mental health crisis.

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<sup>6</sup> The Department of Health retired the previous Mental Health Services Directory in late 2025, replacing it with a new directory. The Department mentions that the new directory provides a single platform to find service details but does not have the same functionality as the previous directory. Consultations for this paper were conducted prior to the launch of the new Mental Health Services Directory and therefore comments relate to the retired directory.

<sup>77</sup> The Royal Commission into Victoria's Mental Health System, Interim Report, November 2018

## General practitioners

We heard that some people contact their GP to get help when they or someone they are close to experiences a mental health crisis. We heard about three main issues that commonly arise when consumers, their families, carers, supporters and kin choose this approach:

- unacceptable delays in getting an appointment with their usual GP, often resulting in people resorting to calling 000 or going to an emergency department (with the inherent challenges this poses)
- GPs facing unacceptable delays when trying to contact the relevant area mental health service triage line which results in further time delays for consumers who need help quickly (emergency services also raised the issue of unacceptable delays when trying to contact area mental health and wellbeing triage lines)
- the lack of uniform or consistent mental health services across geographic areas, including hours of operation, meaning GPs are not always aware of the available service options.

These issues are consistent with issues identified by the Royal Commission.

We spoke with the RACGP and reviewed responses to a survey from a small sample of GPs (n=31) about the pathways GPs use when helping consumers experiencing mental health crises.

GPs commented that connecting consumers with mental health crisis services is usually difficult or extremely difficult (80 percent of respondents) with unclear pathways, long waits and limited feedback about patients provided to GPs when services are accessed. These issues are exacerbated after business hours, including on weekends.

Overwhelming the responses reflected that GPs manage the person experiencing crisis themselves (87 percent of respondents), refer consumers to emergency departments (77 percent of respondents), refer consumers to helplines such as Lifeline (77 percent) or call 000 (61 percent).<sup>8</sup> Some respondents phoned area mental health and wellbeing service outreach or mobile crisis assessment teams and triage lines (55 percent and 52 percent respectively) although GPs indicated that the time spent on hold for these services was unworkable for them and for their patients.

We heard that when GPs assess that consumers need inpatient treatment, they will often look to bypass the public mental health system if their patient has family members who will look after them and supervise medication to keep the person safe until a private facility bed becomes available because the wait times are shorter. This only applies if the consumer or family can pay for an inpatient stay or has private health insurance that covers admission to a private mental health hospital.

GPs highlighted that access to psychiatrists and affordable psychology is harder than before the Royal Commission, with 74 percent of respondents to the small sample survey indicating affordability of mental health services as a pain point. This suggests that the timeliness of help still depends on the financial resources available to the consumer, raises questions about the use of medication as a holding strategy in place of service availability, and speaks to the high burden placed on families, carers, supporters and kin.

GPs told us that once the barriers of connecting a person to the appropriate service were navigated, they usually received good service from which they benefitted.

## Mental Health and Wellbeing Locals

We heard about positive experiences when people experiencing a mental health crisis contact the newly established MHW Locals.

Twenty MHW Locals have been established in a range of locations across Victoria, providing free treatment, care and support for people aged 26 years and over who are experiencing mental health or wellbeing concerns. MHW Locals employ a range of staff depending on the needs of their communities and the

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<sup>8</sup> The survey allowed multiple selections

availability of staff. This includes lived experience workers, social workers, nurses, mental health nurses, counsellors, psychologists, psychiatrists and alcohol and other drug (AOD) workers.

MHW Locals are not available in all parts of Victoria and have varying hours of operation. MHW Locals are not open 24 hours per day / 7 days per week. Some offer limited opening hours after 5pm and/or on weekends, while others operate 3 days per week offering reduced services.

MHW Locals are not designed as crisis services, however we heard from a range of stakeholders that they have become an important access point for some people when experiencing mental health crises, providing the MHW Local is open when the person is in crisis.

MHW Local staff reflected that the model supported the dignity of risk principle by providing a viable alternative to emergency departments for some people experiencing mental health crises.

Some of the comments we heard about the operation of MHW Locals are repeated below.

