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Department of Health Agency Statement
ANNOTATED BIBLIOGRAPHY

ANNOTATED BIBLIOGRAPHY

No.	Document	Footnote reference	Pages
1.	2019 Law Enforcement Assistance Program (LEAP) offence data for offences '596A – Drunk in a public place' and '596B – Drunk and disorderly in a public place'	29, 30	3
2.	Balit Durn Durn: Report to the Royal Commission into Victoria's Mental Health System	32	4
3.	Balit Durn Durn Centre Vision & Purpose	11	16
4.	Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027	6, 12, 21, 22	64
5.	Commission for Children and Young People, Lost not Forgotten	3, 8, 20	118
6.	Department of Health and Human Services, Aboriginal and Torres Strait Islander Cultural Safety Framework	1	224
7.	Expert Reference Group on Decriminalising Public Drunkenness Seeing the Clear Light of Day; Report to the Victorian Attorney-General	27, 31	249
8.	Historic Laws Passed to Decriminalise Public Drunkenness	28	374
9.	Modelling undertaken to inform Victoria's mental health and wellbeing workforce strategy 2021-2024	24	375
10.	Royal Commission into Victoria's Mental Health System, Final Report, Volume 3	2, 4, 5, 10	437
11.	Suicides of Aboriginal and Torres Strait Islander People, Victoria 2018-2021	7	1063
12.	Victorian 2021-2022 State Budget - Budget Overview	26	1065
13.	Victorian 2021-2022 State Budget - Service Delivery Budget Paper	14, 15, 18, 19	1084
14.	Victorian 2022-2023 State Budget - Budget Overview	13, 26	1505
15.	Victorian 2022-2023 State Budget - Service Delivery Budget Paper	16, 17	1569
16.	Victoria's mental health and wellbeing workforce strategy 2021-2024	25	1997

2019 Law Enforcement Assistance Program (LEAP) offence data for Offences
'596A – Drunk in a public place' and '596B – Drunk and disorderly in a public place'

			Year ending December									
Offence Subgroup	Offence Code	Offence Description	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
D22 Drunk and disorderly in public	591HC	FAIL LEAVE LIC PREM-DRUNK/VIOLENT/QSOME	285	268	235	176	164	200	153	71	61	72
	596A	DRUNK IN PUBLIC PLACE	10,677	9,269	7,821	6,934	6,724	6,652	5,308	3,335	2,426	2,723
	596B	DRUNK AND DISORDERLY IN PUBLIC PLACE	1,435	1,223	980	952	939	995	772	565	488	543
	596D	BEHAVE DISORDERLY MANNER WHILST DRUNK	1			2				1		
	596E	BEHAVE RIOTOUS MANNER WHILST DRUNK	8	4	7	1	1	1	1		2	
	599DZ	CONSUME ALCOHOL/DRUNK ON SHRINE RESERVE									1	

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VACCHO

Balit Durn Durn

Strong brain, mind, intellect and sense of self

Report to the Royal Commission into Victoria's Mental Health System

Royal Commission into
Victoria's Mental Health System

RTO No.: 20739

Advice to readers

To our Aboriginal and or Torres Strait Islander readers, we advise that this Report may include photos, quotations and or names of people who are deceased.

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Design: Lily Sawenko

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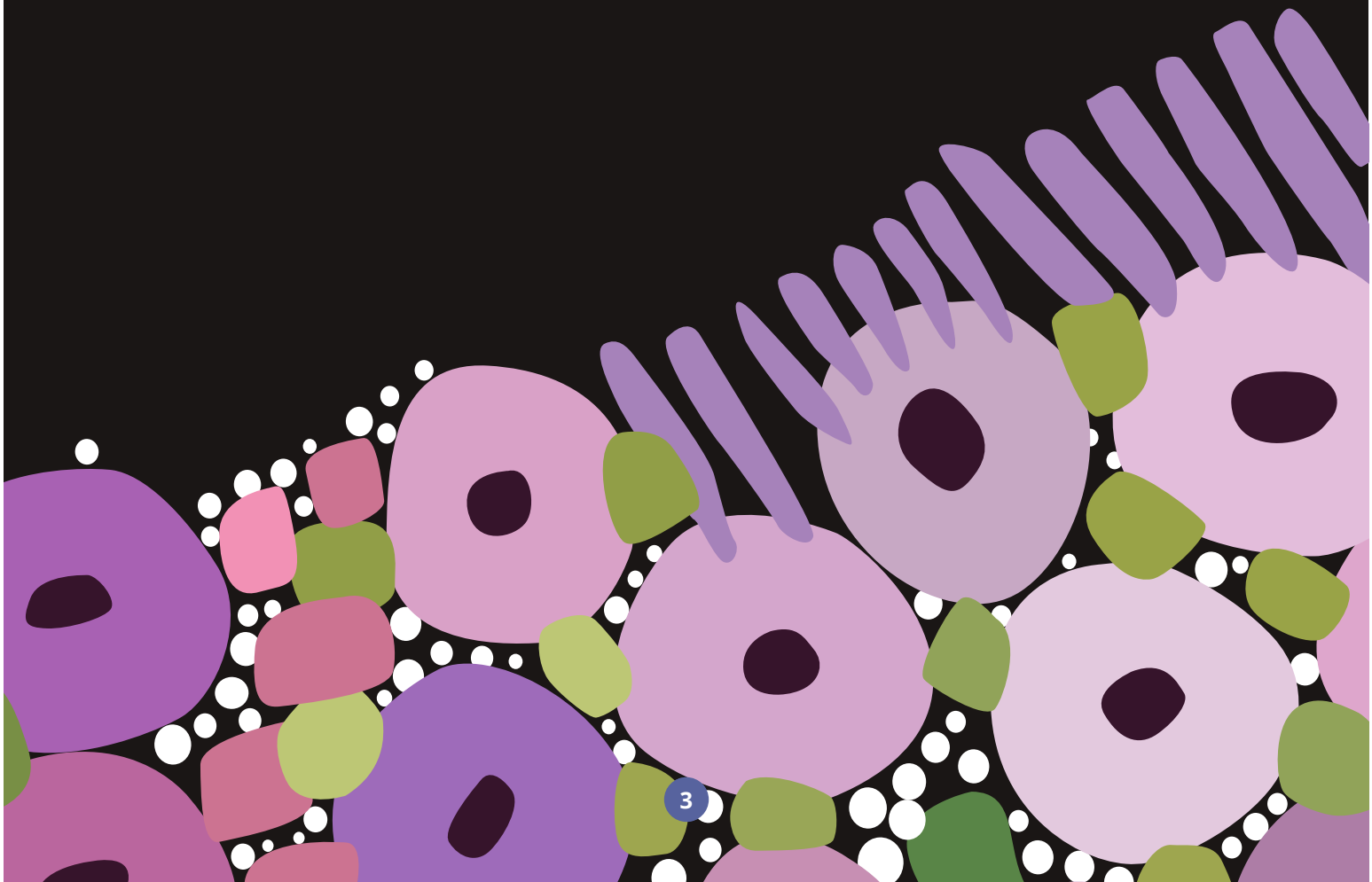
Balit Durn Durn

Strong Brain, Mind, Intellect and Sense of Self

Victorian Aboriginal Community Controlled Health Organisation's Report to the Royal Commission into Victoria's Mental Health System.

Balit Durn Durn comes from the Wurundjeri/Woiwurrung language and means Strong Brain, Mind, Intellect and Sense of Self. Permission to use *Balit Durn Durn* was provided by Wurunjderi Traditional Owners.



Contents

3 Balit Durn Durn Strong brain, mind, intellect and sense of self

7 Acknowledgment and thanks

8 About the artist

9 About the Victorian Aboriginal Community Controlled Health Organisation

10 Foreword by Jill Gallagher

12 Language

13 Summary

14 About this Report

15 Summary of solutions

16 Aboriginal Stories are at the heart of Balit Durn Durn

18 Section 1: The current state of Aboriginal mental health and the case for transformative change

19 1.1 What we know about Aboriginal mental health

20 1.2 Standing on the shoulders of giants

20 We must build upon the hard work of the Aboriginal Community and existing Aboriginal governance structures

21 The Victorian Government has committed to implementing all recommendations outlined in the Final Mental Health Report

21 Aboriginal people are still disproportionately exposed to risk factors that negatively impact on their mental health and social and emotional wellbeing

23 Section 2: Aboriginal stories and truth-telling lead the way for change

24 2.1 The Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework model needs to be embedded across the continuum of mental health care

25 2.2 Balit Durn Durn methodology and consultations

25 Desktop analysis

25 What we heard

25 Surveys

26 Survey results

26 Aboriginal Community surveys

27 Aboriginal workforce surveys

38 Community conversations

29 2.3 Community Story: Connecting back has been the key

34 2.4 Community story: We need an Aboriginal knowledge place

36 Section 3: The solutions for an improved mental health system are with Aboriginal people

37 3.1 What the Interim Report says:

38 The proposed solutions in section 3.2 strengthen Recommendation 4 of the Interim Report. Specifically, Solutions 2 and 3 closely reflect Recommendation 4 of the Interim Report and expand on its principles offering a contextualised Aboriginal-led way forward. Solutions, 1, 4 and 5 are independent from the proposals within Recommendation 4; however, they nonetheless draw from and build on Recommendation 4.

38 Royal Commission Interim Report: Recommendation 4 Aboriginal social and emotional wellbeing

37 Recommendation 4

38 3.2 Aboriginal-led solutions will pave the way by 2025:

44 Solution 3: Invest in recurrent funding arrangements for multidisciplinary social and emotional wellbeing teams in Aboriginal Community Controlled Organisations to secure long-term state-wide coverage.

42 Solution 2: Ensure long-term, sustainable, and flexible investment in Aboriginal social and emotional wellbeing to create generational change.

49 Solution 5: Appropriately invest in Aboriginal leadership and culturally safe service delivery across mainstream primary, secondary and tertiary health services

47 Solution 4: Critically invest in Aboriginal-led solutions to prevent suicide and self-harm

39 Solution 1: By 2025, establish five on Country healing centres to support resilience, healing, and trauma recovery through fostering connection to Country, kinship, and culture

42 Solution 2: By 2025, ensure long-term, sustainable, and flexible investment in Aboriginal social and emotional wellbeing to create generational change

44 Solution 3: By 2025, invest recurrent funding arrangements into multidisciplinary social and emotional wellbeing teams in Aboriginal Community Controlled Organisations to secure long-term state-wide coverage

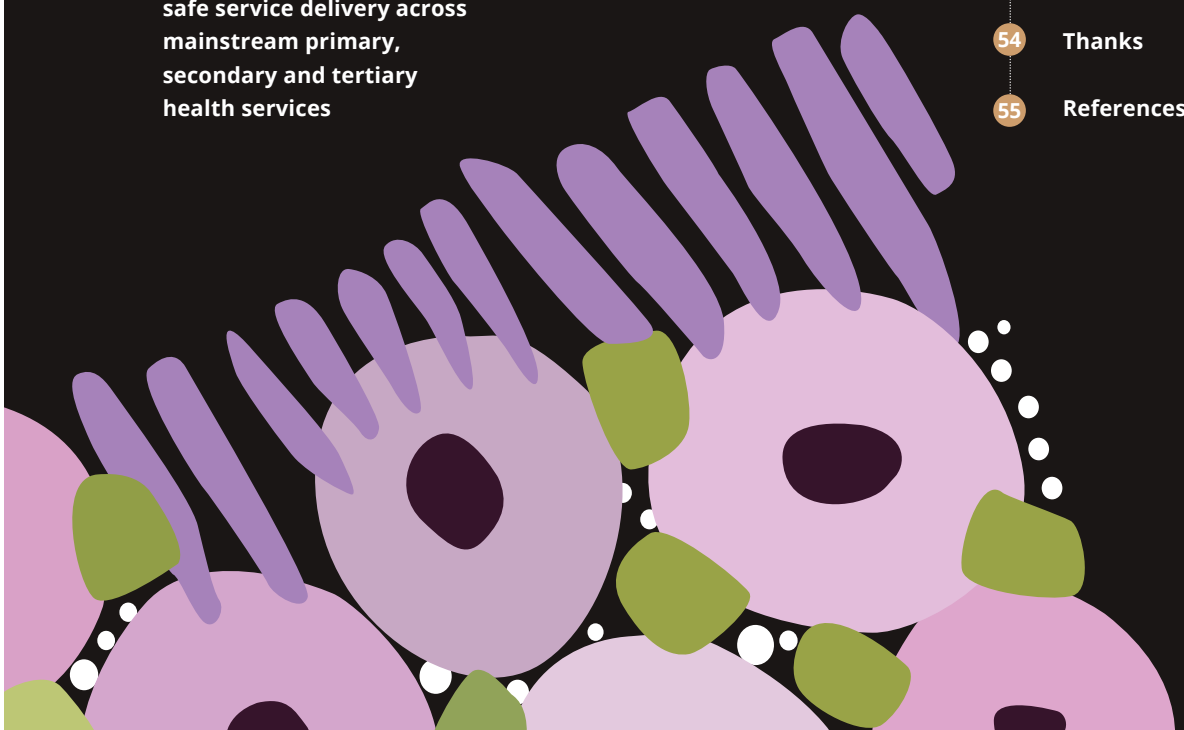
47 Solution 4: Critically invest in Aboriginal-led solutions to prevent suicide and self-harm

47 4.1 As an immediate priority, invest in an initial Victorian specific post suicide intervention and suicide prevention service, attached to an existing ACCHO service. Initially this could be done in partnership with an appropriate mainstream service like the Jesuit Social Services 'Support After Suicide' program, assisting children, young people, families and communities impacted by suicide and providing counselling, support groups and online resources

49 Solution 5: By 2025, appropriately invest in Aboriginal leadership and culturally safe service delivery across mainstream primary, secondary and tertiary health services

54 Thanks

55 References



Acknowledgement and thanks

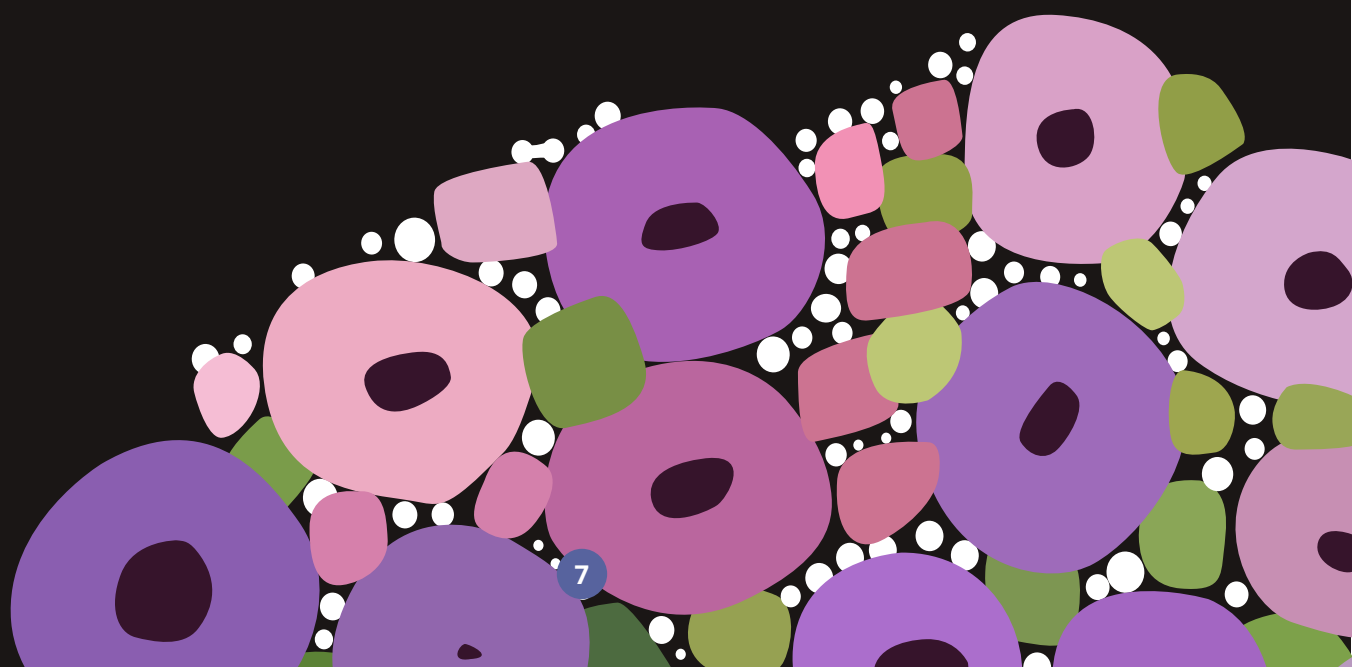
The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) acknowledges the strength of Aboriginal people across the Country and the power and resilience that is shared as members of the world's oldest living culture.

We acknowledge Aboriginal people as Australia's First Peoples' who have never ceded their sovereignty.
We acknowledge this Report was developed on the Traditional Lands of the Wurundjeri/Woiwurrung peoples.
And acknowledge the richness and diversity of all Traditional Owners across Victoria.

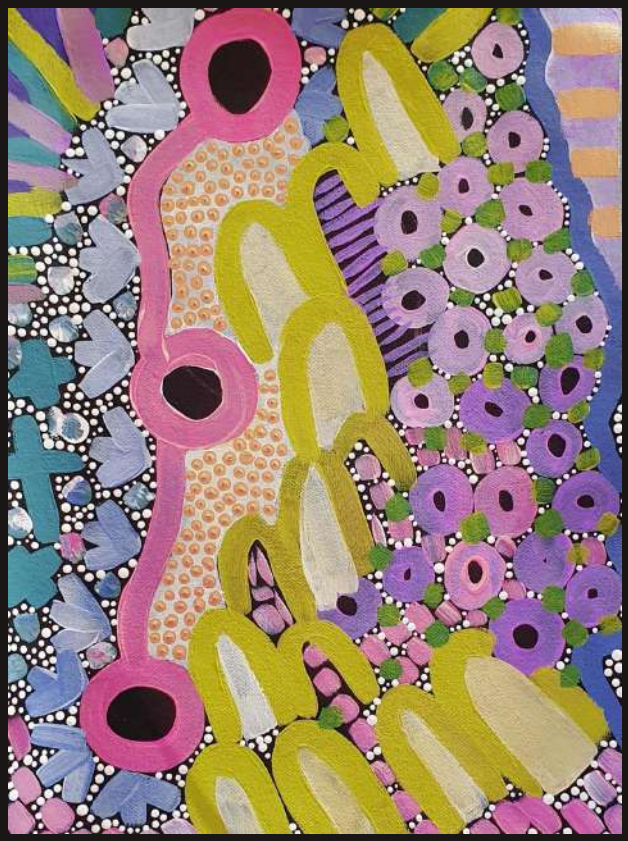
We pay our deepest respect and gratitude to ancestors, Elders, and leaders—past, present, and emerging. They have paved the way, with strength and fortitude, for our future generations.

We would like to acknowledge Jirra Lulla Harvey for her contributions in connecting with Victorian Aboriginal Communities to ensure they had the opportunity to shape this important Report.

We would also like to acknowledge the many contributors who generously provided their wisdom, experience, expertise, and cultural authority in this Report, especially Caroline Kell whose leadership was instrumental in the development this Report.



About the artist



"Nyarri Yathaka" - Now we will no longer be without.

Kenita-Lee McCartney

Kenita-Lee McCartney is an Aboriginal woman from Swan Hill/Balarand. Her bloodlines run through Wemba Wemba, Wiradjuri, Wotjiboluk, Neri Neri, Boon Wurrung country.

A proud kuyinggurrin (mother) of two pembemgguk (children) living on country on the Murray River in Matakupaat (Swan Hill), the land of the platypus.

"I come from strong bloodlines. As an Aboriginal person I've made it my responsibility (like many other blackfullas) to create and empower positive change for my Communities, keeping culture alive, strong and at the forefront of everything I do.

I am inspired by those who have come before me, I'm inspired by Country, our language, our traditions and our people. I have been creating since I was young, dancing and making art wherever I could. Now as an adult, art is very healing for me, whether it's through dancing, painting or weaving."

Story of Artwork

This piece tells the story of bright futures, with our Mobs flourishing and thriving – stories that I am drawn to telling. This piece signifies our path to a brighter future and the healing journey for our mob. With our Communities leading the way to create even brighter and self-determining futures for generations to come.

The colours are vibrant and bright, invoking our past and its impacts that helped plant the seeds of resilience that our Mob have sown. The piece tells a story of the journey our Mobs continue on. Of the beautiful lives that are flourishing, overcoming pain and injustice to move into a new era. Social and emotional wellbeing means connecting to Country and my culture – keeping it close to my heart. This piece expresses that if our people are provided with the right tools in life, we can be empowered. Connecting our people to their culture will empower them to thrive.

Our future is bright. Our days are brighter. We have that fire, that essence of culture, connection, spirituality within. We've overcome huge losses and persevered through the many challenges, but today we bloom. We are here. We are alive. We have survived. We are healing. We are strong. We will thrive.

About the Victorian Aboriginal Community Controlled Health Organisation

VACCHO is the peak body for the health and wellbeing of Aboriginal people in Victoria.

We train, support and advocate with and for 32 Aboriginal Community Controlled Organisations (ACCOs) across Victoria. ACCOs deliver a suite of culturally safe frontline health and community care services for Aboriginal Communities. ACCOs have a proud, long history as sustainable, grassroot organisations that assist in building community capacity for Aboriginal self-determination. Our Members' cultural identities are an important source of strength which informs our way of working and our integrity.

We believe that embracing Aboriginal culture and identity is essential. It will strengthen health care access and inclusion, and lead to improved health and wellbeing outcomes.

Foreword by Jill Gallagher AO

Ngata (which means 'hello' in my traditional Gunditjmara language).

For too long, Aboriginal people have fallen through the cracks of a fragmented and culturally unsafe mental health system.

For the first time in history, Aboriginal leaders, organisations, people, families, carers, and Communities were given the opportunity to have their voices and experiences included in a redesign of the mental health system through the Royal Commission into Victoria's Mental Health System (the Commission).

Balit Durn Durn is a ground-breaking report that reflects these voices and experiences.

Balit Durn Durn is drawn from Woiwurrung language of the Wurundjeri people and means **Strong Brain, Mind, Intellect and Sense of Self.**

This Report explores the power of Aboriginal culture. It outlines ways to build strength, resilience, connectedness and identity in Aboriginal people and Communities to create essential pathways for fostering positive mental health and wellbeing.

Five Aboriginal-led solutions are put forward in this Report that will dramatically transform the Victorian mental health system to better meet the needs of Aboriginal Communities. VACCHO welcomes the Victorian State Government's commitment and investment.

This Report has been developed during a significant time in history with the unprecedented global coronavirus (COVID-19) pandemic.

The pandemic resulted in VACCHO and ACCOs coming together to mobilise and respond to the health and wellbeing needs of Victorian Aboriginal Communities.

For many Aboriginal people and Communities this is a time of increased uncertainty, isolation, fear, depression, and anxiety. During the consultation process, in the span of one week, there were four suicides in Victorian Aboriginal Communities. We were in mourning.

Also, during the consultations process, the world was devastated by the death of a black man, George Floyd, while being arrested by Minnesota police. Floyd's death triggered demonstrations and protests globally that also had enormous reverberations in Victoria and across Australia. It reminded us how we must be prepared to address the injustices and ongoing impacts of colonisation if we ever wish to see improved health and wellbeing outcomes in Aboriginal Communities.

I offer my deepest thanks to the many Aboriginal people who showed enormous courage in re-telling their personal and professional stories. I also thank and acknowledge the valuable input of the many non-Aboriginal people who very generously contributed along the way.

Many interviewees spoke about the direct relationship between poor mental health and wellbeing, and the loss of land, culture, identity, self-worth and the breakdown of traditional kinship structures and roles within our Communities.

Despite the levels of loss, grief, health anxieties and racism felt in Aboriginal Communities, many interviewees were incredibly passionate about their work and optimistic about the future. Interviewees showed a deep commitment to their own and their family's healing and social and emotional wellbeing.

The call to action to anyone reading this is a simple one: Listen to the people's stories in this Report and invest long-term in Aboriginal community-led, trauma-informed solutions. Solutions outlined in this Report are based on connection to Aboriginal Culture, Country, Community, and Kin.

Jill Gallagher AO
Chief Executive Officer
Victorian Aboriginal Community Controlled Health Organisation

Language

Aboriginal Communities/kin: Complex networks of family, kin/kinship structures and friends

Aboriginal Self Determination: Aboriginal people have a right to self-determination. Self-determination is the right to free choice and determination of one's future

Aboriginal Social and Emotional Wellbeing: The Australian Indigenous Psychologists Association describes social and emotional wellbeing as a holistic view of health that "incorporates the physical, social, emotional, and cultural wellbeing of individuals and their communities."

Aboriginal: We use 'Aboriginal' as a term inclusive of Torres Strait Islander peoples. We acknowledge that the terms 'Aboriginal', 'Indigenous' and 'Koori/e' do not capture the entire diversity and complexity of Victoria's Aboriginal and Torres Strait Islander peoples and cultures. Our intent is always to use terms that are respectful, inclusive, and accurate

ACCHO: Aboriginal Community Controlled Health Organisations

ACCO: Aboriginal Community Controlled Organisations

Country: Country for Aboriginal people is land with which Aboriginal people share a spiritual and cultural connection.

Elders: Someone who has gained recognition as a custodian of knowledge and lore, and who has permission to disclose knowledge and beliefs. In some instances, Aboriginal people above a certain age will refer to themselves as Elders

Going bush: We use this term to refer to returning to Traditional Lands such as ones 'Country'

Healing: The Aboriginal concept of 'healing' is an inclusive term that enables mental health to be recognised as part of a holistic and interconnected Aboriginal view of health; it is embedded in the stories told throughout this Report and is central to this Report's proposed solutions. The concept of healing embraces social, emotional, physical, cultural, and spiritual dimensions of health and wellbeing

KHMLO: Koori Mental Health Liaison Officers are based in rural/regional area mental health services. KMHLOs aim to improve access and the cultural appropriateness of services provided to Aboriginal people

Koori/e: Aboriginal peoples from Victoria and Southern New South Wales

Mainstream organisations/non-Aboriginal organisations: This term can often be used interchangeably. In the context of this Report, the term is referred to as non-Aboriginal organisation. It refers to non-Aboriginal organisations that provide services, predominantly health and mental health services, to Victorian
Aboriginal Communities

Mob: Used by many Aboriginal people to describe Aboriginal Communities or a group of Aboriginal people

The Commission: Royal Commission into Victoria's Mental Health System The Final Report: The Mental Health Royal Commission Final Report

The Interim Report: The Mental Health Royal Commission Interim Report

VACCHO: Victorian Aboriginal Community Controlled Health Organisation

Yarning Circle/Yarn: Used by many Aboriginal people, 'yarn' means to share informal dialogue

Summary

"If we grow our children strong in culture from the start – they can deal with anything."

- Aunty Melva Johnston

The Mental Health Royal Commission (the Commission) is a ground-breaking opportunity for people with lived mental health experience, carers, families and the mental health workforce to contribute to improving the current mental health system and creating a system that appropriately supports all people.

The Commission received both written and oral feedback from individuals and organisations that will inform the Mental Health Royal Commission Final Report (the Final Report). At the centre of the work undertaken by the Commission is a desire to challenge the stigma and discrimination that often exists in the mental health system, and to outline and understand gaps in the service system that can be addressed and improved.

Balit Durn Durn was developed by VACCHO to support the Commission's Final Report, which will be tabled in the Victorian Parliament in February 2021.

Balit Durn Durn builds on years of advocacy from Aboriginal organisations, leaders and those delivering front line services to Aboriginal people across Victoria. It relies on hearings and submissions completed by Aboriginal leaders and experts in social and emotional wellbeing, conducted by the Commission in April and May 2019. This includes the culmination of the voices of Aboriginal people, ACCOs and other peak bodies who made submissions, and the advice provided by Aboriginal experts during the Commission's public hearing on 16 July 2019 at the Aboriginal Advancement League in Thornbury.

This report also builds on the Commission's Interim Report (the Interim Report) which contains several priority recommendations that address immediate needs and lay the foundations for a new approach to mental health following changes to the current mental health system.

Following the publication of the Interim Report, VACCHO engaged in Community consultations to further understand the impact of the mental health system on Aboriginal Communities, workers, carers, families, and services. Almost 100 people responded to an online survey and 20 others participated in a series of face-to-face interviews where they shared their personal and professional experiences.

Balit Durn Durn aims to provide an overview of Aboriginal Communities' experience with the current mental health system and offers innovative Aboriginal-led solutions that will see the Final Report deliver transformative outcomes.

About this Report

Balit Durn Durn is divided into three sections.

Section 1 explores the transformative nature of the current social and political landscape, and opportunities that exist for creating meaningful Aboriginal-led changes to the mental health system. This includes an overview of the current mental health system in Victoria, including statistics and information on Aboriginal mental health, as well as an overview of hard-fought advancements on foundational Aboriginal reforms that will complement solutions identified in this report.

Section 2 provides an overview of the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Model as a therapeutic model that emphasises the connected relationship between mental and physical health, and the role of connection to culture as a vital protective factor. It provides an overview of the methods used to gather information for this Report, and outlines findings from research, interviews and conversations that were conducted by VACCHO. At the heart of this section—and *Balit Durn Durn* more broadly—is the idea that Aboriginal stories and truth-telling are fundamental to enacting meaningful, self-determining changes to the mental health system.

Section 3 articulates the flaws that exist within the current service system and is supported by five Aboriginal-led solutions. These solutions will be critical for creating a more equitable, culturally safe mental health system in Victoria, and require the input and participation of whole of Government, Victorian Aboriginal Communities, Aboriginal organisations, and the broader mental health workforce.

Summary of solutions

Five solutions are outlined in *Balit Durn Durn* that will dramatically transform the Victorian mental health system to better meet the needs of Aboriginal Communities. These solutions build on Recommendation 4 of the Interim Report and reflect the voices of Aboriginal and non-Aboriginal organisations and workers, and Aboriginal people with lived mental health experience. The word 'solution' is used in this Report instead of 'recommendation' because Aboriginal Communities have the solutions for creating a culturally-safe, sustainable, self-determining mental health system—the solutions are already in their hands.

The proposed solutions are that by 2025:

- **Solution 1**: Establish five on-country healing centres (or camps) to support resilience, healing, and trauma recovery through fostering connection to Country, kinship, and culture.
- **Solution 2**: Ensure long-term, sustainable, and flexible investment in Aboriginal social and emotional wellbeing to create generational change.
- **Solution 3**: Invest in recurrent funding arrangements into multidisciplinary social and emotional wellbeing teams in ACCOs to secure long-term statewide coverage.
- **Solution 4**: Critically invest in Aboriginal-led solutions to prevent suicide and self-harm.
- **Solution 5**: Appropriately invest in Aboriginal leadership and culturally safe service delivery across mainstream primary, secondary and tertiary health services.

Aboriginal Stories are at the heart of *Balit Durn Durn*

While this Report speaks to a deep sadness and frustration that comes with decades of intergenerational trauma entrenched in Australia's colonial history, it also highlights Victorian Aboriginal Communities' courage, resilience, and hope.

Throughout the consultation process, Victorian Aboriginal Communities were open and honest in sharing both their families', and their own, personal experiences of the Victorian mental health care system.

Their experiences unveil a lack of Aboriginal Community-led and holistic service models of health and wellbeing, and a fragmented funding system that focuses on services rather than people's holistic needs. It highlights a lack of choice in engaging with the current service system. Experiences of worthlessness, grief, loss, trauma, and discrimination were shared with a hope that cycles of poor mental health will be broken for future generations once appropriate, sustainable, culturally safe services are created for Aboriginal Communities.

The Aboriginal concept of 'healing' is an inclusive term that enables mental health to be recognised as part of a holistic and interconnected Aboriginal view of health; it is embedded in the stories told throughout this Report and is central to this Report's proposed solutions. The concept of healing embraces social, emotional, physical, cultural, and spiritual dimensions of health and wellbeing.

Closing the gap in life expectancy between Aboriginal and non-Aboriginal Victorians is as much about improving the social and emotional wellbeing, resilience and mental health of Aboriginal people, families, and Communities as it is about addressing physical health factors.

One interviewee said:

"I hope the Royal Commission will look at the Aboriginal section and think about the ways that our health and healing practises are 60,000+ years old. And (that the Commission) think about it for all people living on these lands. Countless generations have known how life interacts with our Traditional Countries"

(Senior member of the Aboriginal workforce)

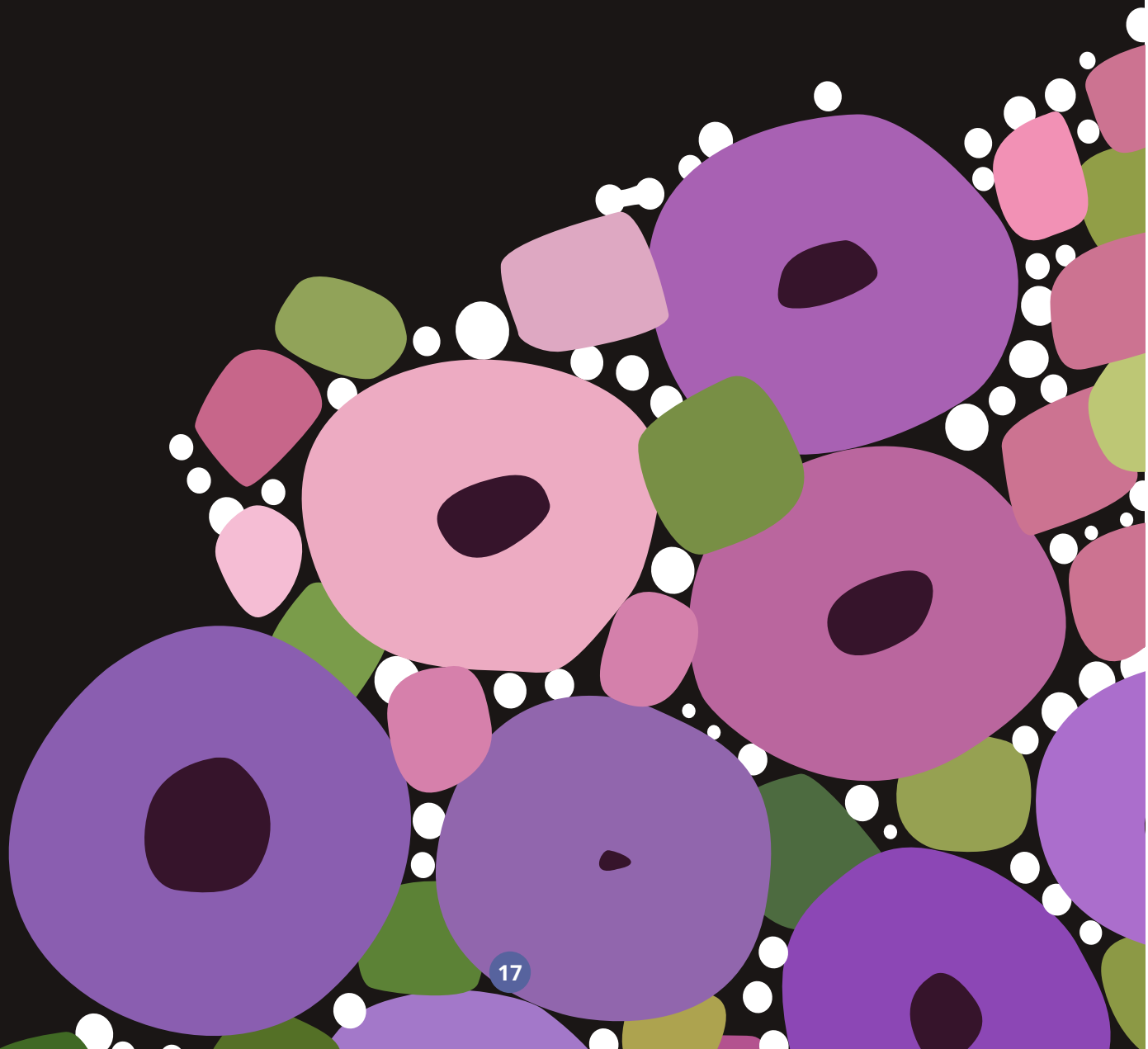
Another interviewee reinforced:

"We need to look at things differently, we don't fit into this prescription-based culture. We respond to different things; we respond to our Elders. We stop and we listen. We take away what our Elders tell us."

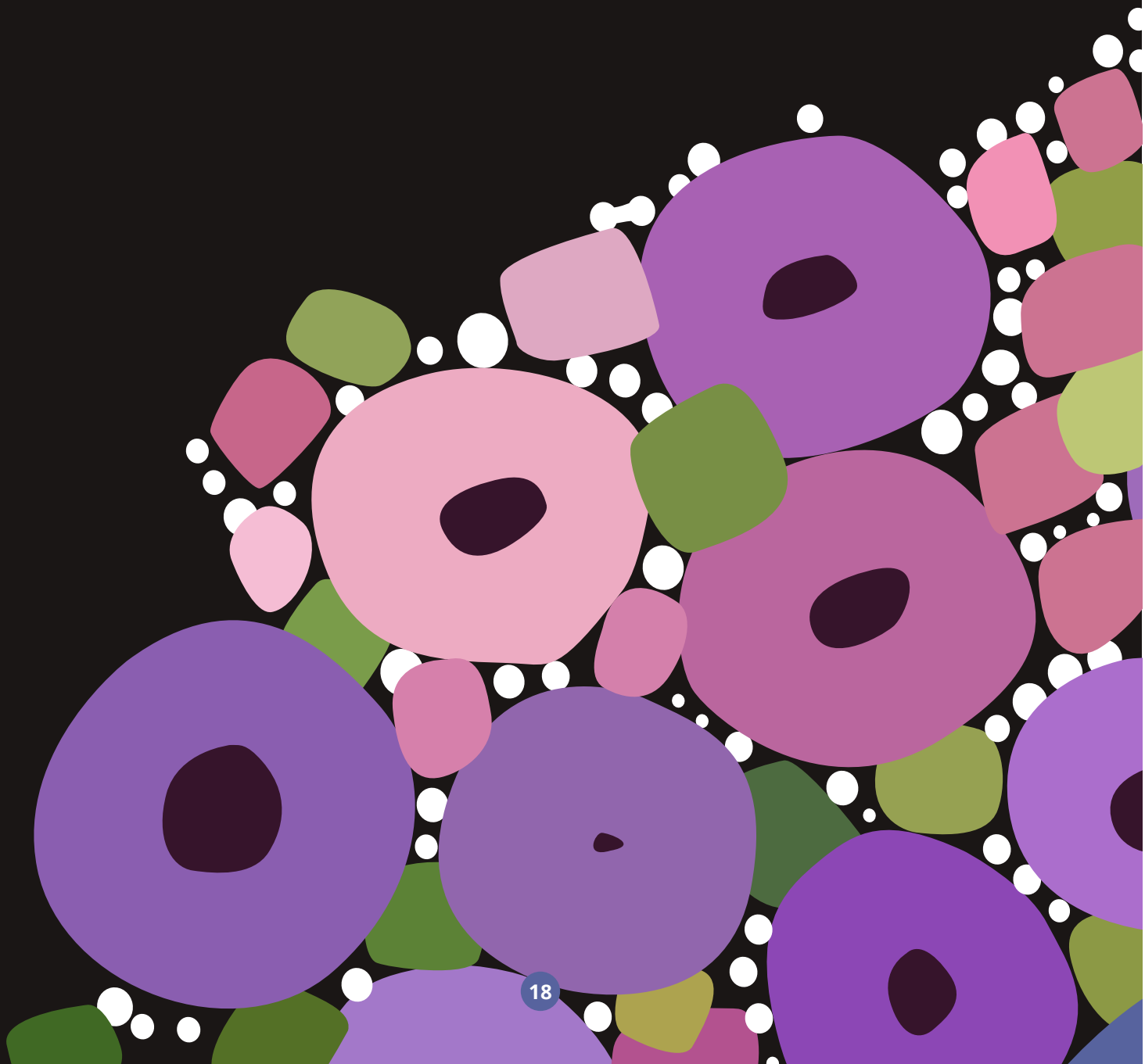
(Aboriginal Community member with lived experience)

Importantly, at the centre of this Report are Aboriginal people's lived experiences and their stories. One of the stories shared in this Report describes a sister's experience of losing her brother to suicide and embarking on her own healing journey with both Western and Aboriginal cultural healing practises. Another story is from a psychiatrist who advocates for an Aboriginal healing space where people can come together to be strong in culture; he describes the need for clinicians to adapt to Aboriginal ways of knowing and healing, instead of the prescription of Western mental health practices.

Aboriginal stories that feature throughout this Report are raw and largely unedited by design. It is recognised that for the first time ever, Aboriginal stories and anecdotes are being considered as evidence for the Commission and VACCHO wants to ensure their voices are heard and valued.



Section 1: The current state of Aboriginal mental health and the case for transformative change



31%

One in three Aboriginal people experience high or very high levels of PSYCHOLOGICAL DISTRESS. That is about 2.5 times the non-Aboriginal rate. (AATSIHS 2018-19)

77%

Of all Indigenous people aged 18–24 who had experienced very high or high psychological distress **had not seen a health professional** (AIHW 2017b)

33%

Of Aboriginal Victorians have been diagnosed with a mental or behavioural condition. **This is nearly 1.6 times the non-Aboriginal rate.** (AATSIHS 2018-19)

55%

The number of ABORIGINAL MENTAL HEALTH-RELATED PRESENTATIONS to Victorian Hospital Emergency departments had increased by **55 per cent** between 2012-13 and 2015-16 (VEMD)

4x

The rate of mental health-related ED presentations for Indigenous Australians was more than **4 times that for other Australians** (AIHW, 2020)

33%

Of organisations providing health care to Aboriginal people provided trauma-informed SEWB services **– 88% of these services were ACCOs.** (AIHW, 2018b)

47.1%

Over 47 per cent of Aboriginal people HAVE A RELATIVE WHO WAS FORCIBLY REMOVED from their family due to STOLEN GENERATIONS POLICIES in Victoria. Transgenerational trauma continues to affect Aboriginal people in Victoria. (DHHS 2015)

39%

Of the years of life lost by Indigenous Australians are due to poor health mental health and substance use disorders, especially alcohol use disorders, **anxiety and depression** (AIHW, 2016)

12x

In Victoria, the average placement rate into OUT-OF HOME CARE for Aboriginal children in care is **87.4 per thousand,** which greatly exceeds the placement rate of six per thousand for non-Aboriginal children. (ROGS 2017)

1.2 Standing on the shoulders of giants

This Report was not developed in isolation. It builds on existing calls for Aboriginal self-determination and must exist within the context of key outcomes and hard-fought advancements from other foundational Aboriginal reforms outlined below.

We must build upon the hard work of Aboriginal Communities and existing Aboriginal governance structures

This Report and the solutions proposed in this Report build on hard-fought advancements in several landmark reforms.

At a national level, this Report supports Gayaa Dhuwi (Proud Spirit)— the Aboriginal and Torres Strait Islander Leadership in Social and Emotional Wellbeing, Mental Health and Suicide Prevention Framework (2020). It is developed with the same sentiments outlined in the 2017 Uluru Statement of the Heart. This Report is also being published during the watershed negotiations between the Coalition of Peaks and the various Australian Governments to revise the national Closing the Gap agreement.

In Victoria, this Report exists alongside the negotiation of Treaties and the establishment of the First Peoples' Assembly of Victoria in 2019.

This Report builds on other whole of government and sector reforms based upon the principles of Aboriginal self-determination, including:

- Balit Murrup: supporting Aboriginal social and emotional wellbeing framework (2017-2027)
- Korin Korin Balit-Djak: supporting Aboriginal health, wellbeing, and safety strategic plan (2017-2027)
- Supporting Self-determination: prioritisation of funding to Aboriginal organisations policy outlined under Korin Korin Balit-Djak (2017-2027)
- Dhelk Dja Safe Our Way: Aboriginal-led agreement to address family violence in Aboriginal communities (2008-2018)
- The Victorian Aboriginal Affairs Framework: Supporting Victorian Aboriginals to reach targets outlined in the new national Close the Gap agreement (2018-2023)
- Burra Lotjpa Dunguludja; Aboriginal led justice agreement (2018)
- Victorian Aboriginal Economic Development Strategy: To build economic prosperity and deliver better life outcomes for Aboriginal Victorians (2013-2020)
- Marrung: To ensure that all Koorie Victorians achieve their learning aspirations (2016-2026)
- Wungurilwil Gapgapduir: A partnership between the Victorian Government, Victorian Aboriginal Communities and the child and family services sector (2018)

While this Report exists amid several major Aboriginal reforms, the journey for each Aboriginal person living with a mental illness is unique and should be viewed in the context of their own lived experiences and their own hopes of leading a full and contributing life. The system-wide changes and self-determining principles that are proposed in the Interim Report offer a transformational opportunity to deliver meaningful outcomes for Aboriginal people.

The Victorian Government has committed to implementing all recommendations outlined in the Final Mental Health Report

This is a rare moment in history—and presents a significant opportunity for system-wide mental health reform—as the Victorian Government has committed to implementing all the findings of the Commission's Final Report tabled in Parliament in February 2021. This action shows a sign of deep commitment to improving Victoria's mental health system. It also means that the personal stories, advice, and expertise given by Victorian Aboriginal Communities and ACCOs will impact wide-reaching change in improving mental health and social and emotional wellbeing outcomes for Victorian Aboriginal Communities.

Aboriginal people are still disproportionately exposed to risk factors that negatively impact on their mental health and social and emotional wellbeing.

In Victorian Aboriginal Communities, the events of the 2020 bushfires and coronavirus pandemic have exacerbated the stress and poor health of many Victorian Aboriginal people. These events have significantly increased social, financial, emotional, and physical pressures and stressors, including widespread grief and loss, which can compound existing impacts from:

- the Stolen Generations and removal of children
- unresolved trauma
- separation from culture and associated identity issues
- discrimination based on race or culture
- economic and social disadvantage
- physical health problems
- high incarceration rates
- violence
- substance misuse.

Sadly, these risk factors are associated with increased suicide risk and suicide rates that are twice the national average. Aboriginal suicides are closely linked to mental health issues, with about 80 per cent of deaths linked to a diagnosed and or a suspected mental illness. This is at a similar level to the overall Victorian population.

Building the Aboriginal evidence base for Recommendation 4 of the Interim Report

The Interim Report highlights the widespread and disproportionate rates of psychological distress, depression and anxiety in Aboriginal Communities and states that these occurrences must be addressed as a priority. Most importantly, the Interim Report acknowledges the ongoing detrimental impact of colonisation and post-invasion policies on the social and emotional wellbeing of Aboriginal Communities.

The Commission has committed to developing a road map for the transformational change required to redesign the Victorian mental health system to meet the needs and expectations of people living with poor mental health

The Interim Report Recommendation 4 proposes the establishment of an Aboriginal Social and Emotional Wellbeing Centre for Excellence, support for statewide social and emotional wellbeing programs in ACCOs and scholarships for Aboriginal social and emotional wellbeing teams to ensure workers can have access to relevant mental health qualifications.