- Having a voluntary, lived-experience-led MHW Local service has reduced the fear some consumers hold that they will be treated involuntarily if they present to a service. This is enabling earlier, richer disclosure and faster rapport building.
- The staff at MHW Locals are often skilled to de-escalate situations when someone is experiencing a mental health crisis and are then able to work with them to determine appropriate next steps. Lived experience workers play a crucial role in this as the ‘peer-first’ engagement model immediately reduces perceptions of power imbalance for consumers. The environment at MHW Locals can be more amenable to de-escalation of someone experiencing a mental health crisis than busy emergency departments.
- Many MHW Locals work very closely with the area mental health service (some share staff) and can discuss consumers’ needs and make warm referrals directly to services as required. Clinicians from some area mental health services come to the MHW Local to see consumers when possible and required. These strong relationships between MHW Locals and hospital clinicians may result in consumers being admitted directly to Adult Prevention and Recovery Care (APARC) or Psychiatric Assessment and Planning Unit (PAPU), bypassing emergency departments, which reduces the need for repeated triage questioning and reduces the demand on the emergency department.
- Initially, MHW Locals were less constrained in terms of limiting services to people who lived within their catchment area. As the services have become busier, they have developed waiting lists and consequently are prioritising people living in their area (noting that catchments are much larger than was originally intended). By way of example, the newly opened Darebin MHW Local’s website specifies that the service is for people living within its catchment.
- In some areas GPs have low awareness of MHW Locals. Only 23 percent of respondents to the small sample survey indicated knowledge of MHW Locals.
- One longer established MHW Local acts as a ‘de facto regional access node due to the lack of full-service Locals across the area’.

We heard that even where MHW Locals are operating well, mental health presentations to emergency departments were rising, which staff considered due to external factors increasing the levels of mental distress in the community.

We also heard that the lack of availability of MHW Locals across Victoria and the inconsistent hours of operation, particularly with regard to MHW Local satellite sites (operating with reduced services and over shorter hours), made it difficult for GPs and emergency services to regularly consider MHW Locals as options to assist people in mental health crisis. This results in emergency departments continuing to be the default destination when people experience a mental health crisis in the community and require transport to an appropriate mental health and wellbeing service.

Stakeholders mentioned that consumers who are too acutely unwell for MHW Locals to support but not sufficiently unwell to meet criteria of area mental health and wellbeing services - the ‘missing middle’ – are

still not receiving the level of support they need. This is likely to result in increased numbers of people experiencing mental health crises in the community.

## Area mental health and wellbeing services' crisis response services

We asked three area mental health and wellbeing services about what has changed regarding the services they offer to support people who experience a mental health crisis in the community (one metropolitan service, one service based in a large regional centre and one rural service).

### First response

All area mental health and wellbeing services with whom we spoke are structuring their services around new age ranges. The age range for services offered to children and young people now include young people to age 25 years, adult services cater for people from 26 to 64 years, and older adult services offered to those aged 65 years and over. Some area mental health and wellbeing services combine some services for adults and older adults.

Area mental health and wellbeing services confirmed that emergency departments remain the default first entry point for people experiencing mental health crises in the community, particularly after hours. The Department of Health requires all designated mental health and wellbeing services to provide a psychiatric triage and referral service that operates 24 hours a day 7 days a week. The three services we heard from confirmed that they do offer this service and that they use the statewide mental health triage scale.

We heard that one regional triage line operates but with response rates that need to improve. The service is investigating how Artificial Intelligence may be able to assist to streamline intake. Services are progressively developing Crisis Assessment and Triage Teams for people aged 25 years and under.

Pathways and service availability for people experiencing mental health crises differ across geographies. Vast catchments create access, timeliness and outreach challenges. One rural based service told us that they now provide emergency department-based crisis assessment 24/7 with mental health clinicians rostered to the emergency department from 10:00-18:30 and 21:30-07:00.

Some localities operate with clear pathways with community mental health clinicians providing assessments at emergency departments. A rural service we spoke with operates acute community crisis outreach during extended business hours with referrals aligned to the statewide mental health triage scale, while another has a fully operational mental health, alcohol and other drug hub embedded in its emergency department, which includes lived experience roles. Lived experience leadership structures are developing.

The Police, Ambulance, Clinical Early Response (PACER) team operates in at least one of the regional areas with whom we spoke.

The RANZCP has pointed out that the rollout of crises response services across a broader continuum has been uneven.<sup>9</sup> The choices available to consumers experiencing mental health crises beyond presenting at emergency departments, such as short-stay, Hospital in the Home, Safe Havens and crisis hub capacity varies widely between localities in Victoria, with regional areas experiencing particular constraints. This is consistent with views we heard from other stakeholders, as is the RANZCP's call for expansion of evidence-supported crisis alternatives based on robust evaluation.

### Emergency department mental health, alcohol and other drug hubs

At least six of the emergency department mental health, alcohol and other drugs hubs operating were announced and construction on three hubs were finished before the Royal Commission handed down its Final Report (Sunshine Hospital, Monash Medical Centre and University Hospital Geelong). Additional emergency mental health, alcohol and other drug hubs have been established following the Royal Commission.

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<sup>9</sup> The Royal Australian & New Zealand College of Psychiatrists Victorian Branch, 2026-2027 Victorian State Budget Submission Staying the Course: Safeguarding the Ambitions of Mental Health Reform, 9

Ambulance Victoria paramedics who spoke to the Commission praised the introduction of these hubs. We heard that they play an important role in reducing distress of the person experiencing a crisis due to reduced waiting times in busy emergency departments, availability of quieter spaces for assessing the person's state of ill-health and distress which enabled the person to de-escalate more quickly, resulting in less harm. Where available, the specialised staffing of the hubs, including Lived Experience workers, contribute to better experiences for consumers, their families, carers, supporters and kin.

## When people call triple zero

### Health led response

The Royal Commission recommended that wherever possible, emergency services' responses to people experiencing time-critical mental health crises should be led by health professionals rather than police (recommendation 10).

We understand that the pathway of an emergency call is heavily dependent on the emergency service requested by the call maker in the first instance. For calls assigned to Ambulance Victoria, priority of the call is determined with secondary clinical triage and mental health clinician input when needed.

We heard about the significant efforts being made to implement recommendation 10 by all parties including Triple Zero Victoria, Victoria Police and Ambulance Victoria. These include joint meetings and working groups. We heard about improved access to mental health clinical assistance for triaging decisions and paramedics attending mental health call outs. We also heard about active cross-agency work developing an in-field escalation pathway for care and control decisions. However, recommendation 10 is yet to be fully implemented.

### Uplift in triaging and access to mental health clinicians

We heard that since the Royal Commission report, there has been an uplift in Ambulance Victoria triage staffing including the introduction of more mental health clinicians. We heard that the increased availability of mental health clinicians is assisting with more appropriate triaging of mental health related calls, including better use of warm referrals to area mental health and wellbeing services, and referral for follow up by the person's GP.

Stakeholders believe the increased availability of mental health clinicians is supporting use of least restrictive options and more appropriate triaging decisions across a wide acuity range. Paramedics who spoke to the Commission reported experiencing improved planning for safer approaches when responding to calls involving mental health episodes. We heard that further improvements would be possible if Ambulance Victoria mental health clinicians had more information about consumers through real time access to CMI.

### Destinations

Ambulance Victoria officers told us that emergency departments remain the default destination when someone experiencing a mental health crisis in the community requires transportation to a mental health and wellbeing service. Occasionally people may be transported to their GP or a community clinic (potentially including MHW Locals) if the crisis occurs within the services' operating hours and paramedics know these pathways are available in the area.

Some stakeholders referred to the PACER joint police/clinician secondary response (also referred to by other acronyms including PAT) as the gold standard for responding to mental health crises in the community. The Commission is not aware of the official status of PACER across Victoria however, stakeholders told us that PACER is not available routinely in all areas and availability seems to have reduced over the past few years. Stakeholders mentioned that PACER staff are frequently redeployed to other duties. The lack of consistency in service availability is problematic and has equity and access implications that are of concern.

## Challenges

We applaud the significant efforts to address issues that arise when people experience a time-critical mental health crisis in the community, however, problems remain. These problems include:

- the lack of an agreed definition of crisis responses being ‘led by health professionals’
- challenges involving the information that is considered and responsibility for determining safety thresholds that trigger joint police / paramedic attendance when there are safety concerns
- different interpretations between agencies of thresholds such as ‘serious and imminent risk’
- powers to take someone into ‘care and control’ to transport them involuntarily to mental health and wellbeing services
- flow on effects of ambulance ramping at emergency departments leading to increased distress for consumers and consequently greater risk of the otherwise avoidable use of restrictive practices including sedation.