The findings were based on the many submissions made by ACCOs and other peak bodies, and the witness statements made by Aboriginal experts during the public hearing on 16 July 2019 at the Aborigines Advancement League in Thornbury.

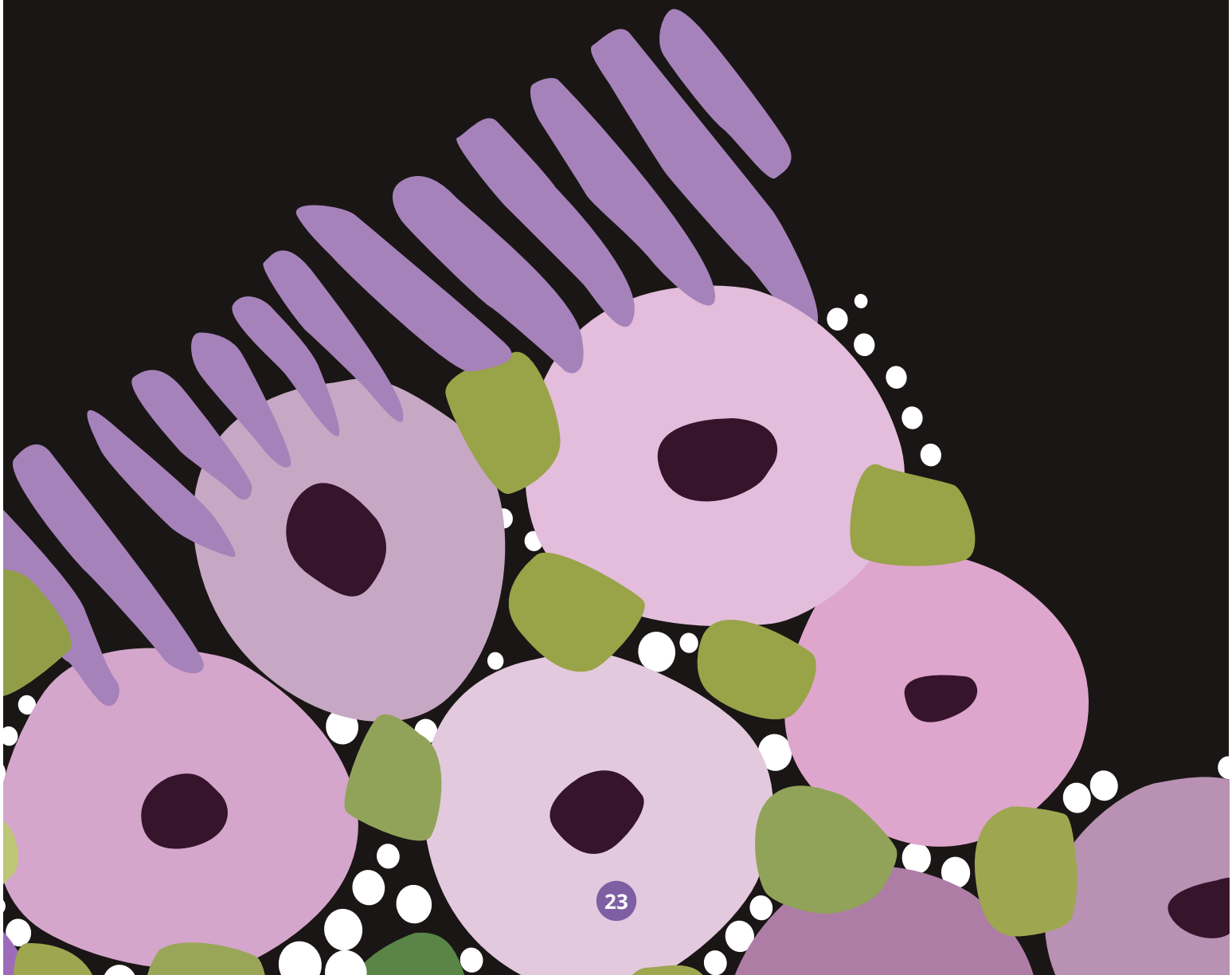
The Interim Report recommendations, in conjunction with the solutions outlined in this Report, will lead to much needed transformative change based on Aboriginal expertise, leadership, and self-determination.

RECOMMENDATION 4: RECOMMENDATIONS

The Royal Commission recommends that the Victorian Government, through the Mental Health Implementation Office, expands social and emotional wellbeing teams throughout Victoria and that these teams be supported by a new Aboriginal Social and Emotional Wellbeing Centre. This should be facilitated through the following mechanisms:

- Dedicated recurrent funding to establish and expand multidisciplinary social and emotional wellbeing teams in Aboriginal Community Controlled Health Organisations, with statewide coverage within five years.
- Scholarships to enable Aboriginal social and emotional wellbeing team members to obtain recognised clinical mental health qualifications from approved public tertiary providers, with a minimum of 30 scholarships awarded over the next five years.
- Recurrent funding for the Victorian Aboriginal Community Controlled Health Organisation to develop, host and maintain the recommended Aboriginal Social and Emotional Wellbeing Centre in partnership with organisations with clinical expertise and research expertise in Aboriginal mental health. The centre will help expand social and emotional wellbeing services through:
    - clinical, organisational and cultural governance planning and development
    - workforce development—including by enabling the recommended scholarships
    - guidance, tools and practical supports for building clinical effectiveness in assessment, diagnosis and treatment
    - developing and disseminating research and evidence for social and emotional wellbeing models and convening associated communities of practice.

Section 2: Aboriginal stories and truth-telling lead the way for change



2.1 The Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework model needs to be embedded across the continuum of mental health care

This Report predominantly focuses on Culture, Family and Kinship, Community, and Country because these are themes and concepts that interviewees most frequently spoke about. Throughout the consultations and surveys, there were consistent references to 'culture' and 'identity' being protective factors against poor mental health, and as being essential tools to grow and develop – to be strong, healthy, and well.

The Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework, otherwise known as the "SEWB model", defines social and emotional wellbeing as a multidimensional concept of health that includes mental health, but which also encompasses health and wellbeing. This includes a connection to land or Country, Culture, Spirituality, Ancestry, Family, and Community.

The "SEWB wheel" represents holistic healing and includes protective factors that support good mental health for Aboriginal Communities.

These include connection to:

- Body
- Mind and emotions
- Family and kinship
- Community
- Culture
- Country
- Spirit, spirituality, and ancestors

The outer wheel speaks to how these factors interact with social, historical, and political determinants of health and wellbeing, and the importance of each element in keeping well.

These determinants of health and wellbeing are defined as:

- **Social determinants** - the impact of poverty, unemployment, housing, educational attainment, and racial discrimination.
- **Historical determinants** - the historical context of colonisation and its legacy. The impact of past government policies and the extent of historical oppression and cultural displacement.
- **Political determinants** - the unresolved issues of land, control of resources, cultural security, and the rights of self-determination and sovereignty.

2.2 Balit Durn Durn methodology and consultations

This Report was completed using a combination of research, surveys and yarns via telephone and video conference.

Initially, VACCHO committed to holding 12 face-to-face consultations with Victorian Aboriginal Communities across the State. Work on organising the consultations was progressing, however the wide-ranging restrictions implemented in Victoria due to COVID-19 meant that VACCHO had to find alternative ways of ensuring Victorian Aboriginal Communities were heard.

Over a three-week period, VACCHO established and promoted two online surveys.

VACCHO engaged Jirra Lulla Harvey of Kalinya Communications to complete 20 in-depth interviews with Aboriginal people with lived mental health experience, workers, and experts with extensive knowledge in the mental health field.

Desktop Analysis

At the project's commencement, a desktop analysis was completed. The desktop review considered existing evidence with a focus on Aboriginal academics, and the Commission's public hearings and evidence provided in the development of the Interim Report. The desktop review also helped in tailoring strength-based and solution focused questions for surveys and interviewees.

What we heard

Surveys

Over a three-week period, VACCHO established and promoted two online surveys. The first survey captured the thoughts and stories of Victorian Aboriginal Communities with lived experiences navigating Victoria's mental health system – whether personally or by supporting a family member, child, or friend.

The second survey captured the experiences and views of Aboriginal front-line service delivery workers across Victoria. These individuals work tirelessly in both ACCOs and non-Aboriginal organisations to support Aboriginal people, families, and Communities.

Survey questions drew on the desktop analysis and were developed by VACCHO's internal Royal Commission into Victoria's Mental Health System working group with input from relevant stakeholders across the organisation.

The surveys were distributed to VACCHO Members and other ACCOs and were promoted widely on VACCHO's social media channels.

While online surveys are not an ideal way to engage Aboriginal Communities, in-person engagement was limited due to COVID-19. VACCHO therefore determined that the surveys were an effective way of gaining Aboriginal Community insights alongside the in-depth interviews held over video and telephone calls.

Survey results

Aboriginal Community Surveys

Forty-five Aboriginal Community members across Victoria responded to the 23-question Community survey, with a completion rate of 53 per cent.

Themes and findings which emerged include:

- ACCOs provide better mental health supports for Aboriginal Communities than non-Aboriginal mental health services.
- Fifteen survey participants (55 per cent of responses) rated ACCO supports as "outstanding" or "good".
- Mainstream ratings were lower across all listed sectors, with hospital treatment articulated as concerning: five survey participants (25 per cent of responses) rated hospital treatment "ok", nine survey participants (45 per cent of responses) rated treatment as "poor" and one survey participant (5 per cent of responses) rated hospital treatment as "unacceptable". Only one survey participant (5 per cent of responses) rated treatment as "outstanding" and four survey participants (20 per cent of responses) rated treatment as "good".
- Area Mental Health Services also fared poorly: seven survey participants (46 per cent of responses) rated treatment as "ok", five survey participants (33 per cent of responses) rated treatment as "poor", and one survey participant (7 per cent of responses) rated treatment as "unacceptable". One response each rated treatment as "outstanding" and "good".

Compellingly, 87 per cent of all survey participant responses ranked it "extremely important" that mental health systems have "more emphasis on holistic health (outside of Western medical treatment)", with another 12 per cent of responses ranking this as "important".

The survey also found that 90 per cent of all participant responses ranked "increasing service providers' capacity to provide culturally safe care" as "extremely important", while the remaining 11 per cent of responses ranked enhanced cultural safety as "important".

"I felt my [counsellor] had no idea about the pain and trauma my family's experience with Stolen Generations and the breakdown of my family as a result."

– Aboriginal Community member

- The survey found 70 per cent of responses stated that being able to talk to an Aboriginal mental health, social and emotional wellbeing or alcohol and other drug (AOD) worker in their local area would help to support them when they (or someone they care for) start to feel unwell mentally and/or emotionally.
- The survey found 70 per cent of responses identified that having a 24-hour telephone counselling line staffed by Aboriginal workers and having better supports from their family and Community would help to better support them when they are feeling down or in a crisis.
- The survey found 78 per cent of responses identified they find support from local ACCOs when they are feeling unwell, 62 per cent said that they find support through friends or family, and only 34 per cent said that they find support from their local non-Aboriginal or mainstream organisation.

Overwhelmingly, Aboriginal Communities demand more Aboriginal workers to be employed throughout the system. Holistic services and safe spaces to heal and re-connect with culture in privacy, free from judgement

and shame, are important for Aboriginal Communities when accessing services. Cultural and clinical training of staff across all levels of the mental health system are fundamental to improving outcomes.

"I lost my 21 [year old] daughter to suicide after she reached out to an inappropriate, unprofessional, poorly trained Aboriginal mental health worker who decided professional help wasn't needed and giving her a hug (would) fix it. My daughter asked to be taken to local hospital as she wasn't ok. Four days later she was no longer here."

– Aboriginal Community member

Aboriginal workforce surveys

Thirty Aboriginal and non-Aboriginal health workers/workforce members responded to the 13-question survey with a 100 per cent completion rate.

Of the 30 individuals who answered the survey, 19 survey participants (65 per cent) identified as Aboriginal with the remaining 11 (36 per cent) workforce members identified as non-Aboriginal.

Some of the themes from survey responses included:

- 72 per cent of participants stated that "more cultural mentoring and peer supports" would make their job easier, while "more resources", "more training and development" and "wellbeing embedded in practice (time off for vicarious trauma, clinical supervision)" were identified by more than half of participants.
- "Dual Diagnosis – AOD and mental health" was selected by 48 per cent of participants as the most pressing concern that their clients present with. "Mental health issues" was selected by 25 per cent of participants, with 11 per cent of participants identifying "housing/homelessness matters" as their client's most pressing concern.

Mirroring the responses of the Aboriginal Community survey, workforces identified the need for more resourcing and training, and for Aboriginal workers to be employed across the mental health system.

The workforce also identified the importance of addressing the breakdown of barriers to access treatment, including ensuring that Aboriginal people can access care while remaining on Country or in an Aboriginal facility. This issue is particularly important to address in mainstream treatment providers, like local prevention and recovery centres (PARC).

"Cultural healing is not an [after-thought] but the first step towards recovery."

– Aboriginal Workforce member

From the workforce's perspective, effective mental health treatment models for Aboriginal people would centre around equitable, client-led, holistic and wrap around care— programs that are centred on a connection to culture, Country and family.

Having skilled and knowledgeable people in the right positions empowering Aboriginal Communities is fundamental to delivering effective and safe care. The workforce identified that an increase in training and educational opportunities is likewise essential for both increasing workforce capacity and providing more effective and inclusive care for Victorian Aboriginal Communities.

The survey found 83 per cent of participants said that they would be "interested in pursuing further education to up-skill"; however, at present too many barriers exist which serve to block equitable access to training. Some ways to address barriers to address training and access to care include:

- Increased funding.
- Enhanced organisational capacity to allow staff time and opportunity to study.
- Improving access to training opportunities, particularly for those living regionally as travel, accommodation and living away from home are barriers.
- Recognising innate knowledge of cultural ways and healing as invaluable and not something that one can learn through a formal qualification. There is a sentiment that formal qualifications and Western modes of learning are valued higher within the mental health system than the knowledge one gains through the lived experiences of being an Aboriginal person; this sentiment should be challenged and lived-experience should be prioritised in the mental health space.

Community Conversations

Building on the surveys, 20 rich and deeply inspiring interviews were also completed. Interviews were conducted with Aboriginal people with lived experience of the mental health care system, including Traditional Owners of Victoria and those who are no longer living on their traditional lands and now call Victoria home. Interviewees also included members of the Aboriginal and non-Aboriginal mental health and community care workforce who have direct relationships with Aboriginal people and programs.

Interviewees lived in both urban and regional areas. Half of interviewees identified as male and half identified as female. Interviewees also included members of an Aboriginal youth organisation, an Aboriginal LGBTI advocacy group and Aboriginal Elders.

Much like the surveys, key themes emerged in the Community conversations. These include:

- To see improved outcomes, there must be increased and sustained funding to support cultural healing models, camps, spaces, and centres led by Aboriginal people.
- It is important to value and embed Aboriginal culture, connection, and kin into clinical practice—not only at ACCOs, but across non-Aboriginal services.
- Aboriginal Communities would like, but are rarely afforded, 'choice' when it comes to treatment.
- Many Aboriginal people want to access both Western and Aboriginal healing practises. However, financial stress makes it difficult to seek alternate models, and treatment options are limited.
- Aboriginal people want to feel safe, heard and understood when accessing non-Aboriginal services. This points to the importance of having Aboriginal units embedded within non-Aboriginal health and community care providers. Aboriginal staff must work in front-facing as well as leadership positions to influence lasting change.

The workforces advised that:

- Across the service system, Aboriginal and non-Aboriginal workforces remain stretched.
- The workload for Aboriginal staff is particularly crippling. The client and worker boundaries that are encouraged for staff in non-Aboriginal environments are not possible for the Aboriginal workforce. Many Aboriginal staff have dual roles; they are Community members first and foremost, and often are 'on call' 24-hours a day, seven days a week.
- The non-Aboriginal mental health workforce must respect and advocate for Aboriginal cultural healing practises, with recognition that they may never fully understand the extent to which cultural healing practises have such a powerful impact for Aboriginal people.
- There needs to be a more accountable and responsive non-Aboriginal mental health service system that can better coordinate culturally appropriate and responsive care.
- The ACCO workforce is made up of Aboriginal Community members who are on their own healing journeys. Many are exposed to high levels of distress with limited opportunities to debrief and heal from vicarious trauma. The Aboriginal workforce wants the true nature of their work seen, acknowledged and remunerated.

2.3 Community Story: Connecting back has been the key

Trigger warning: *This is an personal account of suicide by a family member. Some people find this content deeply distressing. It contains names of people who are resting in power in the Dreaming.*

- Anonymous Aboriginal Community Member

My family are from the Western Desert in Western Australia. Our Tribe is referred to as the last of the nomads, as we were still living on Country when we were discovered by white people in the mid 1960s and 1970s. I was born in 1981, and I am literally the first person in my family to be born outside of the desert.

My family originally lived off Country closer to the Northern Territory border. From the 1950s and 1960s there was nuclear testing and rocket testings and I remember stories being told by my Elders when I was a young girl, about how they saw things 'flying in the sky.' This frightened them as they thought it was bad spirits, so they decided to move more inland. And that is when they had first had contact with European people.

My mother's generation were the first to live in the Western/European world. My grandparents did not want to, it was too foreign for them, so they decided to stay out bush. My grandfather was a traditional warrior who had three wives and 16 children. My mother was the youngest. Mum left our Traditional Country at the age of 16 and moved to Perth. Soon after starting her new life there, she had me. Unfortunately, of my mums 16 siblings, only six are alive today.

My mother went through addiction and alcoholism. She was in and out of jail all the time. At the time, there was a church mission in the town and my family learnt English from the missionaries, and the missionaries learnt our language. My people started to call them mummy and daddy and had a high respect for them.

When I was six or seven, my mother was not able to look after my brother, sister, and I, due to her addictions. As a result, we were put into foster care with a couple from the church, the missionaries who had been working on our country for 30 years. They were very close to our family and understood parts of our culture and knew our language. We stayed living with them until the legal age of 18. During that whole time, we stay connected to our Country and our people, because of our foster parents understanding of our culture. We recognise that we were are one of a million cases of Aboriginal children who were put in the foster care system. When first, we were put into care all together and not separated. Secondly, not only were we safe and loved in our home but we grew up very connected to our culture and family.

We already had significant childhood trauma in the early years of childhood. My mum's identity as a young Aboriginal girl, was a big struggle for her. She was born and raised as little desert kids, traditional way and then coming into town discovering this new Western life and being hit with the poisons of alcohol and cigarettes. It was not until later in life that it was discovered that she was born [with] heart problems; she had been having mild heart attacks since she was 19 years old.

On January 26 2001, my mum had a heart attack and died, she was only 38. My brother was there with her and watched her die. That was the start of everything becoming undone. I did not know how to deal with it. I had just finished a short course at Uni in Sydney and my brother was just about to start year 12. We buried my mother only a couple weeks before school started back for the year for my brother, 17 years old and my sister 14 years old.

The loss of our mother brought up a lot of childhood trauma that was suppressed over the years in foster care. I remember going into counselling for grief, a year after she passed. I then needed to be referred to another

specialist for other trauma, such as child abuse and neglect. Somehow, with my resilience, I was able to overcome the pain and work through a lot of the issues I did not realise I had. And I was able to continue living my life, with further study and working professionally.

The 18 years of turmoil that it had on my brother and the childhood trauma that it brought up for him also, became too much for him to know how to deal with it. He went down a different road and reacted with breaking into cars, smoking and drinking. Later on, down the track, he started smoking methamphetamines and became very addicted to it. He tried to go to counselling and to rehab, but he was unable to cope the past. And feeling the pain of it all. My brother was later diagnosed with drug induced schizophrenia, which didn't help at all when he was on ice. He worked in the mines for many years and somehow his body was able to work the two weeks without drugs but then when it came to the end of that two weeks, his body would start to shake as it needed the hit again. My sister would watch this every month on how it had a hold of him. On his weeks off, he would go days without sleep and food and water, just from being high on meth. With his schizophrenia and paranoia from taking the drugs, he started to believe that the police were after him. There were several failed attempts to take his life due to being so paranoid. And unfortunately, in June 2019, it was his last attempt, that took his life. This was an incredible shock to my family and so difficult for my sister and I to deal with. We immediately arrived into Perth to organise his things and his funeral.

My brother passed away in the garage of his house, and when we went in to look in the garage, a few days after he had passed away, we discovered that most of our grandfathers weapons – even weapons he was initiated with as a boy – and our grandmothers coolamons and clapsticks were laid out on the ground, near where he passed away. The night he had taken his life, my brother had laid them out and polished them with animal fat. He desperately wanted to go back to Country that night, but was unable to, as he did not have his car. His last conversations were, that he wanted to go back out bush so that he could find peace again. I believe, that in that moment, he found some peace in preparing those weapons and dying near them.

Only two months after we lost my brother, our foster mum died. She had been unwell for quite some time, and we believe losing our brother, her son, that it fast tracked her illness.

Losing my brother lead me to fall into a deep depression. Nothing that I had ever experienced before in my life. I was unable to get up out of bed and wanted to be left alone, in my room in the dark, day and night. I did not want to speak to anyone, take any calls or go outside. This was very difficult for me as I have two children - 10 and six. But with this depression, I was unable to be there for them. I am very grateful that I had good people around me and good friends from our school, that were able to help me with my children during this time.

As the days and weeks went by, I realised I was not getting better and I recognised that I was feeling "sick" in my mind. A friend referred me to a neuro-psychotherapist and counsellor who specialised in childhood trauma and brain development. The thing that helped me – the area she specialises in – was helping me to understand how the way brain develops, from when we are growing in the womb, when we are born, and the crucial first weeks and months of our life.

I had explained to my counsellor the life that we had, and what it was like growing up with heavy use of alcohol in the household. As a little girl, I had to grow up very fast and fend for myself and my brother. If all the adults were passed out or hungover, or arrested, I had to learn quickly how to find food for my brother and me. As kids, we would always either hide under the bed or in the closet, under the blankets, when there were a lot people over drinking and fighting. My counsellor helped me realise my flight or fight response and that what worked for us when we were little, could no longer work for us as adults. We couldn't just hide in the closet or under the bed anymore. I was able to find counselling to help me with dealing with the flight or fight response. But my brother resorted to drugs and alcohol.

My counsellor drew pictures of the brain and helped me understand early development of the mind and the connection a mother has with her child. All my life I have had guilt for not looking after my brother better. I felt guilty that I was able to keep going, after our mum passed away. I felt guilty for leaving my brother and sister, after

her funeral to go and live in Sydney. While living in WA, I thought that I could help my brother with his addictions and even had him live with me for six months. But his drug addiction became too risky with my small children around. So, I had to ask him to leave. Again, I felt guilty for that. My counsellor helped me understand the damage that had been done to him early on as a baby. Trauma shuts off parts of the brain and it helped me to realise that he just was not able to have the capacity to cope. As that was damaged in his brain as a young boy.

It was like a huge weight off my shoulders – I felt completely free for the first time in my whole life – even if I had of done everything that I could possibly do, which I thought I was doing, it still wouldn't have helped. He still would never have been able to heal in that way and function properly in life. We had sessions where she would scientifically and biologically show me the impacts of early childhood development. Understanding there was incredible power for me in being able to finally forgive myself and to let that guilt go. That was the start of my healing process.

She gave me strategies and tools, as simple as deep breathing techniques. I struggled for months not being able to sleep. I just could not stop thinking about my brother and his pain and my sadness from losing my best friend. She asked me to describe my perfect place, to describe where I find my peace. For me, it is at the beach, and, around sunset. She asked me to describe the feelings that I feel when I'm sitting watching the sun set. She wanted me to describe it using all of my senses. What I could feel, what I could touch, what I could hear, what I could smell, all to describe a scene where I felt safe and felt happiness. She then suggested that at bedtime to imagine this scene and describe it in my mind every night that I was unable to sleep naturally. The second night after that, I feel asleep before I even got to describing the feel of the sand in my hands. It was the best sleep I had had in months. I was quite crippled for a few months.

I made the decision that I no longer stayed up late. I got into a routine. Go to bed early, so I can get up at 6.30 to do my stretches and meditate. I started to keep a journal and started to write about things I wanted for myself in the future. I would write three things each day: to be more patient and happier.

After working hard to sleep well and practice coping strategies, I was finally starting to feel well. And then two months after I lost my brother, I lost our foster mum.

It was then that I decided, I need to do something more. I felt like I was going backwards again. I decided I needed to go home, back to Country.

Through the bedtime practises and breathing I was able to deal with my foster mum's funeral better. and I found that I had better tools to not go down the same road.

I decided to take two weeks off after the funeral to go back to Country. I spoke to my Aunties and they agreed that I needed to come back home and they would care for me. I went back to the desert. There is a special place, for women only in our tribe. In the middle of nowhere there is this green place with gum trees, green bushes, bush foods, and water holes. My Aunties took me there and showed me that it was a special place for women to heal. It was where they came to give birth, and to heal from that, and to come for other healing and connection. My five Aunties did a special ceremony for me. They had coals already heated covered in fresh gum leaves, so it was safe to lie on them. We have a lot of sandalwood trees out there; it has been part of our culture for thousands of years and it is a part of who we are. They used the sandalwood oil and ochre and covered my body in ochre and oil and sang in language about me being home. It was like a day spa healing treatment that had been done for thousands of years traditionally, with all the bush medicine that needed to be put into my body and my face and my hair – for me to know that I am home and for this pain to go. And right there in that spot, in that water hole, they helped washed me.

The most beautiful thing about it as a grown woman, is that it felt like I was a little girl. I had a lot of my childhood taken away from me. To have that love and nurturing. It was being passed to me, that has been done to our women, for generations. These people who love you and want you to be better and want you to heal. I felt like a little girl, in a good way – these Aunties / Nannas had done this for so long. The smell, the mix of the leaves, the

sandalwood, the smoke, everything was so therapeutic. So perfect. We stayed out there for a couple of days, talking and yarning. It was a beautiful moment. So healing for my soul. Being about connecting with the strong women in my family and to walk bare foot in the red desert to learn from them. It helped me feel my ancestors and to feel happy and at peace. I called this, my desert healing.

My Aunties and Nannas then said, “Because you need healing also in the sea, go talk to other Aunties that live along the Coast.” Go and get your sea salt healing. I had the Yamatji Aunties doing that in the ocean with me. It is something I am so lucky to experience. So lucky that my family still have that connection to be able to practise – that it wasn’t taken from them.

This was a huge part of healing me last year.

I had Western counselling and that has helped me. And my Aunties told to keep that connection back to Country. To pick the gum leaves, keep the sandalwood oil to put on my body or have in my diffuser at home. I have dried leaves and rocks and dirt from the desert. They told me that then when I returned home, to go out bush in that Country. Connect with people so you can find local supports there as well. Find peace in that Country because healing is everywhere, I hear my Aunts say.

I realised that it was more than just one element that I needed. To heal from my past, my trauma, and my grief. I realised that I needed to go and seek all those elements to help me feel normal again.

I needed this to be on Country and Western healing, to heal from my past, and prepare me for my future. As a mother. I knew that I did not want that for my children and that was my hope. In my deepest times, I had thoughts of suicide. I never had before. I knew I couldn’t do that, I needed to be well and happy and healthy for my children. I always had a fear about getting to age 38, because that was the age that my mum was when she died.

For the last six months I had not slept well, not eaten well, and had been grieving heavily. At the beginning of this year, I ended up in hospital. For six days they did test after test and eventually diagnosed me with pneumonia. But when I told my doctor what had been happening recently in my life, she told me what stress and grief does to your cells. And the overall functioning of our organs and body. She believed, a huge contributor to why I got so sick. Since then I have made different choices. I continue to work hard to stay focused and healthy. I know that if I am healthy with what I put in my mouth it helps with my mind, I have clarity.

I know for certain, no one thing is the answer.

Being able to recognise things like alcohol was not going to help. That the first thing I needed was an understanding of my trauma, and strategies to cope and sleep. To heal my heart and the hurt that I had. Working with my counsellor helped me find these strategies. But I would not be where I am now if I had not done my desert and sea salt healing. That connection back with family and Country was a major part of my healing.

I got to the point where I just needed my feet on the dirt. The first thing I did when I got the desert. I don’t think anyone knows what that is like unless you are an Aboriginal person; connected to the land like that.

I do believe having my family around has been healing. Being connected back to strong, positive Aboriginal people. It’s like medicine. Connecting back has been the key.

The twists and turns of grief take an enormous toll. Around my brother’s 12 month anniversary of his passing. I received the full coroner’s report. Reading all the details in the report was incredibly difficult for me and it immediately made me feel like going back to the same habits I was in last year, after he passed away. Back to bed with closed blinds, lying in the darkness, feeling all my pain again.

This time, I called my counsellor immediately. I told her, “I’m going back”. She said “that’s ok to go back to that

sadness, because you are grieving but how about setting some boundaries? If you want to lie down in the darkness in your room, that's is fine. But set an alarm. Plan tasks afterwards. Go out with the kids and have a bike ride or a walk. Allow that moment you need, and then do something afterwards."

This advice helped me so much. I only went to my room twice to do that. I've never felt the need to go back into my darkness again. I felt so good knowing that I could use the tools that she had taught me. I could deal with my "fight or flight "response. I will continue to use those tools. It's important to have accountability to continue healing. If I don't get up for breathing, I make time to practise another tool. My counsellor is the person in my back pocket.

I want to remove the stigma. Its ok to go and talk to a professional, and it doesn't mean there is something wrong with you. Just like when we have a broken leg, we go to the doctor. If we have a hole in our tooth, we go to the dentist. If we have hurt in our mind, you go to a specialist.

My counsellor was very encouraging of going back to Country. She recognised that it was not going to be just that one kind of healing for me, she knew there was the other parts I needed to do. She acknowledges the struggle, the pain. We've developed strategies to change that anger into passion and empowerment. I am grateful that I have found a professional who wants me to use this power and cultural connection, because that is a crucial part of my healing.

2.4 Community Story: We need an Aboriginal knowledge place

- Anonymous Aboriginal Community Member

I truly believe that the more we can get young people back into the bush and connecting to the waterways, the lands and the Ancestors, the more they will be healthy.

Our culture was built on a deep understanding of what's there – in terms of land, waterways, ecology, spiritual connection of how Country came to be. This has certainly helped straighten me out as an old man. I have seen the effect the bush has on so many young people over the years, there is a very deep transformation that can come. I am a Psychiatrist; I have the benefit of Western education. I trained as a doctor and then as a psych. As a young man I spent a lot of time living in the Kimberly learning from people, an immersion in Kimberly culture. As I got older, I realised that for my own physical and mental health, I needed to become far more immersed in our culture here in Victoria. I work with an Elders Group to look at Indigenous cultural practises and healing linked to social and emotional wellbeing for kids and families.

There is something profound about the stillness and the spiritual presence of the bush. It's a bit like a possum skin cloak, an Aunty would talk about this – you wrap a child in a possum skin, they become quiet and still. I have experienced the same in the bush. Something about the sheer power and size – it calms kids, they are a bit in awe of it. The really tough kids, they want to smash you up, they punch a tree, they hurt their hand, they kick a tree, they hurt their foot. Its bigger and tougher, but it's not here to hurt them. There is so much here that the kids can observe – it becomes like a wonderland. You can do all sorts of teaching on Country.

How hungry we are for knowledge and practise. Cultural grounding is the basis for building other aspects of health. A steady platform builds resilience. I want kids to forget labels and diagnoses, to just be kids, in this still, beautiful space. They have to confront this whole space with all they are – not their mental illness or their diagnosis - all of them, here all at once, in this moment. It's way beyond a label.

I did a PhD. I was a classic doctor, psychiatrist, researcher – then all this repressed stuff became really important to me. The Western knowledge I had gained wasn't touching my spirit. Not healing me holistically. I began to immerse myself far more openly in cultural practises, it transformed me, and then my practice. It had a ripple effect. Mum and dad to survive, they hid their Aboriginality. We talked about it at home but never in public. They lived a life of fear of being persecuted. I want kids to move beyond fear. And to understand how profoundly sophisticated Aboriginal culture is.

The problem that the Commission needs to understand is that the dominant culture doesn't listen and is always trying to make Aboriginal people fit in or be more compliant with Western culture rather than hearing the deep benefits. The Commission needs to understand that Aboriginal culture doesn't need to be seen as Western culture – Aboriginal people don't need to assimilate – there is deep value in culture. Clinicians need to listen.

I watched families come in with all these layers of complexity, thinking they had to walk away with a diagnosis, because then you know how to treat it – but it is much bigger than that. We give kids more and more medication, instead of going into the bush, linking in with Aunties and Uncles. Our kids end up on high doses. The most frustrating thing when I saw our kids on all that medication, was trying to get through to their spirit. I remember one boy saying. "It feels like my spirit is stepping away from my body".

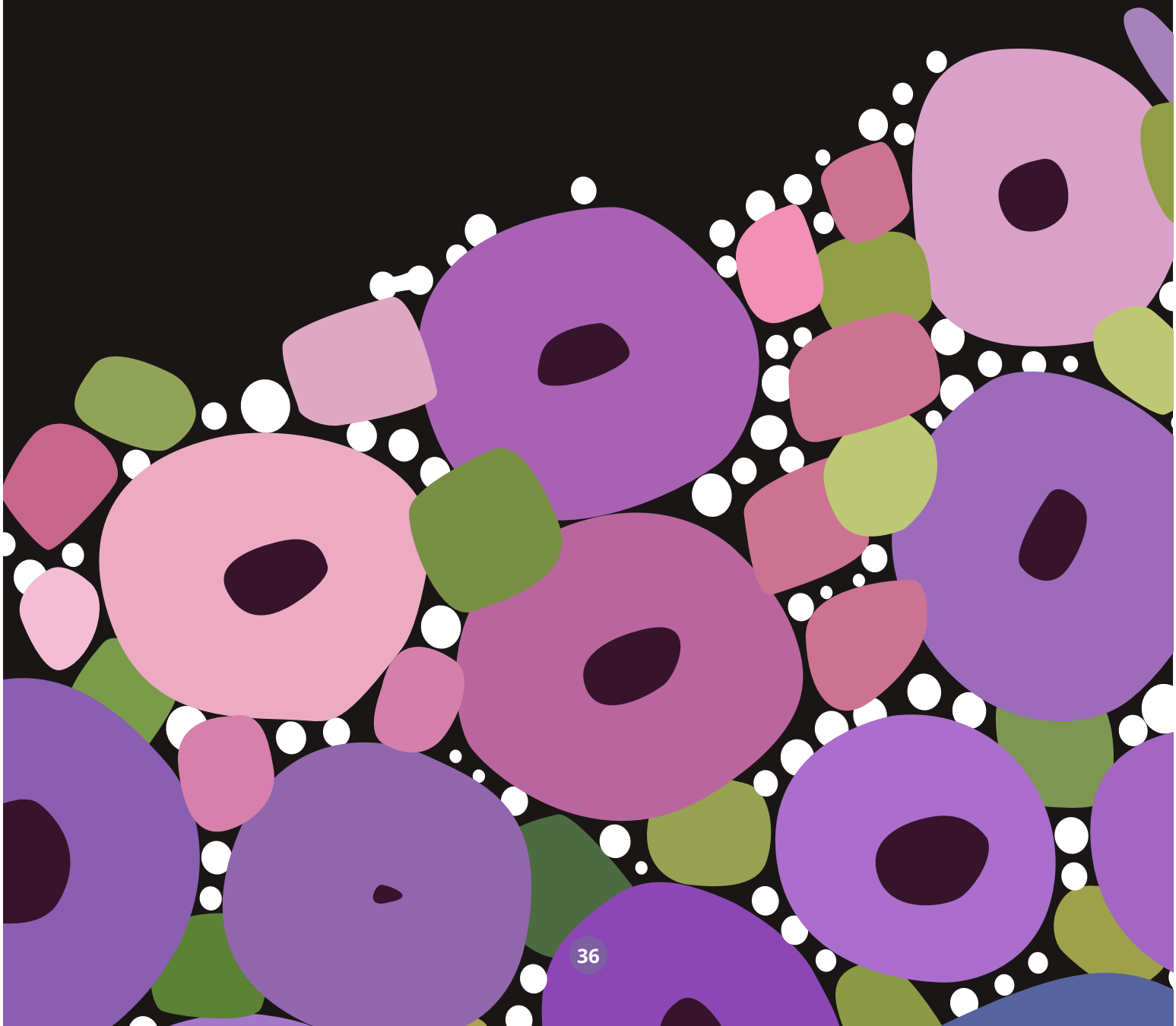
We need our own space to do these practices, to value our Elders. We are losing the next generation of Elders; we need to listen to this knowledge, and we need to do it now. It is urgent.

I have leukemia and am I just finishing chemo, so I value what Western medicine has given me. I want to be honest in that I see the value of Western health practices. But I do not believe our people can be truly healthy and have ongoing wellbeing without being immersed in our culture.

My perfect scenario would be a healing space for us, whether it was land or a multi-purpose building that allowed cultural practice to occur; fire pits, yarning circles, specific areas where you have environmentally friendly therapeutic areas. That is the absolute dream.

We need an Aboriginal Knowledge Place.

Section 3: The solutions for an improved mental health system are with Aboriginal people



3.1 What the Interim Report says:

The Interim Report highlights the widespread and disproportionate rates of psychological distress, depression and anxiety in Aboriginal Communities and states that these occurrences must be addressed as a priority. Most importantly the Interim Report acknowledges the ongoing detrimental impact of colonisation and post-invasion policies on the social and emotional wellbeing of Aboriginal Communities.

The proposed solutions in section 3.2 strengthen Recommendation 4 of the Interim Report. Specifically, Solutions 2 and 3 closely reflect Recommendation 4 of the Interim Report and expand on its principles offering a contextualised Aboriginal-led way forward. Solutions, 1, 4 and 5 are somewhat independent from the proposals within Recommendation 4; however, they nonetheless draw from and build on Recommendation 4.

The five solutions found in Section 3.2 reflect the voices of Aboriginal and non-Aboriginal organisations and workers, and Aboriginal people with lived mental health experience, who have shared their stories in order to create meaningful, enduring changes to the current mental health system through this Report and the broader Commission process.

Royal Commission Interim Report: Recommendation 4 Aboriginal social and emotional wellbeing

Recommendation 4

The Commission recommends that the Victorian Government, through the mental health implementation office, expands social and emotional wellbeing teams throughout Victoria and that these teams be supported by a new Aboriginal Social and Emotional Wellbeing Centre. This should be facilitated through the following mechanisms:

- Dedicated recurrent funding to establish and expand multidisciplinary social and emotional wellbeing teams in Aboriginal Community Controlled Health Organisations, with state-wide coverage within five years.
- Scholarships to enable Aboriginal social and emotional wellbeing team members to obtain recognised clinical mental health qualifications from approved public tertiary providers, with a minimum of 30 scholarships awarded over the next five years.
- Recurrent funding for the Victorian Aboriginal Community Controlled Health Organisation to develop, host and maintain the recommended Aboriginal Social and Emotional Wellbeing Centre in partnership with organisations with clinical expertise and research expertise in Aboriginal mental health. The centre will help expand social and emotional wellbeing services through:
    - clinical, organisational and cultural governance planning and development
    - workforce development—including by enabling the recommended scholarships
    - guidance, tools and practical supports for building clinical effectiveness in assessment, diagnosis and treatment
    - developing and disseminating research and evidence for social and emotional wellbeing models and

3.2 Aboriginal-led solutions will pave the way by 2025:

Solution 1:
Establish five on Country healing centres (or camps) to support resilience, healing, and trauma recovery through fostering connection to Country, kinship, and culture.

Solution 2:
Ensure long-term, sustainable, and flexible investment in Aboriginal social and emotional wellbeing to create generational change

Solution 3:
Invest in recurrent funding arrangements for multidisciplinary social and emotional wellbeing teams in Aboriginal Community Controlled Organisations to secure long-term state-wide coverage.

Solution 4:
Critically invest in Aboriginal-led solutions to prevent suicide and self-harm.

Solution 5:
Appropriately invest in Aboriginal leadership and culturally safe service delivery across mainstream primary, secondary and tertiary health services.

Solution 1: By 2025, establish five on Country healing centres to support resilience, healing, and trauma recovery through fostering connection to Country, kinship, and culture.

1.1 Based on local Aboriginal need, the establishment of five on Country healing centres in Victoria will significantly change the support options available to those in need and respond to sustained calls by Communities for Aboriginal-led, culturally appropriate services. These centres will also create an important alternative to those not wanting to engage with medical systems due to previous or associated trauma.

1.2 On Country healing centres have a multitude of benefits, as they will:

- provide a place for Aboriginal-led trauma informed healing that integrates traditional and contemporary practice
- restore language, knowledge systems, kinship, and Aboriginal customs
- create paid employment opportunities for Elders who will play a critical role in the healing of young people and Communities.

1.3 Drawing on the Department of Health and Human Services (DHHS Supporting Self-determination: Prioritising Funding to Aboriginal Organisations Policy), Aboriginal funding arrangements must be flexible and prioritised to Aboriginal organisations to develop healing centres.

Expertise from Aboriginal Communities and workforces informed this recommendation

Overwhelmingly throughout the consultations, Aboriginal Community and workforce called for a sustained investment in Community-led, cultural healing places.

"We need an Aboriginal knowledge place."

(Anonymous)

Participants spoke about the importance of connection to Country—a place to heal and to come together for young people and the whole Community:

"Our mental health, the suicides, this is beyond a crisis. I really believe that a lot of young people will open to an Elder. Someone who has the empathy and the patience to listen. We need holistic healing, with Elders. Getting on Country."

(Aboriginal Community member with lived experience).

"I truly believe that the more we can get young people back into the bush and connecting to the waterways, the lands and the Ancestors the more they will be healthy. I have seen the effect the bush has on so many young people over the years, there is a very deep transformation that can come."

(Aboriginal member of the workforce)

"We need places where mob can help mob. The system is failing. I was at a psych ward with my daughter a few months ago and I sat down with the psychiatrist. At every step of the way, my daughter has fallen through the cracks.... My dream is to have sessions out in the bush.... We would sit down by the creek, have a cuppa and a yarn. There will be an Elder you can have a yarn with, and then you could head off to the local gathering place and do some art or some storytelling. It's what we need more of."

(Aboriginal Community member with lived experience)

"I watched families come into clinical settings with all these layers of complexity thinking they had to walk away with a diagnosis, because then you know how to treat it – but it's much bigger than that. We give kids more and more medication, instead of going into the bush. Linking in with Aunties and Uncles. Our kids end up on really high doses. The most frustrating thing when I saw our kids on all that medication, was trying to get through to their spirit. I remember one boy saying. "It feels like my spirit is stepping away from my body."

(Aboriginal member of the ACCO workforce)

"We need our own space to do these practises, to value our Elders and families. We are losing the next generation of Elders; we need to listen to this knowledge, and we need to do it now. It is urgent."

(Aboriginal member of the workforce).

"We need holistic healing, with Elders. Getting on Country. We need to look at things differently, we don't fit into this prescription-based culture. We respond to different things; we respond to our Elders. We stop and we listen. We take away what our Elders tell us."

(Aboriginal community member with lived experience)

Reconnection to culture is healing and is not supported in the current system

Cultural healing places will support reconnection with cultural practice and are fundamental to mental health. One participant said:

"Cultural grounding is the basis for building other aspects of health. A steady platform builds resilience. I want kids to have a place to forget labels and diagnoses, to just be kids, in this still, beautiful space. They have to confront the bush with all they are – not their mental illness or their diagnosis - all of them, here all at once, in this moment. It's way beyond a label."

(Aboriginal member of the workforce).

This critical part of healing is not supported in the current system as a senior member of the Aboriginal workforce highlighted:

"I have been in this business a hell of a long time, and now I can see the missing ingredient in what we are doing.... we are losing contact in a cultural context. You look at youth justice centres, kids clearly say to you they are missing their storylines, their cultural connections. This is something we need to invest in very strongly."

(Anonymous)

There must be paid roles for Aunties, Uncles and Elders

Cultural roles, and in particular well-paid roles for Aunties and Uncles, were a common solution put forward by participants. One interviewee described her experience in a paid Auntie role, and the positive impact she saw this having on the young women she worked with.

"I am employed in an Aunty role working with young women. It's about health and wellbeing – young Aboriginal women need culture as that protective force. The role of Aunties is supporting identity. Mainstream organisations, schools, they all erase that stuff off your skin. You think of those Uncles and Aunts that can tell a yarn, and stretch that yarn a bit bigger, you know when they come around, they just make you laugh all the time and you forget sadness. Kids go to them. Kids will go to people who make them feel good... The response we have seen from young women to having Aunt in this role has been really positive... Imagine if rather than going to a Headspace, we could go to Aunties Place."

(ACCO staff member)

Solution 2: By 2025, ensure long-term, sustainable, and flexible investment in Aboriginal social and emotional wellbeing to create generational change.

The introduction of the capital investment fund, as recommended in the *Royal Commission into Victoria's Mental Health System Interim Report*, creates a unique opportunity for this significant investment.

2.1 A fixed funding arrangement of this new revenue stream should be allocated to Aboriginal social and emotional wellbeing. This should be cemented in legislation to protect Aboriginal organisations and Communities from political cycles of government, and the subsequent changes to funding and portfolio agendas.

2.2 All other ongoing or introduced social and emotional wellbeing and mental health funding outside of the new levy/tax must have target investment into Aboriginal organisations and Communities.

2.3 All funding should be prioritised to Aboriginal organisations first, in recognition that Aboriginal self-determination creates sustainable and ongoing mental health and social and emotional wellbeing outcomes for Communities.

Expertise from the community and workforce consultations that informed this recommendation:

A consistent message was that Aboriginal people know what is needed to create better social and emotional wellbeing outcomes for their Communities and that

"Self-determination must be adhered to, as does prioritising and redirecting funding to Aboriginal organisations and outcomes."

(Aboriginal member of workforce)

Funding instability and defunding programs that are working have led to critical setbacks

Short-term funding cycles regularly lead to the closure of high impacting programs and services and prevent long-term positive change. One participant shared their experience:

"In the regions young ones are feeling the same as I did. Nothing has improved. The system hasn't changed. In my town we used to have more positive Community events. What happened to those? They got defunded of course."

(Young Aboriginal member of the workforce)

Short-term funding has a negative impact on both programs and workforce, as this staff member highlighted:

"We have to have psychological support for staff. We did have telephone support through an Aboriginal psych who could give advice and understood the issues and supports staff are providing. It did work and the person did get several calls, Indigenous and non-Indigenous staff used it. It was a part of staff retention. It was funded for six months and then it was dropped."

(ACCO staff member)

Another interviewee talked about the onerous processes to acquire funding:

"The programs that are working, don't get funded based upon the mental health outcomes they achieve… you have to jump through hoops to get funding."

(Young Aboriginal member of the workforce)

Relationships take time to build and programs need to be long-term

Important relationships with clients take time to build and are often disrupted when funding and programs cease; this is often due to 12 month cycles of funding and heavy and/or prescriptive administrative and funding requirements that are not meaningful to the client or service provider.

"We know mob aren't going to go to clinical spaces. We watch this time and time again; they go to women's and men's gatherings. To be in places where people ask, do you want a cuppa or are you right? Those men would never talk to a clinical psych but these programs, they are only ever funded once. By the time the trust and relationships are built, they are defunded."

(Young Aboriginal member of the workforce)

Solution 3: By 2025, invest recurrent funding arrangements into multidisciplinary social and emotional wellbeing teams in Aboriginal Community Controlled Organisations to secure long-term state-wide coverage.

3.1 Secure ongoing recurrent funding arrangements for multi-disciplinary social and emotional wellbeing teams by 2025 to ensure workforce sustainability in ACCOs and ongoing continuity of service to community, families, and individuals. Multi-disciplinary teams must consist of psychologists, general practitioners, psychiatrists, social workers, counsellors, Aboriginal social and emotional wellbeing and mental health workers, Aboriginal health practitioners, and mental health nurses. It is recognised that to ensure self-determination and cultural safety, Aboriginal staff must be in leadership roles within these multi-disciplinary teams.

3.2 Advocate for Commonwealth investment in early intervention and prevention through Aboriginal organisations.

3.3 Significantly increase investment and support for appropriate, meaningful client management systems, information technology systems and related training that allows service workers to understand a client's full story and provides data and data sovereignty for ACCOs and Aboriginal Communities.

3.4 Increase investment into 'Return to Country' programs to allow Aboriginal children in care to stay connected to their culture, and for Community members displaced from their Traditional Lands (e.g. the Stolen Generations) to reconnect for healing.

3.5 Increased investment into Aboriginal family centred AOD models of care

3.6 Fund the development of culturally appropriate assessment diagnostic and treatment tools, developed by Aboriginal people for Aboriginal people.

Invest in Aboriginal Community Control

There were clear calls for ACCOs to be funded to provide necessary social and emotional wellbeing supports.

"There needs to be funding for ACCOs to be service providers for their Community. There needs to be a culturally safe environment. For a lot of Community members, they are not going to go to hospital, religious, or a mainstream organisation if they don't know anyone there. They are more likely to go to an ACCO because they know people there. It's a safer environment."

(Non-Aboriginal Member of the Workforce)

The real solution is that

"ACCOs need to be directly funded for the services, instead of going to mainstream, to provide services as and when required."

(Non-Aboriginal Member of the Workforce)

ACCOs are culturally safe places

Participants spoke about feeling culturally safe in ACCOs.

"Young people are more likely to unpack with someone they know and trust. Rather than going into clinical office with some whitefella off the street who knows nothing about their life."

(Young Aboriginal member of the workforce).

ACCO staff spoke about how supports are targeted to meet unique needs.

"Our organisation is a safe place. You can pop in when you're hungry, thirsty or want to have a chat. Community members will walk past and pop in, we make them a cuppa, pull out a roll and some cheese. We don't want this to feel like a doctor's office. It's less clinical, more informal, safe and comforting. They might recognise a car out the front, so they walk in the door and sit down for a chat. We have food bank every Friday – we don't ask questions. We're not going to ask if someone is Aboriginal, or for their pension cards, they are community members – we live in the community – they need to know we are here for them. Trust is built up, it's genuine and not fabricated. We work really hard on boundaries, but this is how we end up doing stuff that is outside our role, we know the knock-on effect of one small act of kindness."

(Non-Aboriginal ACCO Staff Member)

Increase investment in 'Return to Country programs' to support connection to Country, culture and kinship

Return to Country programs were described as a critical part of trauma informed social and emotional wellbeing support.

"Returning to Country as a part of a wellbeing plan, it's very difficult to put into your mental health care plan. It's so important that people are being made to feel ok about it. To get funding to return."

(Non-Aboriginal member of the workforce)

One participant stated that

"For young people who aren't connected, there's something that's inside that you know is missing. When you don't have that strong connection, it makes you vulnerable. Anything that's developed from the Royal Commission has to heavily focus on culture and connection to Country."

(Member of the Aboriginal Executive Council)

Another young person said

"Knowing genealogy, my family history, it's a privilege. The goal should be that everyone has access to this knowledge. Especially for our young mob who go into care, so they know who they are and where they come from. It is identity, it's who we are, it's understanding our story, our linage. Connection to family and kinship enables you to speak strongly, to position yourself in terms of who your family is. Kinship links you into cultural systems."

(Young Aboriginal member of the workforce)

Fund the development of culturally appropriate assessment, diagnostic and treatment tools

The importance of culturally appropriate assessment diagnostic and treatment tools was also highlighted during conversations.

"We have created our own assessment tool, a culturally friendly one that doesn't trigger our Community members. We designed it as a cultural mind map and Community can sit down and fill out, and then we transfer the information into a mainstream referral form. The mainstream assessment tool - not one member of our Community is going to sit and fill that out. It's not culturally appropriate. Without cultural resources, we are left with clinical paperwork that makes our clients disengage."

(Member of the Aboriginal workforce)

One participant spoke about the cultural inappropriateness of requirements

"No matter what the form, we as staff are filling out 90 per cent of it and I still struggle to get it done. They are repetitive, clients will get frustrated and say, that is the same question and the language is triggering."

(Member of the Aboriginal workforce)

Solution 4: Critically invest in Aboriginal-led solutions to prevent suicide and self-harm

4.1 As an immediate priority, invest in an initial Victorian specific post suicide intervention and suicide prevention service, attached to an existing ACCHO service. Initially this could be done in partnership with an appropriate mainstream service like the Jesuit Social Services 'Support After Suicide' program, assisting children, young people, families and communities impacted by suicide and providing counselling, support groups and online resources.

4.2 Establish 24-hour Aboriginal Crisis Assessment and Treatment (CAT) teams across Victoria so that any individual with an acute mental health crisis (and their families) can receive culturally appropriate and safe support.

4.3 Provide investment to support the employment of Aboriginal management and staff in existing CAT teams to improve cultural safety and outcomes for Aboriginal patients and families.

4.4 Establish a statewide Aboriginal-led suicide and self-harm prevention panel to coordinate and target efforts for Aboriginal patients and families, particularly in areas of most need.

4.5 Continue to fund the statewide rollout of Hospital Outreach Post-Suicidal Engagement (HOPE) program as seen in Bairnsdale, Shepparton and Epping. Support a statewide evaluation of the impact of HOPE programs on Victorian Aboriginal Communities.

4.6 In partnership with the Victorian State Coroner's Office, reform suicide and self-harm reporting to address current underreporting in Victoria.

4.7 Employ additional Aboriginal staff in the Victorian State Coroner's Office to support Aboriginal people and families. There is currently only one Aboriginal staff member in the Victorian State Coroner's Office, which presents a high risk of burnout and trauma in servicing Community.

4.8 Support the investment of new PhD scholarships and specific research grants focusing on improving the evidence base in suicide prevention and better outcomes in Aboriginal mental health and suicide prevention.

Many Community members and workforce shared distressing stories about losing family members to suicide and called for urgent support.

The need for 24-hour support was also highlighted.

"Most incidents are happening on the weekends and after hours. There is no safe place, no afterhours safe place to cool down. They can call the lifelines but it's not culturally appropriate, so we get them on Monday frustrated after a breakdown. We are not a crisis place, but we don't have one and don't have anywhere to direct people to when we are not in the office."

(ACCO staff member)

"I am a strong educated Aboriginal (Wiradjuri) woman who found it very difficult to navigate and access proper treatment for my son. I can only imagine how some people without this background feel while trying to support their child or loved one."

(Anonymous)

Solution 5: By 2025, appropriately invest in Aboriginal leadership and culturally safe service delivery across mainstream primary, secondary and tertiary health services.

5.1 Substantially increase the number of Aboriginal designated beds by a minimum of three per cent in mental health units in hospitals across the State. The current number of beds allocated for Aboriginal people does not meet current demand.

5.2 Undertake a scoping study to determine the viability of a stand-alone Aboriginal mental health residential facility, comparable to those that exist in other jurisdictions.

5.3 Increase the number of Koori Mental Health Liaison Officer (KHMLO) roles across all adult specialist mental health services, as well as child and adolescent mental health services, to ensure there are two Koori Mental Health Liaison Officer positions across each service setting. This includes traineeship positions.

5.4 Formally mandate in the Statement of Priorities (under the Health Services Act 1988) that all services fund KHMLO positions to work in pairs or units to reduce the high rates of isolation and staff burnout.

5.5 Ensure all mainstream services have Aboriginal healing spaces/cultural rooms for open access to Aboriginal patients.

5.6 Increase employment targets for Aboriginal staff in all roles across primary, secondary, and tertiary health services, but particularly focusing on increasing the number of Aboriginal people in leadership roles within mainstreams health services.

5.7 Trauma-informed and healing-based approaches must be integrated into mainstream health care practices, particularly for health services working in mental health and with Aboriginal clients and families.

5.8 Recurrently fund the Aboriginal Centre of Excellence to work with mainstream services to practically apply trauma-informed and Aboriginal healing care models.

5.9 Establish and deliver at least 30 scholarships to support Aboriginal staff to attain psychology, psychiatry, mental health nursing, counselling and diploma or certificate level qualifications by 2025.

5.10 Undertake a statewide review into pay disparity issues between Aboriginal and non-Aboriginal mental health clinical roles, recognising the critical value of cultural knowledge/brokerage roles as well as clinical functions.

5.11 Ensure all mainstream mental health clinical services pledge their support for the Gayaa Dhuwi (Proud Spirit) Declaration and report on what services are doing to support Aboriginal and or Torres Strait Islander leadership in mental health, and to improve mental health and the reduction of suicide. This information would be used to share success stories and ways of turning the words of the Declaration into action. This would consequently ensure better accountability of services and performance measurement.

Institutional racism is widespread and must be eradicated

Institutional racism still plagues the Victorian mental health mainstream system and was widely reported in the consultations.

"The real issue is institutional racism. It is really, really sickening. We have to continuously advocate for Community members while they are at mainstream services and its very time intensive, that's when resources come into it. We get a different response, if we are accompanying them, especially if it's by a registered nurse or someone with authority, they don't get the same response that an Aboriginal person presenting by themselves would. It's not acknowledged that we are doing that work."

(ACCO staff member)

Aboriginal leadership is critical to improve cultural safety

Investing in and supporting Aboriginal leadership in mainstream services is widely reported as fundamental to improving cultural safety.

"It's about supporting Aboriginal leaders. In mainstream organisations we must have Aboriginal staff in leadership positions so they can guide our services and conversations."

(Non-Aboriginal staff member)

"We don't make any decisions about anything for Aboriginal people unless we have an Aboriginal person in the room."

(Non-Aboriginal staff member)

Increase the number of Koori Mental Health Liaison Officers

Participants confirmed that Koori Mental Health Liaison Officers play a fundamental role in supporting individuals and families to navigate mainstream health. One Aboriginal worker said

"Quite often I am the middleman between government agencies, an advocate. To make sure peoples voices are being heard and that their families are being heard. That they are being respected culturally and treated with dignity. Within government organisations there is so much red tape around working therapeutically with Aboriginal families."

(Staff member of an Aboriginal organisation).

"You do need your planner to be culturally competent to understand concepts like returning to Country to heal. Cultural competence training and Aboriginal employment must be prioritised, so people do understand these concepts. If you are talking to a planner who doesn't understand, and if you aren't able to advocate for your needs, not knowing how to articulate it; 'I need to go back home'. Why? 'I need to be around my

mob, with my Uncles.' Why? Even if you have a planner who does understand, there is no 'going back to Country' box to tick."

(Non-Aboriginal Member of the workforce)

Working differently

There were calls to support Aboriginal staff with cultural leave, and other supports such as culturally appropriate debriefing and vicarious trauma leave.

"Mainstream organisations need to be prepared to support Aboriginal staff. People have their own stories, that they will be living and reliving as a part of their own healing. We need to appreciate that and support people through that and we need to be ok with working differently."

(Non-Aboriginal Member of the workforce)

Structured, culturally appropriate support and additional leave were common solutions put forward to address isolation and cultural load.

"My days are filled with high complexity and high trauma from listening to people's stories. Sometimes I just have to leave the office. I wish we had a place at the office where I could just curl up. Sometimes I need time to recover and I don't want to take sick pay, because I'm not sick. I don't want to have to go and get a doctor's certificate for something that's part of my role, I would like an understanding around that. I would like the policy makers to know, it's not us making an excuse, sometimes you can't take on anymore, you can't even look people in the face, you are done – I would like for there to be some respect around that."

(Staff member of an Aboriginal organisation).

Trauma-informed and healing-based approaches should be the cornerstone of all care practices

Participants said that trauma-informed and healing-based approaches need to be widespread.

"We are trying to heal the traumas that come day in and day out."

(Senior member of the Aboriginal workforce)

"When I was at the Peter Mac Cancer Centre, we were a custodian of a possum skin cloak – the healing cloak. It came with instruction from the ladies who made it. There were ways of using that tool, words around being accepting of the gift. I was working with an Aboriginal lady who had cancer, I remember her sitting near the window and asking her if I could drape it around her shoulders. This woman just burst into tears. There are

beautiful cultural healing tools that we are not utilising enough in these spaces. She said told me that the cloak had a profound effect, that she felt protected."

(Member of the Aboriginal workforce)

Isolation, cultural load, lateral violence, and lack of support needs to be addressed

Isolation, lateral violence, and lack of support were common experiences reported by the Aboriginal mental health workforce.

"These are very stressful jobs." said one participant, "...there is lateral violence and if there's a decision taken that a Community member disagrees with then you can be easily accessed at any time, as you are in that Community. To grow the workforce, we have to set up the system so there won't be so much pressure on our people and more emphasis on staff retention."

(Staff member of an Aboriginal Community organisation)

Another participant recommended that

"we need to look at vicarious trauma and how big of a toll it takes. There's work to be done in defining what the role of cultural load is. The term is laced all over documents and frameworks, it is acknowledged but ill-defined. We need to investigate the impact of cultural load and the various mechanisms to support Aboriginal staff."

(Member of the Aboriginal Executive Council)

Pay disparity is widespread between Aboriginal and non-Aboriginal workers

Pay disparity was also a common theme with many Aboriginal workers reporting getting paid less than their non-Aboriginal colleagues; this was observed as common practice across different services.

"The Aboriginal workforce are doing the same work as mainstream, not paid as much, not recognised for the work they do, the cultural load isn't acknowledged, the support and supervision isn't there.... There needs to be respect and recognition of lived experience and knowledge."

(Member of the Aboriginal Executive Council)

Cultural roles in mainstream and Aboriginal organisations

Cultural roles and paid roles for Aunties and Uncles were a common solution put forward by participants. We spoke to one woman who described her experience in a paid Aunty role, and the positive impact this had on the young women she worked with.

"I am employed in an Aunty role working with young women. It's about health and wellbeing – young Aboriginal women need culture as that protective force. The role of Aunties is supporting identity. Mainstream organisations, schools, they all erase that stuff off your skin. You think of those Uncles and Aunts that can tell a yarn, and stretch that yarn a bit bigger, you know when they come around, they just make you laugh all the time and you forget sadness. Kids go to them. Kids will go to people who make them feel good."

(Senior member of the Aboriginal workforce)

Thanks

We offer our sincere thanks to all our readers.

We would also like to thank and acknowledge the many contributors who came together and provided their time, expertise, and cultural authority in the development of *Balit Durn Durn*.

VACCHO would once again like to thank all our Aboriginal Communities who provided their personal stories, statements, and survey-feedback in the hope of seeing the mental health system improve for our future generations.

Thank you to Jirra Lulla Harvey from Kalinya Communications who created a safe space for people to tell their stories.

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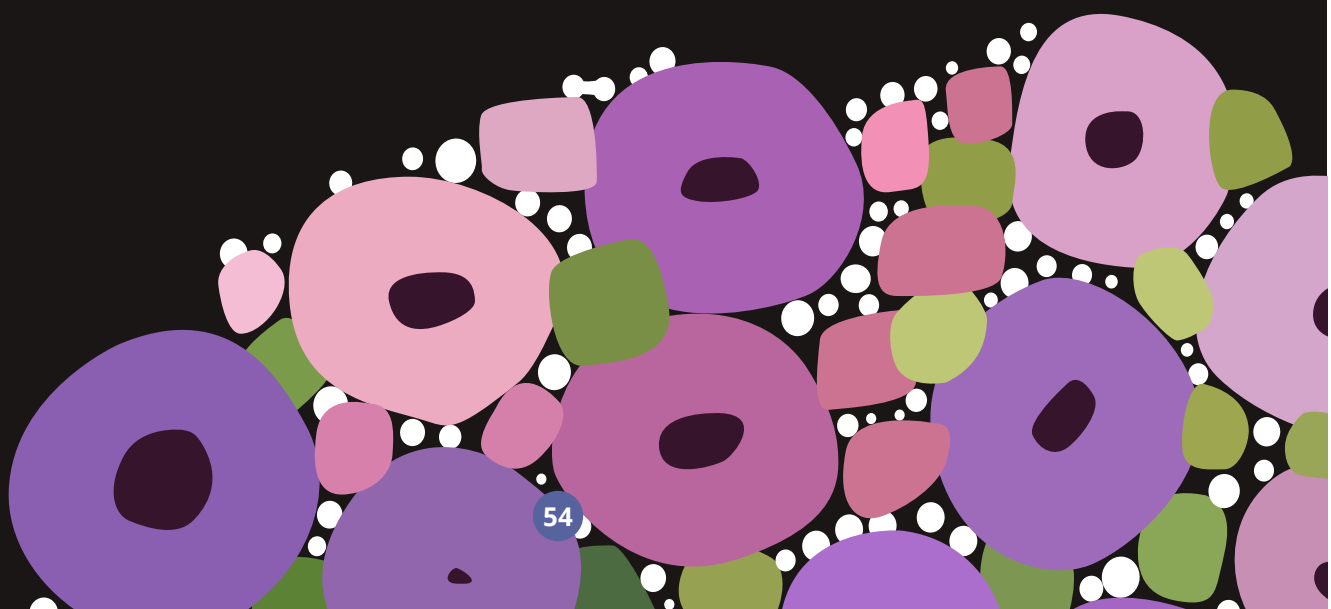

References

- Australia Institute of Health and Welfare 2016, 'Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011', AIHW cat AUS 199, accessed: <https://www.aihw.gov.au/reports/burden-of-disease/australian-bod-study-2011-indigenous-australians/contents/table-of-contents>.
- Australian Bureau of Statistic 2018, 'National Health Survey: First Results 2017-2018', ABS cat 4364.0.55.001.
- Australian Bureau of Statistic 2019, 'Australian Aboriginal and Torres Strait Islander Health Survey 2018-2019', ABS cat 4715.0.
- Australia Institute of Health and Welfare 2017, 'Australia's Welfare 2017', AIHW cat AUS 214.
- Australia Institute of Health and Welfare 2020, 'Mental Health Services in Australia', AIHW cat AUS 232, accessed: <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia>.
- Steering Committee for the Review of Government Service Provision 2017, 'Report on Government Services 2017', Productivity Commission.
- Victorian Department of Education and Training 2016, *Marrung: Aboriginal Education Plan (2016-2026)*, Victorian State Government, Melbourne.
- Victorian Department of Health and Human Services 2015, 'Victorian Emergency Minimum Dataset - Custom data request'.
- Victorian Department of Health and Human Services 2017, *Balit Murrup: DHHS supporting Aboriginal social and emotional wellbeing framework (2017-2027*), Victorian State Government, Melbourne.
- Victorian Department of Health and Human Services 2017, Korin Korin Balit-Djak: DHHS supporting Aboriginal health, wellbeing and safety strategic plan (2017-2027), Victorian State Government, Melbourne.
- Victorian Department of Health and Human Services 2017, *Supporting Self-determination: DHHS prioritisation of funding to Aboriginal organisations policy outlined under Korin Korin Balit-Djak (2017-2027)*, Victorian State Government, Melbourne.
- Victorian Department of Health and Human Services 2018, *Dhelk Dja Safe Our Way – Strong Culture, Strong Peoples, Strong Families: Family Safety Victoria supporting Aboriginal-led agreement to address family violence in Aboriginal communities,* Victorian State Government, Melbourne.
- Victorian Department of Health and Human Services 2018, *The Victorian Aboriginal Affairs framework: The Victorian Aboriginal Affairs framework (2018-2023)*, Victorian State Government, Melbourne.
- Victorian Department of Health and Human Services 2019, 'Victoria's Mental Health Services Annual Report 2018–19', accessed: <https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-annual-report>.
- Victorian Department of Health and Human Services 2018, *Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement*, Victorian State Government, Melbourne.
- Victorian Department of Premier and Cabinet 2013, *Victorian Aboriginal Economic Development Strategy (2013-2020)*, Victorian State Government, Melbourne.
- Victorian State Government 2018, *Burra Lotjpa Dunguludja: The Aboriginal Justice Agreement Phase 4,* Victorian State Government, Melbourne.

Notes

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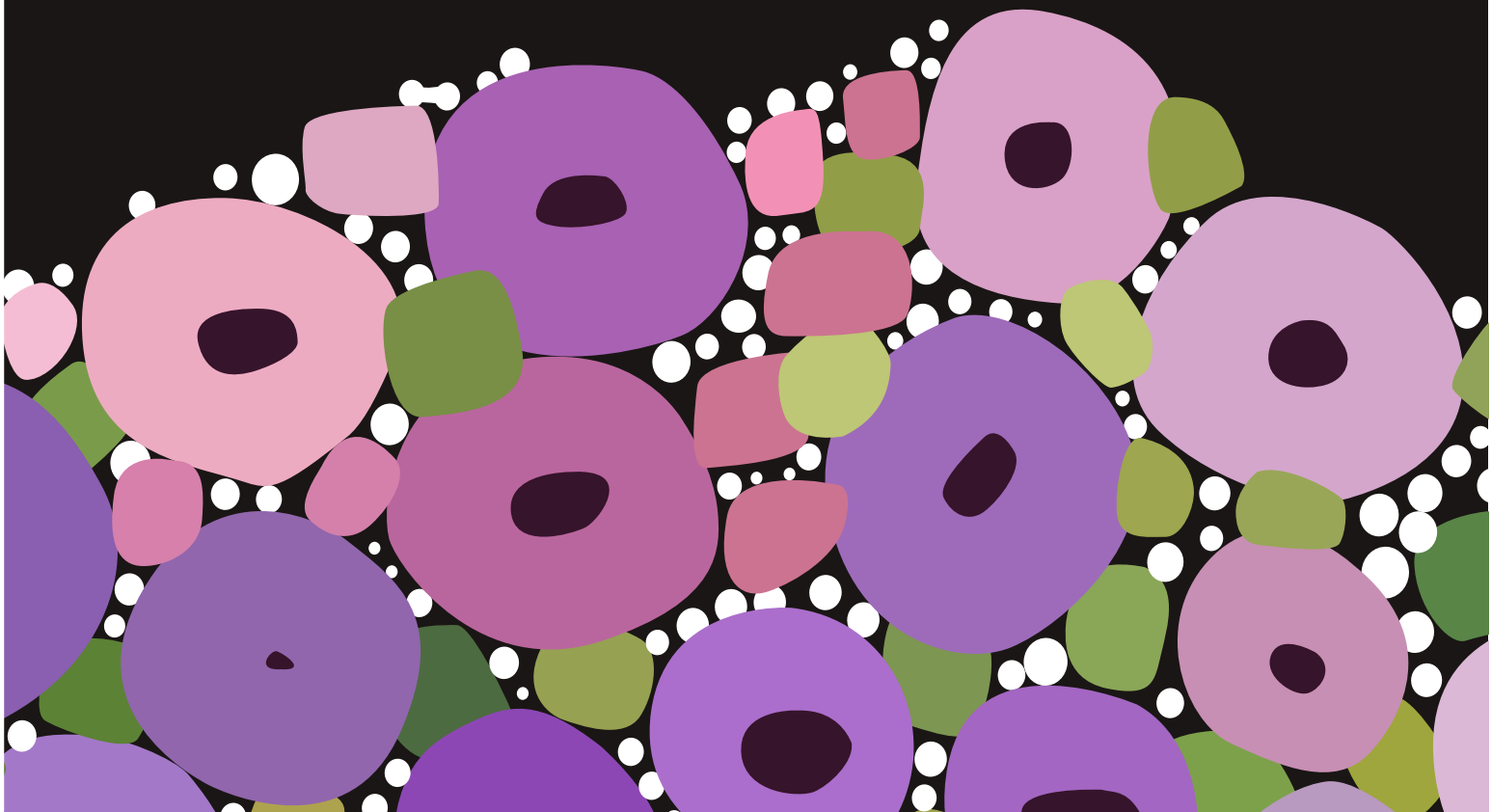

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Balit Murrup

Aboriginal social and emotional wellbeing framework 2017–2027

VICTORIA State Government | Health and Human Services

DOH.0003.0001.0065

Acknowledgement of Aboriginal Victoria

The Victorian Government proudly acknowledges Victoria's Aboriginal community and its rich culture and pays respect to its Elders past and present. We acknowledge Aboriginal people as Australia's First Peoples and the Traditional Owners and custodians of the land and water on which we live, work and play. We recognise and value the ongoing contribution of Aboriginal people and communities to Victorian life and how this enriches our society more broadly. We embrace the spirit of self-determination and reconciliation, working towards equality of outcomes and ensuring equitable voice.

Victorian Aboriginal communities and peoples are culturally diverse, with rich and varied heritages and histories pre- and post-invasion. The impacts of colonisation, while having devastating effects on traditional life of Aboriginal nations, have not diminished Aboriginal peoples' connection to country, culture and community. Aboriginal Nations continue to strengthen and grow with the resurgence of language, lore and cultural knowledge. These rich and varied histories need to be understood and acknowledged by all Victorians, to truly understand the resilience and strength of previous generations, as well as the history of the fight for survival, justice and country that has taken place across and around Australia.

As we work together to ensure Victorian Aboriginal communities continue to thrive, the Victorian Government acknowledges the invaluable contributions of generations of Aboriginal warriors that have come before us, who have fought tirelessly for the rights of their people and communities towards Aboriginal self-determination, and we are now honoured to be part of that vision.

To receive this publication in an accessible format email Aboriginal Health and Wellbeing <aboriginalhealthandwellbeing@dhhs.vic.gov.au>

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Except where otherwise indicated, the images in this publication show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. This publication may contain images of deceased Aboriginal and Torres Strait Islander peoples.

In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when it is part of the title of a report, program or quotation.

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Balit Murrup

***Balit Murrup* means 'Strong Spirit' in the Woi-wurrung language. This is spoken by members of four Koorie clans that lived in adjoining estates in the Port Phillip region.**

Permission to use *Balit Murrup* for this policy was provided by the Wurundjeri Tribe Land Council.

***Korin Korin Balit-Djak* Artwork**

Artist – Dixon Patten

The artwork for Balit Murrup uses a section of the artwork from Korin Korin Balit-Djak, the Aboriginal health, wellbeing and safety strategic plan (2017-2027). It has been adapted with the artists permission and depicts the Aboriginal community and our connection to culture and each other.

Within the detailed circles, Department of Health and Human Services and community work together to help with system reform across the health and human services sector with the ultimate goal of physical, social and emotional wellbeing for all Aboriginal people. The ripples represent the positive impact on community that this work will have and that Aboriginal culture and community is a priority.

The hands represent individuals, couples and families. The white circles represent various tribes/families/ regions. The various paths with the footprints depict our life journeys and transference of knowledge, history and culture.

Dixon Patten was commissioned by the Department of Health and Human Services to produce the artwork for *Korin Korin Balit-Djak*.

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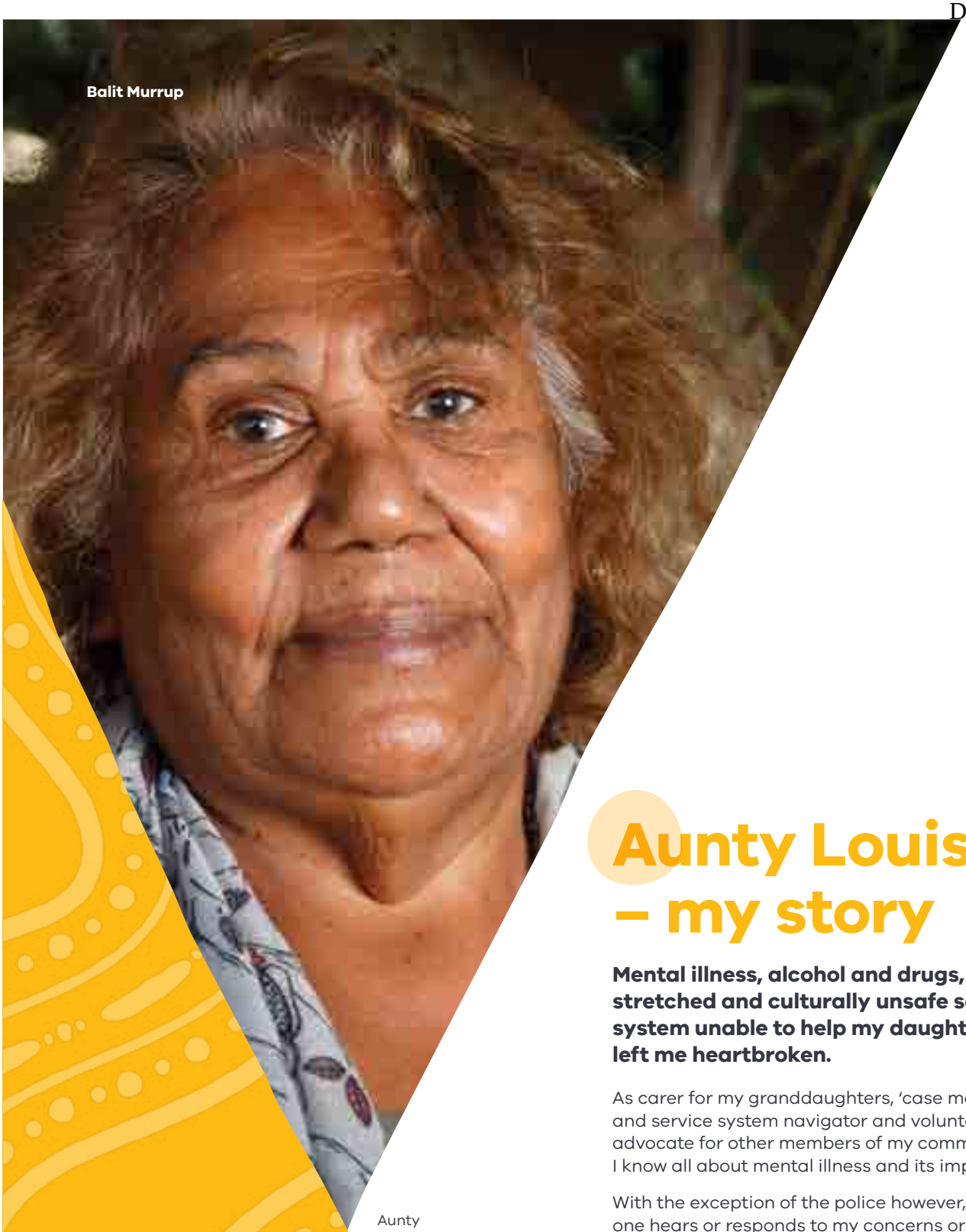

Aunty Louise

Aunty Louise – my story

Mental illness, alcohol and drugs, and a stretched and culturally unsafe service system unable to help my daughter have left me heartbroken.

As carer for my granddaughters, 'case manager' and service system navigator and volunteer advocate for other members of my community, I know all about mental illness and its impact.

With the exception of the police however, I feel no one hears or responds to my concerns or provides the appropriate assistance to my daughter – from urgent psychiatric responses, to ongoing therapy and support, including any form of daytime activities that might enable my daughter to recover and make meaning in her life ... and there is never any respite for me ... not ever.

Rarely do I see a black face or an Aboriginal service where past and present trauma, and the need to heal and connect with culture and community, is recognised. My daughter, family and community need an Aboriginal and mainstream mental health system that listens, engages and responds to our needs and works together with us to find what works best over the long term.

My beautiful daughter will never be the person she once was.

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Contents

Acknowledgement of Aboriginal Victoria	2
Balit Murrup	3
Aunty Louise – my story	4
Minister's foreword	6
The Aboriginal Social and Emotional Wellbeing Reference Group	7
The framework	8
Executive summary	10
New investments supporting Balit Murrup	13
Key facts about Aboriginal social and emotional wellbeing	16
The case for change	17
Policy and reform context	22
The social and emotional wellbeing model	24
Dimensions of social emotional wellbeing	26
Bringing the social and emotional wellbeing model to life	28
The importance of healing	31
Our Commitments to enable reform	34
Domain 1: Improving access to culturally responsive services	36
Domain 2: Supporting resilience, healing and trauma recovery	39
Domain 3: Building a strong, skilled and supported workforce	43
Domain 4: Integrated and seamless service delivery	46
Partners in change	48
Appendix 1: Key concepts	50
Appendix 2: Gayaa Dhuwi (Proud Spirit) Declaration	51
References	52

DOH.0003.0001.0069

Minister's foreword

Closing the gap in life expectancy between Aboriginal and non-Aboriginal Victorians is as much about improving the social and emotional wellbeing, resilience and mental health of Aboriginal people, families and communities as it is about addressing the physical health factors.

Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework is part of the Victorian Government's commitment to doing just that – providing a long-term vision to improve the social and emotional wellbeing and mental health outcomes for Aboriginal communities. It aligns with *Victoria's 10-year mental health plan* (2015), which aims to support all Victorians to achieve their best mental health; and *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017–2027*, which articulates a vision for self-determining Aboriginal communities supported by an integrated culturally responsive service system.

Balit Murrup has been developed with the shared knowledge and wisdom of leaders and experts in Aboriginal social and emotional wellbeing and mental illness, Aboriginal community-controlled organisations and other service providers.

I thank them for their invaluable contribution, leadership and guidance. I would like to thank in particular the Aboriginal Social and Emotional Wellbeing Reference Group, established in August 2016.

Although many Aboriginal people living in Victoria enjoy excellent social and emotional wellbeing, many do not. The impacts of colonisation, trans-generational trauma, racism, discrimination, marginalisation and disadvantage have resulted in poor mental health outcomes. Because of this, we need whole-of-system reform; informed by Aboriginal-led solutions based on the concept of social and emotional wellbeing.

The integration of healing, trauma-informed care and recovery-oriented approaches across the spectrum of prevention and intervention strategies is the cornerstone of *Balit Murrup* – along with the aim of intervening early before serious mental illness occurs. And, where Aboriginal Victorians experience ongoing and severe mental illness, we will build the capacity of the system to support recovery and prevent relapse. The First People of Australia deserve nothing less.

The Victorian Government is providing investment into a number of strategic priorities including the funding of three innovative demonstration projects – *Improving mental health treatment outcomes for Aboriginal and Torres Strait Islander people with moderate to severe mental illness* – that focus on reducing the impacts of unaddressed mental health conditions.

Further investment has been made in trials of suicide prevention initiatives to improve care following a suicide attempt and to help local communities prevent suicide, with Aboriginal people a priority target group. The Victorian Government is also expanding the number of Aboriginal mental health and drug and alcohol positions as a key investment in workforce and service system reform to support services to be more culturally responsive.

We will continue to work closely with Aboriginal organisations and communities to build on existing knowledge and best practice in order to implement a whole-of-government approach to Aboriginal social and emotional wellbeing that works.

Martin Foley MP
Minister for Mental Health

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The Aboriginal Social and Emotional Wellbeing Reference Group

***Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework* has been built through the leadership, experience, expertise and wisdom of the Aboriginal Social and Emotional Reference Group.**

The reference group is made up of Aboriginal people with support from non-Aboriginal representatives from across local and statewide Aboriginal community-controlled organisations, mental health services and government. They have supported, challenged and worked with the Victorian Government to shape a shared vision and approach for working together to improve the social and emotional wellbeing and mental health outcomes for Aboriginal people, families and communities across Victoria.

Improving the social and emotional wellbeing and mental health outcomes for Aboriginal people cannot be achieved by any one agency or sector, or by Aboriginal people alone. It will need to be shaped and led through Aboriginal self-determination with support from government and the mainstream service system, in particular mental health and other services. The leadership, co-design and collaborative process fostered through the Aboriginal Social and Emotional Wellbeing Reference Group in shaping *Balit Murrup* is an important first step in the journey. It establishes an important foundation for the critical partnership and collaboration required to achieve the vision and aspirations set out in *Balit Murrup*.

Reference group members 2016–2017

Belinda Stevens, Chairperson (Victorian Aboriginal Community Controlled Organisation), Annette Vickery (Victorian Aboriginal Legal Service), Daphne Yarram (Yoowinna Wurnalung Healing Service), Gary Hamen (Barwon Health), Gillie Freeman (Ngwala Drug and Alcohol Service), Indi Clarke (Koori Youth Council), Michael Bell (Winda Mara Aboriginal Corporation), Salina Bernard and Joanne Dwyer (Victorian Aboriginal Health Service), Sue Anne Hunter (Victorian Aboriginal Child Care Agency), Tania Dalton (Australian Indigenous Psychologists Association), Jamie Waring (Wadamba Wilam), Alasdair Vance (Royal Children's Hospital) and the late Michelle Hannon (Northern Hospital).

Department of Health and Human Service representatives: Helen Kennedy, Sally Rose, Michelle Smith, Christian Coulahan, Anne Frost, Robyn Humphries and Lorraine Langley.

We would like to acknowledge the inspiring contribution made by Michelle Hannon who worked every day with Aboriginal people at the Northern Area Mental Health Service to improve their social and emotional wellbeing and mental health. Michelle was passionate about the need for workforce expansion and a 'different way' to support healing and recovery. Michelle passed away suddenly in April 2017.

Belinda Stevens
Chairperson, Aboriginal Social Emotional Wellbeing Reference Group

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The framework

Vision: **Victorian Aboriginal people, families and communities achieve and sustain the highest attainable standards of social emotional wellbeing and mental health.**

Objective: **The health gap between Aboriginal Victorians and the general population attributable to suicide, mental illness and psychological distress is reduced.**

Strong communities, strong culture

Victoria's First Peoples draw on a shared culture that extends tens of thousands of years into the past, and continues to be practised now, despite disruptions since colonisation. The history of Aboriginal Victorians is also a history of resistance, reclamation of rights, and community and personal resilience. It is a history that seeks to re-establish self-determination in all aspects of community including the ways in which Aboriginal people and communities access and interact with government. Victoria's First Peoples also share a more recent history of colonisation, dispossession and cultural dislocation and separation from family and community through removal and denial of political power.

Principles

Self-determination and community control

Self-determination is recognised as essential to overcome the disadvantage that Aboriginal people experience. Government and services will support the leadership role of Aboriginal communities and organisations in the planning, delivery, evaluation and measurement of services delivered to Aboriginal people, including social and emotional wellbeing, mental health and healing and recovery services.

Embedding healing and protective factors

Connection to culture, family, community and country are built into all approaches across the promotion, early prevention, early intervention, treatment and recovery continuum.

Culturally capable services

Cultural perspectives are embedded into clinical and therapeutic practice and services respect the rights, views and expectations of individuals and families.

Person-centred care

Mental health and alcohol and other drug services for Aboriginal Victorians are designed around the needs and expectations of individuals, families and communities rather than service providers.

Community engagement

Aboriginal communities self-determine and participate in the co-design and delivery of social and emotional wellbeing and mental health services and programs.

Partnerships

Integrated partnerships between all health service providers and Aboriginal communities will provide the best opportunity to improve mental health outcomes and optimise social and emotional wellbeing and will foster trust, connectivity, and appropriate care.

Supporting and investing in evidence-based interventions and service models that achieve sustainable health outcomes and contribute to closing the health gap.

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Healing

Healing is one of the most common ways of understanding Aboriginal peoples' experience of recovery from trauma and other mental health and social and emotional wellbeing difficulties, including unresolved grief and loss.

Social and emotional wellbeing

- Connection to spirit, spirituality and ancestors
- Connection to land
- Connection to culture
- Connection to community
- Connection to family and kinship
- Connection to mind and emotions
- Connection to body.

Holistic health

The concept of Aboriginal health and wellbeing is different to the universal concept as it is regarded and recognised as a more holistic and whole-of-life view. It encompasses the social, emotional and cultural wellbeing of not only the individual, but the wider community thereby bringing about the total wellbeing of community.' ACCO submission *Korin Korin Balit-Djak*.

Domains

Improving access to culturally responsive services

Strengthening access to culturally responsive social and emotional wellbeing and mental health services

More Aboriginal people accessing culturally appropriate treatment and care

Supporting resilience, healing and trauma recovery

Aboriginal-led health promotion and prevention initiatives

Recognition of the integral importance of traditional and contemporary healing approaches

Promotion of trauma-informed services models and clinical practice

Building a strong, skilled and supported workforce

New Aboriginal social and emotional wellbeing and mental health workforce training program

Expansion of Aboriginal social and emotional wellbeing, mental health and alcohol and drug workforce in Aboriginal and mainstream services

Supporting new multi-disciplinary social and emotional wellbeing teams

Integrated and seamless service delivery

Exploration of new services models and integrated continuity of care

Promotion of partnerships for prevention and recovery

Executive summary

Many Victorian Aboriginal people and communities are thriving and enjoy excellent social and emotional wellbeing and mental health. Through connections to culture, community, country and family they are resilient and able to deal successfully with life's difficulties and challenges. But too many are not.

The impacts of colonisation, trans-generational trauma, racism, discrimination, marginalisation and disadvantage have resulted in poor mental health outcomes.

Aboriginal people and communities are more likely than the general population to face risk factors for poor mental health and barriers to emotional and social wellbeing. This includes mental illness; drug and alcohol abuse; family violence; self-harm and suicide; all of which are experienced by Aboriginal Victorians at significantly higher rates than non-Aboriginal Victorians. For Aboriginal Victorians with a disability – physical, intellectual or cognitive – the challenges to social and emotional wellbeing can be multiplied.

By improving the social and emotional wellbeing and mental health of Aboriginal people, families and communities, we can make a significant contribution to reducing the incidence, severity and duration of mental illness and suicide.

The development of *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework* is a key commitment under *Victoria's 10-year mental health plan*. It is also a companion document to *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan* 2017–2027. *Korin Korin Balit-Djak* provides an overarching framework for action to improve the health, wellbeing and safety of Aboriginal Victorians by providing high-level strategic actions to reform the health and human services sector in order to advance Aboriginal self-determination in health, wellbeing and safety.

Balit Murrup is underpinned by a comprehensive analysis of the case for change.

What is social and emotional wellbeing?

The Aboriginal concept of social and emotional wellbeing is an inclusive term that enables concepts of mental health to be recognised as part of a holistic and interconnected Aboriginal view of health which embraces social, emotional, physical, cultural and spiritual dimensions of wellbeing.

While acknowledging mental health as a critical area of wellbeing, social and emotional wellbeing emphasises the importance of individual, family and community strengths and resilience, feelings of cultural safety and connection to culture, and the importance of realising aspirations, and experiencing satisfaction and purpose in life. Importantly, social and emotional wellbeing is a source of resilience which can help protect against the worst impacts of stressful life events for Aboriginal people and provide a buffer to mitigate risks of poor mental health.

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In *Balit Murrup*, mental health and related services for Aboriginal people need to be designed and delivered incorporating Aboriginal concepts of social and emotional wellbeing, and supported by Aboriginal leadership.

The strategic directions of *Balit Murrup* have been informed and underpinned by a consultation process. Aboriginal people have emphasised that improving resilience, wellbeing and mental health requires:

- Action across the health promotion, early intervention, treatment and recovery continuum.
- Aboriginal experiences of trauma and concepts of social and emotional wellbeing, healing and resilience to inform all service models.
- Improved access to timely, integrated, local and culturally responsive mental health and alcohol and drug services with a skilled and expanded Aboriginal workforce across mainstream and Aboriginal community-controlled organisations (ACCOs).
- Concentrated effort on improving mental health outcomes for individuals, families and population groups who may be at risk and vulnerable.
- Improved treatment and recovery responses for Aboriginal people and their families living with acute, episodic and chronic mental illness.
- Recognition and investment in best practice approaches and research, including the sharing and expansion of programs delivering effective outcomes.
- An increased focus on suicide prevention.
- All Aboriginal community-controlled organisations to inform or deliver mental health services and social and emotional wellbeing solutions and initiatives.

The key focus of *Balit Murrup* is to improve the social and emotional wellbeing and mental health of Aboriginal people, families and communities. This includes carers. *Balit Murrup* commits to action on delivering locally-designed community responses that underpin and inform the building of a more culturally responsive service system with an expanded skilled Aboriginal workforce.

Key aims of *Balit Murrup* include:

- Building the resilience, engagement, skills and self-determination of Aboriginal people.
- Enabling Aboriginal people to be heard, to make decisions, and to plan and shape their own journeys of care, recovery and healing.
- Supporting the planning and delivery of culturally appropriate care for the clinical, cultural and social and emotional wellbeing needs of Aboriginal people across all service systems.
- Supporting and investing in local Aboriginal community-led initiatives and strategies.

Balit Murrup identifies four key domain areas as set out on the following page . Each domain has a number of strategic priorities which are underpinned by a set of immediate actions and longer-term deliverables. Taken together, they are the building blocks for improving the social and emotional wellbeing of Aboriginal Victorians.

Key domains

Improving access to culturally responsive services

We will work with health services to build their capacity to provide culturally safe and appropriate mental health care and treatment free of racism for Aboriginal people of all ages. We will work to ensure that more Aboriginal people with a mental illness who need support are engaged in appropriate treatment and care and that Aboriginal people, families and communities are engaged in service design and review.

Supporting resilience, healing and trauma recovery

Aboriginal people will lead and co-design health promotion and prevention focused on building resilience and wellbeing. This includes:

- safe and secure housing
- individual and community safety
- family and community connections
- connecting with country
- access to information, services and resources.

We will develop mental health literacy, acknowledge past, current and intergenerational trauma, enable opportunities for people to heal and recover, and adopt approaches that include whole-of-person and whole-of-community strategies. This includes traditional and contemporary Aboriginal healing approaches as well as the importance of trauma-informed, family-centred therapeutic practices that build on protective factors and supports recovery, resilience and healing.

Building a strong, skilled and supported workforce

We will grow and sustain Aboriginal mental health and social and emotional wellbeing workforces across Aboriginal community-controlled organisations and mainstream mental health services. Planning and supporting the development of this workforce will respond to the growing Aboriginal population and impacts of trauma within the Aboriginal community. Multidisciplinary mental health and social and emotional wellbeing teams will be supported across Victoria.

Integrated and seamless service delivery

We will explore new service models with Aboriginal communities and mental health consumers that facilitate access, focuses on outcomes and provides clear pathways and transition support to ensure continuity and service integration. We will work collaboratively across governments to support the development of joined-up approaches to social and emotional wellbeing support, mental health, suicide prevention, and alcohol and drug services. This will be underpinned by recognising the importance of holistic and integrated services to Aboriginal people. Particular emphasis will be placed on building partnerships between mainstream clinical mental health services, Aboriginal community controlled health organisations and other primary and community health providers to support the continuity of care for Aboriginal people entering and leaving hospital.

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New investments supporting Balit Murrup

New investments have been made to ensure that the strategic priorities linked with each of the four *Balit Murrup* domains are translated into initiatives that will make a tangible difference to the social and emotional wellbeing outcomes of Aboriginal people.