We heard how many of these issues are exacerbated during night times when resourcing and service availability is reduced and demand can be high. The issues are further exacerbated in border communities where legislation governing first responders’ powers differ between states and individual officers’ understanding of the status of memoranda of understanding may not be current.

These issues have even greater impact in country areas where distances involved can significantly increase the time required to attend calls and transport consumers to mental health and wellbeing services, which again impacts on the availability of emergency services to the rest of the community.

The Commission notes with concern the statement made by VMIAC indicating their temporary withdrawal from the Department of Health’s work on recommendations 8, 9 and 10 due to ongoing failure to centre lived experience expertise and looks forward to resolution of consumers’ concerns so that collaboration can recommence.<sup>10</sup>

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<sup>10</sup> Statement by VMIAC on 8 June 2025, <https://www.vmiac.org.au/vmiac-withdraws-from-victorian-department-of-health-work-on-recommendations-8-9-and10-due-to-ongoing-failure-to-centre-lived-experience-expertise/>

# Other changes we heard are working well

We asked stakeholders about changes that had occurred since the Royal Commission ended that are working well. We thought this would be of interest to stakeholders including government, so have included a range of comments here. We note that some of these changes are not directly linked to crisis response services.

## Relationships between services

- Since the Royal Commission partnerships with community based services are maturing and facilitating new models of service delivery and operation, such as in a newly established YPARC.
- The mature (tranche 1) MHW Locals often have strong connections to a wide range of community-based services which support warm referrals and linkages to more services that supports participant-led recovery. The range of therapies offered by MHW Locals are highly valued by consumers including holistic approaches to recovery that include art therapy, dietetics, exercise physiology and peer work.
- Pathways between community and acute services have been strengthened including relationships between area mental health and wellbeing services, headspace, Forensicare and non-government organisations such as Mind Australia, Wellways, Neami and EACH to name a few.

## New service types

- Consumers, families and clinicians have provided positive feedback about the Womens Recovery Network (WREN), which is a joint venture between Alfred Health, GV Health and Ramsay Mental Health offering specialised, trauma-informed inpatient and hospital-in-the-home mental health care for people identifying as women aged 18 years and over, presenting with severe mental illness.
- The establishment of the Hamilton Centre, a statewide specialist centre for addiction and mental health, is helping to improve the quality of treatment and support for people with dual diagnoses including through support for the workforce and for families, carers, supporters and kin.
- The combination of MHW Locals, the WREN and the Hamilton Centre are helping to bridge the gap between GPs and area mental health and wellbeing services.

## Area mental health and wellbeing services

- Recruitment of integrated alcohol and other drugs clinicians is working well, as is progress on an integrated framework between bed-based and community services.
- Lived experience roles have become embedded in the mental health, alcohol and other drugs hub and across the service more broadly. The benefits and value of this is evident and further expansion is warranted, including dedicated resourcing for lived experience leadership.
- The expanded focus on youth and older adults is viewed as a positive step, as are the expanded community outreach service models.

## Shared learning

- We heard that learnings from sentinel events have translated into concrete improvements around issues such as sedation protocols and CAD phrasing for emergency call takers.

# Priorities to address gaps and challenges

We heard from consumers and stakeholders that the following actions would help to improve the way in which people who experience mental health crises in the community are responded to in the first instance. We have not explored the feasibility or validity of each action, but recommend that the government give serious consideration to them. In doing so, the Commission encourages government to report transparently on the data, modelling and evaluations on which future rollout decisions are made.

These actions are not listed in order of priority. They are numbered to make discussion of them easier.

## System architecture and navigation

1. Publish a clear articulation of the transformed mental health crisis system and where each service type sits within this system. The crisis system must allow for consumer choice and lived experience-led services, utilise digital technologies as appropriate, and include on-country services for Aboriginal people that are culturally safe. The system needs to consider people who experience crisis after hours / on weekends and extend after-hours outreach services for people who aren't already under case-management by an area mental health service.

An increased range of options that are consistently available and whose role in the mental health crisis system would also mean paramedics could transport consumers to a wider range of services besides emergency departments and provide warm handovers. This should include assessing when non-emergency patient transport / family transport to services is appropriate, releasing ambulances to attend other emergencies.