Improving Mental Health Treatment Outcomes for Aboriginal and Torres Strait Islander People with Moderate to Severe Mental Illness demonstrations sites

Funding of $7.7 million has been allocated across three demonstration projects to test new service models for Aboriginal Victorians with moderate to severe mental illness, trauma and other complex health and social support needs who often fall through the gap between primary and tertiary mental health services. Each site will provide culturally responsive mental health care, treatment, counselling and care coordination. Evidence emerging on successful practices will be used to inform the development of future Aboriginal social and emotional wellbeing and mental health models and resources.

Expanded workforce – Aboriginal social and emotional wellbeing, mental health and alcohol and drug treatment

The Victorian Budget 2017–18 provided an additional $22 million as initial investment in an expanded Aboriginal mental health and drug and alcohol workforce:

- Ten Aboriginal-specific clinical and therapeutic positions will be established in ACCOs to ensure that ACCOs can respond to increased demand for social and emotional wellbeing and mental health services.
- An Aboriginal Mental Health Workforce Training Program will be established to address entry barriers. This program will help build a workforce that can respond to the needs of Aboriginal Victorians. Fifteen initial trainee positions will be created with pathways into a bachelor degree.
- An additional 24 Aboriginal drug and alcohol positions will provide specialist counselling and treatment for Aboriginal Victorians facing alcohol and other drug addiction.

Victorian suicide prevention

The Victorian Budget 2016–17 provided $27 million over four years to deliver the *Victorian suicide prevention framework*. A key initiative is underway, in partnership with Primary Health Networks, to support twelve local communities to develop proactive suicide prevention strategies through place-based pilots. An important focus of this work is seeking Aboriginal input into culturally appropriate and safe suicide prevention approaches for Aboriginal communities.

Aboriginal youth mentoring

The government will provide $1.8 million to extend the Aboriginal youth mentoring program, delivered by Aboriginal community controlled organisations. This program will be continued to ensure that young Aboriginal people are connected to protective factors including culture, family and social support systems.

Self-determination and treaty

The Victorian Budget 2017–18 includes $68 million to support self-determination and to create a better relationship between government and Aboriginal Victorians so that both can deliver better outcomes, empower communities and develop a strong culture. This allocation will fund treaty negotiations and make sure that Aboriginal communities remain at the heart of these discussions. It will also be used to create an Aboriginal Community Infrastructure Fund for significant innovative community infrastructure projects.

Initiatives to support Marrung: *Aboriginal education plan 2016–26* – establishing the foundations for better outcomes

The Victorian Government will provide funding to support the delivery of Marrung: Aboriginal education plan 2016– 2026.

Initiatives include:

- Koorie Families as First Educators
- Koorie Supported Playgroups to provide high-quality and culturally-responsive parenting support
- the piloting of an accredited Aboriginal languages program for Aboriginal community members to support the delivery of language programs in schools and kindergartens.

These initiatives are in addition to the 2016–17 Marrung investment which includes:

- Children's Koori Court Liaison Officers: to support young Aboriginal people appearing before the Children's Koori Court and the Children's Court in selected regional locations to re-engage or remain engaged in education
- delivery of cultural understanding and safety training to all government schools
- expanding the Koorie Academy of Excellence from one to four locations: this will build secondary students' aspirations to complete year 12 and pursue further pathways through a focus on culture, leadership and academia.

Growing strong in culture, Victorian Aboriginal Child Care Agency

DOH.0003.0001.0078

More support for Aboriginal prisoners – strengthening cultural connections and reducing recidivism

The Victorian Budget 2016–17 has committed $2.5 million to support the development of culturally appropriate Aboriginal rehabilitation programs that have a focus on cultural strengthening, healing, family violence, parenting and women's programs.

An additional $710,000 has also been allocated to support a 'Continuity of Aboriginal Health Care' pilot, led by Justice Health to ensure post-release access to healthcare services in the community, including mental health. The Continuity of Aboriginal Health Care pilot will be delivered by three Aboriginal community controlled organisations.

More support for Koori kids and families

The government is committed to implementing recommendations aimed at improving the cultural connections of Koori children and young people who are unable to live with their families – and providing better help for families earlier.

This commitment is a response to a landmark report examining the circumstances of 1,000 Aboriginal children and young people in out-of-home care. A key government response is to implement Section 18 of the *Children, Youth and Families Act 2005* which provides for Aboriginal organisations to assume responsibility for Aboriginal children on child protection orders.

This support includes a focus on promoting healing and culturally responsive counselling and wrap-around services for the growing number of children, their families and carers who have been victims of trauma, family violence and sexual abuse.

Better support for youth justice and forensic mental health

The Victorian Government has committed $83 million to implement priority initiatives as part of the *Forensic mental health implementation plan,* under *Victoria's 10-year mental health plan. The Forensic mental health implementation plan* is a framework to reform Victoria's forensic mental health system over the next ten years and delivers on the commitment to address the over-representation of people with a mental illness in Victoria's criminal justice system, including Aboriginal and Torres Strait Islander people.

The *Forensic mental health implementation plan* will expand mental health support for those who are in (or at risk of entering) the criminal justice system with a focus on preventing offending in the first place. The funding will mean more forensic mental health beds, more specialist treatment and create a range of community, prison and court programs.

Six new forensic mental health programs will be supported to provide culturally safe partnerships between the programs and Aboriginal community-controlled organisations for those on community corrections orders with a mental health illness.

Supporting Healing Models and Therapeutic Responses

- The Victorian Government has allocated $22.87 million to work in partnership with Aboriginal communities to develop and provide holistic and healing therapeutic responses for survivors of family violence including child survivors.
- A further $17 million has been allocated for specialist family violence advisors in major mental health and alcohol and other drug services to identify and respond to alcohol, drug and mental health issues.

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Key facts about Aboriginal social and emotional wellbeing

32%

One in three Aboriginal people experience high or very high levels of **PSYCHOLOGICAL DISTRESS**. That is nearly three times the non-Aboriginal rate. (AATSIHS 2012-13)

55%

The number of **ABORIGINAL MENTAL HEALTH-RELATED PRESENTATIONS** to Victorian Hospital Emergency departments had increased by 55 per cent between 2012-13 and 2015-16 (VEMD)

34.8%

34.8 per cent of Aboriginal Victorians experience medically-diagnosed **DEPRESSION AND ANXIETY** compared with 19.6 per cent of non-Aboriginal Victorians. (VPHS 2008)

47.1%

Over 47 per cent of Aboriginal people **HAVE A RELATIVE WHO WAS FORCIBLY REMOVED** from their family due to **STOLEN GENERATIONS POLICIES** in Victoria. Transgenerational trauma continues to affect Aboriginal people in Victoria. (DHHS 2015)

22%

MENTAL HEALTH AND RELATED CONDITIONS have been estimated to account for as much as 22 per cent of the **HEALTH GAP** (12 per cent mental health conditions, 6 per cent alcohol and substance abuse and 4 per cent suicide). Mental health problems, self-harm and suicide have been reported at double the rate of non-Aboriginal people for at least a decade. (Burden of Disease 2003 p.2)

As a result of the level of social and emotional wellbeing and mental health problems in Victorian Aboriginal communities; the following impacts are apparent:

12x more likely

In Victoria, the average placement rate into **OUT-OF-HOME CARE** for Aboriginal children in care is 87.4 per thousand, which greatly exceeds the placement rate of six per thousand for non-Aboriginal children. (ROGS 2017)

60%

Family violence, parental mental illness and alcohol and drug issues are the most significant contributing factors in the placement of Aboriginal children in out-of-home care. **MENTAL HEALTH WAS A DRIVER INTO CARE** in more than 60 per cent of cases, and was also the reason many children could not be returned (Commission for Children and Young People 2016)

DOH.0003.0001.0080

The case for change

Despite having greater need, Aboriginal people experience barriers in accessing mental health services and professionals. Aboriginal people have historically not accessed mainstream mental health services at levels appropriate to their needs. Contact is mostly limited to acute episodes of illness, and often following presentation at an Aboriginal community controlled health organisation.

In 2012–2013, the most common Closing the Gap service deficits reported by Aboriginal community controlled health organisations were around mental health and social and emotional wellbeing services.

Aboriginal people with high or very high levels of psychological distress have poorer general health outcomes and are more likely to:

- self-report poor or fair health
- smoke
- drink at chronic or risky levels
- use illicit substances
- be a victim of violence.

This is compounded by experiences of racism across health and human service settings and the broader community. Racism continues to have a significant impact on Aboriginal peoples' decisions about when and why they seek health services, their acceptance of and adherence to treatment (DOH 2015). Stigma and discrimination are strongly correlated with poorer health and wellbeing outcomes (ABS 2016; Ferdinand, Paradies & Kelaher 2012).

Suicide

Suicides were the fifth leading cause of death among Indigenous Australians in 2014, approximately twice as high as the non-Indigenous rate. The most vulnerable age group of Indigenous Australians is 15–24 years where suicide is over five times more prevalent than in non-Indigenous Australians of the same age (Dudgeon, et al. 2016).

With suicide rates among Aboriginal people rising, Victorian Aboriginal families and community members are experiencing greater distress and profound grief. Aboriginal young people, lesbian, gay, bisexual, trans and gender diverse and intersex (LGBTI) people are particularly at risk of suicide and self-harm, as are prisoners immediately following release.

Aboriginal children and young people

Childhood experiences of social and emotional wellbeing issues are also more extreme for Aboriginal children than non-Aboriginal children:

- The average placement rate into out-of-home care for Aboriginal children in Victoria is 87.4 per thousand children, far greater than the 6.1 per thousand children in non-Aboriginal family situations.
- Family violence, parental mental illness and alcohol and other drug issues are the most significant factors leading to the placement of Aboriginal children in out-of-home care with two-thirds (60 per cent) of children unable return to their families.
- There is continued overrepresentation of Victorian Aboriginal young people subject to youth justice supervision and detention, with Aboriginal young people more likely to offend earlier (age 14 for Aboriginal people compared with age 19 for non-Aboriginal people).

High levels of trauma

Research conducted by the Victorian Aboriginal Health Service investigated the extent of trauma exposure among Aboriginal clients attending family counselling services. The number of traumatic events clients reported experiencing in a lifetime was very high, with levels of trauma exposure comparable to that of refugee populations who had experienced large-scale collective trauma (Mollica, et al. 2014; Sabin, et al. 2002). Of further concern, 91 per cent of the clients interviewed reported having experienced family violence, with 40 per cent reporting trauma symptoms consistent with post-traumatic stress disorder (Gee 2016).

The current service system is unable to meet the needs of Aboriginal Victorians

About half of the Aboriginal population in Australia uses mainstream services because an Aboriginal service they need is not available or accessible, or they prefer mainstream services. Although culturally safe mainstream services are important, we know from community feedback that many people would use Aboriginal services if a more extensive suite of services were available, including counsellors and clinicians.

Overall, the mental health and primary health service systems have been largely ineffective in responding to the high rates of psychological distress experienced within Aboriginal communities. Much of the service system has been unable to embrace Aboriginal concepts of health and wellbeing and has failed to understand the historical context and pervasiveness of racial oppression and social disadvantage. This can contribute to poorer outcomes for clients and increasing client dissatisfaction and distrust, which then discourages future access and perpetuates the cycle.

Although Aboriginal people experience greater levels of psycho-social problems compared with the general population, they are under-represented in the service system because of:

- historical fear and distrust of mainstream and government services due to past policies and practices of removing children, discrimination, racism and negative staff attitudes
- relatively few Aboriginal people working in the mental health system resulting in Aboriginal people being less likely to access health services or 'return' for follow-up treatment
- inflexible models of service delivery, including the use of inappropriate assessment and diagnostic tools
- lack of service coordination and integration between primary mental health and specialist clinical services (NMHC 2014)
- poor investment in Aboriginal mental health and Aboriginal-led mainstream models
- the relative poverty of Aboriginal people affecting their capacity to access services
- limited 'mental health literacy' and awareness identifying and responding to social and emotional wellbeing problems in Aboriginal communities (NSW Government 2007).

These barriers result in infrequent contact with primary health and early intervention services, leading to increased engagement with more complex tertiary services. If not treated early, acute, episodic and chronic mental illness can lead to major disruption for individuals and their families across all areas of their lives.

Improving access to mental health services and treatment outcomes for clients requires addressing:

- the barriers of entry to mainstream services
- ensuring Aboriginal community controlled health organisations are appropriately resourced and trained to respond to increased demand to provide primary mental health care.

Building resilience, Victorian Aboriginal Child Care Agency

Priority groups

Children and young people

While many Aboriginal children and young people live in loving connected families, others do not. Too many Aboriginal children experience stressful, traumatic life events. Social and economic disadvantage (often intergenerational) places Aboriginal children at greater risk of behavioural and environmental harm including exposure to racism, family violence, or poor-quality parenting. The impact of this is an often undetected, underestimated and misunderstood determinant of mental health.

Because of under-recognition of mental health impacts, only one in four Aboriginal children experiencing traumatic life events are accessing appropriate services – compounding displacement and trauma impacts (Sawyer et al. 2000).

Culturally safe, Aboriginal-led, social and emotional wellbeing approaches and programs targeted across education, health, housing, child welfare and the youth justice system are necessary to prevent the escalation of social and emotional wellbeing and mental health issues immediately and in later years.

Young people in the justice system

A snapshot of the characteristics of young offenders in custody, inclusive of Aboriginal young people, showed 33 per cent presented with mental health issues, and 23 percent had a history of self-harm or suicidal ideation. Further to this, 22 per cent were registered with Disability Services; 19 per cent had a current child protection order, with 62 per cent being victims of abuse, trauma or neglect; and 60 per cent of young people presenting with a history of alcohol and drug misuse. According to the Victorian Youth Parole Board, 'effective treatment of mental health concerns is crucial to improve recovery, health and social outcomes, and reduce the likelihood of further offending'. (DHHS *Youth Parole Board Annual Report 2014*).

Our experience has shown us that identity, culture and being connected to community and culture are powerful underpinnings of resilience for children in their development, especially those who have experienced trauma in their lives.

(Victorian Aboriginal Child Care Agency, Healing Centre Report)

DOH.0003.0001.0083

Elders and older people

Many older people, community Elders and members of the Stolen Generations are burdened with grief, loss and trauma. Removal of children, the erosion of family and community structures, high rates of incarceration and frequent deaths affect all members of extended kinship structures. Older Aboriginal people are often also carers for their extended families, particularly grandchildren where parents are unable to care for their children. Mental health services need to recognise the diversity of roles and burdens on Elders as well as the importance of engaging with Elders to inform and co-design effective mental health responses for their families and communities.

The Stolen Generations

Many Aboriginal children were forcibly removed from their families as a result of various government policies between 1910–1970. The generations of children removed under these policies became known as the Stolen Generations. These policies of child removal have left a legacy of trauma and loss that continues to affect Aboriginal communities, families and individuals. Many of the stolen generations were psychologically, physically and sexually abused while in care or with their adoptive families. This trauma impacts their lives directly as well as those of their children, grandchildren, great-grandchildren and beyond.

Aboriginal prisoners

Increased rates of incarceration, harsh prison environments, marginalisation, poor health outcomes and lost employment opportunities have profound negative impacts for individuals, families and communities. A study into Victorian Aboriginal prisoner mental health and cognitive function found that across their lives Aboriginal prisoners, particularly female prisoners, are exposed to high rates of social adversity, trauma and health problems. The study found that 72 per cent of men and 92 per cent of women had received a lifetime diagnosis of mental illness, compared with a lifetime prevalence of 45 per cent in the general population (Ogloff, Patterson, Cutajar, Adams, Thomas and Halacas, 2013). For both males and females, the most prevalent illnesses included major depressive episodes and post-traumatic stress disorder.

Lesbian, gay, bisexual, transgender and intersex community (LGBTI)

Aboriginal LGBTI Victorians are more likely to experience poorer physical and mental health outcomes due to the compounding effects of marginalisation and discrimination. Better understanding the experience of Aboriginal people who belong to LGBTI communities is critical to reducing the impacts of depression, alcohol and drug use, self-harm and suicidal behaviour. Discrimination on the basis of sexual orientation or gender identity and reduced access to culturally responsive healthcare can affect these poorer health and wellbeing outcomes.

Aboriginal people misusing alcohol and other drugs

Alcohol use alone causes eight per cent of the preventable burden of disease for Aboriginal people. This high need is reflected in the over-representation of Aboriginal people as clients in Victoria's alcohol and other drug treatment system, and in further unmet need highlighted by the Aboriginal community. In 2015–16, seven per cent (or 2,056 clients) of alcohol and drug service clients were Aboriginal. This rose to nine percent (699 clients) of clients aged 25 years or under and 10 per cent (590 clients) of forensic clients, who access treatment as a result of contact with the criminal justice system.

Sistagirl Brotherboy

Long-term unemployed

Aboriginal people have an unemployment rate three times higher than non-Aboriginal people. The resulting low socioeconomic status is associated with poor health and increased exposure to health risk factors (ABS 2009). Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control create social and emotional wellbeing risks that can lead to poor mental health and premature death (Wilkinson & Marmot 2003).

People who have experienced family violence

Family violence can be both a cause and outcome of mental illness. Aboriginal women are 25 times more likely to be killed or injured than non-Aboriginal women as a result of family violence. Eighty-eight per cent of children in out-of-home care have experienced family violence.

For many victim-survivors speaking through the Victorian Royal Commission into Family Violence 'navigating ... confusing systems' was a major barrier. New Support and Safety Hubs with skilled case managers and service navigators will '*support women and children from crisis through to recovery working in collaboration across Aboriginal, primary and mental services*'. (State Government of Victoria 2016)

People who experienced childhood sexual assault

Psychological and emotional trauma as an impact of early childhood sexual assault is experienced by many Aboriginal people. Sexual assault is often the reason for the removal and placement of Aboriginal children in out-of-home care. The intergenerational impacts of sexual assault in institutions or foster family placements for the Stolen Generation are documented in the *Bringing them home report* (HREOC 1997) and the Royal Commission into Institutional Responses to Sexual Abuse (Australian Government 2017).

People who are homeless or living in insecure housing

Aboriginal people experience homelessness at four times the rate of non-Aboriginal Australians (AIHW 2011). Homelessness and housing instability are outcomes and causes of poor mental health.

Coordinating culturally safe responses across housing, homelessness and mental health sectors is critical. The Victorian Government recognises the successful outcomes being achieved by Wadamba Wilam in inner city Melbourne, which provides a model of care that is culturally responsive, with integrated support for Aboriginal people who are homeless and have poor mental health.

Their forced removal led to psychological and emotional damage which has been inherited by today's Aboriginal and Torres Strait Islander children.

Justice McClellan 2016

Joe's story – Thomas Embling

Joe* is a proud Yorta Yorta man who identifies strongly with his culture, mob, and family.

Joe is on a community treatment order. At his first meeting with his case manager Will, he appeared disinterested and disengaged. Will wondered if Joe might be feeling uncomfortable and shamed. He invited Joe to walk to the hospital courtyard and yarn under a spreading gumtree. Joe began to engage. Will asked Joe about his culture, family and community, sharing some of his own story.

At their second meeting, Joe began talking about his mental health issues and profound fears of talking with 'mainstream' health providers because of their past lack of understanding of him and his culture. As a result, Joe's cultural needs were recognised in his planning and clinical setting – also linking him to Aboriginal-specific supports and services. With his cultural connection and identity recognised and respected, Joe was able to positively engage with treatment and support.

*not his real name

DOH.0003.0001.0085

Policy and reform context

***Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework* is one of the first three priorities in *Victoria's 10-year mental health plan*, which outlines a long-term vision to improve mental health services and outcomes for Victorians with a mental illness. *Victoria's 10-year mental health plan* is also supported by the Victorian suicide prevention framework 2016–25, the Mental Health Workforce Strategy and new initiatives to strengthen and expand clinical mental health services and undertake reforms under the Forensic mental health implementation plan. Importantly, it is a companion document to *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan*. Key plans and frameworks that support this framework are provided below.**

Victorian Government

Victorian Aboriginal affairs framework 2013–2018 – the Victorian Government's overarching framework that defines the narrative for a long-term approach to Aboriginal affairs. The Victorian Aboriginal Affairs Framework commits to improving outcomes for Victorian Aboriginal people though focused and integrated strategic action areas, headline indicators and targets which are measured on an ongoing basis through the annual Victorian Aboriginal affairs report.

Ending family violence: Victoria's plan for change – the Indigenous Family Violence Partnership Forum is working with the Victorian Government to strengthen family violence reforms in an Aboriginal context. This includes the development of a complementary Aboriginal 10-year plan. This work is framed by the Victorian Government's response to the Royal Commission into Family Violence.

Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan - provides an overarching framework for action to advance Aboriginal self-determination and improve the health, wellbeing and safety of Aboriginal Victorians now and over the next 10 years. Coordinating efforts across the department, the plan sets strategic directions for reform across the health and human services system to achieve the vision of 'self-determining, healthy and safe Aboriginal people and communities'.

Aboriginal governance and accountability framework – will strengthen the department's accountability to community through planning, policy development, service implementation and decision-making in consultation with the Aboriginal community and Aboriginal community-controlled organisations.

Roadmap for Reform: Strong families, safe children – focuses on prevention, early intervention, and creating services that are coordinated and work together to meet the needs of vulnerable families and children.

Another corresponding critical document under development is the ***Aboriginal children and families agreement and strategic action plan*** – designed to improve outcomes for Aboriginal children and families in Victoria. *Balit Murrup* is also informed by ***Always was, always will be Koori children: Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria*** (2016).

Victorian public health and wellbeing plan 2015–2019 – outlines the government's key priorities to improve the health and wellbeing of Victorians, with a particular focus on addressing inequities in health outcomes. The release of the Victorian public health and wellbeing outcomes framework provides a new approach to monitoring and reporting on our collective efforts to improve health and wellbeing over the long term.

Absolutely everyone: State disability plan 2017–2020 – is the way the government is taking a lead on promoting the inclusion of Victorians with a disability.

DOH.0003.0001.0086

Marrung: Aboriginal education plan 2016–2026 – sets out a 10-year vision for delivering on the 'Education State' to Aboriginal Victorians. It is underpinned by the principle of self-determination and delivers on Victoria's commitment to ensuring Aboriginal people, at every stage of their learning and development journey, achieve their potential, succeed in life, and feel strong in their cultural identity.

Aboriginal Justice Agreement – a formal agreement between the Victorian Government and the Koori community to work together to improve Koori justice outcomes. It is currently in its third phase, which will be implemented from 2013–2018.

Aboriginal Social and Emotional Wellbeing Plan (Justice Health and Corrections Victoria 2015) – focuses on improving the mental health and wellbeing of Aboriginal people while incarcerated and upon their release. The plan aims to prevent, stabilise and effectively manage mental illness while in prison, as well as improve the transition processes to ensure improvements are maintained upon release.

Local government

Victorian Aboriginal local government action plan – emphasises the central role that local government has as planner and service provider in closing the gap in disadvantage experienced by Aboriginal people within their local communities.

National

National framework on recovery-oriented mental health services **(2013)** – provides a national understanding and consistent approach to support recovery-oriented mental health practices and service delivery that is 'responsive to Aboriginal and Torres Strait Islander people, families and communities'.

Recognising that consumers' self-determination is a vital part of successful treatment and recovery, the principles of recovery emphasise choice and self-determination within clinical requirements and duty of care.

Australia's Fifth National Mental Health Plan **(draft)** – Priority Area 4: Aboriginal and Torres Strait Islander mental health and suicide prevention emphasises the importance of culturally responsive care through integrating social and emotional wellbeing services within a range of mental health, drug and alcohol, and suicide prevention services.

National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023 **(draft)** – will guide and inform Aboriginal and Torres Strait Islander mental health and wellbeing reforms.

Closing the Gap – In February 2011, the Council of Australian Governments agreed that Aboriginal reform and 'Closing the Gap' was one of five national priorities for governments.

DOH.0003.0001.0087

The social and emotional wellbeing model

The Aboriginal social and emotional wellbeing model has informed the development of *Balit Murrup*. It is a therapeutic model that includes mental health and mental illness as elements of social and emotional wellbeing. The model is a strengths-based approach to working with mental health and wellbeing. The aim is to emphasise the importance of building strengths, resilience and connectedness in Aboriginal people and communities as pathways to positive mental health and wellbeing (Gee et al 2014).

The model can be applied across the continuum of mental health care including:

- symptom reduction
- recovery and ongoing support
- health promotion
- preventative and early intervention responses to protect and promote resilience and reduce psychological distress.

It can also be used in conjunction with other interventions. For example, in acute crises that require immediate mental health response many of the dimensions included in the model are not recognised in conventional approaches to working with mental health. Culturally-informed therapeutic practices that differ markedly from conventional western mental health approaches (Westerman 2004) have been developed and are increasingly used in practice.

The foundational assumptions of the model are:

- health is holistic
- self-determination is a right
- kinship is central
- aboriginal cultures are diverse
- human rights are respected
- cultural understanding is essential
- aboriginal strengths are acknowledged
- historical trauma and loss and the experience of racism and stigma have and continue to negatively affect Aboriginal social and emotional wellbeing.

Figure 1: The social and emotional wellbeing model

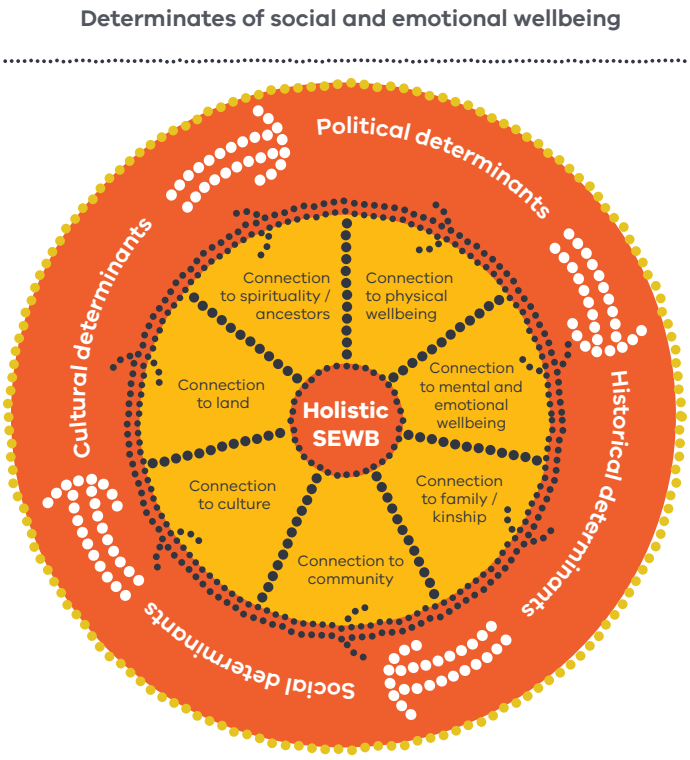

Figure 1 presents the dimensions of Aboriginal social and emotional wellbeing which are:

- connection to spirit, spirituality and ancestors
- connection to land
- connection to culture
- connection to community
- connection to family and kinship
- connection to mind and emotions
- connection to body.

The outer ring shows the determining influence of social, political, historical and cultural factors on social and emotional wellbeing.

Artist: Tristian Schultz, RelativeCreative. Reference: Gee, Dudgeon, Schultz, Hart & Kelly 2013 on behalf of the Australian Indigenous Psychologists Association

Weaving together, Victorian Aboriginal Health Service

Importantly, social and emotional wellbeing as a source of resilience can help protect against the worst impacts of stressful life events for Aboriginal people and provide a buffer to mitigate risks of poor mental health.

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Dimensions of social emotional wellbeing

Embracing Aboriginal concepts of social and emotional wellbeing can assist policy makers, organisations, clinicians and support staff to:

- **Situate mental health risk and protective factors within the broader social, cultural and historical determinants.**
- **Enable a strengths-based approach to support resilience through a 'whole-of-person' approach. In a therapeutic setting for example, it encourages clients to direct their own healing and recovery.**

Table 1 provides a description of each dimension and outlines some examples of potential protective and enabling factors. Each dimension relates directly to important protective factors. Promoting social and emotional wellbeing maximises the benefits of protective factors while minimising the risk factors.

Table 1: The social and emotional wellbeing dimensions

Dimension	Description	Examples of protective and enabling factors
Connection to body	Physical wellbeing that includes biological markers reflecting the physical health of a person such as age, weight, nutrition, illness, disability and mortality.	• A healthy diet and nutrition, access to effective health services • Participating in sports, exercise and healthy lifestyles • Non use of drugs and alcohol, and a healthy lifestyle
Connection to mind and emotions	Mental wellbeing or mental ill-health, and emotional, psychological and cognitive wellbeing.	• Having access to internal and external resources that meet core human needs, such as personal and cultural safety, security, a sense of control, self-worth, values, purpose or meaning, and motivation • Developing a positive mindset, managing difficult emotions, strong coping skills such as resilience, managing stress, adaptability and humour, positive mental health and wellbeing
Connection to family and kinship	Family and kinship systems that maintain interconnectedness through cultural ties and reciprocal relationships of sharing, caring, responsibilities and obligations.	• Understanding Aboriginal history and spending time with Elders • Spending time with family and kinship relations, family cohesions • Talking to friends, social support and not feeling lonely
Connection to community	Collective spaces and places that strengthen Aboriginal identity, belonging and culture. Family and kinship networks where personal connections and socio-cultural norms are developed and maintained.	• Using Aboriginal community-controlled organisations and other Aboriginal organisations • Accessing Aboriginal Healing centres and Elders, men's, women's and children's groups • Engaging in local, state and national cultural community events

Dimension	Description	Examples of protective and enabling factors
Connection to culture	The capacity and opportunity to create and maintain a healthy, strong relationship to heritage, including the systems of knowledge, lore and practices that comprise a person's distinct heritage. A body of collectively shared values, practices, customs and traditions.	• Being able to maintain and develop a secure sense of cultural identity and cultural values. The opportunity to participate in cultural practices such as music, dance and art • The opportunity to exercise cultural rights and responsibilities • Experiencing pride in cultural identity
Connection to land	Connection to land or 'country' where there may be strong ancestral, spiritual or emotional connections and belonging.	• Land rights, access to traditional land, Native Title settlements, access to country and spaces for healing, ceremony and connection to land
Connection to spirituality	Systems of knowledge and beliefs that include the stories, rituals, ceremonies and cultural practices that connect people, land and place. May involve critical transitions from childhood to adulthood and other life stages.	• The retrieval and maintenance of traditional cultural knowledge • The renewal, recreation and resourcing of cultural knowledge related to spirit • Renewing contemporary Aboriginal healing practices, and holistic philosophies of care, and other forms of spirituality, meaning and purpose
Social determinants	Socioeconomic status, education, employment, housing, racism, social inclusion or exclusion.	• Opportunities to access education, training and skills development • Access to community resources such as services related to housing and community infrastructure, welfare services, family and children's services • Achievement in education and employment • Receiving continuity in coordinated service support
Political determinants	Land rights, control of resources, cultural security, and the rights of self-determination and sovereignty.	• Political control and self-determination that allows a cultural group or community to maintain or build the capacity to retain language, traditions, cultural values and practices • Building positive relationships with non-Aboriginal communities
Historical determinants	The impact of past government policies.	• Supporting communities to overcome cultural displacement and building capacity for self-governance, cultural continuity, and control and community infrastructure

Adapted from Gee et al. 2014

DOH.0003.0001.0091

Bringing the social and emotional wellbeing model to life

The following case study was developed by Wadamba Wilam.

It maps out the way in which the social and emotional wellbeing model can underpin therapeutic, recovery and health promotion approaches when working with Aboriginal people. Wadamba Wilam is a program funded through the Department of Health and Human Services. It is built on a partnership between Neami National, Uniting Care ReGen, Northern Area Mental Health Service and the Victorian Aboriginal Health Service.

The program has been formed to deliver a holistic, assertive outreach service for Aboriginal people with complex needs, including severe and enduring mental illness, who are homeless or at high risk of homelessness. The program has achieved numerous positive outcomes for consumers and has been awarded a Victorian Homelessness Achievement Award (Excellence in Ending Homelessness – Adults CHP 2015) and a Highly Commended Community Award (Melbourne Health Celebrating Excellence Awards 2016).

Narelle's story – Connecting Narelle

Narelle* had at least weekly contact (sometimes daily when distressed) with Wadamba Wilam over an 18-month period.

At times when she needed to access subacute services, Wadamba Wilam continued to provide her with care and support. Narelle responded well to a trauma-informed holistic approach, using the principles of the social and emotional wellbeing model. The following outline discusses how each of the elements of the model were embedded in the caring, therapeutic and recovery journey that Narelle took with Wadamba Wilam, leading to significant improvements in her overall health.

* Not her real name

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Connection to family and kinship

Narelle's mother has permanent custody of Narelle's son and lives nearby with her large family. Ongoing conflict with her mother, however, made connection and support difficult. Over the 18-month journey with Wadamba Wilam, as Narelle's social and emotional wellbeing improved, so too did her relationship with her family. She now sees her son regularly, with overnight stays for the first time in many years. The Wadamba Wilam worker's regular contact with Narelle and her mother built trust and confidence; resulting in many of Narelle's siblings and cousins now seeking assistance. Outreach visits with Narelle and her family reinforced the importance of family and relationships on her overall wellbeing. Having contact with her son was the single greatest motivator for change for Narelle.

Connection to community

As Narelle's substance use significantly reduced, her self-confidence and connection with community grew. Her social anxiety decreased and she developed strategies to manage anxiety and take a more active role in community. This was facilitated over time in gentle phases. Narelle attended women's groups with her mother and accessed support from Elders, attending NAIDOC and other community events. Through greater connection to community Narelle had to navigate grief and loss with the passing of family, friends and community members but has done this well as part of her own healing journey.

Connection to land or 'country'

Narelle feels a strong connection to the land that she lives on and has spent most of her life in Melbourne. Spending time in nature and walking is soothing and grounding when Narelle is emotionally overwhelmed. Many outreach visits included nature and walking. This dynamic dimension enabled Narelle to connect place and relationships, and provided her with positive coping strategies which she has continued independently, including a recent return to country with her family. She experienced a profound connection to her country and healing and plans to visit often. The service provides material support for transport to enable this.

Wadamba Wilam staff 2017

Connection to culture

Prior to referral, Narelle was in remand with a prison psychiatric unit. This provided her with a period of time to be substance free. She had used alcohol significantly on a daily basis for over 10 years. As her social and emotional wellbeing improved, so did her connection to culture – including her choice that her trial be held through the Koori County Court. The support worker visited Narelle weekly in prison over the months prior to trial. With tailored intensive support, and Narelle's own motivation kicking in, she began to change her life. The Koori County Court gave Narelle, her family and support workers a forum to demonstrate this to the judge and the Elders present at the court. The sentence of a community corrections order, rather than likely incarceration through the mainstream court system, gave Narelle an opportunity to create positive change in her life. She met all the requirements of her community orders.

Connection to spirituality

Narelle's strong connection to spirituality and regular contact with the spirits of her Elders included a belief that there were negative spirits in her house. She is now waiting for the Wurundjeri Council to cleanse her new place.

Connection to body

Narelle had been abusing her body for many years since aged 14 through daily substance use and self-harm in response to extreme emotional and psychological distress. She uses alcohol now only on occasion, and through a stronger understanding and connection between her body and previous traumatic experiences, she is better able to manage potential triggers in a proactive manner. Narelle has a regular appointment with her GP and is now looking to more active treatment for her hepatitis C. Her epilepsy is better managed, and walking, boxing and other physical activity continues to be effective in managing distress.

Connection to mind and emotions

Narelle has had numerous diagnoses throughout her mainstream healthcare system journey including – but not limited to – schizophrenia, schizoaffective disorder, bipolar affective disorder, depression with psychotic features, borderline personality disorder and antisocial personality disorder. The Wadamba Wilam team uses a trauma lens for all interactions with clients. The diagnosis of complex trauma fits well with a large number of their clients. Narelle has developed an awareness of past traumas and their impact on her day-to-day life and emotional regulation.

The service's long-term approach allows the establishment of trust, changing from crisis management to developing coping skills and fostering resilience. The team uses a three-stage integrated model of recovery for working through complex trauma: developing safety and security, remembrance and mourning, and reconnection. Narelle is working through the first stage and developing coping skills and strength to move into the later stages. She had previously trusted few services and workers and had only limited meaningful community mental health follow-up.

Through a solid therapeutic relationship, Narelle has had the opportunity to explore her strengths and vulnerabilities for managing psychological distress. She has developed coping strategies to manage fluctuating moods, psychotic symptoms and high anxiety, and now seeks supports from her trusted workers when needed. Narelle no longer engages in self-harming behaviour and has greatly reduced her suicidal thinking and ideation. After 18 months Narelle has not returned to heavy substance use and is developing self-esteem and the confidence to live her life to the fullest.

Healing circle, Her Tribe

The importance of healing

Healing is a culturally informed therapeutic approach to promote Aboriginal social and emotional wellbeing

Healing is one of the most common ways of understanding Aboriginal peoples' experiences of recovery from trauma and other mental health and social and emotional wellbeing difficulties, including transgenerational trauma, unresolved grief and loss (Phillips & O'Brien 2009; Atkinson 2002; Caruana 2010). Often recovery is understood to be implicit in healing, although healing can also refer to aspects of personal growth and renewal that have been argued to extend beyond concepts of recovery (Milroy in Mackean 2009).

Healing involves growth and recovery across many dimensions. It can be used with individuals, groups and families – young people, men, women, Elders and whole communities. The common denominator in healing programs is the incorporation of the protective factors of connection to land, culture, spirituality, ancestry, family and community (Healing Foundation 2016).

Healing involves the application of existing cultural knowledge to address direct and cross-generational trauma using traditional and contemporary practices. Healing programs and services focus on gaining and sustaining hope and achieving a sense of identity and belonging, wellbeing, empowerment, control and renewal.

For many years, those of us who tried to get assistance to heal were misdiagnosed, left to flounder in our distress, or met with blank stares from non-Aboriginal mental health practitioners that left us feeling that our pain had no meaning and made no sense. Our healing journey is one of recovering our culture and our identity as Aboriginal people.

Aunty Lorraine Peeters, Marumali Journey of Healing (Peeters, Hamann & Kelly 2014:500)

Growing international and national evidence suggests the following benefits of investing in healing approaches:

- minimisation or elimination of the impact of trauma and abuse
- greater social inclusion and connection
- improved mental health and social and emotional wellbeing
- reductions in suicide
- alleviation of health system stresses
- improved engagement in education
- improved mental health literacy for Aboriginal participants
- reductions in domestic violence and sexual violence
- improved Aboriginal and mainstream service system integration
- reduced recidivism rates
- reconciliation
- intergenerational learning.

Factors that support resilience

Recent research on resilience and recovery from trauma among Aboriginal help-seeking clients in Victoria found that a wide range of personal, relationship, and cultural strengths reported by clients were associated with lower trauma and depression symptoms of distress, and lower rates of alcohol and other drug use. Some resilience factors demonstrated even stronger protective effects at the highest levels of trauma, suggesting these factors may play a particularly important role in trauma recovery (Gee 2016).

Qualitative reports by clients involved in the study also identified that having a positive relationships with others, access to counselling and involvement in Aboriginal healing groups and activities were among the most important factors associated with their experiences of healing and recovery from trauma (Gee 2017).

There's an innate capacity in us to heal. It's all about establishing safety, security and trust, and having the opportunity to work with someone you trust and get support from. As long as we remain committed to our healing, be really true and honest with ourselves, and reach out for support, the healing does come. But often we need help, that's the thing, and there's no shame in reaching out and asking for help.

Gee 2017

DOH.0003.0001.0096

Healing works best when solutions are culturally strong, developed and driven at the local level, and led by Aboriginal and Torres Strait Islander people.

Healing Foundation http://healingfoundation.org.au/community-healing/

Our Commitments to enable reform

The strategic priorities and actions provide direction on commitments within the next few years, and point to areas that need to be a focus for development over the 10-year life of *Balit Murrup* and beyond. Some actions will take immediate effect with funding already confirmed while other initiatives can be progressed through existing resources. For example, improving the cultural responsiveness of services. As *Balit Murrup*'s implementation progresses and the evidence base builds, there will be the potential for further investment in the programs that demonstrate what can work best in delivering positive social and emotional wellbeing outcomes for Aboriginal communities. The domains, strategic priorities and actions will be supported by Victorian, national and local policy and planning contexts.

Resourcing

Specific initiatives within *Balit Murrup* have been funded as part of the 2016–17 and 2017–18 State Budget, and outlined in the Executive Summary ' New Investments supporting *Balit Murrup*'.

Other emerging and aspirational actions identified as part of the strategic actions will be further developed and implemented over the 10-year life of the framework and beyond. Potential sources of funding will include the Aboriginal health and wellbeing (previously *Koolin Balit*) funding and Commonwealth Government funding through Primary Health Networks.

In future, Aboriginal health wellbeing and safety funding will be allocated under the new policy: Supporting Aboriginal Self-determination: Prioritising Funding to Aboriginal Organisations. This policy is a key commitment of the Victorian Government and is supported by evidence including findings from the *Koolin Balit* evaluations.

Measuring success

Our commitment is to make progress on improving the social and emotional wellbeing and mental health of Aboriginal Victorians. This will take time. If progress stalls, we will find out why and try new approaches. The success of the actions set out below and *Balit Murrup* overall will be measured against the outcomes framework developed as part of the implementation of the *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017–27.* Success will also be measured by the outcomes set for *Victoria's 10-year mental health plan*, which include reducing the gap in mental health and wellbeing for Aboriginal Victorians.

Implementation, governance and accountability

Achieving the vision of *Balit Murrup* in line with the *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017–27* and *Victoria's 10-year mental health plan* will require significant effort from all parts of the Victorian health and human services system, Aboriginal communities, Aboriginal organisations, non-government organisations, the funded sector and government agencies. Many solutions still need to be developed, tested and modelled. Despite this uncertainty, we are committed to being clear about our direction, our successes and our failures.

Implementation will require system-level action across the broader cultural and social determinants of health, wellbeing and safety. Flexible placed-based solutions at the local level that embody the principal of self-determination will be prioritised and focus efforts.

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We are committed to supporting self-determination as well as co-production through all aspects of the implementation of this plan. The *Aboriginal Governance and Accountability Framework* provides a key mechanism for oversight and development of *Korin Korin Balit-Djak*, as well as *Balit Murrup*. This also responds to the need for our engagement mechanisms and planning systems to reflect and mirror holistic understandings of Aboriginal health, which recognise the inseparable and interconnected nature of physical, social, spiritual and emotional health and wellbeing.

The Aboriginal Social and Emotional Wellbeing Reference Group was established to support the development of *Balit Murrup*. The group will continue with a new role focused on guiding the implementation of this framework; monitoring its implementation through regular reports from governments and agencies, and identifying emerging issues and good practice.

This will be achieved in close collaboration with other relevant groups such as Aboriginal community organisations and groups, those living with mental illness, mental health services, alcohol and other drugs service providers, consumers and carers, clinicians, professional representative bodies, other workers and researchers.

The Aboriginal Social and Emotional Wellbeing Reference Group will meet at least four times a year, and work closely with the 10-Year Mental Health Expert Taskforce and its reference groups to implement the overarching *Victorian 10-year mental health plan*.

It will also support emerging working groups that will focus on workforce development and suicide prevention.

The group will also host a roundtable at least once every two years during the life of this framework to seek the views of Aboriginal community members, including those with lived experience, carers, members of the stolen generation, and leaders. This will be supported by local and regional engagement processes including yarning circles.

Monitoring and evaluating outcomes

A detailed evaluation approach will be developed with key Aboriginal research, evaluation and service delivery organisations in consultation with Aboriginal communities. The design, development and delivery of the evaluation plan, and the subsequent monitoring and evaluating of Aboriginal health, wellbeing and safety, will be Aboriginal-community led.

Central to this approach is the function of Aboriginal communities holding the government to account for improving Aboriginal health, wellbeing and safety. The *Aboriginal governance and accountability framework* will ensure that the department is accountable to Aboriginal communities for delivering the actions in this framework at statewide, divisional and local levels.

We will identify the indicators to monitor progress, recognising that measuring social and emotional wellbeing is a responsibility that will be shared by working closely with the Commonwealth Government, including data reported in the National Social Survey and other sources. Where necessary we will invest in new ways to collect this information. These measures will give us a much better understanding of whether we are improving social and emotional wellbeing and mental health and doing the right things to support those with lived experiences, including reducing suicide.

Continuing reform

Balit Murrup is one of many steps that need to be taken to support social and emotional wellbeing. It is important that improvements and reforms continue over time and are able to adjust to changing circumstances and need.

Domain 1: Improving access to culturally responsive services

Historically, Aboriginal people have not accessed mental health services at the levels appropriate to the needs that exist. This results in infrequent contact with mental health services that is mostly limited to acute episodes of illness, and often too late to avert major disruptions to individuals and families. Increasing access and utilisation of culturally responsive specialist mental health services is a priority.

There is a recognised need for services to support clinicians and other relevant allied health professionals to embed cultural capability into their practice. However, few non-Aboriginal health professionals have the knowledge and skills to do this, nor the access they need to culturally responsive assessment tools. Such gaps in cultural understanding, knowledge and lack of access to resources can lead to misdiagnosis or to mental health issues remaining undiagnosed.

We will work with health services to build their capacity to provide culturally safe and appropriate mental health care and treatment for Aboriginal people of all ages, while strengthening accountability measures for delivering tangible benefits and outcomes to clients. Specialist mental health services need to be culturally responsive and supported by cultural safety frameworks with professional development that supports the use of trauma-informed social and emotional wellbeing models in their treatment of Aboriginal clients. In addition to this, we will promote service utilisation and ensure culturally responsive service provision.

Community consultations and research indicate that engaging with Aboriginal people and keeping them engaged in the service system is often challenging. This is due to such barriers as lack of transport, difficulty with access, and family and community responsibilities (for example, to attend 'sorry business'). We know that proactive and assertive outreach care, including home visits, can facilitate improved access and support, thereby enabling Aboriginal people to follow through with treatment and ongoing care.

Locally designed and implemented models of care that are flexible, responsive, safe and encourage early and ongoing engagement can be the most effective way of delivering better social and emotional wellbeing and mental health outcomes for all people. The promotion and embedding of Aboriginal understandings of holistic health and social and emotional wellbeing within the broader service system will also enable the delivery of culturally responsive services more generally.

Strategic priorities

- More Aboriginal people with a mental illness needing support are engaged in appropriate treatment and care.
- Services providing mental health and social and emotional wellbeing care and support are culturally safe and free from racism.
- Aboriginal people, families and communities are engaged in service design and review.

Bouverie staff at the 2016 NAIDOC March

Our aspiration: where we want to be in ten years time

- Mental health and social emotional wellbeing services for Aboriginal consumers and their families are informed by the cultural, historical and social issues that continue to impact on the social and emotional wellbeing of Aboriginal people.
- Aboriginal mental health specialists are based at, or available to, each mental health service across Victoria.
- Male and female Aboriginal Elders, other respected leaders and community members are active participants in informing and co-designing mental health responses for their families and communities, including the design and delivery of cultural awareness programs for mental health services.
- Collaboration occurs across funding streams to target funding to innovative Aboriginal community designed social and emotional wellbeing, treatment and recovery approaches that embed traditional and contemporary healing practices.
- The built, social and clinical environments of Victorian mental health facilities, including hospital emergency centres, acute and sub-acute inpatient units and community health settings reflect local Aboriginal culture and promote cultural safety.
- Aboriginal people with a psycho-social disability who are eligible for National Disability Insurance Scheme funding can choose to purchase services from Aboriginal community-controlled organisations and/or culturally responsive mainstream services.