2. Assist consumers, their families, carers, supporters and kin, referrers and emergency responders to navigate the mental health and wellbeing system by:
  - a. adopting consistent (and preferably enduring) language for mental health and wellbeing services
  - b. providing a live, easily navigable statewide directory of mental health and wellbeing services that clearly identifies 'doorways' for people experiencing mental health crises and operating hours
  - c. replacing or refreshing the Mental Health Destination Tool used by Ambulance Victoria to include real time catchment / age / service availability.

## First responders

3. Develop interagency protocols including a single signed authorising protocol that standardises emergency services' interpretations of 'serious and imminent risk', clarifies on scene decision authority and escalation, and appropriately clarifies / amends existing legislation regarding 'care and control' powers and use of restrictive practices. Senior officials may need to further prioritise this work which potentially includes legislative changes regarding definitions and the powers of police and paramedics.
4. Institute mandatory scenario-based training involving police, Ambulance Victoria and mental health services to operationalise shared definitions, escalation thresholds and safety.
5. Clarify and update protocols for situations involving cross border 'care and control' powers which will lead to improved responses to mental health crises in border communities including reduced delays, less conservative decision making, reduced stress for first responders and improved resource utilisation.
6. Improve triaging and ambulance attendance decisions (including safety assessments) by increasing the information available to Ambulance Victoria mental health clinicians through granting them access to CMI.

7. Improve the knowledge, skills and confidence of paramedics to respond appropriately to people experiencing mental health crises by providing more training in assessing suicide risk, using least restrictive practices, use of teleprompt and area mental health services expertise including paediatric mental health.
8. Improve the appropriateness of emergency responses to mental health crises and decrease the number of avoidable transports to emergency departments by increasing the availability / re-establishing PACER / PAT or similar co-responder models across all areas. This also increases the availability of first responders to service the wider community.
9. Reduce the need for consumers to be avoidably transported including over long distances by introducing in-field mental health assessments using technology.

## Emergency departments and crisis assessment and triage

10. Develop an integrated emergency department mental health model as medical-leaning emergency department approaches can clash with recovery-oriented care.
11. Establish multidisciplinary Crisis Assessment Triage Teams in all areas that include lived experience roles and operate 24/7, and increase their size to better meet demand and prevent overloading staff which leads to burnout and other health impacts.
12. Improve the experience of consumers at emergency departments and increase community access to first responders by increasing the number of mental health and alcohol and other drug hubs at emergency departments.
13. Embed and support the lived experience workforce safely through appropriate supervision, debriefing and training.

## MHW Locals

14. Expand MHW Local satellite sites to full service / full hours of operation if Locals are to continue to provide an option for de-escalating people experiencing crisis.

## System wide issues

15. Address workforce shortages by implementing a mental health and wellbeing workforce strategy that reflects and incorporates the realities of rural communities, incorporates alcohol and other drug workforces, the needs of MHW Locals, and articulate the career pathways needed to take people from all mental health and wellbeing disciplines from formal training including placements, through to early career/graduate positions.
16. Recognise and act with urgency to address the interconnection between the social determinants of mental health and safety, with specific emphasis on people in unstable housing and those requiring AOD services.
17. Increase the visibility of relevant consumer information between services (emergency departments and community services specifically) to support better understanding of issues and safer, more holistic treatment and support.
18. Capture, share and report the data needed to evaluate and understand the MHW crisis system including where programs or services divert people from emergency departments.
19. Increase the availability of non-crisis mental health services, including follow-up services, to decrease the demand for crisis responses.

# Conclusion

The Mental Health and Wellbeing Commission recognises the dedicated workforces that are working hard to transform the mental health and wellbeing system, so it better meets the needs of the Victorian community.

We understand that this work involves major change and that it is difficult to design and implement change at the same times as delivering critical services. We also understand that much work is needed to deliver change before practice on the ground can change and that this work is often not obvious to the community.

This paper outlines many actions that have been taken to improve the way in which people who experience a mental health crisis in the community are supported. It also repeats ideas we heard from consumers and stakeholders about what else is needed.

Stakeholders raised with us the issue of increasing demand for mental health and wellbeing services and, in some instances, growing delays in people receiving the services they need. These stakeholders commented that they felt their ability to deliver the intended system transformation was at risk. This is of significant concern and is likely to result in further strain being placed on crisis response services.