Fresh Tracks

Fresh Tracks is an initiative developed by Geelong-based Wauthorong Aboriginal Cooperative. Fresh Tracks uses an 'assertive outreach' model of care – a service model that is often applied to clients with a high degree of complex needs and lower rates of attending clinical care.

A key feature of this approach is to make sure that the services are tailored to the needs of the client, not the service. This means that a service may be provided in the client's home or a public setting, rather than a clinical setting such as a counselling room.

The 'assertive' aspect of this model refers to the efforts of the practitioner to support the client from 'falling through the cracks.' If a client does not keep an appointment, the practitioner will (assertively) follow-up. This requires professional skills and judgment to achieve the balance between not neglecting the client, nor over-riding the client's wishes.

Our immediate actions: what we will do over the next four years

- Utilise the Aboriginal governance and accountability framework structures and other engagement and co-design processes to enable Aboriginal mental health consumers, families and organisations to inform local, statewide and regional mental health programs, policy and planning.
- Support the promotion and implementation of the Gayaa Dhuwi (Proud Spirit) Declaration that sets out principles for governments, professional bodies and services to support a new paradigm for shaping mental health responses to Aboriginal mental health problems and provides a platform to work collaboratively to embed culturally safe services (Refer Appendix 2).
- Strengthen the role of designated lead clinicians and managers across clinical mental health services responsible for the development of services, workforce expansion and partnerships in Aboriginal mental health and social emotional wellbeing.
- Support the allocation of culturally responsive specialist family violence advisors in major mental health and alcohol and drug services that will identify and respond to alcohol, drug and mental health issues.
- Resource Aboriginal organisations to provide specialist supports, including culturally responsive counselling and wrap-around services to children, families and carers who have experienced family violence.
- Support the implementation of the Forensic mental health improvement plan to address the over-representation of people with a mental illness in the criminal justice system with a focus on preventing reoffending in the first place.
- Create an Aboriginal Coordinator's position to ensure culturally safe partnerships with Aboriginal community-controlled organisations and culturally responsive mental health interventions for Aboriginal offenders on a Mental Health Treatment and Rehabilitation Condition.

Fresh Tracks, Wathaurong Aboriginal Co-operative

Domain 2: Supporting resilience, healing and trauma recovery

Health promotion and prevention needs to include approaches focused on building resilience and wellbeing, such as safe and secure housing, individual and community safety, family and community connections, connecting with culture and country and access to information, services and resources. Across the health promotion-care continuum, healing and trauma informed approaches enable Aboriginal people to engage and participate, building their resilience and capacity for self care and recovery.

Acknowledging past, current and intergenerational trauma, and enabling opportunities for people to heal and recover, are also critical. Increased social and economic participation will also help build and maintain resilience and empower Aboriginal communities, families and individuals to live healthy lives.

In addition, Aboriginal communities need access to information that builds mental health literacy. This knowledge and understanding will enable people to talk about and understand what might be happening for them and/or members of their family; to make decisions and to access the right supports and services at the right time.

Health promotion, prevention and early intervention policy, planning, program design and delivery must also include diverse strategies to reach priority groups effectively – particularly new parents, children and young people, Elders and the LGBTI communities.

Approaches that include whole-of-person and whole-of-community strategies will be most successful.

Examples of this include Aboriginal sports carnivals, the Victorian Aboriginal Health Service's 'Her Tribe' program, the Indigenous Family Violence Prevention and Legal Services 'Sisters Day Out', the 'Return to Country program' to help Aboriginal people children in care stay connected to their culture and the LGBTI Kungah gathering.

Healing involves the application of existing cultural knowledge to address trauma and post-generational trauma using traditional and contemporary practices. Healing programs and services focus on gaining and sustaining hope and achieving a sense of identity and belonging, wellbeing, empowerment, control and renewal. The common denominator in all healing programs and services is the incorporation of the protective factors of connection to land, culture, spirituality, ancestry, family and community (Healing Foundation 2016).

The Jekkora Spear Group

The Jekkora Spear Group was designed and developed by the Njernda Aboriginal Corporation in response to the growing levels of suicide in the Echuca Aboriginal community.

It is recognised by independent evaluators as 'a unique and promising suicide prevention model'. Slowly and steadily it has involved the entire community – in a culturally safe and non-stigmatising way – to support those at risk. Community members are trained to identify and support people at risk of suicide by making sure that those experiencing psychological distress are referred to a GP, a resident mental health nurse or the Echuca mental health services. The aim of this voluntary program is to establish a group of 'strong dependable community members to become support people'. All Jekkora Spear Group members have received training in suicide assessment, including training in 'Mental Health First Aid' and 'Applied Suicide Intervention Skills Training (ASIST)'.

Strategic priorities

- Aboriginal-led and co-designed health promotion and local prevention activities are implemented to promote social and emotional wellbeing, resilience and healing.
- Aboriginal people and communities have well-developed mental health literacy and awareness of the causes, impacts and supports for social and emotional wellbeing, mental health and healing.
- Traditional and contemporary Aboriginal healing approaches are recognised as integral to mental health promotion, prevention, treatment and recovery.
- Trauma-informed clinical practice is promoted which focuses on healing and recovery.

Our aspiration: where we want to be in ten years time

- Aboriginal communities are involved in the design and delivery of:
  - Aboriginal mental health literacy information resources and information sessions, including the delivery of Aboriginal Mental Health First Aid courses across Victoria
  - strategies aimed at reducing the stigma of mental illness in Aboriginal communities using contemporary and traditional platforms including social media, community information, training sessions and brochures.
- Regional Aboriginal social and emotional wellbeing planning is inclusive of Aboriginal community-controlled organisations; mental and community health, housing and children and family services; education; local government; and Primary Health Networks.
- Effective platforms are in place to build on and share evidence of good practice and emerging service models of effective social and emotional wellbeing and mental health promotion, and of early intervention approaches that embed healing, enhance protective factors, build resilience, and include the work of gathering places as well as Healing centres.
- Victorian Aboriginal-led research, resources, assessment tools on resilience, protective factors, and recovery and support inform practice, emerging service models and initiatives.

- Strategies and initiatives that will support healing, resilience and recovery are informed by a strong evidence base.
- Gathering places and healing centres are supported to provide or link to prevention and early intervention, clinical, therapeutic and cultural-strengthening activities for all age groups.
- Partnerships exist between key government agencies, mental health services and Aboriginal community organisations to reach priority groups effectively, particularly new parents, children and young people, Elders and LGBTI communities.
- The Koorie Youth Council plays a key role in informing initiatives to improve the social and emotional wellbeing and mental health of young people, including through suicide and self-harm prevention strategies.
- Regional forums on healing, with the support of the National Healing Foundation and key Aboriginal stakeholder groups. inform the promotion of evidence-based practice and community engagement.

Our immediate actions: what we will do over the next four years

- Identify opportunities to support investment in innovative, Aboriginal community-designed local health promotion and early intervention approaches that focus on healing and strengthening resilience and protective factors.
- Continue to support community, cultural and sporting activities that promote community and cultural connection and strengthening, resilience, healthy lifestyles, and language reclamation - particularly for children, young people and other vulnerable groups within Aboriginal communities.
- Aboriginal-led, culturally responsive, family-centred services and programs are supported. This includes those that focus on cultural strengthening, therapeutic child-centred programs and 'one-door' integrated services, where family members can obtain a range of supports.
- In partnership with Aboriginal communities, develop and implement the *Aboriginal Children and Families strategic action plan*, which will prioritise effort on prevention and early intervention services to build protective and resilience factors.
- Support and strengthen the engagement and participation of Elders through the resourcing of Aboriginal-led, place-based initiatives.
- Resource the continuation of the Aboriginal Youth Mentoring Program, which supports young people to remain connected to culture, families and friends.
- Develop culturally appropriate and safe suicide prevention approaches which respond to the particular issues for Aboriginal communities. This includes the current work with Primary Health Networks to implement coordinated place-based approaches to suicide prevention in 12 sites across Victoria.
- Support the 'Healing the Stolen Generations' program which seeks to help members of the Stolen Generations to trace their family history and connection to community, and provides trauma counselling and referrals to healing and support services.
- Work with the Aboriginal Victorian community to co-design and implement a strong, sustainable and culturally appropriate healing model which addresses the effects of Aboriginal family violence.
- Continue to provide support for the gatherings of Aboriginal LGBTI communities, such as the Kungah retreat.

Walking Together, Her Tribe

Aboriginal workers can experience high levels of vicarious trauma which can have serious impacts because of the depth and breadth of trauma across the community and potentially in their own lives.

Koolin Balit Evaluation 2016

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Domain 3: Building a strong, skilled and supported workforce

A highly skilled and supported workforce, operating in a clinically competent and culturally safe way, is required to meet the greater mental health needs of Victorian Aboriginal people, families and communities.

Aboriginal communities and mainstream services have long advocated for increased investment in an expanded and skilled Aboriginal and mainstream mental health workforce to deliver culturally responsive services that:

- build, protect and promote the social and emotional wellbeing of Aboriginal communities
- intervene early to reduce the impacts of mental illness, suicide risk and misuse of alcohol and other drugs
- enable and support recovery and connection to family, community and culture.

To address the social and emotional wellbeing and mental health needs of Aboriginal people in Victoria, and to meet the expected growth in service demand, the number of workers available within the mental health system to deliver services will increase. These workers will be equipped with the skills, tools and support to deliver culturally responsive, trauma-informed services across practice and geographic areas.

Victoria needs a highly skilled Aboriginal, mainstream mental health and social and emotional wellbeing workforce that is supported at the organisational level as well as within the health and human services system. Increased demand will necessitate this given the projected growth of the Victorian Aboriginal population and the increasing recognition of complex social and emotional wellbeing and mental health challenges experienced by Aboriginal people, families and communities.

Aboriginal and mental health organisations, their leadership and management need to be strengthened to enable supportive, safe and functioning workplaces. Aboriginal workers can experience vicarious trauma which can have serious impact because of the depth and breadth of trauma across the community and potentially in their own lives. This must be supported by a broader sector that promotes cultural responsiveness, integration, worker safety and care, collaboration and innovation.

A key goal in building a skilled workforce is to enable Aboriginal community-controlled organisations to self-determine and sustain a workforce that engages, builds and supports the social and emotional wellbeing of its community.

There are three foundations reinforced by the Koolin Balit evaluations for building a skilled workforce:

1. Workforce planning – where workforce redesign and expansion is led by Aboriginal people.
2. Learning and development – including access to continued learning and development to reduce the impacts of vicarious trauma and stress from work and cultural loads.
3. Worker safety and wellbeing – overseen by employers who have responsibility to support the social and emotional wellbeing of staff to sustain their participation in the workforce, and to recognise some of the unique pressures and challenges faced by many Aboriginal people.

It is important that current capacity and gaps in the workforce be identified to better target current and future investment. This includes examining the organisational capacity of Aboriginal and mainstream mental health services as well as identifying any skill and availability gaps in the primary mental health professions – of mental health nursing, occupational therapy, psychiatry, psychology and social work – across all Victorian catchments.

It is also vital to consider the links and shared workforce development opportunities across the mental health, social and emotional wellbeing, alcohol and other drugs, family violence, statutory and relevant NDIS services workforces.

A mental health and social and emotional wellbeing workforce shaped around an integrated multidisciplinary team model ensures that Aboriginal people have access to the high-quality services and supports they need. Teams will include mental health nurses, occupational therapists, psychiatrists, psychologists and social workers underpinned by strong partnerships and effective working arrangements with Aboriginal community-controlled organisations, mental health services, family violence hubs, drug and alcohol teams, statutory services, and the National Disability Insurance Agency and their Local Area Coordination teams.

Strategic priorities

- Aboriginal mental health and social and emotional wellbeing workforces across Aboriginal community controlled organisations and mainstream mental health services are grown and sustained.
- Multidisciplinary mental health and social and emotional wellbeing teams are supported across Victoria.
- Mental health workforce planning responds to the growing Aboriginal population and impacts of trauma within the Aboriginal community.

Our aspiration: where we want to be in ten years time

- Interagency, multi-disciplinary Aboriginal social and emotional wellbeing teams exist across Aboriginal community controlled organisations and mainstream services agencies. They will provide culturally appropriate support and treatment to Aboriginal mental health consumers. Teams to include psychologists, psychiatrists, counsellors, mental health nurses, allied health, and Aboriginal mental health and community mental health support workers.
- A suite of practice guidelines, case studies and resources are available to enable Victoria's specialist mental health, Aboriginal mental health, alcohol and other drugs, family violence, child protection and justice system services to implement an Aboriginal social and emotional wellbeing model within their program design, clinical practice and delivery of services.
- All staff working in mental health services have the opportunity to participate in relevant culturally responsive learning and development.
- Relevant undergraduate education and ongoing professional learning and development courses include a mental health cultural responsive module.[1]

Our immediate actions: what we will do over the next four years

- Through the Centre for Mental Health Workforce Learning and Development, ensure learning and development in culturally responsive health and trauma-informed models of care is readily available and accessible to Aboriginal and non-Aboriginal mental health service staff.
- Fund an Aboriginal Mental Health Workforce Training Program to provide full-time mental health trainee positions for Aboriginal people in mainstream mental health services and some Aboriginal community controlled organisations which will include support to complete a Bachelor of Applied Science in a mental health related discipline.
- Establish an initial 10 Aboriginal mental health therapeutic and clinical positions within Aboriginal community controlled organisations.
- Establish an Aboriginal Social and Emotional Wellbeing and Mental Health Practice Network.

[1] For example inclusive of the social and emotional wellbeing model and recovery oriented cultural knowledge, skills and behaviours, practices and leadership capabilities set out in the NFROMS Guide's Domain 2, Capability 2.

- Investigate the establishment of a statewide Aboriginal Mental Health Workforce Coordinator position to provide strategic advice across the Aboriginal mental health workforce.
- Invest in 24 Aboriginal alcohol and other drug worker positions to provide specialist treatment for Aboriginal Victorians facing alcohol and drug addiction with the final design of the additional positions to be determined in collaboration with the Aboriginal community.
- Promote and support career pathways from secondary school through to mental health and social and emotional wellbeing roles.

VACCHO is confident that Aboriginal workforce expansion alone would go a long way to increasing access to locally delivered mental health and social and emotional well-being services. This in the short term will increase cultural sensitivity, strengthen meaningful relationships, establish referral pathways, improve care coordination and program collaborations with more accessible entry and exit points.

Victorian Aboriginal Community Controlled Health Organisation Submission, 2015

Njernda Aboriginal Cooperative 2017

Domain 4: Integrated and seamless service delivery

To ensure better outcomes in Aboriginal mental health and wellbeing, we need to drive change and support better integration of services that are culturally safe and appropriate for Aboriginal people. Governments will work collaboratively to support the development of a joined-up approach to social and emotional wellbeing support, mental health, suicide prevention, and alcohol and other drug services – recognising the importance of what an integrated service offers Aboriginal people.

Whole-of-person assessments, appropriate referral and integrated seamless service responses across primary health, human, community, mental health, alcohol and other drugs and family violence services, as well as education and employment programs, will improve prevention, early intervention and treatment of mental health issues leading to more successful recovery. Clear pathways are essential to ensure that care is continuous, person-centred and holistic as people transition between parts of the service system.

One of the most critical interfaces in Aboriginal mental health care is between acute clinical and sub-acute mental health services and primary healthcare providers. Particular emphasis will be placed on building partnerships between mainstream clinical mental health services, Aboriginal community health organisations and other primary and community health providers to support continuity of care for Aboriginal people entering and leaving hospital and to reduce admissions.

Strategic priorities

- Aboriginal mental health consumers have access to integrated services, pathways and transitions.
- New service models are explored to improve outcomes for Aboriginal mental health consumers and their families, building on the learnings of other initiatives.
- Improved pathways exist between mainstream clinical mental health services, Aboriginal community controlled health organisations and other primary and community health providers to improve the continuity of care for Aboriginal people entering and leaving hospital and to reduce admissions.

Our aspiration: where we want to be in ten years time

- Aboriginal people in key leadership and co-design roles, including those with lived experience, routinely work with community-based health and human services to better integrate planning and models of care that support seamless mental health care and pathways for Aboriginal people.
- Good practice models of care, to support a seamless integrated patient journey between the primary and acute mental health sectors, are identified, promoted and adapted across Victoria.
- Aboriginal mental health consumers receive holistic, person-centred care through arrangements such as co-location of services, including care navigators and coordinators who will help connect people with non-health services to navigate service and referral pathways, and facilitate follow-up.
- Strong connections between child protection services and culturally responsive family and child support services exist for children and families to reduce the impact of mental illness in families at risk of engagement with child protection.

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- All Aboriginal people leaving hospital will have clear documentation about how to access ongoing support and care they may need.
- Aboriginal people with severe and persistent mental illness will have a single care plan that links their physical, social and emotional wellbeing and mental health needs with other community-based social and disability support services they may require.
- The social and emotional wellbeing model is applied across service settings – primary health, Aboriginal community controlled organisations and mainstream – and will include family violence, alcohol and other drugs, justice, housing and employment streams.

Our immediate actions: what we will do over the next four years

- Support and monitor the implementation of three Improving Mental Health Treatment Outcomes for Aboriginal and Torres Strait Islander People with Moderate to Severe Mental Illness demonstrations sites.
- Enable the learnings from the Improving Mental Health Treatment Outcomes for Aboriginal and Torres Strait Islander People with Moderate to Severe Mental Illness demonstrations sites to be shared and translated into broader practice.
- Enhance opportunities for Aboriginal people with lived experience of mental health as consumers or carers to contribute their expertise to initiatives to improve service design and delivery.
- Promote and support access to the NDIS for Aboriginal people experiencing severe and persistent mental illness and associated psychosocial disability to provide certainty of funding for support and give participants more choice and control.

Improving Mental Health Treatment Outcomes for Aboriginal and Torres Strait Islander People with Moderate to Severe Mental Illness demonstrations sites

The government has allocated $7.7 million across three demonstration projects to test some new service models for Aboriginal Victorians with moderate to severe mental illness, trauma and other complex health and social support needs who often fall through the gap between primary and tertiary mental health services. The funded sites and their primary focus are as follows:

- Wathaurong Aboriginal Cooperative (rural) and the Victorian Aboriginal Health Service (metropolitan) – focusing on adults
- Ballarat and District Aboriginal Cooperative – focusing on reducing the impact of parental mental illness for children engaged with child protection, supporting family reunification (response to Taskforce 1000)
- Mallee and District Aboriginal Services – focusing on the mental health of people engaged with the justice system with the aim of reducing recidivism and re-entry.

Each site will provide culturally responsive mental health care, treatment, counselling and care coordination. The evidence emerging on what works best will be used to inform the development of future Aboriginal social and emotional wellbeing and mental health guidelines and resources.

Partners in change

Key stakeholders who work in partnership across the continuum of social and emotional wellbeing and mental health programs and services achieve better mental health outcomes for Aboriginal people as shown in the following table.

Table 1: Key stakeholders – roles and responsibilities

Aboriginal individuals, families and communities	Participate in and contribute to, the design and delivery of mental health and social and emotional wellbeing policy, programs and services, as well as their own healing, treatment and recovery.
Aboriginal community-controlled organisations	Self-determining, co-designing and implementing social and emotional wellbeing programs and services that prevent, intervene early, treat and manage mental health problems and mental illnesses through integrated service models and referral to culturally safe mental health services that work within a social and emotional wellbeing framework.
Health services, mainstream primary healthcare providers and community services	Developing programs for promoting social and emotional wellbeing, and for the prevention, early detection, treatment and management of mental health problems and mental illnesses, by integrated service models and referral to culturally safe mental health services that work within a social and emotional wellbeing framework.
Mental health services	Treating ongoing and severe mental illness and promoting recovery in a culturally safe manner within a social and emotional wellbeing framework.
Alcohol and other drugs and family violence services	Recognising and responding to the social and emotional wellbeing and mental health needs of all clients seeking their services.
Victorian Government	Guiding priorities for funding and program and service development across government to support Aboriginal mental health and social and emotional wellbeing.
Local government	Key role in closing the gap in disadvantage experienced by Aboriginal people in local communities.
Commonwealth Government	Policy, resourcing and delivery of programs through Primary Health Networks, general practice and Aboriginal community-controlled organisations in partnership with the broader health system.

The essential elements for success include the recruitment of Aboriginal staff members, strong executive and management support, creating strong linkages with Aboriginal community controlled organisations and the local service system.

Koolin Balit Evaluation 2016

Thomas Embling NAIDOC event smoking ceremony with Aunty Joy Murphy

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Appendix 1: Key concepts

The Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. Land is central to wellbeing. This holistic concept does not merely refer to the 'whole body' but in fact is steeped in the harmonised interrelations that constitute cultural wellbeing. These interrelating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill-health will persist (Swan & Raphael 1995).

Mental health is a state of wellbeing in which an individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2014).

Social and emotional wellbeing means being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life.

Trauma refers to experiences and reactions to particularly intensive life events, including threats (real or perceived) that can overwhelm a person's ability to cope and have long-term impacts on their mental health. A person may respond with intense fear, helplessness or horror. These can include sexual abuse (including institutional abuse), experience of violence and tragic/unexpected events and loss (including as a result of suicide, accidents, illness). For Aboriginal and Torres Strait Islander people this trauma is predominantly the result of colonisation and past government policies. If people do not have the opportunity to heal, then they may 'deal' with their pain in negative ways, including physical or emotional violence, abuse or addiction.

Trauma-informed care is a strengths-based service delivery approach that is grounded in an understanding of, and responsiveness to, the impact of trauma, that emphasises physical, psychological and emotional safety for both providers and survivors to rebuild a sense of control and empowerment (SAMHSA 2014).

Healing refers to recovery from the psychological and physical impacts of trauma. Healing is not an outcome or a cure but a process that is unique to each individual. It enables individuals, families and communities to gain control over the direction of their lives and to reach their full potential. Healing continues throughout a person's lifetime and across generations. It can take many forms and is underpinned by a strong cultural and spiritual base (Healing Foundation 2015, cited November 2016).

Resilience refers to a person's capacity to think and act in ways that help them adapt and cope with adversity without suffering from long-term, harmful consequences due to stress. Strong, supportive relationships, connection to culture and community, and participating in support programs can help.

Abbreviations

ACCOs
Aboriginal community-controlled organisations

LGBTI
lesbian, gay, bisexual, transgender and intersex

NDIS
National Disability Insurance Scheme

SEWB
social and emotional wellbeing

DOH.0003.0001.0114

Appendix 2: Gayaa Dhuwi (Proud Spirit) Declaration

Gayaa Dhuwi was developed and launched by the Aboriginal and Torres Strait Islander Leadership group[2] in Mental Health in 2015, and has since been endorsed by the Victorian 10-Year Mental Health Taskforce. The declaration sets out principles for governments, professional bodies and services to support a new paradigm for shaping mental health system responses to Aboriginal mental health problems. It provides a platform for governments to work collaboratively to embed culturally safe services within the mental health system that are adaptable and accountable to Aboriginal and Torres Strait Islander people.

This includes supporting Aboriginal leadership in mental health and suicide prevention as the foundation upon which to address the high rates of mental health conditions and suicide through both culturally and clinically based approaches.

The five themes of the Gayaa Dhuwi Declaration are:

1. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.
2. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.
3. Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcomes measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programs for Aboriginal and Torres Strait Islander peoples.
4. Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.
5. Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system.

[2] This is a core group of senior Aboriginal and Torres Strait Islander people working in the areas of social and emotional wellbeing, mental health and suicide prevention. Most are based in, or associated with, national and state mental health commissions or other nationally important mental health bodies. (http://natsilmh.org.au/)

References

Atkinson, J 2002, Trauma trails, recreating song lines: The transgenerational effects of trauma in Indigenous Australia, Spinifex Press, North Melbourne, Vic.

Australian Bureau of Statistics (ABS) 2009, 4714.0 – National Aboriginal and Torres Strait Islander Social Survey, 2008, ABS Canberra. Available at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4714.02008?OpenDocument.

Australian Bureau of Statistics 2013, 4727.0.55.001 - Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13. Available at: http://www.abs.gov.au/ausstats/abs@.nsf/0/9F3C9BDE98B3C5F1CA257C2F00145721?opendocument;

Australian Bureau of Statistics 2016, National Aboriginal and Torres Strait Islander Social Survey, 2014–15, No. 4714.0, ABS, Canberra.

Australian Government 2017, 'Royal Commission into Institutional Responses to Sexual Abuse'. Available at: http://childabuseroyalcommission.gov.au/.

Australian Institute of Health and Welfare (AIHW) 2011, The health and welfare of Australia's Aboriginal and Torres Strait Islander people, an overview 2011, Cat. no. IHW 42, AIHW, Canberra.

Australian Institute of Health and Welfare 2016, Aboriginal and Torres Strait Islander health organisations online services report: Key results 2014–15, AIHW, Canberra.

Commission for Children and Young People 2016, 'Always was, always will be Koori children': Systemic inquiry into service provided to Aboriginal children and young people in out-of-home care in Victoria, Melbourne

Caruana, C 2010, 'Healing services for Indigenous people', Family Relationships Quarterly, no. 17, Australian Institute of Family Studies, pp. 3–9.

Department of Health and Human Services, 2015, Mental Health and Aboriginal people and Communities, 10 Year Mental Health Plan Technical Paper

Department of Health, 2013 and 2016 Victorian Emergency Minimum Dataset, Victorian Government

Department of Health (DoH) 2015, Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, Australian Government, Canberra.

Department of Health and Human Services 2015, Evaluation plan for the Koolin Balit investment, Victorian Government, Melbourne.

Department of Health and Human Services 2016, Health and wellbeing outcomes of the Aboriginal and Torres Strait Islander gathering place model in Victoria: A place for inclusion, connection and empowerment: Final report, State Government of Victoria, Melbourne.

Department of Health and Human Services 2016, Evaluation of Aboriginal Health Case Management and Care Coordination Models in Victoria, State Government of Victoria, Melbourne.

Department of Health and Human Services 2016, Improving Cultural Responsiveness of Victorian Hospitals: Final Report, State Government of Victoria, Melbourne.

Department of Health and Human Services 2016, Evaluation of Traineeships for Aboriginal Workforce Development in Victoria: Final Report, State Government of Victoria, Melbourne.

Dudgeon, P, Milroy, J, Calma, T, Luxford, Y, Ring, I, Walker, R, Cox, A, Georgatos, G & Holland, C 2016, Solutions that work: What the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP), Department of Prime Minister and Cabinet, Australian Government, Canberra. Available at: http://www.atsispep.sis.uwa.edu.au/.

Ferdinand, A, Paradies, Y & Kelaher, M 2012, Mental health impacts of racial discrimination in Victorian Aboriginal communities: The Localities Embracing and Accepting Diversity (LEAD) Experiences of Racism Survey, The Lowitja Institute, Melbourne. Available at: https://www.lowitja.org.au/lowitja-publishing/L023.

Gee 2017 (Dr. Graham Gee, personal communication, 1 March 2017) Dr. Graham Gee Masters/PhD Psychology, Registered Psychologist, Victorian Aboriginal Health Service 238-250 Plenty Road, Preston 3072, VIC, Ph: (03) 9403 3300.

Gee, G. (2016). Resilience and Recovery from Trauma among Aboriginal Help Seeking Clients in an Urban Aboriginal Community Controlled Health Organisation. Unpublished Doctor of Philosophy thesis. University of Melbourne Australia.

Gee, G, Dudgeon, P, Schultz, C, Hart, A & Kelly, K 2014, 'Aboriginal and Torres Strait Islander social and emotional wellbeing', in P Dudgeon, H Milroy & R Walker (eds), Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice, Australian Government, Canberra, pp. 55–68.

Healing Foundation 2016, Healing for our Stolen Generations: Sharing our stories, Healing

Foundation, Canberra. Available at: https://healingfoundation.org.au/resources/?resource_type=24.

Human Rights and Equal Opportunity Commission (HREOC) 1997 Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families, Commonwealth Government, Canberra.

Mollica, R F, Brooks, R, Tor, S, Lopes-Cardozo, B & Silove, D 2014, 'The enduring mental health impacts of mass violence: A community study of Cambodian civilians living in Cambodia and Thailand', International Journal of Social Psychiatry, vol. 60, no. 1, pp. 6–20.

National Aboriginal and Torres Strait Islander Leadership (NATSILMH) in Mental Health 2015, Gayaa Dhuwi (Proud Spirit) Declaration, NATSILMH, Canberra. Available at: http://natsilmh.org.au/.

National Mental Health Commission 2014, The national review of mental health programmes and services, NMHC, Sydney.

National Mental Health Commission Secretariat 2014, Expert advice on specific challenges for Aboriginal and Torres Strait Islander people's mental health: Background Paper, NHMC, Sydney.

New South Wales (NSW) Government 2007, NSW Aboriginal Mental Health and Well Being Policy 2006–2010, NSW Government, Sydney.

Ogloff RP, Patterson J, Cutajar M, Adams K, Thomas S and Halacas C, 2013, Koori prisoner mental health and cognitive function study, Monash University, prepared for the Department of Justice, State Government of Victoria, Melbourne.

Peeters, L, Hamann, S & Kelly, K 2014, 'The Marumali Program: Healing for Stolen Generations, in P Dudgeon, H Milroy & R Walker (eds), Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice, Australian Government, Canberra.

Phillips, G, O'Brien, M & Aboriginal and Torres Strait Islander Healing Foundation Development Team 2009, Voices from the campfires: Establishing the Aboriginal and Torres Strait Islander Healing Foundation, Commonwealth of Australia, Canberra.

Sabin, M, Cardozo, L, Nackerud, R, Kaiser, R & Varese, L 2003, 'Factors associated with poor mental health among Guatemalan refugees living in Mexico 20 years after civil conflict', Journal of the American Medical Association, vol. 290, no. 5, pp. 635–42.

Sawyer, M G, Arney, F M, Baghurst, P A, Clark, J J, Graetz, B W, Kosky, R J, Nurcombe, B, Patton, G C, Prior, M R, Raphael, B, Rey, J, Whaites, L C & Zubrick, S R 2000, The mental health of young people in Australia, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2017, Report on Government Services 2017, Chapter 16, Productivity commission, Canberra, Vol. F Community Services.

State of Victoria 2012, Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012–2022, Department of Health, State Government of Victoria, Melbourne.

State of Victoria 2016, Ending Family Violence, Victoria's Plan for Change, Victorian Government, Melbourne.

Substance Abuse and Mental Health Services Administration 2014, SAMHSA's Concept of trauma and guidance for a trauma-informed approach, HHS Publication No. (SMA) 14–4884, Substance Abuse and Mental Health Services Administration, Rockville, MD.

Swan, P & Raphael, B 1995, Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy National Consultancy Report, Department of Health and Ageing, Australian Government, Canberra.

Victorian Government Department of Health 2011, The health and wellbeing of Aboriginal Victorians, Victorian Population Health Survey 2008, Supplementary report, Health Intelligence Unit, Prevention and Population Health Branch, Wellbeing, Integrated Care and Ageing, Victorian Government.

Vos T, Barker B, Stanley L, Lopez AD 2007. The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003. Brisbane: School of Population Health, The University of Queensland.

World Health Organization 2014, available at http://www.who.int/features/factfiles/mental_health/en/

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Lost, not forgotten

Inquiry into children who died by suicide and were known to Child Protection

COMMISSION FOR CHILDREN AND YOUNG PEOPLE

The Commission respectfully acknowledges and celebrates the Traditional Owners of the lands throughout Victoria and pays its respects to their Elders, children and young people of past, current and future generations.

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COMMISSION FOR CHILDREN
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Dear Mr Young and Ms Noonan

Lost, not forgotten – Inquiry into children who died by suicide and were known to Child Protection

I hereby request that the Inquiry report produced by the Commission for Children and Young People be tabled in accordance with section 50 of the *Commission for Children and Young People Act 2012* (the Act).

I would be grateful if you could arrange for the report to be tabled in both the Legislative Council and Legislative Assembly on 30 October 2019.

I confirm that the Minister for Child Protection and the Secretary to the Department of Health and Human Services have each been provided with a copy of the Inquiry report in accordance with section 49 of the Act.

Yours sincerely

Liana Buchanan

Principal Commissioner

15 October 2019

Looking after yourself

This inquiry features descriptions of reported harm and abuse that may be confronting and in some cases, distressing. If anything in this inquiry causes you to feel distress, it is really important that you take steps to look after yourself and talk to someone about your feelings.

The following 24-hour supports are available to help you.

For children and young people

- Kids Helpline: 1800 551 800
  kidshelpline.com.au
- Headspace: 1800 650 890
- ReachOut: **au.reachout.com**

Other resources

- Life in Mind (suicide prevention portal):
  lifeinmindaustralia.com.au
- Head to Health (mental health portal):
  headtohealth.gov.au
- SANE (online forums): **saneforums.org**

For adults

- Lifeline: 13 11 14
  lifeline.org.au
- Suicide Call Back Service: 1300 659 467
  suicidecallbackservice.org.au
- Beyond Blue: 1300 224 636
  beyondblue.org.au/forums
- MensLine Australia: 1300 789 978
  mensline.org.au

Message from the Commissioners

It is devastating to think of someone's life feeling so unbearable that they have no hope for the future, and even more devastating when a child or young person takes their own life. Yet this is, tragically, more common than it should be. For adolescents aged between 15 and 17 years, or Aboriginal children aged between five and 17 years, it is the leading cause of death.

In our role as commissioners for Victoria's children and young people, we are required to review the circumstances of every child who dies having had Child Protection involvement in the 12 months preceding their death. The purpose of this is to examine how effectively risks were managed and whether services provided to the child and their family were adequate and appropriate. Where these inquiries reveal weaknesses, we make recommendations designed to strengthen the service response.

Some of the children whose experiences we review through our child death inquiries have taken their own lives, sometimes at a very young age. Sadly, when we look at these children's lives, we see some distressing themes emerge. In this inquiry we examine these themes, tell the stories of 35 children who died through suicide between 2007 and 2019, and reflect on the responses these children received from different service systems.

These children's lives were marred by family violence, dysfunction and often chronic neglect. For many, their parents' capacity to care for them was impeded by mental illness and/or substance abuse. Half of the children were thought to have experienced sexual abuse. Aboriginal children were overrepresented in the cases we reviewed and their experiences were compounded by the additional pain of intergenerational trauma and grief.

The systems we hope and expect will protect children from adverse experiences did not serve these children well. This report shows that, despite repeated and

often early reports to Child Protection, many cases were successively closed and critical opportunities for much-needed intervention and support missed. Where Child Protection referred these children's families for further support, they were lost in a referral roundabout across a fragmented service system. This meant that despite multiple reports and often severe levels of harm, nothing changed for these children.

This pattern is not unique to the children who come to our attention because they commit suicide. Indeed, we see the pattern described in this inquiry in most of our child death inquiries involving older children; a pattern of multiple reports to Child Protection, followed by case closure, referral to child and family services, followed by no engagement and no effective intervention.

Message from the Commissioners

This report also illustrates how, as children grow older and their trauma starts to manifest in challenging behaviour, disengagement from school, risk taking, violence or mental ill health, professionals lose empathy. The children become seen as the problem. Our reviews found these children referred to as 'difficult', 'needy', 'angry' and 'bad'.

This report highlights the chasm between formal, coercive child protection interventions and a child and family service system reliant on voluntary engagement. Many of the children in this inquiry fell squarely into this system gap.

We initiated this inquiry because these children's experiences are otherwise invisible. Yet, as a community, we need to confront how many children we fail. We need to understand the need for investment in child and family services, in the development of new, intensive models of service to work with families who are struggling, to support parents to address the issues that are preventing them from giving their children safe and loving childhoods. We need to recognise the devastating impact of our current service system on the youngest and most vulnerable members of our community.

The last five years has represented a time of significant reform by the Victorian Government. We have seen efforts to transform responses to family violence and investment in the Child Protection workforce. These efforts are welcome and long overdue. However, this report reinforces that more is needed; radical reform and investment to improve early intervention and better protect children is necessary if we are to prevent the suffering described in this report.

Of course, one limitation of this report is that we could not speak to the 35 children themselves. But from file notes and descriptions we gleaned a sense of children who, despite their circumstances, were incredibly brave and wise beyond their years. Many desperately craved help, safety and recovery for themselves and their families. They deserved hope. We trust their stories will contribute to change – and hope – for children today and in the future.

Liana Buchanan
Principal Commissioner

Justin Mohamed
Commissioner for Aboriginal Children and Young People

Contents

Looking after yourself 2

Message from the Commissioners 3

Abbreviations and acronyms 8

Definitions 9

Executive summary 11

Purpose of the inquiry 12

What the inquiry found 12

Demand versus investment in early intervention child and family services 13

Suicide and adverse childhood experiences 14

The children 14

Their experiences of harm 14

Their parents 15

Contact with Child Protection 15

Responding to Aboriginal children 16

Child Protection response and use of child and family support services 16

Contact with health, mental health services and police 17

Contact with police 17

Help-seeking behaviours 18

'Under the radar' 18

Themes arising from the findings 18

Findings 20

Findings related to the child and family system 20

Findings related to the mental health system 21

Findings related to collaboration and information sharing 21

Recommendations 22

Chapter 1: Introduction 24

Jurisdiction 24

Terms of reference 24

Methodology 24

Contents

Chapter 2: Service systems relevant to this inquiry **25**
The child and family system 25
Statutory child protection system 26
Voluntary child and family service system 27
The child and youth mental health service system 32

Chapter 3: Suicide and adverse childhood experiences **34**
Suicide and adverse childhood experiences 34
Aboriginal children and intergenerational trauma 35
Contact with the statutory child protection system 36

Chapter 4: The children and their experiences **38**
Harms experienced by the 35 children 39
The impacts of harm as experienced by the children 42
Gender differences 43
Risk factors in the children's lives 45

Chapter 5: Contact with the statutory child protection system **48**
Length and nature of contact 48
Responding to Aboriginal children 54

Chapter 6: Contact with health, mental health services and police **56**
Evidence of mental health status, substance misuse, self-harming 56
Early contact with mental health services 58
Contact with health, mental health and other services in the 12 months preceding death 60
Help-seeking behaviours 63
'Under the radar' 63

Chapter 7: Findings related to the child and family system **65**
Statutory child protection system 65
Voluntary child and family service system 71
Lack of child-focussed practice 76

Chapter 8: Findings related to the mental health system **80**
Ineffective early intervention 80
Inadequate focus on integrated family-based interventions 85

Chapter 9: Findings related to collaboration and information sharing **88**
Inadequate information sharing and collaborative practice 88
Role clarity and assumptions regarding the role of service systems 89
Shared responsibility for suicide prevention 90

Chapter 10: Recommendations **91**

Appendices **93**

List of figures

Figure 1: Public health pyramid 25
Figure 2: Children by age, sex, Aboriginal status 38
Figure 3: Geographic location prior to death 38
Figure 4: Most common risk indicators in the cases involving female children 43
Figure 5: Most common risk indicators in the cases involving male children 43
Figure 6: Numbers of children who experienced harm, per type 46
Figure 7: Age at time of first report to Child Protection 48
Figure 8: Age at time of first contact with mental health services 58

List of tables

Table 1: Number of new cases opened 2007–2018 30
Table 2: Allocation rates to family services by complexity 2017–2018 31
Table 3: Victoria's comparative investment in child protection services 2013–14 to 2017–2018 32
Table 4: Residence immediately prior to death 39
Table 5: Harms experienced by children as known to Child Protection 39
Table 6: Impacts of harm on children and coexisting vulnerabilities 42
Table 7: Nature of impacts and co-existing vulnerabilities for children 43
Table 8: Risk indicators per age and gender (children aged 12–14 at time of death) 44
Table 9: Risk indicators per age and gender (children aged 15–17 at time of death) 44
Table 10: Risk factors relating to parents in cases reviewed 47
Table 11: Final report outcomes prior to child's death 49
Table 12: Reports to Child Protection closed at intake or investigation 49
Table 13: Actions undertaken by Child Protection upon closure 51
Table 14: Actions undertaken by Child Protection upon substantiation 52
Table 15: Time between first report and initiation of protective proceedings 53
Table 16: Highest level of intervention received over course of child's life 53
Table 17: Mental health status by sex and selected diagnoses 56
Table 18: Evidence of substance misuse 57
Table 19: Evidence of prior self-harming behaviours 57
Table 20: Contact with health services in the 12 months preceding death 60
Table 21: Contact with health services in the six weeks preceding death 61
Table 22: Emergency department presentations in 12 months and six weeks preceding death 61
Table 23: Police contact in 12 months and six weeks preceding death 62
Table 24: Communication of suicidal intent in seven days leading up to suicide 63
Table 25: Themes identified related to ineffective engagement 72
Table 26: Themes identified related to mental health service provision 80
Table 27: Summary of Child Protection Phases 93
Table 28: Engagement with Child FIRST (between 1 April 2014 and 1 April 2019) 98
Table 29: Quality and effectiveness of mental health service intervention 100

Abbreviations and acronyms

ACCO	Aboriginal Community-Controlled Organisation
ACPP	Aboriginal Child Placement Principle
ADHD	Attention Deficit Hyperactivity Disorder
AFLDM	Aboriginal Family-Led Decision Making
ASD	Autism Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Service
CCOPMM	Consultative Council on Paediatric Mortality and Morbidity
CCYP Act	*Commission for Children and Young People Act 2012* (Vic)
Charter	*Charter of Human Rights and Responsibilities Act 2006* (Vic)
Child FIRST	Child and Family Information Referral and Support Teams
Commission	Commission for Children and Young People
CRIS	Client Relationship Information System
CSO	Community sector organisation (non-Aboriginal)
CYFA	*Children, Youth and Families Act 2005* (Vic)
CYMHS	Child and Youth Mental Health Service
Department	Department of Health and Human Services
IFS	Integrated Family Services
Inquiry	Lost, not forgotten: Inquiry into children who died by suicide and were known to Child Protection

Definitions

Aboriginal

The term Aboriginal in this report refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a program, report or quotation.

The term Koori refers to Aboriginal people from south-east Australia.

Children

The term children in this report refers to children 0–17 years of age.

Child and family system

The service systems that supports vulnerable children and families, and includes family services (The Orange Door/Child FIRST, IFS (family services) and ACCOs), Child Protection and out-of-home care services.

Child death inquiry

Section 34 of the CCYP Act provides that the Commission must conduct an inquiry in relation to a child who has died and who was a child protection client at the time, or within 12 months, of their death.

Child Protection

The Victorian child protection program is delivered by the department and is specifically targeted for those children at risk of harm where parents are unable or unwilling to protect them.

Child FIRST/The Orange Door

Child FIRST provides a community-based referral point into integrated family services in a geographical area. Children and families are referred to Child FIRST where there are concerns about a child's wellbeing. Child FIRST assesses the risk to and needs of the child and the family, prioritises accepted referrals on the basis of need, then allocates to family services. Under current family violence reforms, Child FIRST is being incorporated into The Orange Door.

Cumulative harm

Cumulative harm refers to the effects of multiple adverse or harmful circumstances and events in a child's life. It may be caused by an accumulation of a single recurring adverse circumstance or event or by multiple circumstances or events.

Development

Under section 3 of the CYFA, development means physical, emotional, intellectual, cultural and spiritual development.

Early intervention

Intervention that occurs when vulnerabilities have been identified for the child or their family. The role of child and family services is to provide critical, timely and responsive services before risks and concerns escalate and lead to Child Protection intervention.

Family service system

Relates to the part of the child and family system that provides family services, including Integrated Family Services.

Family violence

According to section 5 of the *Family Violence Protection Act 2008* (Vic) family violence is behaviour by a person towards a family member that is physically, sexually, psychologically or economically abusive; or is threatening, coercive or in any other way controls or dominates the family member to feel fear for their safety or the wellbeing of another person; or behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of these behaviours.

Harm

Under section 162 of the CYFA, harm encompasses physical injury, sexual abuse and damage to emotional or psychological development, physical development or health. It may result from a single act or omission, or circumstances may be cumulative.

Mental health system for children

The mental health system for children describes a system of funded mental health services for children with moderate to severe mental health problems.

Mental illness

A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory. In this report, mental illness refers to a specific diagnosed disorder under section 4 of the *Mental Health Act 2014* (Vic).

Report (to Child Protection)

Consistent with the CYFA, 'a person may make a report to the Secretary if the person has a significant concern for the wellbeing of a child'.

Significant harm

The accepted definition of 'significant' within the child protection system means more than trivial or insignificant but need not be as high as serious; important or of consequence to the child's development and it is irrelevant that the evidence may not prove some lasting permanent effect or that the condition could not be treated.

Statutory child protection system

Relates to the part of the child and family service system that provides the legislative and policy frameworks to protect children from significant harm and neglect.

Suicide

Suicide is defined as 'the intentional taking of one's life.'[1] It is also a category of death; includes deaths due to suicide and high-risk taking behaviours.

Vulnerable child

According to section 5 of the CCYP Act, a vulnerable child includes:

- a child or young person who is or was a child protection client and/or a youth justice client
- a person attending a youth justice unit in accordance with an order of the Children's Court
- a child who is receiving or has received services from a registered community service
- a child who has died from abuse or neglect
- a person under the age of 21 years who is leaving or has left the custody or guardianship of the Secretary to live independently.

1 Mendoza, J, and Rosenberg, S, *Suicide and Suicide Prevention in Australia: Breaking the Silence*, Lifeline Australian and Suicide Prevention Australia, Sydney, 2010, p.12.

Executive summary

'If I died, would you love me? Would you cry?'
A child, aged 13

The Commission conducts a child death inquiry when a child dies, if they were a Child Protection client at the time of death or in the 12 months prior to their death. Through the review of the circumstances in which children's deaths occurred, the Commission identified a pattern in cases of children who died by suicide.

On 3 July 2019, the Commission established an own motion systemic inquiry pursuant to section 39 of the CCYP Act, into the deaths of 35 children from suicide between 1 April 2007 and 1 April 2019.

The inquiry is intended to build upon analysis completed by a previous (and untabled) systemic inquiry completed by the Commission, *Inquiry into issues of cumulative harm and suicide in child deaths* (Cumulative harm inquiry), completed in June 2018. The Cumulative harm inquiry examined the provision or omission of services to 26 children who died from suicide between 1 April 2007 and 22 December 2015, and had a strong focus on evaluating operational and practice-based issues. This inquiry examines a number of the same issues from a broader systemic perspective.

The inquiry provides an important opportunity to reflect upon service provision in the context of a child taking their life, however, it is essential to be clear about its limitations:

- First, this is an inquiry that is primarily focussed on examining the quality and effectiveness of Child Protection and child and family services delivered (or omitted to be delivered) to 35 children, many of whom had been known by Child Protection since early childhood, and the extent to which these services responded to their changing and often significant needs. The services delivered (or omitted to be delivered) to these children occurred in the context of reported abuse or harm and rarely as a result of these children being identified as at risk of suicide.
- Second, the child death inquiries reviewed span a 12-year period, between 1 April 2007 and 1 April 2019. During this time, the landscape has changed significantly. The Commission has exercised careful judgment in balancing the need to honour the experiences of all 35 children, while maintaining a measured focus on exploring systemic issues raised in more recent child death inquiries conducted in the last five years (n=15).
- Third, the constellation of events and characteristics that came together in these cases to produce an outcome of fatality cannot be distilled into a check list of predictive risk factors. The nature of harms experienced by these 35 children and the corresponding level and frequency of exposure, makes them in some ways indistinguishable from other children in contact with the child protection system. In most cases with similar characteristics and experiences, however, a child will not come to such catastrophic harm. Yet there are still opportunities to learn from the lives of these 35 children and the points at which service intervention may help to contain these risks.

- Fourth, this inquiry does not examine in detail the quality and effectiveness of mental health services delivered to these children. The *Commission for Children and Young People Act 2012* (CCYP Act) does not provide the Commission with jurisdiction to review the appropriateness or otherwise of clinical-decision making by a registered health or mental health practitioner. The Commission has focussed instead on identifying the points and scope of mental health service delivery, and its intersection with the child protection system.
- Fifth, it is important to acknowledge the limitations inherent with any review process that seeks to examine the quality and effectiveness of services being delivered to children, without hearing from children themselves. Where available, this inquiry has sought to capture and prioritise the voices and recorded experiences of the 35 children.

Purpose of the inquiry

In Victoria, the importance of earlier intervention has been a major focus of reforms to legislation, government policies and services delivered in the last two decades, including:

- the Victorian Government's 2005 White Paper *Protecting Children: the next steps* established the need for a more integrated system of children and family services, and resulted in the introduction of the *Child Wellbeing and Safety Act 2005* and *Children, Youth and Families Act 2005*
- the Department of Health and Human Services' 2012 *Vulnerable children: our shared responsibility strategy 2013–2022* identified a key role for learning and development services to achieve improved and more timely outcomes for vulnerable children and their families.

Early intervention is a focus of current child and family policy, *Roadmap for Reform: stronger families, safe children* (2016), which advocates for strategic reforms that support children and families in need, with integrated wraparound supports and targeted early interventions.

This inquiry represents an important opportunity to reflect upon the extent to which past reforms have delivered for vulnerable children and their families, and reinforce the need to ensure that ongoing reforms are prioritised for delivery.

What the inquiry found

The 35 children presented with multiple, often chronic, risk indicators that brought them into recurring contact with different service systems. Every recorded contact they had represented an opportunity for positive intervention, particularly in response to early concerns.

What they mostly received, however, was ineffective early intervention – characterised by delays, fragmentation, unsuccessful engagement and shallow focus – and a largely static response from Child Protection, who continued to receive, assess and close re-reports.

For the children, this meant that complex risks, such as exposure to family violence and parental substance misuse, became an entrenched feature of their lives. That mental health issues identified in early childhood remained untreated (beyond prescribed medication) until presenting symptoms escalated and they posed a significant risk of physical harm to themselves or others.

For these children, in almost every case nothing changed as a result of reports to Child Protection.

Nothing changed until the point of imminent crisis, usually much later in life, by which stage, the children were highly vulnerable and traumatised individuals, described variously as 'hard to help', 'needy', 'rageful', 'chaotic', and 'out of control'.

The Commission sees evidence of the systemic issues identified in this inquiry in all aspects of its work. These 35 children died by suicide, and that is a profound point of difference between them and most children known to Child Protection and the family service system. However, in almost all other respects, including the nature of risks identified and the extent to which the child and family system was equipped to respond to these risks, the experiences of these 35 children is reflective of a much wider experience.

The inquiry acknowledges there are inherent challenges in the delivery of intervention services to vulnerable children and their families, particularly where these services are voluntary and rely on families' preparedness to engage – but, if we are to protect children, these are challenges that must be met.

Demand versus investment in early intervention child and family services

The last decade has seen a rapid increase in demand for child protection and child and family services. It is widely acknowledged that the increase in demand has included an increase in demand for families experiencing 'complex' issues.

For example:

- reports to Child Protection have almost tripled in ten years, from less than 42,000 in 2007–2008 to more than 115,000 in 2017–2018
- the number of new cases opened by Child FIRST has increased six-fold in 10 years, from 3,888 in 2007–2008[2] to 22,332 in 2017–2018
- more than 80 per cent of families (18,130 cases) referred to Child FIRST in 2017–2018 presented with complex issues such as family violence, mental health, substance abuse and disability, compared with 66 per cent in 2013–2014, and 55 per cent in 2007–2008[3]
- more than half of families (6,402 cases) who received help from a family service in 2017–2018 were identified to have two or more complex issues, compared with one-third of cases in 2013–2014 (3,436 cases), and one-fifth in 2007–2008 (2,660 cases).

Currently, the demand for Child FIRST and family services exceeds the funding provided to the sector. This has been the case since 2011–2012.[4] Despite a 474 per cent increase in new Child FIRST cases in the last 10 years, funding to Child FIRST and family services has only increased by 176 per cent.

The department has, however, sought to address the need for longer-term responses for families experiencing complex issues by adopting a targeted approach. The Commission acknowledges that since 2014–2015, allocation of funding to Child FIRST and family services has shifted towards investment in the delivery of longer forms of family service response.

This means that cases allocated to a family service are now more likely to receive a longer and more intensive response than 10 years ago. For example, the average number of hours allocated per family by family services has increased from 29 hours in 2007–2008, to 79 hours in 2017–2018 – a 172 per cent increase in hours per case.

It is positive to note that targeted investment in the Child FIRST and family service sector has improved the type and intensity of response available to families. However, based on allocation rates from 2017–2018, only one in three cases featuring a complex issue will be allocated a family service.[5] Under the current system, families identified as having complex issues are nearly twice as likely to not be allocated a family service, and receive instead, only limited entry-level help from Child FIRST.[6]

At the same time, most of Victoria's investment in the broader child and family system is directed towards statutory services at the crisis end. Statutory services relate to those delivered by Child Protection in response to protective intervention and when a child enters out-of-home care.

For example, over the five years from 2013–2014 to 2017–2018, early intervention services received around a quarter of the total investment, with around three-quarters going into statutory child protection and out-of-home care services.[7] The Commission recognises that since 2017, considerable investment has been made into the rollout of The Orange Door.

This inquiry demonstrates however, that further investment and reform in line with the commitments made in *Roadmap to Reform* are urgently needed.

2 The Commission notes that the establishment of Child FIRST was based on a successful pilot between 2003 and 2006, and that full rollout of Child FIRST across Victoria did not occur until 2009–2010.

3 *Roadmap to Reform: stronger families, safe children*, Department of Health and Human Services, Victorian Government Printer, April 2016 at page 10.

4 *Early Intervention Services for Vulnerable Children and Families*, Victoria Auditor-General's Report, Victorian Government Printer, May 2015 at page 23.

5 Calculation based on 2017–2018 cases allocated an IFS (where there is an identified complex issue) (6,605 cases) compared with total cases referred to Child FIRST (where there is an identified complex issue) (18,130 cases), 37 per cent allocation rate.

6 Calculation based on 2017–2018 cases not allocated an IFS (where there is an identified complex issue) (11,525 cases) compared with total cases referred to Child FIRST (where there is an identified complex issue) (18,130 cases), 64 per cent non-allocation rate.

7 Based on interpretation of Report on Government Services data (see Table 3, page 32).

Suicide and adverse childhood experiences

In Victoria, suicide is the leading cause of death for children aged 15–17 years (30.4 per cent) and the cause of 12.5 per cent of all deaths recorded for children aged 10–14 years.[8]

Factors that make children more vulnerable to suicide include exposure to adverse childhood experiences, including physical and sexual abuse, and neglect. Aboriginal children and children who have contact with the child protection system are at a higher risk of dying by suicide. Children that have contact with the child protection system are at an increased risk of suicide because, as a population, they are more likely to present with the risk factors associated with suicide.

The children

- The 35 children ranged in age from 12 years, 11 months to 17 years, seven months at the time of death. Almost one-third (n=11) had ended their lives by the age of 14.
- 40 per cent of the children were female (n=14) and 60 per cent were male (n=21). Males aged 15 to 17 years at time of death were significantly over-represented, representing 40 per cent of all children reviewed (n=14).
- Aboriginal children were also over-represented among the 35 children with a total of six children (17 per cent) identifying as Aboriginal.
- 49 per cent (n=17) of the children were residing in metropolitan areas at the time of their deaths and 51 per cent (n=18) in regional or rural areas.
- 31 per cent (n=11) of the children were identified as having learning difficulties as a result of developmental delays or an intellectual disability.
- 11 per cent (n=4) were recorded as identifying as lesbian, gay, bisexual, transgender, intersex or queer.
- 71 per cent (n=25) of the children were living at home with at least one parent at the time of their death.
- 83 per cent (n=29) were disengaged from education in the months or weeks preceding their death.

Their experiences of harm

Descriptive details of the children's experiences of harm were not available in all cases. Where the information was available, it revealed that the children had, in most instances, experienced multiple and recurring forms of abuse. The harms these children faced were often severe. Of the many risk factors present in the lives of the children reviewed, the most prominent was family violence. Family violence was a feature of nearly all cases, frequently in conjunction with parental mental illness and substance abuse issues.

- 94 per cent of the children (n=33) were reported to have experienced family violence (several children witnessed severe physical and sexual violence perpetrated against their mothers, including a father punching a mother to the face and breaking her jaw; a step-father head-butting a mother, resulting in a broken nose; a father strangling a mother; a mother being violently raped by her partner; and a mother being thrown to the ground by her throat).
- 89 per cent of the children (n=31) were reported to have experienced one or more elements of neglect during their childhood (one child was described as 'hungry, filthy and had flea bites all over his body'; there were cases involving children living week-to-week in different locations, including one who slept in a barn for two months; school lunches were frequently referenced as containing 'mouldy food' and 'rancid meat'; and there were multiple examples of health issues arising in the context of neglect, such as scabies, hearing problems attributable to wax build-up, sores, loss of teeth, blackened teeth, fleas and lice).

8 https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality/mothers-babies-children-report

- 51 per cent of the children (n=18) were reported to have been sexually abused by a family member or person known by the family (one child was reported to have been sexually abused by a number of adult males, including her step-father, but did not want to make disclosures to police; another child was reported to have been sexually abused by a number of adult males, including her father and gymnastics coach; and another was sexually abused by a family member from the age of seven and then went on to abuse a younger sibling).
- Where sexual harm was reported, it was always in combination with physical, emotional and neglect abuse types.

Their parents

Most of the children came from families where trauma was entrenched and compounded by the 'toxic trifecta' of family violence, parental mental illness and substance abuse issues:

- 97 per cent (n=34) had a mother who had been the victim of family violence
- 83 per cent (n=29) had a parent with a diagnosed mental illness
- 71 per cent (n=25) had a parent with a reported substance abuse issue
- 63 per cent (n=22) had a parent with a reported history of trauma, including a history of child protection involvement
- 40 per cent (n=14) had a father or step-father who had spent time in prison
- 37 per cent (n=13) of the children reviewed had a parent who had attempted or completed suicide.

It is important to acknowledge that for many of the children reviewed, their experiences of harm represented an extension of the harm experienced by their parents (often in childhood). Unresolved trauma and untreated parental mental illness featured prominently in the majority of cases (n=29).

Contact with Child Protection

For the 35 children, the length and nature of contact with Child Protection varied. For the majority of children (n=26), there was lengthy contact which began early in the child's life.

The key stages for Child Protection processes are intake and investigation, protective intervention and protective order. The inquiry attempted to examine the assessments and decisions made by Child Protection at these stages and found:

- the number of reports to Child Protection ranged from two to 25, with an average of seven reports per child
- 66 per cent (n=23) of the children had their first contact with Child Protection before they turned eight years of age, with the majority of these (65 per cent) having their initial contact in the first three years of life
- for the 35 children, Child Protection received a total of 229 reports
  - 90 per cent (n=206) of the reports received were closed at intake or investigation
  - 78 per cent (n=161) were closed at intake
  - 22 per cent (n=45) were closed at investigation
- of the reports received, 69 per cent (n=158) were closed with no further action and 23 per cent (n=52) were referred to, or recommended to contact, Child FIRST, with a view to engaging community-based child and family services
- of the reports received, 14 per cent (n=33) were substantiated, and of these:
  - 20 were closed with no further action recorded
  - 12 resulted in initiation of Protection Application proceedings in the Children's Court
- for the 12 children who were the subject of a Protection Application:
  - proceedings were initiated (on average) at the seventh report to Child Protection
  - the average time between first report and initiation of protection proceedings was six years, four months.

Responding to Aboriginal children

Aboriginal children were over-represented in the 35 cases reviewed in the following ways:

- 17 per cent of the children identified as Aboriginal (n=6)
- all of the Aboriginal children were recorded as having experienced four forms of child abuse or maltreatment
- intergenerational trauma was a feature in the lives of all Aboriginal children reviewed
- 83 per cent of the children had their first contact with Child Protection by age five (n=5)
- of the 41 reports received by Child Protection in relation to the six Aboriginal children
  - 85 per cent (n=35) were closed at intake or investigation
  - 29 per cent were substantiated (n=12), which was double the rate of substantiation for the non-Aboriginal children in this review (14 per cent)
- although only featuring six Aboriginal children, the inquiry found these children represented 33 per cent of all substantiated reports that resulted in initiation of protective proceedings.

Child Protection response and use of child and family support services

Despite the severity of reported harms received, across multiple and frequently escalating reports, the rate of closure without further action by Child Protection was concerningly high.

Ninety per cent of the total reports received (n=229) were closed at intake (n=161) or investigation (n=45). Where intervention was recommended, families were in most instances assessed to require only periodic community-based child and family service support (n=52).

For the 35 children reviewed:

- approximately 23 per cent (n=52) of reports resulted in children and their families being referred (either directly or indirectly via letter) to Child FIRST with a view to engaging an appropriate community-based child and family service
- the 52 reports resulting in referrals to Child FIRST related to 25 individual children and their families
- of the 25 families, approximately one-third (n=9) expressed a persistent unwillingness to engage with services.

Despite the majority of families indicating a preparedness to engage, the inquiry found that community-based child and family services were, in fact, unable to engage them.

Of the 25 families referred to, or recommended to contact, Child FIRST, the inquiry found that successful engagement of families was impeded by a range of factors, including:

- delays in family service commencement represented a significant barrier to the successful engagement of families in one-quarter of cases reviewed (n=7)
- in almost half (48 per cent) of the cases referred to Child FIRST, services provided by community-based child and family services appeared inadequate to meet the complex and frequently chronic protective concerns that families required help to address (n=12)
- only 10 per cent of families recommended to contact Child FIRST via letter subsequently initiated contact.

Unsuccessful engagement with families did not result in Child Protection adopting a different approach to re-reports or re-referrals. Over half (56 per cent) of the families referred to Child FIRST were referred more than once (n=14). None of the referrals resulted in successful engagement with a family service.

Contact with health, mental health services and police

The inquiry found that the length and nature of contact children had with mental health and other health services varied depending on the child's age, gender and age at first contact with Child Protection.

In terms of the children's mental health:

- 83 per cent were either diagnosed (n=24) or suspected (n=5) to have a mental illness
- 83 per cent were recorded as having engaged in deliberate self-harming behaviours (n=29)
- 69 per cent were recorded as having previously attempted suicide (n=24)
- 60 per cent were recorded as being drug dependent at the time of their death (n=21).

In terms of the children's contact with health and mental health services in the 12 months preceding death:

- 74 per cent (n=26) had contact with a health service for care related to their mental health
- 43 per cent (n=15) had contact with a Child and Adolescent Mental Health Service or Child and Youth Mental Health Service, most frequently following an emergency department presentation
- over 90 per cent of female children (n=13) had contact with a health service for care related to their mental health in the six weeks preceding their death, whereas only 38 per cent of male children had contact with services in the six weeks preceding death (n=7)
- 43 per cent (n=15) attended at an emergency department in the 12 months preceding their death, of which 87 per cent presented with an attempted suicide by overdose (n=13).

Of the 35 children reviewed, 89 per cent had a recorded contact with a mental health service (n=31). Of these:

- 35 per cent had their first contact between the ages of nine and 13 (n=11)
- 39 per cent had their first contact by the age of eight (n=12)
- half of all male children had received a mental health diagnosis by the age of seven (n=9).

The inquiry found that children's contact with mental health services as generally preceded, or occurred simultaneously with, contact from Child Protection. This trend was particularly pronounced for the children who received a diagnosis by age seven, of which:

- 92 per cent had their first contact with Child Protection by the age of three (n=11)
- 50 per cent had been referred to a paediatrician by the age of five (n=6)
- 75 per cent were male children, who all received an initial diagnosis of ADHD and/or ASD (n=9).

Of the children who had contact with a mental health service but remained undiagnosed, 86 per cent lived in regional or rural parts of Victoria (n=6). For this group, their presenting issues, which included threats to suicide, were generally considered not to meet the threshold for tertiary-level mental health service intervention.

Contact with police

Of the 35 children reviewed, 51 per cent (n=18) had contact with police in the 12 months before their death and 43 per cent (n=15) within six weeks of death.

Of the children who came into police contact:

- 44 per cent were alleged to have perpetrated violence against a family member (n=8) – in all instances, substance misuse preceded the alleged violence
- 22 per cent came in contact with police for high-risk taking behaviours including fire-lighting, joy-riding and behaving in an offensive manner (n=4)
- 11 per cent had contact with police in the context of ongoing drug use (n=2).

Help-seeking behaviours

In a significant number of cases (49 per cent), there was evidence that children had disclosed an intention or plan to suicide in the seven days prior to death. Of those that did disclose an intent (n=17), 59 per cent told a friend or peer, sometimes via social media.

Notably, help-seeking behaviours were markedly different for the cohort of children aged between 12 and 14 years at the time of death. Of these children, 73 per cent (n=8) disclosed an intention or plan to suicide in the seven days prior to death. In the majority of these cases, this disclosure was made to a worker or mental health professional (n=5).

'Under the radar'

Of the 35 children reviewed, just under one-fifth (n=6) were subsequently identified amongst family members as having flown 'under the radar' prior to their deaths. As one family member reflected 'we just didn't see it coming'. The inquiry found a number of shared characteristics among these children, including:

- All had been exposed to high levels of family violence.
- On average, they were the subject of eight reports to Child Protection, which was higher than the recorded average of seven reports per child recorded for all 35 children.
- None were diagnosed with a mental illness and only one child had received services from a mental health service (but disengaged after one appointment).
- Two-thirds (n=4) were reported to have experienced sexual abuse in early childhood.
- Two-thirds (n=4) were known to use substances, have frequent contact with the criminal justice system and be disengaged from school (usually via suspension or expulsion as a result of violence).
- They were invisible in that there was little or no information recorded about these children, their perspectives or wishes by service providers.

Themes arising from the findings

Responding to children at risk of harm

Children in this inquiry were the subject of multiple reports to Child Protection. Each new report was assessed in isolation, without proper consideration being given to the impact or outcome of earlier reports, or earlier referrals to Child FIRST. As a result, opportunities for timely and escalated intervention were lost, and with this, the ability to help improve the individual circumstances of these children and their families.

The gap between statutory and voluntary services

Children in this inquiry presented with a range of complex and significant issues that consistently fell beneath the threshold for statutory intervention. This meant their families were referred, sometimes repeatedly, to Child FIRST, for potential engagement with voluntary family services. Families who cannot be easily engaged by voluntary child and family services create a specific challenge for the child and family system. The children in these families are at an increased risk of falling between the gap created by disconnected statutory and voluntary service systems.

Identifying and responding to adolescent vulnerability

Children who had reached the point of adolescence were rarely assessed or described as vulnerable. They were frequently characterised as 'hard to help', 'difficult to engage', 'out of control', 'needy' and in one case 'damaged'. Many of these children had been known to Child Protection from early childhood. As young children they were not helped, and as older children, help was increasingly not provided due to their perceived ability to 'self-protect'.

Responding to Aboriginal children

The cases featuring Aboriginal children featured lengthy, intergenerational child protection histories. Despite this, there was no evidence that Child Protection considered cumulative harm when assessing risk or planning. Research establishes that connection to culture is a protective factor for Aboriginal children, particularly those at risk of suicide. For some of the Aboriginal children, connections to culture were inadequately prioritised by both the child and family system and the mental health system.

Failure to engage children

Children were for the most part, invisible participants – neither seen, nor heard by Child Protection on issues central to their safety and wellbeing. There was a notable absence of direct contact by Child Protection with children, particularly during the phases of investigation and protective intervention. Where direct contact occurred, children were required to speak to multiple people within Child Protection, which in some instances resulted in children disengaging completely. Children were rarely interviewed away from family members and rarely engaged in decision-making processes or case planning.

Concurrent contact with child protection and mental health systems

Most of the children in this inquiry had concurrent contact with the child protection and mental health systems. Where contact did coincide, the focus of each system was quite different. Child Protection largely assessed the circumstances of children in terms of mitigating parental risk, without addressing how exposure to these risks may have impacted the child. This was particularly the case where there was family violence. Mental health interventions, by comparison, were child-focussed – in that they focussed on addressing the mental health symptoms displayed by the child – but were not always well-informed regarding family history or the child's exposure to parental risks.

Recovery from childhood abuse and trauma

Children who are known to have experienced childhood abuse and trauma are likely to require help to recover from their experiences. This was not, however, identified as a focus of Child Protection or mental health interventions for the children reviewed.

Coordination and information sharing

Poor coordination and inadequate information sharing contributed to reports to Child Protection being closed without further action in circumstances where children should have received help. The inquiry found a lack of information sharing between the statutory child protection and mental health systems, meaning that in many cases neither system had complete knowledge of children's circumstances.

Findings

FINDINGS RELATED TO THE CHILD AND FAMILY SYSTEM

Finding 1: Statutory child protection – episodic risk assessments that focussed on imminent harm

The Commission found that risk assessments undertaken by Child Protection at the intake and investigation phases were frequently shallow in focus and based on immediate and episodic risk prediction.

This led to children who were at risk of significant harm, including cumulative harm, being left to endure multiple, and often chronic forms of harm, without support or effective and timely intervention.

The inquiry identified a range of barriers to Child Protection undertaking effective and responsive risk assessments in the cases reviewed, including:

- Child Protection appearing to operate as an emergency response service
- failure by Child Protection to identify and respond to risks of cumulative harm
- lack of coordination and information sharing between Child Protection and Child FIRST regarding the outcome of referrals, re-referrals and on-referrals to family services
- absence of timely escalation by Child Protection in cases involving re-reports.

Finding 2: Child FIRST and family services – ineffective early intervention

There was no evidence that any of the 25 children and their families who were referred to Child FIRST were successfully engaged with family services. In all instances, the children and their families referred to Child FIRST were re-reported to Child Protection – in most cases, within quick proximity to referral.[9]

This led, in some cases, to multiple referrals being made to Child FIRST, who made multiple on-referrals to family services. This approach resulted, ultimately, in recurring concerns remaining unaddressed for children at risk of harm.

The ability of the Child FIRST and family service system to successfully engage the families reviewed was impeded by a range of factors, including:

- delays in the allocation of families to particular services
- the intensity and duration of services were inadequate to meet the complexity of issues identified
- the handling of re-reports and re-referrals
- the practice of Child Protection recommending to families, by letter, that they contact Child FIRST for support.

9 The Commission acknowledges that in some cases, re-reports were not made in quick proximity, but occurred across the course of a child's life, and occasionally with multiple years in between.

Finding 3: Statutory child protection – lack of child-focussed practice

The Commission found there was an absence of child-focussed engagement in response to the 35 children reviewed. This resulted in children's voices not always being heard by services, and their experiences often not being taken into account.

Children were rarely interviewed away from family members and rarely engaged in decision-making processes or participated in case planning.

For those children who had reached adolescence, they were rarely assessed or described as 'vulnerable' but frequently described as 'self-protective'. In some cases, the depth of sadness they experienced only revealed itself after their death, in the form of a suicide note or diary entry.

FINDINGS RELATED TO THE MENTAL HEALTH SYSTEM

Finding 4: Ineffective early intervention

For the majority of children reviewed, there was an absence of effective early mental health intervention. The inquiry found a range of systemic barriers to the provision of early mental health intervention, including:

- an absence of specialised mental health services for children diagnosed with mental illness or other mental health presentations by the age of seven years
- a lack of targeted support to help children recover from childhood abuse and trauma
- an inadequate focus on delivering integrated family-based interventions to support the recovery of children experiencing mental illness.

FINDINGS RELATED TO COLLABORATION AND INFORMATION SHARING

Finding 5: Inadequate information sharing and collaborative practice

Children in contact with the statutory child protection and mental health systems benefit from a coordinated service response, which recognises the need to explore the intersection between protective and mental health issues. The inquiry identified a range of barriers to effective information sharing and collaborative practice, including:

- an absence of assertive information sharing by both service systems
- a failure to understand the significance of information potentially held by the respective service systems
- a lack of clarity or understanding regarding the role of each service system in respect of child safeguarding.

Finding 6: A shared responsibility for suicide prevention

Service systems in contact with vulnerable children have a shared responsibility to promote suicide prevention in children by ensuring they deliver a service response that prioritises the children's particular circumstances and experiences, and their recovery from harm and abuse.

Recommendations

Recommendation 1

That, in line with *Roadmap to Reform*, the Victorian Government develop, resource and implement an integrated and whole-of-system **investment model and strategy** for the child and family system, focussed on:

- earlier intervention and prevention services to reduce risks to children and build child and family wellbeing
- reducing the rate of entry to care
- meeting the distinct needs of children who need to live away from the family home.

The **investment model** should recognise the drivers of demand and the need for coordinated service responses. It should use client data, analytics and service evidence to identify the:

- resource levels needed to meet demand for safe, quality services for vulnerable children and their families
- most efficient and effective investment options to achieve maximum impact.

The **investment strategy** should increase and improve safe, quality services in line with demand, by targeting early intervention and prevention, prioritising the most vulnerable cohorts, including families with chronic and complex issues and children exposed to cumulative harm.

Recommendation 2

That the Department of Health and Human Services develop, resource and implement a set of standard analytical data sets for Child FIRST/ The Orange Door and IFS to monitor and report on the timeliness and effectiveness of their engagement with children and families, including:

- time between initial assessment and commencement of case management
- rates of unsuccessful engagement
- referral outcomes
- re-referrals
- re-reports.

Recommendation 3

That the Department of Health and Human Services review and revise all foundational practice guidance, training and tools to embed children's participation in decision making during the investigation, protective intervention and protection order phases of Child Protection intervention.

Recommendation 4

That the Department of Health and Human Services develop practice advice in relation to children involved with Child Protection who are identified as at risk of suicide. Practice advice should confirm the importance of information gathering, information sharing and service coordination, and include requirements to gather and consider:

- information regarding the child's involvement with different mental health services
- a child's mental health diagnosis
- any known history of exposure to abuse, harm or trauma
- a child's treatment plan and (where relevant) any actions taken or planned to address any history of exposure to abuse, harm or trauma
- the existence of any parent-related issues that may be impacting a child's ability to successfully engage in therapeutic intervention
- the existence of any placement-related issues that may be impacting a child's ability to successfully engage in therapeutic intervention
- identifying which service or agency involved is able to co-ordinate a child's access to mental health and other relevant services.

Recommendation 5

That the Victorian Government commit to proceeding with, and investing in, the Child Link Register, with a view to ensuring commencement of its operation by 31 December 2021.

Recommendation 6

That the Department of Health and Human Services develop and implement a suicide prevention strategy for children known to Child Protection that incorporates any relevant findings and recommendations made by the Royal Commission into the Victorian Mental Health System.

For noting

The Commission will provide a copy of the inquiry to the Royal Commission into the Victorian Mental Health System, and ask that consideration be given to its findings, particularly those relevant to:

- the points of intersection between the child protection, child and family service and mental health systems
- the need for greater levels of specialist early intervention mental health services for children known to have experienced harm and abuse.

Chapter 1
Introduction

The Commission is an independent statutory body established to promote improvement and innovation in policies and practices affecting the safety and wellbeing of Victorian children. The Commission's oversight functions have a particular focus on vulnerable children.

Jurisdiction

The inquiry was formally established on 3 July 2019 pursuant to section 39 of the *Commission for Children and Young People Act 2012* (the CCYP Act), which provides that the Commission may conduct an own motion inquiry into the provision or omission of services provided by a health service, human service or school to a group of vulnerable children or young persons. The CCYP Act does not provide jurisdiction to review services provided by non-government schools or review the appropriateness or otherwise of clinical decision-making by a registered health practitioner.

Under section 34 of the CCYP Act, the Commission conducts child death inquiries for any child who was a client of Child Protection at the time of death or within 12 months of the death. This inquiry reviewed a sample of child death inquiries completed by the Commission (formerly the Office of the Child Safety Commissioner) between 1 April 2007 and 1 April 2019, where the cause of death was suicide.

Terms of reference

- Consider the circumstances and experiences of 35 children who died by suicide and identify the points at which service intervention occurred.
- Assess the effectiveness of service interventions delivered, with a particular focus on early intervention.
- Review the coordination and integration of services delivered across multiple systems.
- Identify how the children's experiences may inform suicide prevention strategies for other children in contact with the child protection system.

Methodology

The methodology involved:

- analysis of relevant legislation, policy and practice manuals, previous reviews relating to the provision of child protection and mental health services to children, and human rights requirements[10]
- conducting a literature review relevant to adolescent vulnerability, youth suicide and mental health
- reviewing current data relevant to statutory child protection and youth suicide
- identifying child death inquiries where the Commission nominated suicide as the cause of death between 1 April 2007 and 1 April 2019
- reviewing in detail, issues identified in the child death inquiries finalised in the last five years, between 1 April 2014 and 1 April 2019
- reviewing each child death inquiry, noting in particular where reports included interviews with families, carers and services
- aggregating data from each child death inquiry to ascertain the circumstances of the child's background, protective risks and strengths, and engagement with services.

10 For a full list of legislation and policies reviewed, see Appendix A.

Chapter 2
Service systems relevant to this inquiry

The child and family system

The child and family system describes the overarching service system for vulnerable children and families that includes:

- Child FIRST/The Orange Door
- voluntary family services
- statutory child protection.

The child and family system is designed to support families to address risks early by providing voluntary interventions designed to prevent children becoming involved in the statutory child protection system.

The statutory child protection and voluntary child and family service systems (Child FIRST/The Orange Door/IFS) are important subsets of the broader child and family system, and for this reason, are referenced as separate systems by the inquiry.[11]

Vulnerable children and families

Victoria's Vulnerable Children – Our Shared Responsibility Strategy 2013–2022 defined children as vulnerable 'if the capacity of parents and family to effectively care, protect and provide for their long-term development and wellbeing is limited'.

Children may be vulnerable for a range of reasons:

- a parent, family member or caregiver may have a history of trauma, family violence, substance abuse issues or mental illness
- a child may have health issues or disability
- there may be societal factors, including poverty, low-quality housing, and community or cultural disconnection.

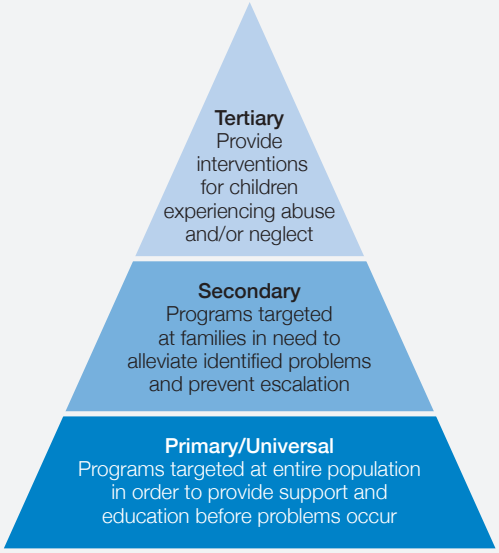
Some unborn children may be identified as vulnerable during a women's pregnancy if particular risk factors are present.

Early intervention

The inquiry refers to early intervention services as intervention that occurs when vulnerabilities have been identified for the child or their family. The role of child and family services is to provide critical, timely and responsive services before risks and concerns escalate and lead to Child Protection intervention.

Figure 1 shows the public health model, which describes the range of interventions that apply to protecting children.

Figure 1: Public health pyramid



Source: Bromfield and Holzer (2008)

11 None of the children reviewed by this inquiry had contact with The Orange Door.

The model depicts a pyramid of escalating interventions:

- Primary or universal interventions are strategies that target whole communities or populations in order to build public resources and attend to the societal factors that contribute to child maltreatment (for example, maternal and child health nurses).
- Secondary interventions are intended to target families who are at risk (or exhibit risk indicators) for child maltreatment and prioritise early intervention (for example, Child FIRST and family services).
- Tertiary interventions are intended to target families in which child maltreatment has already occurred.

Statutory child protection system

The Department of Health and Human Services (the department) operates Victoria's Child Protection service. Child Protection's main functions reflect functions set out in the *Children, Youth and Families Act 2005* and include:

- receiving reports from people with a significant concern for a child's wellbeing or who believe a child is in need of protection[12]
- investigating reports that suggest 'a child is at risk of significant harm' and may be in need of protection,[13] as defined in section 162 of the CYFA (see box adjacent)
- referring children and families to services, including community-based child and family services, 'that assist in providing the ongoing safety and wellbeing of children'[14]
- applying to the Children's Court for a protection order 'if the child's safety cannot be ensured within the family'[15]
- administering protection orders made by the Children's Court.[16]

For a summary of the legal frameworks used when making decisions under the CYFA, please refer to Appendix B.

Section 162 of the CYFA: When is a child in need of protection?

Section 162 provides that a child is in need of protection if certain grounds exist, including:

- the child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, from that type of harm
- the child has suffered, or is likely to suffer, significant harm, as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from that type of harm
- the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that their emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from that type of harm
- the child's physical development or health has been, or is likely to be, significantly harmed and the child's parents have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.

The harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances.

12 Part 3.2 and sections 183-184, CYFA.

13 Department of Health and Human Services, 'Families & Children: Child protection', at https://services.dhhs.vic.gov.au/child-protection, as at 19 August 2019; sections 30, 34 and 187 and Part 4.6, CYFA.

14 Department of Health and Human Services, 'Families & Children: Child protection', at https://services.dhhs.vic.gov.au/child-protection, as at 19 August 2019; sections 30 and 187, CYFA.

15 Department of Health and Human Services, 'Families & Children: Child protection', at https://services.dhhs.vic.gov.au/child-protection, as at 19 August 2019; Parts 4.7-4.9. CYFA.

16 Department of Health and Human Services, 'Families & Children: Child protection', at https://services.dhhs.vic.gov.au/child-protection, as at 19 August 2019.

Phases under the Child Protection Manual

The Child Protection Manual sets out five 'phases' of work reflecting Child Protection's functions: intake, investigation, protective intervention, protection order and case closure:

- **intake**, where Child Protection receives and assesses reports and decides on the appropriate response
- **investigation**, where Child Protection investigates reports assessed as being 'protective intervention reports' to determine whether a child requires protection, as defined by section 162 of the CYFA
- **protective intervention**, which is a 'period of intervention with a child and family' following an investigation finding that a protective intervention report is substantiated, and may include seeking a protection order in the Children's Court if Child Protection considers a child is in need of protection
- **protection order**, where Child Protection administers a protection order
- **closure**, which can occur during any of these phases.

Further detail about each phase is provided in Appendix A.

Substantiation

Substantiation is a possible outcome of the investigation phase. The Child Protection Manual states:

The substantiation decision will focus on whether the protective intervener is satisfied on reasonable grounds that a child is in need of protection. This generally involves considering whether the child has experienced, or is likely to be at risk of, significant harm to their safety or development and will focus on current and past harm, and an assessment of likelihood of future harm. An assessment of a person's responsibility for causing harm or likely capacity to cause harm to a child is connected with the substantiation decision.

Increases in Child Protection reports

Reports to Child Protection have surged in the last decade. In the decade from 2007–2008 to 2017–2018, reports to Child Protection almost tripled – from 41,607 to 115,600. Over the same period, investigations substantiated tripled from 6,365 to 18,333.[17]

In its 2017–2018 Annual Report, the department reported that Child Protection received a lower number of reports than forecast for that financial year (121,600). This is described as being 'due to slower growth than historically has occurred as reforms to the intake system provide more appropriate referral pathways'.[18]

In December 2018, the department reported:

> *The number of reports received in 2017–18 was 4.2 per cent higher than the number in the previous year, while investigations increased by 8.5 per cent. Substantiations showed a 10.9 per cent increase from the previous year. Of the 18,621 substantiated cases 3,335 (18.0 per cent) involved children who had been part of a previously substantiated case that had been closed in the previous 12 months.*[19]

Voluntary child and family service system

The CYFA has a focus on early intervention through community services for children and families. One of the main purposes of the CYFA is 'to provide for community services to support children and families'.[20] The Secretary may register organisations as community-based child and family services and allocate funds to them.[21] The CYFA sets out the services' purposes, including providing 'a point of entry into an integrated local service network that is readily accessible by families, that allows for early

17 ROGS Child Protection Services, Table 16A.4 (2019).
18 Department of Health and Human Services annual report 2017–2018, page 92.
19 Department of Health and Human Services, Child Protection and family services additional service delivery data 2017–2018, page 4.
20 Section 1(a).
21 Sections 23 and 46-47.

intervention in support of families and that provides child and family services'.[22]

These provisions were part of major system reforms in 2005 that aimed to increase 'earlier intervention where families have problems'[23] and 'bring the earlier intervention sector and child protection sector together and link them to early childhood services to form a more coordinated system'.[24]

Establishment of the CYFA provided the legal framework for 'a new model of earlier intervention, prevention and service coordination' based on 'community-based intake, assessment and referral services'.[25]

As the then Minister for Children explained, these services would provide 'entry points into voluntary community services' – rather than 'over-relying on child protection to provide a gateway into services for children and families' – and this system would provide 'flexible and graduated' responses for families according to their risks and needs, with community-based services focussing on helping families 'before problems escalate to the point that the children are placed at risk of significant harm' and Child Protection focussing on its 'specialist function' of intervening when children need protection.[26] It was envisioned that the sectors would work together in partnership, and family support services would be targeted to assist 'the most vulnerable children, young people and families'.[27]

Child FIRST and Integrated Family Services (family services)

To give effect to the 2005 legislation, Child and Family Information, Referral and Support Teams (Child FIRST) were established in 2007 as the 'new central community-based intake model' in an 'integrated system of family services' within catchment areas.[28] This system was a central component of the 2007 reform framework, *A Strategic Framework for Family Services*, and came to be known as Child FIRST and IFS (family services). Before Child FIRST was introduced, 'there were multiple entry points into family services, which had led to inefficient and sometimes duplicated services'.[29]

Child FIRST was based on a successful trial conducted by the then Department of Human Services from 2003 to 2006 and implemented from 2007 to 2009.[30]

From that time – and for the period reviewed for this inquiry – Child FIRST has operated as an entry point into the community-based child and family service system, with the object of providing an 'easily accessible entry point' in each catchment area.[31] Its role has been to receive referrals from anyone in the community;[32] conduct intake; engage with families and make initial assessments of risks and needs 'to determine the priority of a response'; and, if necessary, connect vulnerable children, young people and families with family services provided by IFS services (IFS providers) in the local area, to prevent escalation of problems and divert families from becoming involved with Child Protection.[33]

22 Section 22(a). The other purposes are: receiving referrals about vulnerable children and families where there are significant concerns about their wellbeing (s 22(b)); assessing children and families' needs and risks, to assist in the provision of services to them and in determining if a child is in need of protection (s 22(c)); making referrals to other relevant agencies if necessary to assist vulnerable children and families (s 22(d)); promoting and facilitating integrated local service networks working collaboratively to co-ordinate services and supports to children and families (s 22(e)); providing ongoing services to support vulnerable children and families' (s 22(f)).

23 Department of Human Services 2007, *A strategic framework for Family Services*, pages 79-80.

24 Second Reading Speech, *Children Youth and Families Bill*, Minister for Children, 6 October 2005, page 1370.

25 Ibid

26 Ibid

27 Ibid

28 Victorian Auditor-General's Report 2015, *Early Intervention Services for Vulnerable Children and Families*, page 5; Department of Human Services 2007, *A strategic framework for Family Services*, page 7.

29 Ibid

30 Ibid

31 Department of Health and Human Services 2018, 'Child FIRST and family services' at **https://services.dhhs.vic.gov.au/child-first-and-family-services**, as at 24 August 2019; Victorian Auditor-General's Report 2015, *Early Intervention Services for Vulnerable Children and Families*, page 7.

32 Sections 31-32, CYFA; Department of Health and Human Services 2018, 'Child FIRST and family services' at **https://services.dhhs.vic.gov.au/child-first-and-family-services**, as at 24 August 2019

33 Victorian Auditor-General's Report 2015, *Early Intervention Services for Vulnerable Children and Families*, pages 7-9; Lonne, B, Brown, G, Wagner, I & Gillespie, K 2015, 'Victoria's Child FIRST and IFS differential response system: Progress and issues', *Child Abuse & Neglect*, 39, pages

Child FIRST can receive referrals from Child Protection and consult with or make referrals to Child Protection. Its functions have also included providing information and advice and 'deliver[ing] timely responses through the provision or oversight of "active-holding responses" that involves [sic] short-term work with children and families, before they are allocated to family services'.[34]

The department has 'the oversight and leadership role of funding the community-based organisations and operated alliances in each catchment area to support an integrated and coordinated service response'.[35] The alliances have included Child FIRST, family services, Child Protection, the Department and, 'where capacity exists', an Aboriginal Community-Controlled Organisation.[36]

In 2013–2014, 96 community-based child and family services were registered and funded by the Department to provide Child FIRST and family services.[37] The number of assessments and interventions provided by Child FIRST increased each year from 2014–2015 (13,576) to 2017–2018 (22,310).[38]

The child and family service system is now undergoing further reform, with a strong focus on early intervention. The department's *Roadmap for Reform: strong families, safe children*, released in 2016, aims to transform 'Victoria's children and family services system' by moving 'from crisis response to prevention and early intervention'.[39]

A key strategic focus is 'integrated wraparound supports and targeted early interventions for children and families in need'.[40] As part of the changes, Child FIRST is progressively transitioning to the new support and safety hubs for women, children and young people experiencing family violence – The Orange Door – that also provide support to families needing help with children or young people's care, wellbeing and development.[41] This 'migration of Child FIRST into the Orange Door' is 'to enable family support and specialist family violence practitioners to work side-by-side and combine their expertise to improve responses to both women and children'.[42]

2015 VAGO audit of Child FIRST and family services

An audit of early intervention services by VAGO in 2015 found that 'Child FIRST and (family services) are failing to provide effective services for vulnerable children and families'[43] and recommended the department undertake a 'comprehensive and urgent review of its current approach to early intervention'.[44] VAGO identified issues including:

- the number and complexity of cases referred to Child FIRST and family services had increased significantly,[45] and Child FIRST and IFS were 'operating above their funded capacity'[46]
- the department had not forecast demand for services or responded to drivers such as family violence adequately[47]
- families who needed early intervention were missing out on services.

The Auditor-General wrote:

> *I found that Child FIRST and (family services) are struggling to cope with the increased number and complexity of referrals. This means that increasingly these services need to focus on families with high needs rather than those families assessed as low or moderate risk. Yet these are the very families that would benefit most from being able to access early intervention services—when intervention is early enough to prevent escalation.*[48]

42–43 and 46.

34 Ibid, page 8.

35 Ibid

36 Ibid

37 Ibid, page 6.

38 Department of Health and Human Services annual report 2017–2018, page 52. Child FIRST provided 15,190 assessments and interventions in 2015–2016 and 20,016 in 2016–2017.

39 Department of Health and Human Services annual report 2017–2018, page 14.

40 See https://www.strongfamiliessafechildren.vic.gov.au/roadmap-for-reform-strong-families-safe children.

41 Department of Health and Human Services annual report 2017–2018, page 38; Department of Health and Human Services 2018, 'Child FIRST and family services' at https://services.dhhs.vic.gov.au/child-first-and-family-services, as at 24 August 2019.

42 Department of Health and Human Services annual report 2017–2018, page 43.

43 Victorian Auditor-General's Report 2015, *Early Intervention Services for Vulnerable Children and Families*, page xii.

44 Ibid, page xiii.

45 Ibid, page xiii.

46 Ibid, page xiii.

47 Ibid, page xiii.

48 Ibid, pages vii–viii.

VAGO recommended that the comprehensive and urgent review include the 'whole-of-system funding for early intervention to better reflect the impact of demand drivers' on Child FIRST and family services.[49] The department accepted VAGO's recommendations.

Demand versus investment in Child FIRST and family services

The last decade has seen a rapid increase in demand for statutory child protection and child and family services. It is widely acknowledged that the increase in demand has included an increase in demand for families experiencing 'complex' issues.

For example:

- reports to Child Protection have almost tripled in 10 years, from 42,000 in 2007–2008 to 115,000 in 2017–2018
- the number of new cases opened by Child FIRST has increased six-fold in 10 years, from 3,888 in 2007–2008[50] to 22,332 in 2017–2018
- more than 80 per cent of families (18,130 cases or 81 per cent) referred to Child FIRST in 2017–2018 presented with complex issues such as family violence, mental health, substance abuse and disability, compared with 66 per cent in 2013–2014, and 55 per cent in 2007–2008[51]
- more than half of families (6,402 cases) who received help from a family service in 2017–2018 were identified to have two or more complex issues, compared with one-third of cases in 2013–2014 (3,436), and one-fifth in 2007–2008 (2,660 cases).

Currently, demand for Child FIRST and family services exceeds the funding provided to the sector. This has been the case since 2011–2012.[52]

Despite a 474 per cent increase in new Child FIRST cases in the last 10 years, funding for Child FIRST and family services has only increased by 176 per cent.

The department has, however, sought to address the need for longer-term responses for families experiencing complex issues by adopting a targeted approach to its investment. The Commission acknowledges that since 2014–2015, allocation of funding to Child FIRST and family services has shifted towards investment in the delivery of longer forms of family service response.

For example, in 2017–2018, just over half of funds allocated to Child FIRST and family services were directed towards the delivery of long and intensive responses by family services ($71,563,897.90 or 52 per cent of total spend).[53]

Table 1: Number of new cases opened 2007–2018

Case type	2007 –2008	2008 –2009	2009 –2010	2010 –2011	2011 –2012	2012 –2013	2013 –2014	2014 –2015	2015 –2016	2016 –2017	2017 –2018
Child FIRST	3,888	7,331	8,244	9,194	10,169	11,849	12,711	13,891	16,485	21,204	22,332
Family Services	12,359	10,129	8,528	9,531	10,463	10,607	10,317	11,655	12,337	12,570	12,712

49 Ibid, page xiii.

50 The Commission notes that the establishment of Child FIRST was based on a successful pilot between 2003 and 2006, and that full rollout of Child FIRST across Victoria did not occur until 2009–2010.