From what we heard and what we've seen, confusion remains about where people should go and what services are available to help people experiencing mental health crises. This reflects that Victoria is still developing a consistent, statewide, easily understood mental health system that people can navigate easily.

The issues raised with us are all critically important and require timely resolution. All these issues have the potential to significantly impact on outcomes for people experiencing a mental health crisis, sometimes catastrophically. The impact on those who serve them can also be severe, as can the impact on resourcing and service availability for other members of the community.

Much more needs to be done to bring to life this aspect of the vision described by the Royal Commission into Victoria's Mental Health System. The costs of not doing so remain unacceptably high.

# Appendix A

Recommendations from the Royal Commission into Victoria’s Mental Health System’s Final Report that link directly to responding to people experiencing a mental health crisis in the community.

Recommendation number	Aspects relevant to responding to mental health crises in the community
5	Area Mental Health and Wellbeing Services core functions include services that respond to crises 24 hours a day, seven days a week
8	<ol style="list-style-type: none"> <li>1. ensure each Adult and Older Adult Area Mental Health and Wellbeing Service delivers a centrally coordinated 24-hours-a-day telephone/telehealth crisis response service accessible to both service providers and to members of the community of all ages that provides:               <ol style="list-style-type: none"> <li>a. crisis assessment and immediate support;</li> <li>b. mobilisation of a crisis outreach team or emergency service response where necessary; and</li> <li>c. referral for follow-up by mental health and wellbeing services and/or other appropriate services.</li> </ol> </li> <li>2. expand crisis outreach services in each Adult and Older Adult Area Mental Health and Wellbeing Service to provide treatment, care and support from a clinician and non-clinical worker such as a peer worker.</li> <li>3. improve emergency departments’ ability to respond to mental health crises by:               <ol style="list-style-type: none"> <li>a. establishing a classification framework for all emergency departments and urgent care centres, based on their capability to respond to people experiencing mental health crises;</li> <li>b. using the classification framework to ensure that health services are appropriately resourced to perform their role in a regional network of emergency departments and urgent care centres; and</li> <li>c. ensuring there is at least one highest-level emergency department suitable for mental health and alcohol and other drug treatment in each region.</li> </ol> </li> </ol>
9	<ol style="list-style-type: none"> <li>1. invest in diverse and innovative ‘safe spaces’ and crisis respite facilities for the resolution of mental health and suicidal crises which are consumer led and, where appropriate, delivered in partnership with non-government organisations.</li> <li>2. in collaboration with the new agency led by people with lived experience of mental illness or psychological distress (refer to recommendation 29) and non-government organisations that deliver wellbeing supports, establish:               <ol style="list-style-type: none"> <li>a. one drop-in or crisis respite facility for adults and older Victorians per region (refer to recommendation 3(3)); and</li> <li>b. four safe space facilities across the state, comprising a mix of drop-in spaces and crisis response services, co-designed with and for young people.</li> </ol> </li> <li>3. establish a crisis stabilisation facility, in consultation with people with lived experience, led by a public health service or public hospital in partnership with a non-government organisation that delivers wellbeing supports.</li> </ol>

Recommendation number	Aspects relevant to responding to mental health crises in the community
10	<ol style="list-style-type: none"> <li>1. ensure that, wherever possible, emergency services' responses to people experiencing time-critical mental health crises are led by health professionals rather than police.</li> <li>2. support Ambulance Victoria, Victoria Police and the Emergency Services Telecommunications Authority to work together to revise current protocols and practices such that, wherever possible and safe: <ol style="list-style-type: none"> <li>a. Triple Zero (000) calls concerning mental health crises are diverted to Ambulance Victoria rather than Victoria Police; and</li> <li>b. responses to mental health crises requiring the attendance of both ambulance and police are led by paramedics (with support from mental health clinicians where required).</li> </ol> </li> <li>3. ensure that mental health clinical assistance is available to ambulance and police via: <ol style="list-style-type: none"> <li>a. 24-hours-a-day telehealth consultation systems for officers responding to mental health crises;</li> <li>b. in-person co-responders in high-volume areas and time periods; and</li> <li>c. diversion secondary triage and referral services for Triple Zero (000) callers who do not require a police or ambulance dispatch.</li> </ol> </li> </ol>



## Mental Health and Wellbeing Commission

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