51 *Roadmap to Reform: strong families, safe children*, Department of Health and Human Services, Victorian Government Printer, April 2016 at page 10.

52 *Early Intervention Services for Vulnerable Children and Families*, Victoria Auditor-General's Report, Victorian Government Printer, May 2015 at page 23.

53 Calculation based on unit prices extracted from the department's financial systems. Total spend calculated by references to case targets as $137,454,955.50.

The change in funding has translated to changes in the following case targets:

- Child FIRST entry response (up to 10 hours) increased by 333 per cent
- family services entry level response (up to 10 hours) decreased six per cent
- family services short response (between 10 and 40 hours) increased 29 per cent
- family services long response (between 40 and 110 hours) increased 61 per cent
- in 2014–2015, a new family services intensive response (between 110 and 200 hours) was introduced, and case targets for this form of response have increased 371 per cent in the last three years.

This means that cases allocated to a family service are now more likely to receive a longer, and more intensive response than 10 years ago. For example, the average number of hours allocated per family by family services has increased from 29 hours in 2007–2008, to 79 hours in 2017–2018, a 172 per cent increase in hours per case.

It is positive to note that targeted investment in the Child FIRST and family service sector has improved the type and intensity of response available to some families.

However, based on allocation rates from 2017–2018, only one in three cases featuring a complex issue will be allocated a family service.[54]

For example:

- Of the Child FIRST referrals received in 2017–2018, less than 40 per cent of these cases resulted in allocation to a family service (8,362 cases or 37 per cent).
- Of the reports that remained unallocated, over 80 per cent involved between one and six complex issues (11,525 cases or 82 per cent).
- Concerningly, over 20 per cent of the unallocated cases involved between three and six complex issues (2,529 cases or 22 per cent).

This means that families identified as having complex issues are nearly twice as likely to not be allocated a family service, and receive instead, only limited entry-level help from Child FIRST.[55] In 2017–2018, 81 per cent of cases referred to Child FIRST had between one and six complex issues (18,130), and of these, only 37 per cent were allocated a family service (6,605). Put another way, 63 per cent of cases identified as having up to six complex issues were not allocated an IFS (11,525 cases).

Despite targeted investment, the actual number of new cases being opened by family services remains concerningly static. The number of new cases opened by family services in 2007–2008 was 12,359, compared with 12,712 in 2017–2018.

Table 2: Allocation rates to family services by complexity 2017–2018

New cases started			No. of complexities								
Financial year	Case type	Case allocated	0	1	2	3	4	5	6	7	Total
2017–2018	Child FIRST	Yes	1,757	2,442	1,994	1,408	632	114	15	0	8,362
		No	2,445	5,461	3,535	1,830	585	102	12	0	13,970

Source: DHHS

54 Calculation based on 2017–2018 cases allocated an IFS (where there is an identified complex issue) (6,605 cases) compared with total cases referred to Child FIRST (where there is an identified complex issue) (18,130 cases), 37 per cent allocation rate.

55 Calculation based on 2017–2018 cases not allocated an IFS (where there is an identified complex issue) (11,525 cases) compared with total cases referred to Child FIRST (where there is an identified complex issue) (18,130 cases), 64 per cent non-allocation rate.

Table 3: Victoria's comparative investment in child protection services 2013–14 to 2017–2018

Year	Statutory child protection (including out-of-home care)	Intensive family support services and family support services
2013–2014	$618,766,000 (75%)	$201,345,000 (25%)
2014–2015	$665,435,000 (75%)	$215,313,000 (25%)
2015–2016	$733,845,000 (75%)	$244,068,000 (25%)
2016–2017	$816,053,000 (74%)	$282,523,000 (26%)
2017–2018	$942,687,000 (73%)	$350,128,000 (27%)

Source: RoGS, Table 16A.7

At the same time, most of Victoria's investment in the broader child and family system is directed towards statutory services at the crisis end. Statutory services relate to those delivered by Child Protection in response to protective intervention and when a child enters out-of-home care. Over the five years from 2013–2014 to 2017–2018, early intervention services received around a quarter of the total investment, with around three-quarters going into statutory Child Protection services.

It is important to acknowledge that despite child and family services receiving only one-third of the funds provided to statutory child protection, investment in child and family services has increased 74 per cent since 2013–2014, a higher rate of increase than in statutory services (52 per cent).

The Commission also recognises that considerable investment has been made into the rollout of The Orange Door.

This inquiry demonstrates however, that further investment and reform in line with the commitments made in *Roadmap to Reform* are urgently needed.

The child and youth mental health service system

The mental health service system for children and young people consists of a complicated patchwork of services funded by the Victorian Government and the Australian Government, including through Primary Health Networks (PHNs) and the Medicare Benefits Schedule (MBS).

The department distributes funding to Victoria's public mental health services for children and young people with moderate to severe mental health problems. These include child and adolescent mental health services (CAMHS) for people up to 18 years of age, and child and youth mental health services (CYMHS), which has expanded eligibility to 25 years of age and were developed in recognition that 'current barriers between CAMHS and adult mental health services fall at a critical developmental time, and need to be addressed through a response tailored to this age group'.[56]

CAMHS and CYMHS support children and young people through a mix of community-based or outpatient programs and inpatient treatment in hospitals, as well as a small number of community residential programs.

There are also early intervention *headspace* centres for young people aged 12 to 25 years with mild to moderate mental health problems, which are supported by Australian Government funding. These offer enhanced primary care services, including mental health, physical and sexual health, and life skill support around work and study in an accessible, youth-friendly environment 'spanning the divide between traditional child and adult services'.[57]

56 'Child and Adolescent Mental Health Services' at https://www2.health.vic.gov.au/mental-health/mental-health-services/area-based-services/services-for-children-and-adolescents/child-and-adolescent-mental-health-services.

57 Victorian Auditor-General's Report 2018, *Child and Youth Mental Health*, page 20; McGorry, PD 2018, 'Beyond Psychosis: Early Intervention and Youth Mental Health', *Journal of the American Academy of Child & Adolescent Psychiatry*, Volume 57, Issue 10, S77.

There are 27 *headspace* centres in Victoria, and 102 nationally.[58]

PHNs were introduced in 2015. There are 32 PHNs across Australia, with six in Victoria. They plan, commission and co-ordinate mental health services, with funding provided by the Australian Government. PHNs have had a role in 'maintain[ing] service delivery within headspace centres, in line with the existing headspace service delivery model' and 'improv[ing] the integration of headspace centres with broader primary mental health care services; physical health services; drug and alcohol services; and social and vocational support services'.[59]

Children and young people who need support for mental ill-health also see general practitioners and private psychologists and psychiatrists, who provide rebated services on the MBS.

The 2019 VAGO report into child and youth mental health

The recent VAGO report *Child and Youth Mental Health* identified successive failures of the Victorian Government to articulate a framework for child and youth mental health services.

The Auditor-General wrote:

> *Under-resourcing combined with a lack of DHHS service co-ordination and oversight mean that many vulnerable Victorians cannot access [child and adolescent mental health services] for the support they need. Those who do get access often need multiple providers that are unable to coordinate around their shared clients' needs …*
>
> *Our analysis of three years of client groups accessing [child and adolescent mental health services] shows that the rates of vulnerable client groups accessing them is low compared to less vulnerable groups.*

VAGO concluded that Victoria's child and youth mental health system is fragmented, over-stretched, under-resourced and unable to meet service demand, and that many children and young people cannot access the support they need.[60] VAGO's findings are consistent with observations in other recent reviews, and from the sector itself. The 2017 Armytage and Ogloff *Youth Justice Review and Strategy* found that '[s]ystem gaps and demand pressures on mental health services currently limit the access of all young Victorians to essential mental health services'.[61]

Royal Commission into Victoria's Mental Health System

In February 2019, the Premier the Honourable Daniel Andrews MP and Minister for Mental Health, the Honourable Martin Foley MP released the terms of reference for the Royal Commission into Victoria's Mental Health System.

The Royal Commission has been asked to make recommendations on how to most effectively prevent mental illness and suicide, and support people to recover from mental illness, early in life, early in illness and early in episode, through Victoria's mental health system, and in close partnership with other services.

The Commission hopes this inquiry will be considered as a contribution to the Royal Commission's task, particularly its findings relevant to the points of intersection between the child protection, child and family service and mental health systems. The Commission's submission to the Royal Commission can be found on our website at **https://ccyp.vic.gov.au/upholding-childrens-rights/submissions/.**

58 headspace Annual Report 2018, page 6.

59 Department of Health, 'PHN Primary Mental Health Care Flexible Funding Pool Implementation Guide (2016–17)', page 1.

60 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 8, 24, 26, 79.

61 *Youth Justice Review and Strategy 2017*, part 2, page 45.

Chapter 3
Suicide and adverse childhood experiences

In Victoria, the main cause of death for children aged between 15–17 years is intentional self-harm or suicide. In 2017, the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) reported that:

- suicide was the main cause of death for children who died when aged 15–17 years (30.4 per cent)
- suicide was an attributed cause of death for 12.5 per cent of children who died when aged 10–14 years
- rates of death due to intentional self-harm should be viewed as an underestimate.[62]

Suicide and adverse childhood experiences

Adverse childhood experiences are situations which lead to an elevated risk of children experiencing damaging impacts on health, or other social outcomes across the life course.[63] It is not always the case that children will be harmed by exposure to adverse childhood experiences, however, evidence consistently shows that children who are exposed to adverse childhood experiences are at a greater risk of death or injury before reaching adulthood.

Early adverse childhood experiences, such as physical and sexual abuse and parental neglect are risk factors for suicidal behaviour in adolescence.[64]

Research has found that adolescents who are sexually or physically abused in childhood are two to five times more likely to attempt suicide than those who do not have such experiences:[65]

- a 2007 Scandinavian study found that adolescents who had experienced sexual or physical abuse in childhood were at a greater risk of suicide[66]
- a 2008 American study identified an association between childhood physical abuse, witnessing family violence and suicide related behaviours[67]
- a 2010 Canadian study confirmed the link between physical abuse and suicide related behaviours in children under the age of 18[68]
- the renowned New Zealand longitudinal study, the Dunedin Multidisciplinary Health and Development Study, conducted over a 21-year period using a randomly selected group of 1,265 participants, found that rates of suicidal behaviour were related to a wide range of factors, including neglect in early

62 https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality/mothers-babies-children-report

63 Briere, J et al (2015) Traumatic stress, affect dysregulation and dysfunctional avoidance: a structural equation model, *Journal of Traumatic Stress*, 23 (6), pages 767–774.

64 Brodsky B et al, *Adverse Childhood Experiences and Suicidal Behaviour, Psychiatric Clinics*, Volume 31, Issue 2, June 2008, pages 223–235.

65 Dube, S, Anda, R, Felitti, V, Chapman, D, Williamson, D & Giles, W, 'Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings from the Adverse Experiences Study', *Journal of the American Medical Association*, vol. 266, no. 24, 2001, p. 3094; Mironova, P, Rhodes, A, Bethell, J, Tonmy, L, Boyle, M, Wekerle, C, Goodman, D & Leslie, B, 'Childhood physical abuse and suicide-related behaviour: A systemic review', *Vulnerable Children and Youth Studies*, vol. 6, no. 1, 2011, pages 1–7.

66 Brent, D.A., Perper, J.A., Moritz, G., Liotus, L., Schweers, J., Balach, L. and Roth, C. (2007) 'Familial risk factors for adolescent suicide: A case-control study.' *Acta Psychiatrica Scandinavica* pages 89, 1, 52–55

67 T Afifi, M Enns, B Cox, G Asmundson, M Stein & J Sareen, 'Population Attributable Fractions of Psychiatric Disorders and Suicide Ideation and Attempts Associated with Adverse Childhood Experiences', *American Journal of Public Health*, vol. 98, no. 5, 2008, pages 946–952.

68 Dube, S, Anda, R, Felitti, V, Chapman, D, Dilliamson, D & Giles, W, 'Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings from the Adverse Experiences Study', *Journal of the American Medical Association*, vol. 266 no. 24, 2001, page 3094.

childhood, impaired parenting and poor family function and family violence[69]

- a 2011 Israeli study found that adolescent in-patients exhibiting severe suicidal behaviours reported higher levels of family dysfunction, including physical and emotional abuse and lower levels of maternal bonding when compared with non-suicidal adolescent in-patients.[70]

Early adverse childhood experiences that are traumatic in nature and occur cumulatively have been strongly associated with a significantly increased risk of mental health problems, including post-traumatic stress, eating disorders, depression, anxiety, substance use and suicidality.[71] Research has consistently found that an accumulation of adverse childhood experiences increases the likelihood of poor outcomes for children, particularly when compared with isolated experiences of adversity:

- the 'Adverse Childhood Experiences Study: A Springboard to Hope' (the ACE Study), analysed the lifetime experiences of more than 17,000 people in the United States and identified 10 categories of childhood trauma that predict health, behavioural and social problems as adults
- the ACE Study found that the more categories of trauma experienced in childhood, the more likely it is that a young person will suffer a greater number of health effects, including an increase in the risk of suicide.[72]

It is important to note that categories of adverse childhood experiences are risk factors rather than predictive factors. The extent and depth of impact of cumulative harm on a child or young person will depend largely on the resilience of the individual. The effect of cumulative harm, irrespective of resilience, remains a risk for children.

69 https://dunedinstudy.otago.ac.nz/

70 Freudenstein, O, Zohar, A, Apter, Al, *European Psychiatry*, Published online: 11 March 2011. Doi: 10.1016/j.eurpsy.2011.01.006, 2011

71 Greene, CA, et al (2014) Posttraumatic stress mediates the relationship between childhood victimisation and current mental health burden in newly incarcerated adults, *Child Abuse and Neglect*, 38 (10), pages 1569–1580

72 http://acestudy.org/index.html

Aboriginal children and intergenerational trauma

Aboriginal people in Australia experience significantly lower life expectancy and much higher rates of suicide, with suicide being the leading cause of death for Aboriginal people aged between five to 17 years.[73]

While there is no data relating specifically to Victorian Aboriginal children and young people, the higher rates of psychological distress and higher rates of suicide among Aboriginal children and young people nationally are well-known[74] – and recognised nationally as requiring urgent action.[75] Last year, the Australian Institute of Health and Welfare reported that Victoria (along with Tasmania) had the highest rate of Aboriginal young people aged 15 to 24 years reporting mental health conditions.[76] This is the 'most vulnerable age group of Indigenous Australians… where suicide is over five times more prevalent than in non-Indigenous Australians of the same age'.[77]

The systemic disadvantages faced by Aboriginal families and the overrepresentation of Aboriginal children in the child protection system and in data collected on suicide cannot be understood without recognising the impact of colonisation across generations, including the loss of culture and forced removal of children from their families. This fundamental disruption to social order occurred due to dispossession and continues to be repeated.[78]

73 https://www.beyondblue.org.au/who-does-it-affect/aboriginal-and-torres-strait-islander-people/close-the-gap

74 See, for example, Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 8 and 82. Also see the Australian Institute of Health Welfare's report *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018.*

75 See National Mental Health Commission Media Release, *Government-led roundtable meeting to review investment to date in mental health and suicide prevention*, 5 June 2019; Royal Australasian College of Physicians Media Release, *Health bodies declare Aboriginal youth suicide an urgent national priority*

76 Australian Institute of Health Welfare 2018, *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018*, Cat. no. IHW 202. Canberra: AIHW, page 129.

77 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027*, page 17

78 *Neither seen nor heard*, Commission for Children and Young People (2016), page 19.

The transmission of trauma across generations is now widely accepted as having had a devastating impact on the social, emotional and health wellbeing of Aboriginal children.[79]

Contact with the statutory child protection system

National and international research has found that children who have had contact with the child protection system are at an increased risk of suicide.

In 2001, a New Zealand study found that:

> *Young people in contact with [Child Protection] are about 10 times more likely to kill themselves than New Zealand youth of the same age who have never had contact with the Department.*[80]

In its summary of findings, the New Zealand study was careful to emphasise that the results recorded were 'not intended to imply that contact with child protection services contribute to children committing suicide',[81] but rather confirm, that young people who come into contact with the statutory children protection system are, by definition, a population at a particularly high-risk of suicide. They are at an increased risk because they tend to have many of the risk factors which have been shown to be associated with suicidal behaviour.

In 2012, a Canadian study found that people who had experienced child protection services had significantly worse mental health outcomes over their lifetime and were more likely to report suicide attempts, compared with adults who reported an experience of child abuse but had not had contact with Child Protection.[82]

In 2015, the New South Wales Ombudsman's office reviewed the deaths of all children who had suicided in 2014. There were 26 deaths reviewed, with eight recorded as having had contact with the child protection system. The report found that the children who had a history of child protection involvement were four times more likely to die from suicide than children who have had no contact or involvement with child protection services.[83]

In 2016, the Queensland Family and Child Commission released its Annual Report into the deaths of children in Queensland for 2015–2016. It examined 20 deaths of young people attributable to suicide:

> *Of the 20 deaths, five (25%) were of young people known to the Queensland child protection system within the year before their death. An increased risk of suicide is identified among children known to child protection agencies.*[84]

In its 2017 Annual Report, the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) stated that:

> *Children and adolescents with previous or current involvement with Child Protection or Youth Justice are over-represented among those who commit suicide.*[85]

In 2018, in its Annual Report into the deaths of children in Queensland for 2016–2017, the Queensland Family and Child Commission found:

> *An increased risk of suicide has been identified among children and young people known to child protection agencies. The suicide rate for young people known to the child protection system in the 12 months prior to their death was three times the Queensland average for all children over the last three reporting periods.*[86]

79 Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2005*, Sydney, Human Rights and Equal Opportunity Commission.

80 Beautrais, A, Ellis, P and Smith, D, 'The risk of suicide among youth in contact with Child, Youth and Family', *Social Work Now*, no. 19, 2001, page 9.

81 Beautrais, A, Ellis, P and Smith, D, 'The risk of suicide among youth in contact with Child, Youth and Family', *Social Work Now*, no. 19, 2001, page 9.

82 Afifi TO, McTavish, J, Turner, S, MacMillan, HL, Wathen, CN, 'The relationship between child protection contact and mental health outcomes among Canadian adults with a child abuse history', *Child Abuse & Neglect*, Volume 79, 2018, pages 22–30, ISSN 0145-2134, https://doi.org/10.1016/j.chiabu.2018.01.019).

83 https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0009/28359/CDRT-Annual-Report-2014.pdf

84 https://www.qfcc.qld.gov.au/annual-report-deaths-children-and-young-people-queensland-2015–16

85 https://www.bettersafercare.vic.gov.au/sites/default/files/2019-05/Mother%27s%20Babies%20and%20Children%20Report%202017_FINAL-WEB.pdf, page 64

86 Annual Report, Deaths of children and young people in Queensland 2017–2018, page 49 https://www.qfcc.qld.gov.au/sites/default/files/Chapter_6__Suicide.pdf).

Chapter 3 at a glance

- In Victoria, suicide is the leading cause of death for adolescents aged 15–17 years (30.4 per cent).
- Suicide is the cause of 12.5 per cent of all deaths recorded for children aged 10–14 years.
- Factors which make children more vulnerable to suicide include cumulative exposure to adverse childhood experiences, including physical and sexual abuse and neglect.
- Aboriginal children and children who have contact with the child protection system are at a higher risk of dying by suicide.
- Children who have contact with the child protection system are at an increased risk of suicide because, as a population, they are more likely to present with the risk factors associated with suicide.

Chapter 4
The children and their experiences

'I'm really not safe here and it's really scary … [mum] can get really bad and scream and bash her head against the walls and I love her and she can be nice and she buys me things and really does care about me and love me but like what I've been through [with her] I really need support … I don't know if that's good information or not but I thought it might help you guys understand that it's not like one huge thing that stops me from being okay here it's a lot of little things as well.'

A child, aged 15 (extracted from a Child Protection file note)

The 35 children whose cases were examined died between 1 April 2007 and 1 April 2019. Fourteen of the children were female and 21 were male. Their ages at time of death ranged from 12 years, 11 months to 17 years, seven months. The average age at the time of death was 14 years, seven months. Due to the small numbers in the sample, comparisons with other data should be made with caution.

Figure 2: Children by age, sex, Aboriginal status

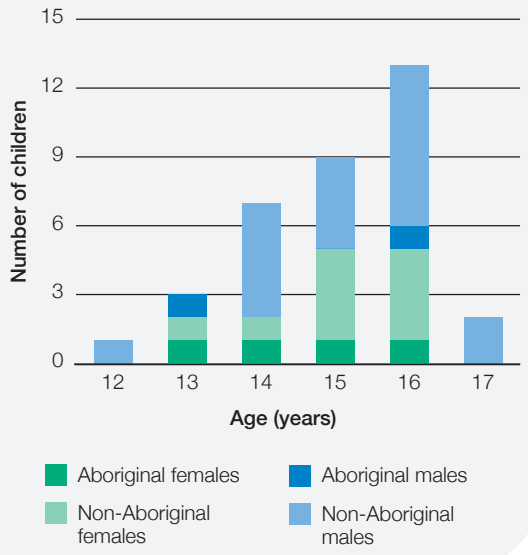


Figure 3: Geographic location prior to death

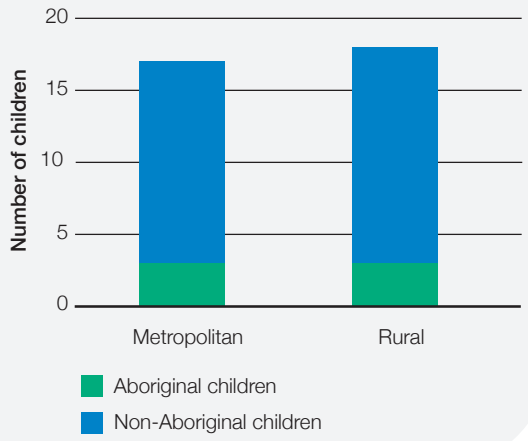


Table 4: Residence immediately prior to death

Residence at death	Aboriginal	Non-Aboriginal	Total
Living with at least one parent	4	21	**25**
Kinship care	2	2	**4**
Residential care	–	3	**3**
Independent living	–	3	**3**

Harms experienced by the 35 children

Descriptive details of the children's experiences of harm were not available in all cases. Where the information was available, it revealed that the children had, in almost all instances, experienced multiple and recurring forms of abuse, including family violence, neglect, sexual and emotional abuse. Of the many risk factors present in the lives of the children reviewed, the most prominent was family violence. Family violence was a feature of all cases, frequently in conjunction with parental mental health and substance abuse issues.

The harms that these children faced were often severe, as the examples in Table 5 demonstrate.

Table 5: Harms experienced by children as known to Child Protection

Nature of harm	Child and young person's experiences
Family violence	• Every case in the sample featuring family violence involved a history of violence toward the children's mother and children witnessing their assaults and injuries. • Several children witnessed severe physical and sexual violence perpetrated against their mothers. This included: a father punching a mother to the face and breaking her jaw, a step-father head-butting a mother, resulting in a broken nose, a father strangling a mother to the point of unconsciousness and incontinence, a mother being violently raped by a partner, a mother being thrown to the ground by her throat. As one child said to the police after witnessing a violent assault on her mother: *'If nothing is done, someone will end up dead'.* • Fifteen male children went on to perpetrate family violence against their mothers, siblings or partners. One child, at aged eight, self-reported to the police after assaulting his mother. Two years earlier he had witnessed his step-father hit his mother repeatedly with a chair. At 13, he threatened his mother with a weapon and told her he wanted to kill her. • All of the boys in the sample who had experienced family violence, had witnessed the perpetration of violence by their fathers or step-fathers. • Thirteen of the 14 girls in the sample had experienced family violence. The remaining child had alleged her parents used physical restraints to restrain her and was also reported as perpetrating family violence herself. The violence she was reported to perpetrate was not assessed to constitute family violence and the case was closed at intake. • Several girls who had witnessed family violence within the home had partnered with violent, sometimes much older males. • Early examples of neglect detailed an overall lack of parental supervision or ability to provide basic care. Two children were observed wandering in the streets unsupervised, late at night, sometimes with a younger sibling. This occurred in the context of feeling unsafe at home because of family violence. The parents of these two children had been raised in institutional care. Both were reported to have suffered institutional abuse.

Table 5: Harms experienced by children as known to Child Protection continued

Nature of harm	Child and young person's experiences
Family violence in combination with drug and alcohol abuse/ parental mental illness	• Several children witnessed their mother or father overdose on drugs. Two were required to call an ambulance. One witnessed their mother inject the family dog with heroin; another had a needle-stick injury as a result of stepping on a needle in their lounge room. • A number of children witnessed their mother or father self-harming or attempting suicide. One child who had witnessed their mother stab herself with a kitchen knife wrote to their Child Protection worker: *'Sorry about all this I feel really bad about it but it's been years and I can't wait any longer. [Mum] can get really bad and she'll scream and bash herself against the walls and I love her and she can be nice and she buys me lots of things and she really does care about me and love me but like after all I've been through I really need support and not only am I not getting support here I'm having the negative temptations and stuff as well here. I'm really not safe here and it's really scary and I'm sick of trying to be strong for the both of us all the time and being such a failure at it all.'* Child Protection closed the case investigation. The child died two weeks later. • One child described living with their mother, who struggled with substance issues and poor mental health: *'I don't know whether I'll get nice mummy or horrible mummy'*. This mother lived in a relationship with a partner who regularly beat her to the point of hospitalisation. The mother described a childhood marred by physical abuse and parental alcoholism.
Neglect, including transience	• One child was described as 'hungry, filthy and had flea bites all over [their] body'. Their mother was a young woman with a suspected learning disability and untreated mental illness. She was identified to have limited social or family supports. • There were cases involving children living week-to-week in different locations; one slept in a barn for two months and another lived and slept on the floor of a caravan. One child described that when the family moved, they moved quickly *'we don't take any personal things or electrical things'.* • An Aboriginal child, aged four at the time, was reported to be underweight, with insufficient access to food and water, which resulted in them drinking the water from a marijuana pipe (bong) while unsupervised. The house was described as *'filthy with dogs living inside and dog faeces on the floor'*. The child's parent was a reported victim of childhood sexual abuse who had used heroin since adolescence. • School lunches were frequently referenced: one child attended school with lunches that contained 'rancid meat', another with 'mouldy sandwiches' and 'mouldy food'. • One child's house was described as *'unclean, with electrical wires hanging from the room, dangerous power points, and no gas available for showers, cooking or heating. The lounge room window was broken and a blanket had been taped to the roof to minimise the wind. A "bong" was observed in the children's bedroom.'* The child's parent was chronically depressed and avoided contact with services because they were 'scared' their child would be removed. • There were multiple examples of associated health issues arising in the context of neglect. These included scabies, hearing problems attributable to untreated wax build-up, sores, loss of teeth due to poor diet and hygiene, fleas and lice. • In one case, a child and their family were reported to have relocated to 12 different schools during the course of 18 months. In another, a child and their mother had moved 13 times in two years.

Table 5: Harms experienced by children as known to Child Protection continued

Nature of harm	Child and young person's experiences
Sexual abuse	• Allegations of sexual abuse by a family member or person known by the family were present in 50 per cent of cases reviewed. • One child, who was reported to have been sexually abused by a number of adult males, including a step-father, refused to make disclosures to the police. There were six separate reports detailing sexual abuse and only one face-to-face contact with Child Protection. All cases were closed at intake. The child death inquiry concluded that this child 'flew under the radar' until their suicide. Their suicide 'shocked the school community'. • One child, who was reported to have been sexually abused by a number of adult males, including their father and sports coach, was raped by a group of men who photographed the incident.
Emotional or psychological violence	• Several children dealt with emotional rejection from their mothers, which impacted on their ability to feel safe and loved. One child, at the age of eight, was present while their mother advised Child Protection *'I've come to the end of my journey with [child]. [The child] has been trouble since they were two years old. I don't want to harm them, but I will. I don't want them.'* This mother had been removed from her family as a young child in the context of severe physical and emotional abuse. She had been violently assaulted by the child's father during her pregnancy and expressed difficulties forming an attachment with the child since birth. These difficulties remained unaddressed and were compounded by escalating family violence between the parents, witnessed by the child. The child's subsequent aggression towards their mother resulted in emotional rejection from which neither recovered. • One child, aged eight, was 'kicked out' of their mother's home after alleging their mother's partner sexually assaulted them.

The impacts of harm as experienced by the children

To understand how these 35 children experienced the child protection system, it is helpful to first gain a sense of how the system experienced and perceived them. Across the sample of 35 cases, a number of themes emerged regarding the perceived strengths, vulnerabilities and circumstances of these children. These themes related largely to how they 'behaved'. In many instances, behaviours were extreme and frequently anti-social, however they could also be self-destructive. A consistent feature of the behaviours exhibited by this sample is that they were almost always shaped by history and circumstance.

Table 6: Impacts of harm on children and coexisting vulnerabilities

Behavioural impacts as experienced by the children
• The children within this sample were frequently described as: 'out of control', 'angry', 'manipulative', 'wild', 'bad', 'difficult', 'hard work', 'high-risk' but also, 'sad', 'needy', 'damaged', 'fragile' and 'vulnerable'. • All female children engaged in deliberate self-harming, with one child explaining after she had razored her thighs: *'it makes me feel better'.* • Over half of all children complained of sleep disturbance or insomnia. • Nearly three quarters of the children used alcohol and drugs, with several using marijuana, cigarettes and alcohol from the age of eight years. • Many of the children talked about suicide from a very early age. One child made their first threat to suicide at age seven, another at age nine. At age 12, one child asked that for their birthday, they receive: *'a suicide platform, chair and rope'.* • A number of female children who had been the victims of sexual abuse as young children, engaged in high-risk behaviours as adolescents, which frequently involved alcohol, drugs and older males. Two of these children would run in front of moving traffic. • The children with symptoms of depression evidenced a lack of self-care: *'[child] will not brush her hair, rarely showers, regularly self-harms, and has not been to school for two years and uses a container in her bedroom to urinate in'.* This child was the subject of six reports to Child Protection, all of which were closed at intake or investigation. • Nine male children who had been the victims of family violence, frequently in combination with parental substance abuse or sexual abuse, engaged in high-risk activities that saw them come into increasing levels of contact with the criminal justice system. At least three were picked up 'joy-riding'. • A large number of children damaged property belonging to their parents, carers or school. One boy took to his family home with a baseball bat, another damaged computers at school. • One child was observed at school to drink liquid paper, cut himself with scissors, extract the blade from a pencil sharpener and cut the insides of his mouth. His behaviours were described by a health professional as 'attention seeking'. • One child, diagnosed with high functioning autism, made repeated allegations of physical abuse by his step-father that included the use of physical restraints. He exhibited extreme aggressive behaviours, hitting, biting, spitting, made threats to kill students at his school, physically assaulted younger siblings and threw a television at school. • Two male children and one female child engaged in fire-lighting. • A number of children were described as 'old before their time'; one 16-year-old female was described as 'always trying to be older than her years'. A 14-year-old boy was described by their parent as 'more like a man, not a boy at all.'

Gender differences

In the cases analysed, there were 14 females and 21 males. The inquiry identified some differences between the impacts and co-existing vulnerabilities for the males and females within the sample, which are consistent with other studies.[87]

Table 7: Nature of impacts and co-existing vulnerabilities for children

	Males		Females		
	n	%	n	%	Total
Exposure to family violence	20	95%	13	93%	**94%**
Disengaged from school	19	90%	10	71%	**83%**
Self-harming	15	71%	14	100%	**83%**
Prior suicide attempts	14	67%	12	86%	**74%**
Use of family violence	19	90%	6	43%	**71%**
Substance abuse	15	71%	8	57%	**66%**
Contact with criminal justice system	15	71%	7	50%	**63%**
Behavioural problems resulting in multiple placements	9	43%	10	71%	**54%**
Reported sexual abuse	10	48%	8	57%	**51%**
Disability	9	64%	2	14%	**31%**

Figure 4: Most common risk indicators in the cases involving female children

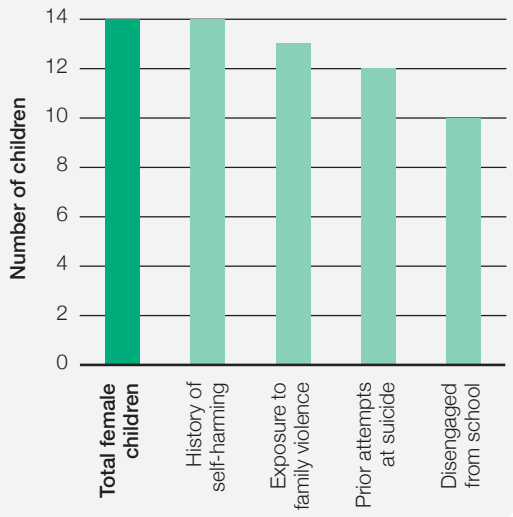
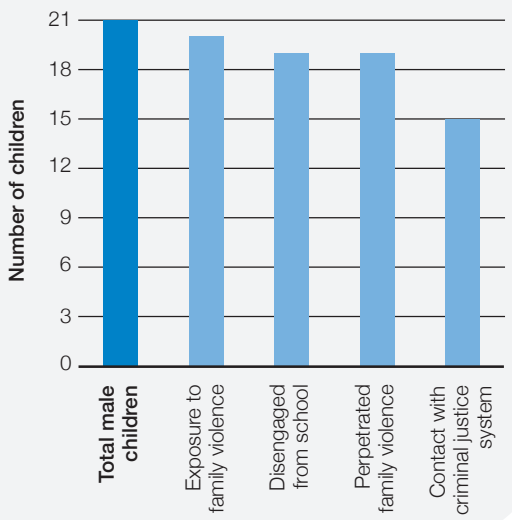


Figure 5: Most common risk indicators in the cases involving male children



87 Doan, J, LeBlanc, A, Roggenbaum, S, and Lazear, KJ (2012). *Youth suicide prevention school-based guide: —Issue brief 3a: Risk Factors: Risk and protective factors, and warning signs*. Tampa, FL: University of South Florida, College of Behavioral and Community Sciences, Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies (FMHI Series Publication #218-3a-Rev 2012).

The inquiry found that gendered risk indicators changed depending on the children's age at time of death.

Table 8: Risk indicators per age and gender (children aged 12–14 at time of death)

	Male		Female		
	n	%	n	%	Total
Self-harming	7	100%	4	100%	**100%**
Exposure to family violence	7	100%	3	75%	**91%**
Prior attempt at suicide	6	85%	3	75%	**82%**
Perpetrated family violence	6	85%	2	50%	**73%**
Mental health diagnoses	5	71%	2	50%	**64%**
History of sexual abuse	4	57%	2	50%	**55%**
Substance misuse	3	43%	3	75%	**55%**
Contact with criminal justice system	3	43%	2	50%	**45%**
Disengaged from school	3	43%	2	50%	**45%**
Disability	3	43%	–	–	**27%**

Table 9: Risk indicators per age and gender (children aged 15–17 at time of death)

	Male		Female		
	n	%	n	%	Total
Exposure to family violence	13	93%	10	100%	**96%**
Disengaged from school	13	93%	8	80%	**88%**
Contact with criminal justice system	12	86%	5	50%	**71%**
Mental health diagnoses	9	64%	8	80%	**71%**
Perpetrated family violence	13	93%	4	40%	**71%**
Self-harming	7	50%	10	100%	**71%**
Substance misuse	12	86%	5	50%	**71%**
Prior attempt at suicide	6	43%	9	90%	**63%**
History of sexual abuse	5	36%	6	60%	**46%**
Disability	6	43%	2	20%	**33%**

Younger children (aged 12–14) at time of death

Almost one-third of the children reviewed for this inquiry ended their lives by the age of 14 (n=11). Of these, 21 per cent of the children were Aboriginal (n=3) and over half (64 per cent) had received a mental health diagnosis (n=7).

The inquiry found that this cohort of younger children represented a particularly vulnerable subset. They were proportionately more likely to have engaged in self-harming behaviour, been exposed to and perpetrated family violence and been the victim of reported sexual abuse.

Almost two-thirds (64 per cent) of this group of children had their first contact with Child Protection in the first three years of their life.[88] In all instances, they had come to the attention of Child Protection services following reports of family violence, in combination with parental substance misuse.

In the years that followed, all of the children engaged in self-harming behaviours.

Boys aged 14 and under at time of death, were more likely than girls of the same age to have perpetrated family violence, made a prior attempt at suicide and have a history of reported sexual abuse. For this cohort of children, boys were also more likely to have received a mental health diagnosis, frequently following intervention from primary schools. Of the seven boys, 43 per cent had been assessed as having a disability (n=3).

For the girls aged 14 and under at time of death, they were more likely to have disengaged from school, misused substances (most commonly in the context of relationships with older men) and had some level of contact with the criminal justice system.

Older children (aged 15–17) at time of death

Over two-thirds of the children (69 per cent) died between the ages of 15 and 17 years (n=24). Male children accounted for 58 per cent (n=14) and female children, 42 per cent (n=10). Three of the children were Aboriginal (13 per cent). Young men aged 15 to 17 years were significantly over-represented in the children reviewed by this inquiry, representing 40 per cent of the total number of recorded deaths (n=14).

One third of older children had been assessed to have disability (n=8) and over two-thirds were diagnosed with mental illness (n=17).

Within this cohort, there were extremely high levels of exposure to family violence (n=23) and disengagement from school (n=21).

For older male children, the reported use of violence and aggression was frequent, often serious and generally impulsive. Within this group, boys and young men were often described as 'rageful', 'lacking in remorse', 'scary', 'explosive' and 'unpredictable'.

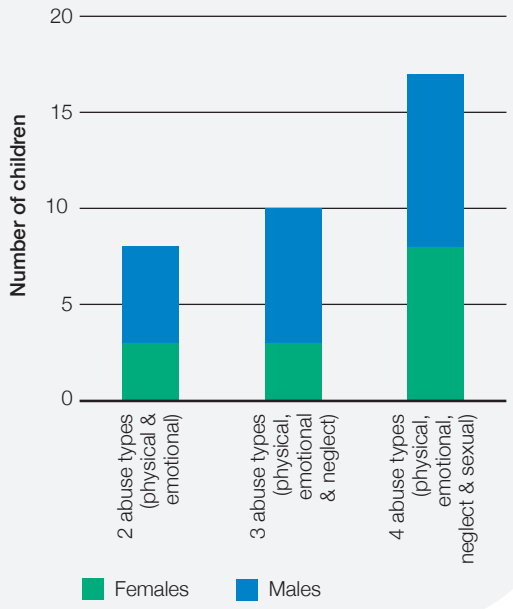
The older cohort of girls and young women were more likely to have a diagnosed mental illness, have made a previous attempt at suicide and experienced sexual abuse. Of note, the older cohort of girls and young women were less likely to have perpetrated family violence and have contact with the criminal justice system. Female children in the older cohort were just as likely as the younger cohort to engage in self-harming behaviours.

Risk factors in the children's lives

In the majority of cases analysed by the inquiry, the children faced recurring risk and vulnerability issues, with very few verified protective factors. For most of the children, the risk factors occurred on multiple occasions and escalated across reports, whilst the vulnerabilities tended to remain static (for example, the presence of disability) or ebb and flow (for example, maternal ambivalence). This section examines the most frequently occurring and co-occurring types of abuse reported in the cases assessed.

88 The children were the subject of an average of seven reports each. Three of the boys (43 per cent) were the subject of protection orders at the time of death.

Figure 6: Numbers of children who experienced harm, per type



Almost half of the children in the sample (n=17) experienced four co-occurring abuse types that were present during the course of multiple, often recurring reports. In a number of cases, the types of risks and the length of time they had been occurring would fit the definition of a family with 'multiple and complex needs'.

The children and their families

Over half (57 per cent) of the children reviewed by this inquiry came from families who were known to Child Protection as a result of earlier intervention involving a parent (n=20). This occurred in the context of a parent being a former child-client of Child Protection or as a result of previous contact associated with a child's sibling.

Nearly two-thirds of the families reviewed had a known and recorded history of trauma that was both entrenched and unresolved (n=22). It is important to acknowledge that for many of these parents, their experience of parenting was shaped by their own experiences in childhood. These parents' experience of childhood often involved family violence, sexual abuse and untreated mental illness. All of the Aboriginal children had a history of intergenerational trauma, including older family members directly impacted by the Stolen Generations.

In just under half of the cases reviewed (46 per cent), parents were involved in highly acrimonious separations (n=16), frequently in the context of family violence and substance abuse issues.

Of the 35 children reviewed, 69 per cent (n=24) had no or only intermittent contact with their fathers. A high proportion of the children (40 per cent) had a father or step-father who had spent time in prison, which resulted in gaps in contact (n=14). Of these children, half were male children (n=7) and half were female children (n=7).

Nearly all of the parents had a diagnosed or suspected mental illness (n=33). Of these, 45 per cent had attempted or completed suicide (n=13). Four of the children had lost a parent to suicide. All children who died at 14 years or under had a parent with a diagnosed or suspected mental illness, as did all female children (across both the younger and older cohorts).

In terms of the specific risk factors identified, Table 10 outlines those relating to parents in the cases reviewed. The child death inquiries noted that in general, Child Protection had not fully assessed the risk factors associated with the children's parents. However, many were apparent from reading the chronology of service files.

Residence at time of death

Just under half (49 per cent) of the children lived in metropolitan Melbourne (n=17) and 51 per cent lived in regional or rural Victoria at the time of death (n=18).

Almost three quarters of the children (71 per cent) were living at home with at least one parent at the time of their death (n=25). A further 11 per cent were living with family, in kinship care arrangements. For the remaining 18 per cent, their deaths occurred while they were living independently or in residential care (n=6).

The three children who died while in residential care had experienced between five and fourteen placement changes.

Four of the six Aboriginal children were living at home, with at least one parent, at the time of their death. The remaining two children were living in kinship care.

Table 10: Risk factors relating to parents in cases reviewed

Known risk factors in parents	Males		Females		Total
	n	%	n	%	
Mother who had experienced family violence[89]	20	95%	14	100%	**97%**
Parent with a diagnosed or suspected mental illness	19	90%	14	100%	**94%**
Parent with a reported substance abuse issue	17	81%	7	50%	**71%**
Parent with a known history of trauma (including history of reported sexual abuse)	11	53%	11	79%	**63%**
Parent known to Child Protection at time of first report relating to child reviewed	12	57%	8	57%	**57%**
Reportedly acrimonious separation between parents of child	10	48%	6	43%	**46%**
Father or step-father who had spent time in prison	7	33%	7	50%	**40%**

Chapter 4 at a glance

- In the deaths studied for this inquiry, the children faced multiple risk factors and forms of harm, often from an early age. These harms included family violence, sexual abuse, parental substance abuse and untreated mental illness, neglect and community isolation.
- Family violence, often severe, was a feature of 94 per cent of these children's lives, frequently in combination with neglect.
- The children studied for this inquiry presented with different risk indicators based on their gender and age at time of death.
- The impact of trauma manifest differently for boys and girls. Female children were more likely to engage in self-harming behaviours, attempt suicide and have a diagnosed mental illness. Male children were more likely to perpetrate family violence and engage in high-risk taking behaviours that brought them into contact with the criminal justice system. Across both genders, exposure to family violence, disengagement from school and sexual abuse by a family member or person known to the family were relatively equal.
- Children who died by the age of 14 were found to be an especially vulnerable group who were more likely to have had contact with Child Protection in the first three years of their life.
- Most of the children came from families where trauma was entrenched and compounded by the 'toxic trifecta' of family violence, parental mental illness and substance abuse issues. Unresolved trauma and untreated parental mental illness featured prominently in the majority of children's lives reviewed.

89 In one case, violence was only perpetrated against the mother, by the child.

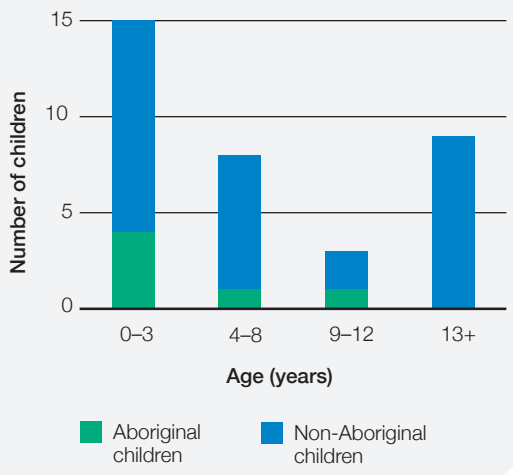
Chapter 5
Contact with the statutory child protection system

Length and nature of contact

The length and nature of contact with Child Protection varied across the cases reviewed, but in most cases, there had been lengthy contact, which sometimes began very early in the child's life. For example, one Aboriginal child was known to Child Protection from the time of birth up until the time they died.[90]

Two-thirds of all children (66 per cent) had their first contact with Child Protection before they turned eight (n=23), with the majority of these children (65 per cent) having their first contact in the first three years of their life (n=15). For the Aboriginal children, 67 per cent (n=4) had contact with Child Protection before they had turned two.

Figure 7: Age at time of first report to Child Protection



For the younger cohort who died by the age of 14 years (n=11), 64 per cent of these children were three years or under at the time of their first contact with Child Protection (n=7).

Children came to the attention of Child Protection an average of seven times. Over half of the children in the inquiry (57 per cent) were the subject of between six and ten reports.

In cases where there were multiple reports, there was an overall pattern of closing cases at intake or after a brief investigation. For example, Child Protection closed the case of one child at intake 13 times from 16 reports – the final three closures occurred in the context of them being recently reunified to their family following several years of living in out-of-home care on a Guardianship to Secretary Order. Another child had their case closed at intake 15 times from 20 reports; the first report was received shortly after their birth (it was closed at intake) and the final report (also closed at intake) five weeks before their suicide.

The average period between when Child Protection closed the final report and the death of the child was three and a half months. One-third (34 per cent) of the children reviewed died within eight weeks of their final report being closed or placed in closure phase (with closure having been communicated to the child) (n=12).

Ten of the 12 children who died within eight weeks of their final report being closed or moved to closure phase had their reports closed with 'no further action' from Child Protection. One child was recorded to have a 'safety plan in place' and another was closed following a case conference. For six of the 12 children, the final report received marked their sixth or more report to Child Protection.

90 This did not mean there had been active Child Protection involvement throughout the child's life.

Table 11: Final report outcomes prior to child's death

	Closed at intake with no further action	Closed with a referral to Child FIRST	Closed with information sent about Child FIRST	Protective intervention or child on current order
Aboriginal children	2 of 6 (33%)	1 of 6 (17%)	n/a	3 of 6 (50%)
Non-Aboriginal children	14 of 29 (48%)	3 of 29 (10%)	3 of 29 (10%)	9 of 29 (31%)
Total	**16 of 35 (46%)**	**4 of 35 (11%)**	**3 of 35 (9%)**	**12 of 35 (34%)**

For those children with closed cases at the time they died, many had previous interventions, including protective intervention. Of the children who had closed cases at the time of their death, approximately 40 per cent had earlier reports substantiated and almost one-quarter had prior protective intervention. In several cases, reports received following periods of protective intervention were assessed with unwarranted optimism, usually in the context of a recent reunification.

Table 12: Reports to Child Protection closed at intake or investigation[91]

Child	No. of reports	Closed at intake or at investigation[92]	No. of reports substantiated	Child Protection status at death of child
1	2	2 closed at intake	0	Closed (9 months prior to death)
2	2	1 closed at intake, 1 closed at investigation	0	Closed (5 months prior to death)
3	25[93]	12 closed at intake, 12 closed at investigation (SA) 1 closed at investigation (VIC)	0	Closed (6 weeks prior to death)
4	11	6 closed at intake, 3 closed at investigation	2	Protective order
5	16	8 closed at intake, 5 closed at investigation	2	Closed (4 months prior to death)
6	2	1 closed at intake, 1 closed at investigation	0	Open
7	2	2 closed at intake	0	Closed (8 weeks prior to death)
8	7	6 closed at intake, 1 closed at investigation	1	Closed (4 months prior to death)
9	3	3 closed at intake	0	Closed (11 months prior to death)
10	2	2 closed at intake	1	Protective order
11	7	6 closed at intake, 1 closed at investigation	0	Closed (four weeks prior to death)

91 For further information concerning actions undertaken upon substantiation, see Table 14. For further information concerning statutory intervention via initiation of protective proceedings, see Table 15.

92 The table does not detail reports closed at protective intervention that did not result in protective proceedings. This leads to, in some instances, a greater number of total reports than those recorded as closed at intake or investigation.

93 Only 1 of the 25 reports was received in Victoria, with the remaining received by Families South Australia. Of the 25 reports dealt with by Families South Australia, 12 were closed at intake and the remaining 12 were closed at investigation. Only the Victorian figure has been included in our total calculations.

Table 12: Involvement with Child Protection continued

Child	No. of reports	Closed at intake or at investigation[92]	No. of reports substantiated	Child Protection status at death of child
12	2	1 closed at intake, 2nd report in closure phase following investigation	1	Open, closure phase (decision to close communicated to child 5 days prior to death)
13	8	5 closed at intake, 2 closed at investigation	1	Protective order
14	6	5 closed at intake	1	Protective order
15	9	5 closed at intake, 3 closed at investigation	3	Protective order
16	14	7 closed at intake, 5 closed at investigation, 14th report was to be closed at investigation	2	Open, closure phase (decision to close communicated to child 2 weeks prior to death)
17	7	6 closed at intake, 1 closed at investigation	0	Closed (9 months prior to death)
18	5	5 closed at intake, decision to close 5th at intake made 2 days prior to death	0	Closure phase (decision to close communicated to child 2 days prior to death)
19	2	2 closed at intake	0	Closed (3 months prior to death)
20	5	3 closed at intake, 1 closed at investigation	2	Protective order
21	6	5 closed at intake, 1 closed at investigation	1	Closed (two weeks prior to death)
22	7	5 closed at intake, 1 closed at investigation	0	Closed (8 months prior to death)
23	11	8 closed at intake	1	Protective order
24	20	15 closed at intake, 2 closed at investigation	4	Closed (five weeks prior to death)
25	6	3 closed at intake, 2 closed at investigation	2	Closed (10 days prior to death)
26	6	4 closed at intake	2	Protective order
27	3	3 closed at intake	0	Closed (9 months prior to death)
28	9	4 closed at intake, 3 closed at investigation	3	Protective order
29	6	5 closed at intake	1	Protective order
30	4	3 closed at intake, 1 at investigation	0	Closed (10 months prior to death)
31	3	2 closed at intake, 1 at investigation	1	Closed (2 weeks prior to death)
32	2	1 closed at intake, 1 closed at investigation	0	Closed (3 weeks prior to death)

Table 12: Involvement with Child Protection continued

Child	No. of reports	Closed at intake or at investigation[92]	No. of reports substantiated	Child Protection status at death of child
33	3	2 closed at intake, 1 closed at investigation	0	Closed (5 months prior to death)
34	8	7 closed at intake	1	Protective order
35	22	17 reports at intake, 5 closed at investigation	1	Closed (decision to close communicated to carer 1 day prior to death)
Total reports	**229**[94]	**78% of reports closed at intake (161 reports)** **22% of reports closed at investigation (45 reports)** **90% of reports closed at intake or investigation (206 reports)**	**33 (14%)**	

Analysis of actions undertaken by Child Protection at the time they closed reports suggest:

- in 69 per cent of cases, reports were closed without further action (n=158)
- in 23 per cent of cases, reports were closed with Child Protection providing referrals to Child FIRST (or writing to encourage families to make contact with Child FIRST) (n=52)
- in the remaining eight per cent of cases, reports resulted in protective intervention or there was an active investigation at time of death (n=19).

All children who were referred by Child Protection to Child FIRST services were the subject of re-reports. None of the children or their families were engaged with community-based child and family services at the time of their death.

Table 13: Actions undertaken by Child Protection upon closure

	Closed with no further action	Closed with referral to Child FIRST	Closed with information sent about Child FIRST	Protective intervention or active investigation at time of death
Aboriginal children	27 of 33	2 of 33	3 of 33	3 of 33
Non-Aboriginal children	132 of 196	36 of 196	11 of 196	16 of 196
Total	**158 of 229 (69%)**	**42 of 229 (18%)**	**10 of 229 (4%)**	**19 of 229 (8%)**

The 20 children who were the subject of substantiated reports were the subject of, on average, nine reports. Early reports (for example, reports one to five) that were substantiated tended to be closed with no further action, except in two cases (in the first, the parent relinquished care of their child due to mental illness and in the second, the child's parent overdosed and was admitted to hospital).

In 61 per cent of reports where Child Protection found there to be a substantiated risk to the child, Child Protection nonetheless closed the case with no further action (n=20). Where action did occur, it generally involved initiation of protection proceedings (n=12). One substantiated report resulted in closure with a referral to Child FIRST.

94 Excluding the 24 reports received by Families South Australia

Table 14: Actions undertaken by Child Protection upon substantiation

Child	No. of reports	Report substantiated	Action upon substantiation	Re-reports
A	11	Report 2 Report 6	Closure, no further action Protection Application	Yes Yes
B	16	Report 2 Report 3	Closure, no further action Protection Application	Yes Yes
C	7	Report 7	Closure, no further action	No
D	3	Report 2	Protection Application	n/a
E	2	Report 2	Closure, no further action	No
F	8	Report 7	Closure, no further action	Yes
G	6	Report 6	Protection Application	n/a
H	9	Report 2 Report 6 Report 9	Closure, no further action Closure, no further action Protection Application	Yes Yes Yes
I	14	Report 5 Report 14	Closure, no further action Closure, no further action	Yes No
J	5	Report 3 Report 5	Closure, no further action Protection Application	Yes n/a
K	6	Report 6	Closure, no further action	No
L	11	Report 11	Protection Application	n/a
M	20	Report 2 Report 6 Report 13 Report 16	Closure, no further action Closure, no further action Closure, no further action Protection Application	Yes Yes Yes Yes
N	6	Report 2 Report 4	Closure, no further action Closure, no further action	Yes Yes
O	6	Report 3 Report 6	Closure, no further action Protection Application	Yes n/a
P	9	Report 1 Report 2 Report 9	Closure, no further action Closure, referral to Child FIRST Protection Application	Yes Yes No
Q	6	Report 6	Protection Application	n/a
R	3	Report 3	Closure, no further action	No
S	8	Report 8	Protection Application	n/a
T	22	Report 2	Closure, no further action	Yes
178 reports		**33 (19%) substantiated**	**20 reports closed with no further action (61%) 12 Protection Applications (36%) 1 closed with referral to CF (3%)**	

For the 12 children who were the subject of protection applications, proceedings were initiated (on average) at the point of report seven. Of these children, three quarters (n=9) had their first contact with Child Protection by the age of three. The earliest reports recorded to result in protective proceedings was report two (in circumstances where the parent had relinquished or was incapable of providing care) and the latest was the sixteenth report. One-third of the children in this subset identified as Aboriginal (n=4).

For the 12 children who were the subject of protection applications, the average time between the first recorded report and the initiation of protection proceedings was six years, four months.[95]

Table 15: Time between first report and initiation of protective proceedings

Child	Age at first report	Report resulting in statutory intervention	Age at statutory intervention	Period between first report and statutory intervention
A	2 years	Report 6	3.5 years	18 months
B	2 years	Report 3	3 years	12 months
C	Birth	Report 2	2 years	21 months
D	10 years	Report 6	13 years	3 years, 10 months
E	2 years	Report 9	17 years	5 years, 3 months
F	8 years	Report 5	14 years	5 years, 9 months
G	5 years	Report 11	15 years	10 years
H	3 months	Report 16	10 years	10 years, 9 months
I	18 months	Report 6	9 years	8 years, 8 months
J	18 months	Report 9	10 years	9 years, 11 months
K	9 months	Report 6	8 years	7 years, 10 months
L	3 years	Report 8	13 years	10 years, 6 months

Table 16: Highest level of intervention received over course of child's life

	Aboriginal	Non-Aboriginal	Total
Intake phase		6	6 (17%)
Investigation phase	2	10	12 (34%)
Protective intervention phase		4	4 (11%)
Interim Protection Order		2	2 (6%)
Supervision Order/Family Preservation Order	1	2	3 (9%)
Custody to Secretary Order/Family Reunification Order	2	4	6 (17%)
Guardianship to Secretary Order/Care By Secretary Order	1	1	2 (6%)
Totals	**6**	**29**	**35 (100%)**

95 The delay in commencing statutory intervention should not be viewed as necessarily reflecting poor practice; provided families are supported in a timely way by community-based services to care for and keep their children safe during the intervening period.

Responding to Aboriginal children

Meaningful and culturally safe practice with Aboriginal children requires an understanding of the role of culture and identity in the child's life, an awareness of the location of the child's family and community, and action to ensure other requirements of the CYFA are met.

Aboriginal children were over-represented in the children reviewed, accounting for 17 per cent of the total children who died (n=6). Of the six children, four were female and two were male. Four of the children had their first contact with Child Protection by the age of two. The Aboriginal children were more likely to have a report substantiated and be the subject of protective proceedings, compared with their non-Aboriginal peers.

Half of the Aboriginal children were recorded as having disability. Five of the six children were recorded to have a diagnosed mental illness. All had a history of self-harming behaviours and reported sexual abuse in early childhood. All of the Aboriginal families had experienced intergenerational trauma – five of the six children were raised by mothers who had spent time in care as children. Five of the six children had a parent with severe mental illness and of these, all had made attempts to take their own life. In two cases, these attempts were made in the presence of their children.

In the six cases involving Aboriginal children:

- Four of the six children were eligible for an Aboriginal family-led decision-making meeting, but a meeting was held for only one of the children.
- Two children were at various stages entitled to a Cultural Support Plan, but in neither case was one completed.
- Failure to comply with the Aboriginal Child Placement Principle was recorded with respect to three of the children placed in out-of-home care.
- Consultation with the Aboriginal Specialist Advice and Support Service occurred in four of the six cases.
- Koori Education Support Officers worked with four of the six Aboriginal children.

Research establishes that connection to culture is protective for Aboriginal children, particularly those at risk of suicide. For the six Aboriginal children reviewed for this inquiry, connections to culture were inadequately prioritised.

Chapter 5 at a glance

- Each child in this inquiry was, on average, the subject of seven reports to Child Protection.
- The children had typically lengthy contact with Child Protection, frequently beginning in early childhood. Two-thirds (n=23) of the children had their first contact with Child Protection before they turned eight years of age, with the majority of these (65 per cent) having their initial contact in the first three years of life.
- There was a pattern whereby Child Protection closed cases at intake or after a brief investigation. Ninety per cent of all reports made raising concerns for these children were closed at intake or investigation.
- Over two-thirds of reports received, 69 per cent, were closed without further action (n=158). Twenty-three per cent (n=52) were referred (via letter or formal referral) to Child FIRST, with a view to engaging community-based child and family services.
- Of the reports that were substantiated (n=33), 61 per cent (n=20) were closed with no further action recorded, while 36 per cent (n=12) resulted in initiation of protection application proceedings.
- For those children who were the subject of a protection application, proceedings were initiated (on average) at the seventh report to Child Protection, with the average time between first report and initiation of protection proceedings being six years, four months.
- Approximately one-third of families (n=9) expressed a persistent unwillingness to engage with services.
- Despite the majority of families indicating a preparedness to engage, the inquiry found that none of the families were successfully engaged by community-based child and family support services.

Chapter 6
Contact with health, mental health services and police

Evidence of mental health status, substance misuse, self-harming

The inquiry found that the length and nature of contact that children had with mental health and other health services varied depending on the child's gender, age and presence of a diagnosed mental illness.

Table 17: Mental health status by sex and selected diagnoses

	Male		Female		
	n	%	n	%	Total
Diagnosed mental illness	**14**	**66%**	**10**	**72%**	**69%**
• Mood (bipolar/depression/major depressive)	5	36%	6	60%	
• Anxiety (anxiety/OCD/PTSD)[96]	5	36%	8	80%	
• Substance (includes substance induced psychosis)	5	36%	1	10%	
• Personality	2	15%	4	40%	
• Behavioural (ADHD/ODD/ASD/conduct)[97]	11	79%	3	30%	
• Schizophrenia	1	7%	–	–	
• Attachment	–	–	3	30%	
Suspected mental illness	**2**	**9%**	**3**	**21%**	**14%**
No evidence of mental illness	**5**	**24%**	**1**	**7%**	**17%**
Total	**21**	**100%**	**14**	**100%**	**100%**

Of the 35 children reviewed, 83 per cent had a diagnosed or suspected mental illness. Of this cohort, 22 (71 per cent) had received multiple or comorbid diagnoses.

Girls and young women tended to present with anxiety and mood disorders, including depression, while male children were more likely to be diagnosed with behavioural based disorders, including ADHD, ASD and various conduct disorders.

All children with a diagnosed mental illness were prescribed a combination of medications. Scrutiny of the reports revealed that at least one child was prescribed medication by their doctor without a mental health assessment.

The Commission's powers preclude an assessment of clinical decision making and therefore this inquiry has not examined whether prescribed medications were considered to be effective, regularly reviewed or whether underlying issues such as trauma were considered.

96 OCD is Obsessive Compulsive Disorder and PTSD is Post-traumatic stress disorder.
97 ADHD is Attention Deficit Hyperactivity Disorder, ODD is Oppositional Defiance Disorder.

Table 18: Evidence of substance misuse

Substance misuse	Male		Female	
	n	%	n	%
Evidence of substance misuse	**16**	**76%**	**8**	**57%**
• Drug dependence	14	88%	7	88%
• Non-dependent substance misuse	1	6%	1	12%
• Insufficient evidence to categorise	1	6%		
No evidence of substance misuse	**5**	**24%**	**6**	**43%**
Total	**21**	**100%**	**14**	**100%**

Among those who were drug dependent at the time of their death, alcohol and cannabis were the two most frequently used drugs.

Of the males aged 10–14 at time of death, 19 per cent displayed evidence of substance misuse (n=1), with 81 per cent displaying no evidence of substance misuse (n=6). By comparison, 88 per cent of males aged 15–17 at time of death displayed evidence of substance misuse (n=12), with only seven per cent displaying no evidence of substance misuse (n=1).

Despite three-quarters of male children evidencing drug dependence (n=16), only one-quarter had accessed drug and alcohol services (n=5).

Despite evidence of drug dependence in 60 per cent of the cases reviewed (n=21), only a quarter (25 per cent) of the children had a diagnosis of substance dependence and less than a quarter (24 per cent) had accessed drug and alcohol services.

Table 19: Evidence of prior self-harming behaviours

	Male		Female	
	n	%	n	%
Evidence of prior self-harming behaviours	15	71%	14	100%
No evidence of prior self-harming behaviours	6	29%	–	–
Total	**21**	**100%**	**14**	**100%**

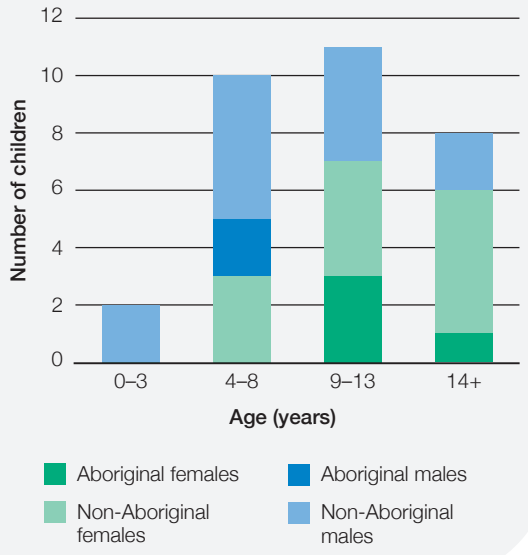
For the girls and young women reviewed, all were recorded to have engaged in serious and long-term self-harming behaviours (n=14).

Significantly, all male children who died by the age of 14 engaged in self-harming behaviours. For the older cohort, aged between 15 and 17 years at time of death, 57 per cent were recorded as engaging in self-harming (n=8). For this cohort, the marked decrease in use of self-harming behaviours was matched by a corresponding increase in the perpetration of family violence, substance misuse and contact with the criminal justice system.

Where self-harming behaviours occurred in the context of a diagnosed mental illness, they were generally considered an adjunct to mental illness, rather than an externalisation or manifestation of trauma. Significantly, all of the children (both male and female) who were reported to have experienced childhood sexual abuse, engaged in self-harming behaviours (n=18).

Early contact with mental health services

Figure 8: Age at time of first contact with mental health services



Of the 35 children reviewed, 89 per cent (n=31) had at least one recorded contact with a mental health service. Of these, a large number had their first contact between the ages of nine and 13 years (n=11). However, most children (39 per cent) had their first contact by age eight (n=12). Significantly, half of all male children who had contact with a mental health service had received a diagnosis by age seven (n=9).

For those children who had received an early diagnosis (by the age of seven) all had been referred to a mental health service by a paediatrician. Contact with a paediatrician was generally preceded by, or occurred simultaneously with, contact from Child Protection. For example, of the 12 children who received an early diagnosis:

- 92 per cent had their first contact with Child Protection by the age of three (n=11)
- 50 per cent had been referred to a paediatrician by the age of five (n=6)
- 75 per cent were male children, of whom all received an initial diagnosis of ADHD and/or ASD (n=9).

Children who received an early diagnosis shared a range of presenting issues:

- they were frequently described as 'out of control', 'angry', 'challenging', 'hard work', 'aggressive', 'violent', 'non-verbal' and 'delayed'
- many presented with self-soothing repetitive behaviours including head-banging, rocking back and forth, biting, chewing, hitting, picking, hair-pulling
- some were reported to display persistent crying and/or screaming
- several displayed sexualised behaviours
- incontinence and encopresis[98]
- insomnia.

They also shared a range of other co-existing vulnerabilities, including:

- 100 per cent had been exposed to severe family violence in early childhood between their mother and father or step-father (n=12)
- 100 per cent were reported to have experienced neglect (n=12)
- 92 per cent had a mother who had reported to Child Protection a history of post-natal depression and difficulties 'bonding' with her child (n=11)
- 75 per cent had a parent with drug and/or alcohol addiction (n=9)
- 75 per cent had no, or limited and sporadic contact with their fathers (n=9)
- 67 per cent had a parent who had attempted or completed suicide (n=8)
- 67 per cent had an intellectual disability (n=8)
- 67 per cent were reported to have experienced sexual abuse in early childhood (n=8).

A large number of children reviewed by this inquiry were considered to have attachment-related issues stemming from poor early attachment with their mothers.

98 Encopresis is the soiling of underwear with stool by children who are past the age of toilet training.

Case study

One child was first reported to Child Protection as a young infant after their mother attended at her general practitioner 'distressed and tearful, expressing difficulties with her child and little support from her husband who works long hours'. She disclosed thoughts about smothering her infant. The mother was diagnosed by her doctor to have post-natal depression and recommended to enlist the support of extended family members to help her care for her children.

Child Protection assessed that adequate family supports were in place and closed the report without further action.

Within eight weeks, the mother had attempted suicide. Her diagnosis of post-natal depression was reconfirmed, and her child placed away from her care for a short time, but nil services were engaged to support her recovery. Child Protection again assessed adequate family supports and closed without further action.

In the next few months, multiple reports detailed numerous hospital presentations by the mother who expressed concerns that she might 'attack' her infant. She repeatedly sought an 'assessment' of the young child, who she described as 'difficult' and 'not sleeping'. At two years of age, the child was referred to a paediatrician who diagnosed the child as having ADHD.

By five years of age and following four more reports, the mother presented the child at another hospital describing him as 'out of control' – the child was witnessed to bite, kick, scream and spit. The child was observed by the hospital to have bite marks and bruising to their back and shoulders. A second assessment by a different paediatrician concluded that 'the child's behaviour is not medically based'.

By this stage, the mother's untreated mental health issues were obscured by the 'behaviours' of her young child, which became the context in which risk was assessed.

By eight years of age, following another seven reports, the mother asked for the child to be 'locked up'.

For this child, as with all children who received early diagnoses, although they had contact with multiple service systems at approximately the same point in their lives, services rarely sought or shared information. The paediatrician who first diagnosed this child at age two had no knowledge of the multiple reports to Child Protection.

Of the 31 children recorded as having contact with a mental health service, 55 per cent had their first contact with mental health services at the point of adolescence (n=19). Of these, 53 per cent (n=10) were male and 47 per cent female (n=9). For the children who received contact (or a diagnosis) in early adolescence:

- 84 per cent presented with self-harming behaviours (n=16)
- 63 per cent received a formal diagnosis by the age of 13 (n=12)
- 58 per cent presented to emergency departments following suicide attempts (n=11)
- 37 per cent had contact with a service, but received no formal diagnoses (n=7)
- 50 per cent received a diagnosis that related to substance use, in combination with depression and/or ADHD (n=6).

These children shared a range of co-existing vulnerabilities, including:

- 89 per cent were reported to have been exposed to family violence (n=17)
- 68 per cent had a parent with a diagnosed mental illness that included a history of suicidal ideation, attempted or completed suicide (n=13)
- 68 per cent were disengaged from school (n=13)
- 58 per cent were reported to have perpetrated family violence against a parent, sibling or partner (n=11)
- 53 per cent had a parent with a reported drug and/or alcohol addiction (n=10)
- 89 per cent of the female children in this group were reportedly sexually active and engaging in high-risk sexual activity, frequently with older males (n=8)
- 70 per cent of the male children in this group were in contact with the criminal justice system (n=7).

Of the children who had contact with a mental health service but remained undiagnosed (n=7), 86 per cent lived in regional or rural parts of Victoria (n=6). This group's presenting issues, which included threats to suicide, were generally considered not to meet the threshold for tertiary-level mental health service intervention.

Contact with health, mental health and other services in the 12 months preceding death

Table 20: Contact with health services in the 12 months preceding death

	Male		Female	
Presence and nature of health service contact	**n**	**%**	**n**	**%**
Contact within 12 months	**13**	**62%**	**13**	**93%**
• CAMHS or CYMHS	7	33%	8	57%
• Community-based mental health service	6	29%	9	64%
• Emergency Department	6	29%	9	64%
• Private psychologist	7	33%	3	21%
• School counsellor/welfare worker	4	19%	4	29%
• Drug and Alcohol (including residential detox)	5	24%	3	21%
• General practitioner	4	19%	3	21%
• Private Psychiatrist	3	14%	3	21%
• In-patient admission	3	14%	3	21%
• Recovery and prevention of psychosis service	1	5%	1	7%
No contact within 12 months	**8**	**38%**	**1**	**7%**
Total	**21**	**100%**	**14**	**100%**

Over 90 per cent of female children had contact with a health service in the 12 months preceding their death (n=13). They were most likely to self-initiate contact with a health service via presentation at a hospital emergency department or with a 'walk-in' community-based mental health service, such as headspace or Orygen. By comparison, male children tended to have family members or carers initiate contact with health services via referral to CAMHS or a private psychologist. This meant male children were significantly less likely to self-present at a hospital emergency department or a 'walk-in' community-based service.

Notably, over one-third of male children had no contact with a health service in the 12 months preceding their suicide (n=8).

Table 21: Contact with health services in the six weeks preceding death

	Male		Female	
Presence and nature of health service contact	**n**	**%**	**n**	**%**
Contact within six weeks	**8**	**38%**	**13**	**93%**
• CAMHS or CYMHS	4	19%	5	36%
• Emergency department	4	19%	4	29%
• Community-based mental health service for yp	3	14%	5	36%
• Recovery and prevention of psychosis service	1	5%	0	–
• Private Psychiatrist	2	10%	0	–
• School counsellor/welfare worker	0	–	2	14%
• Private psychologist	2	10%	1	7%
• In-patient admission	1	5%	2	14%
• General practitioner	1	5%	0	–
• Drug and Alcohol (including residential detox)	1	5%	1	7%
• Secure Welfare Service	0	–	0	–
No contact within 6 weeks	**13**	**62%**	**1**	**7%**
Total	**21**	**100%**	**14**	**100%**

Over 90 per cent of the female children had contact with health services in the six weeks preceding death, although overall, the female children had contact with fewer different health service types.

By comparison, the trend for male children shifted significantly. Whereas 62 per cent (n=13) of male children had some form of contact with health services in the 12 months prior to death, this rate drops dramatically to only 38 per cent (n=8) in the six weeks preceding suicide.

Table 22: Emergency department presentations in 12 months and six weeks preceding death

	Male		Female		Total	
	n	%	n	%	n	%
Emergency presentations 12 months	**6**		**9**		**15**	**43%**
• Deliberate self-harm	–	–	1	11%		
• Attempted overdose	6	100%	7	78%		
• Suicidal ideation	–	–	1	11%		
Emergency presentations 6 weeks	**4**		**4**		**8**	**23%**
• Deliberate self-harm	–	–	1	25%		
• Attempted overdose	4	100%	3	75%		
• Suicidal ideation	–	–	–	–		

Of the 35 children reviewed, 43 per cent attended at an emergency department in the 12 months preceding their suicide (n=15). Of those, 87 per cent presented with an attempted suicide by overdose (n=13).

Almost one-quarter of the children reviewed (n=8) had attended at a hospital emergency department within six weeks of death, of these, 88 per cent presented with an attempted suicide by overdose (n=7).

Table 23: Police contact in 12 months and six weeks preceding death[99]

	Male		Female		Total	
	n	%	n	%	n	%
Diagnosed mental illness	**14**		**13**		**27**	**77%**
• Any contact within 12 months	8	57%	5	38%		
• Contact within six weeks of death	8	57%	3	23%		
No diagnosed mental illness	**7**		**1**	**–**	**8**	**23%**
• Any contact within 12 months	5	71%	–	–		
• Contact within six weeks of death	4	57%	–	–		

Of the 35 children reviewed, 51 per cent (n=18) had contact with police within 12 months of their death and 43 per cent (n=15) within six weeks of death.

More than 60 per cent of male children had contact with police in the twelve months preceding their death (n=13) and 57 per cent had contact within six weeks of their death (n=12). Of those male children with no diagnosed mental illness, 71 per cent (n=5) had contact with police in the preceding 12 months and 57 per cent (n=4) in the six weeks prior to death.

By comparison, of the 13 female children with a diagnosed mental illness, only 38 per cent (n=5) had contact with police in the preceding 12 months – one of those as a victim of a rape.

Of the children who came into police contact:

- 44 per cent were alleged to have perpetrated violence against a family member (n=8) – in all instances, substance misuse preceded the alleged violence
- 22 per cent were picked up for high-risk taking behaviours including fire-lighting, joy-riding and behaving in an offensive manner (n=4)
- 11 per cent had contact with police in the context of ongoing drug use (n=2).

99 Information was not available in all cases so the data is potentially underestimated.

Help-seeking behaviours

In a significant number of cases (49 per cent), there was evidence that children had disclosed an intention or plan to suicide in the seven days prior to death. Of those that did disclose an intent, 59 per cent told a friend or peer, sometimes via social media (n=10).

Of the 17 children with a recorded communication of intent to commit suicide in the seven days leading up to their suicide, 12 used informal pathways involving family or peers, with the remaining five using formal pathways involving health professionals or other service providers.

Help-seeking behaviours were markedly different for the cohort of children aged between 12 and 14 years at the time of death. Of these children, 73 per cent disclosed an intention or plan to suicide in the seven days prior to death (n=8). In the majority of cases, this disclosure was made to a worker or mental health professional (n=5).

Table 24: Communication of suicidal intent in seven days leading up to suicide

	Male		Female	
	n	%	n	%
Informal pathways	**3**		**9**	
• Family member			2	(22%)
• Peers	3	(100%)	7	(78%)
Formal pathways	**4**		**1**	
• Mental health practitioner	1	(25%)	1	(100%)
• Worker	3	(75%)		
No known communication of intent	**14**	**57%**	**4**	**21%**
Total	**21**		**14**	

'Under the radar'

Just under one-fifth (n=6) of the children were identified after their deaths as having flown 'under the radar' amongst family members and services. The suicide of each child was met with shock and disbelief. As one family member reflected 'we just didn't see it coming'. As a group, these children were not known to present with mental illness or be considered 'at risk' of suicide; and despite recurring contact with Child Protection, they were never the subject of protective intervention.

The inquiry found a number of shared characteristics among these children, including:

- All had been exposed to high levels of family violence.
- On average, they were the subject of eight reports to Child Protection, which was higher than the recorded average of seven reports per child recorded for all 35 children.
- 83 per cent had been referred to but refused to engage with a school welfare counsellor (n=5).
- None were diagnosed with a mental illness and only one child had received services from a mental health service (but disengaged after one appointment).
- Two-thirds (n=4) were reported to have experienced sexual abuse in early childhood.
- Two-thirds (n=4) were known to use substances and had frequent contact with the criminal justice system.
- Two-thirds (n=4) were suspended from school for selling drugs to other students. The same four misused alcohol and cannabis. One child was repeatedly suspended and ultimately expelled from school for throwing a table at a student. He was described variously as 'explosive', 'intimidating' and 'difficult to engage'. Another was described as 'rude' and 'defiant and confrontational' towards teachers.
- They possessed a shared invisibility – there was a notable absence of information recorded about these children, their perspectives or wishes by service providers.

Chapter 6 at a glance

- The length and nature of contact that children had with mental health and other health services varied depending on the child's age, gender and age at first contact with Child Protection.
- Of the children reviewed:
  - 83 per cent were either diagnosed (n=24) or suspected (n=5) to have a mental illness
  - 83 per cent were recorded as having engaged in deliberate self-harming behaviours (n=29)
  - 60 per cent were recorded as being drug dependent at the time of their death (n=21).
- In terms of the children's contact with health and mental health services in the 12 months preceding death:
  - 74 per cent (n=26) had contact with a health service for care related to their mental health
  - 43 per cent (n=15) had contact with CAMHS or CYMHS, most frequently following an emergency department presentation
  - over 90 per cent of female children (n=13) had contact with a health service for care related to their mental health in the six weeks preceding their death, whereas only 38 per cent of male children had contact with health services in the six weeks preceding death (n=7)
  - 43 per cent (n=15) attended at an emergency department in the 12 months preceding their death; of these 87 per cent presented with an attempted suicide by overdose (n=13).
- 89 per cent had a recorded contact with a mental health service (n=31).
- The inquiry found that children's contact with mental health services was generally preceded by or occurred simultaneously with contact from Child Protection. This trend was particularly pronounced for the children who received a diagnosis by age seven.
- Of the children who had contact with a mental health service but remained without a mental health diagnosis (n=7), 86 per cent of these children lived in regional or rural parts of Victoria (n=6). This group's presenting issues, which included threats to suicide, were generally considered not to meet the threshold for tertiary-level mental health service intervention.
- 51 per cent (n=18) had contact with police within 12 months of their death and 43 per cent (n=15) within six weeks of death.
- Almost half of the children had disclosed an intention or plan to suicide in the seven days prior to their death. Of those, 59 per cent (n=10) told a friend or peer, sometimes via social media. Help-seeking behaviours were markedly different for children aged between 12 and 14 years at the time of death.

Chapter 7
Findings related to the child and family system

In Victoria, the importance of early intervention has been recognised in reforms to legislation, government policies and service delivery in the last two decades. This inquiry represents an important opportunity to reflect upon the extent to which these reforms have translated into real change for children and their families.

For the 35 children reviewed by this inquiry, early reports rarely resulted in substantiation or statutory intervention but frequently involved referrals to Child FIRST. Two-thirds of the children had their first contact with Child Protection before they turned eight – with the majority of these children (65 per cent) having their first contact before the age of three. These children needed the system to provide effective and timely early intervention.

What they received instead, was a service response characterised by delays, fragmentation and shallow focus. For these children, an ineffective early intervention system meant that protective concerns, such as exposure to family violence and parental substance misuse, became an entrenched feature of their lives.

As reports multiplied, and more information concerning the children and their experiences was captured via intake and investigation records, the response by Child Protection remained largely unchanged. Ninety per cent of the 229 reports received were closed at intake or investigation (n=206). Of these reports, three-quarters were closed without further action (n=158) and a further 20 per cent (n=42) were closed with a referral to Child FIRST. Re-reports were frequently met with the same response.

For these children, in almost every case nothing changed as a result of reports to Child Protection.

Nothing changed until the point of imminent crisis, usually much later in life, by which stage, the children were highly vulnerable and traumatised individuals, described variously as 'hard to help', 'needy', 'rageful', 'chaotic', and 'out of control'.

Over half of the children were the subject of substantiated reports at some stage (n=20), but over 60 per cent of these substantiated reports were closed without further action (61 per cent).

One-third of the children were the subject of protective proceedings in the Children's Court (n=12). The average period between Child Protection receiving the first report concerning a child and initiating protective proceedings was six years, four months. This group of children averaged nine reports each, and protective proceedings were initiated (on average) at report seven.

For the children reviewed, opportunities for timely and escalated intervention were missed and with this, the ability to make much-needed positive and long-lasting change for these children and their families.

Statutory child protection system

Child Protection operating as an emergency response service

Reports received at intake were frequently assessed episodically and with a strong focus on 'triaging' for imminent risk, similar to an emergency response service. However, Child Protection was commonly triaging a child's risk based on unverified information, almost always received from a secondary source. In most instances, this required Child Protection to take steps to verify the information by speaking to other sources or situating new information within its historical context. The Commission found that these steps were not always followed.

For the 35 children, 90 per cent of reports were closed at intake or investigation. Of these, over three-quarters (78 per cent) were closed at intake.

Of the children who died in the most recent five years (n=17):

- they were the subject of 91 total reports
- 93 per cent of reports were closed at intake or investigation (n=85)
  - 75 per cent were closed at intake (n=68)
  - 19 per cent were closed at investigation (n=17)
- approximately six per cent proceeded to protective intervention or resulted in the initiation of protective proceedings (n=6).

The Commission reviewed a sample of reports received for those children who died in the most recent five years, to assess how the overlay of 'imminent' risk in the assessment of reports translated in practice terms.

Case study

A child was the subject of their eighth report. The report detailed the child's behaviour was increasingly challenging and had escalated considerably in recent weeks. The child's appearance was dirty and they smelt unwashed. They attended school hungry. The reporter suspected that the child's parent had resumed intravenous drug use.

Child Protection intake reviewed the last contact the family had with a child and family service and contacted the child's school to verify information.

The last recorded contact with Child FIRST was three months earlier (at report six).

Child Protection contacted the child's school and they confirmed the reported concerns and provided additional information concerning the parent's untreated mental illness. Child Protection recommended that the school discuss Child FIRST with the family.

The report was closed at intake with the following rationale: *[The child] has a slight learning disorder. School appears to be [the child's] primary support. School to continue to support."*

Child Protection did not contact the child, the child's parent or Child FIRST. Within three weeks, the child was the subject of a re-report to Child Protection.

This child was the subject of nine reports, eight of which were closed at intake or investigation. Earlier reports detailed a lengthy history of family violence, exposure to drug-use, neglect and sexual abuse. Accompanying these reports was a similarly lengthy history of unsuccessful engagement of the child's parents by child and family services.

The child's child death inquiry found:

> *Closure decisions were often based on untested assumptions that existing services would continue to manage and monitor the situation or that [the child] was able to look after [themselves]. On at least one occasion, Child Protection found that the reporter, a professional with considerable knowledge of the family, did not understand the threshold of Child Protection risk.*[100]

Case study

A child was the subject of their seventh report. The child was missing at the time of report. The report detailed the child's increasingly erratic behaviour, including recent commencement of antidepressant medication, illicit drug use and suspension from school. The child's family was reported as finding it difficult to cope with the child's behaviours.

100 Extract taken from a child death inquiry

The child was located within three days and returned home to their parent.

The report was closed at intake and a letter was sent recommending Child FIRST. No contact was made with the child, the child's family, school or mental health service.

Within one week, the child was the subject of a re-report to Child Protection.

This child was the subject of eight reports, of which seven were closed at intake. Earlier reports detailed a lengthy history of exposure to severe family violence and reported sexual abuse. A number of assumptions were made regarding the seriousness of the report and risk posed to the child. Most notably, risk was framed by the threshold of 'imminence' and the child's 'ability to self-protect' as a young adolescent.

Case study

A child was the subject of their second report. The child was reported to be suicidal and had researched a method, venue and time. The child's parents had recently separated and a current intervention order excluded all contact between the child and their father.

At the time of report, the child was reported to be at home, in the care of their mother.

No contact was made with the child, the child's mother, police or school.

Two days later, the child's school contacted Child Protection and confirmed the child had not returned to school and that the mother was supportive of this decision. The mother had reported to the principal that the child was 'doing better'. The school agreed to refer the child to a mental health service.

The report was closed at intake due to the school's involvement.

Within four months, the child was the subject of a re-report to Child Protection.

This child was the subject of three reports, two closed at intake and one at investigation. An earlier report detailed a lengthy history of severe family violence (commencing in early childhood) and physical abuse. Again, the risk posed to the child in this case was framed by 'imminence' and the child's adolescent age.

The Commission cannot say whether the sample of children reviewed by this inquiry is representative of Child Protection practice more broadly. However, the Commission sees these issues frequently in all child death inquiries involving children who are older when they die. In these 35 children's cases, it is clear that the practice of triaging based on imminent risk resulted in significant risks to these children remaining overlooked and unaddressed.

Failure by Child Protection to identify and respond to risks of cumulative harm

The 35 children were the subject of an average of seven reports per child. The majority of reports received detailed evidence of multiple parental issues and behaviours that were risk indicators for cumulative harm. This was particularly the case for children who had been exposed (from an early age) to ongoing neglect and family violence, in the context of parental drug and alcohol misuse and mental health illness. There was however, little evidence that the impact or effects of cumulative harm on the children was considered.

The CYFA makes explicit that consideration of cumulative harm must inform part of the service response to reports of child abuse or maltreatment.[101] Central to this requirement is the need to avoid an episodic approach to assessing and responding to information that raises concerns about a child's wellbeing.

101 Section 10(3)(e) and section 162(2) of the CYFA.

The department's practice tool *Cumulative harm: a conceptual overview* describes the practice implications of assessing cumulative harm:

> *Each intake/assessment needs to be historically grounded and mindful of the cumulative impacts of harm, and the exponential impact on the child. In practice, the challenge for Child Protection when required is to present evidence to the court that shows the effects of the cumulative nature of harm on children and how it impacts on their development and safety.*[102]

The inquiry found that this advice was rarely translated into practice. As one child death inquiry found:

> *Risk assessments completed in the intake teams considered vulnerabilities and risk factors. What was missing was an analysis of what the information might mean for the [the child's] developmental and emotional trajectory. [The child's] emotional, psychological and cognitive development needed to be viewed through a clinical lens of trauma theory and cumulative harm and the impact on their safety and development.*[103]

Another child death inquiry found:

> *It is impossible to see how decision making in relation to [the child], in light of the multiple reports, could be viewed as having regard to the best interest principles. The importance of reviewing each report to Child Protection and each adverse childhood experience in conjunction with new information cannot be over-emphasised. Despite multiple reports, there was no evidence of an analysis of the likelihood of cumulative harm or its impact upon [the child's] safety and wellbeing.*[104]

And another found:

> *Opportunities for intervention were lost due to a tendency to focus on episodic assessments and to overlook the risk of cumulative harm across a number of separate reports. The consequences of this meant that the problems were entrenched and the cumulative impact of trauma was well-established by the time of adolescence.*[105]

In the majority of cases, consideration of the effects of cumulative patterns of harm was notably absent from the risk assessment processes, particularly those conducted at the intake stage. This was especially so once a child reached adolescence, but also applied to younger children.

In the majority of cases, consideration of 'pattern and history' was shallow or not apparent, which resulted in multiple and episodic risk assessments, where assumptions were drawn regarding the resolution of issues based on a previous report being closed.

In some cases, vulnerabilities such as mental health issues, disability and medical issues were compounded by the cumulative effects of abuse and neglect. However, the intersection between exposure to cumulative patterns of harm and mental health, disability or health issues was rarely explored.

A report involving a 14-year-old child, who had been the subject of a total of seven reports, all closed at intake or investigation found:

> *It was also apparent that each report was viewed in isolation without an adequate consideration of the history and emerging patterns which indicated that the family may not be coping and using inappropriate discipline to manage difficult behaviour. Consequently, overall risk assessment did not adequately incorporate both an understanding of immediate and cumulative harm.*[106]

A report involving a 13-year-old child, who had been the subject of a total of nine reports, eight closed at intake or investigation found:

> *A key learning from the early years of service involvement in [the child's] life relates to the enduring and problematic nature of an approach to reports of abuse which was episodic and event driven. Despite new information, the risk assessment remained static. The report highlights the importance of workers reading and understanding the significance of historical information and during analysis phase of assessment, looking for emerging and repetitious patterns of behaviour and events.*[107]

102 *Cumulative Harm: a conceptual overview*, page 10.
103 Extract taken from a child death inquiry
104 Extract taken from a child death inquiry
105 Extract taken from a child death inquiry
106 Extract taken from a child death inquiry
107 Extract taken from a child death inquiry

For the majority of children, reports were considered and assessed in isolation. A number of these cases identified a concurrent focus on closure.

One child death inquiry observed:

> *A Child Protection staff member interviewed expressed the view that constant heavy demand on the front end of service means that workers are under pressure to close cases at the earliest possible opportunity.*[108]

Another child death inquiry noted:

> *A feature of this case was repeated closures by Child Protection on the basis of inadequate evidence that the children were safe. Closure of the case as soon as the presenting problems are no longer visible is probably premature, particularly in a case where the parent is socially isolated and therefore the main source of information.*[109]

And another:

> *Adequate risk assessment should also have included consideration and assessment of the impact of ongoing neglect and cumulative harm on [the child]. The Commission found that Child Protection needed to assess more thoroughly and intervene earlier to prevent the cumulative harms experienced by [the child] as a result of ongoing abuse and neglect.*[110]

The Commission acknowledges that assessments of risk occur in the context of escalating demand for Child Protection and child and family services. However, a large number of these children were the subject of multiple reports, featuring co-occurring allegations of abuse and maltreatment, and yet the service response remained largely static.

Of the 229 reports received for the 35 children, 90 per cent were closed at intake or investigation. Over two-thirds of reports (69 per cent) were closed without further action. The chronic nature of some reports should have resulted in consideration being given to the impact of cumulative harm, consistent with the Cumulative harm practice resource. Unfortunately, this rarely occurred.

Lack of coordination and information sharing between Child Protection and Child FIRST regarding referrals, re-reports and re-referrals

All of the children referred to Child FIRST were the subject of re-reports to Child Protection and over half (56 per cent) were the subject of re-referrals to Child FIRST by Child Protection.

For the 12 children who died in the last five years, exactly half (n=6) were re-referred or recommended to contact Child FIRST, with no apparent consideration given by Child Protection to the outcome of earlier referrals when making a repeat referral.

There was very little evidence of Child FIRST proactively reporting back to Child Protection where engagement with a family via on-referral to a family service had been unsuccessful, which meant Child Protection rarely factored the history of prior engagement with child and family services into their overall risk assessment. There appeared, in the majority of cases, a disconnect between Child Protection and Child FIRST services that seriously impeded the ability of either service to offer any form of wrap-around support. This disconnect was to the detriment of many of the children included in this inquiry.

It is the Commission's view that assessments of risk should include information about Child FIRST referral outcomes. This will enable patterns of non-engagement to be identified earlier, and consideration given to providing a more assertive approach, including the possibility of statutory intervention where risks are assessed as significant.

There was some evidence, in more recent cases, of child and family services utilising the community-based Child Protection worker to help engage with families. Unfortunately, this did not result in subsequent engagement. However, the Commission found that joint visits featuring child and family services and community-based Child Protection were well attended by parents and nearly always resulted in positive exchanges between parents and workers, and a commitment (or recommitment) from the parent to engage.

108 Extract taken from a child death inquiry
109 Extract taken from a child death inquiry
110 Extract taken from a child death inquiry

The Commission acknowledges that (as outlined in Finding 2) child and family services were not resourced or equipped to provide these families with the escalated, intensive response they needed.

The Commission further acknowledges that families who present with safety concerns that fall beneath the threshold of statutory intervention, yet who resist engaging with voluntary community-based child and family services, create a specific challenge for the current child protection system. The children in these families are at an increased risk of falling between the gap created by the statutory and community-based service systems. For the 35 children reviewed, the impacts of these challenges were especially profound.

Absence of timely escalation by Child Protection in cases involving re-reports

This inquiry does not advocate for the greater use of statutory intervention for children who come into contact with the child and family system. Rather, the Commission advocates for a child and family system that is capable of supporting the principle of limited intervention – one that has the capacity to offer a timely response that meets the needs of complex families before the need for statutory intervention arises. For some families, this is likely to require long-term and intensive supports involving multiple service systems.

Where, however, attempts at intervention are consistently unsuccessful and children remain at significant risk, statutory Child Protection intervention should be pursued in a timely fashion. The Commission found this did not occur in cases involving re-reports.

Only one-third of the children were the subject of protective proceedings in the Children's Court (n=12), despite over three-quarters of these children having had their first contact with Child Protection by the age of three (n=9). One-third of these children were Aboriginal (n=4). The average period between Child Protection receiving the first report concerning a child and initiating protective proceedings was six years and four months. This group of children averaged nine reports each, and protective proceedings were initiated (on average) at report seven.

These children required timely intervention and it did not occur. Because intervention was delayed until the point of crisis, these children entered the child protection system as highly vulnerable and traumatised individuals – frequently characterised as 'too hard to help'.

Finding 1: Statutory child protection – episodic risk assessments that focussed on imminent harm

The Commission found that risk assessments undertaken by Child Protection at the intake and investigation phases were frequently shallow in focus and based on immediate and episodic risk prediction.

This led to children who were at risk of significant harm, including cumulative harm, being left to endure multiple, and often chronic forms of harm, without support or effective and timely intervention.

The inquiry identified a range of barriers to Child Protection undertaking effective and responsive risk assessments in the cases reviewed, including:

- **Child Protection appearing to operate as an emergency response service**
- **failure by Child Protection to identify and respond to risks of cumulative harm**
- **lack of coordination and information sharing between Child Protection and Child FIRST regarding the outcome of referrals, re-referrals and on-referrals to family services**
- **absence of timely escalation by Child Protection in cases involving re-reports.**

Voluntary child and family service system

Ineffective early intervention

Approximately one-fifth of reports made to Child Protection resulted in Child Protection referring families to Child FIRST for assessment and potential allocation to a family service (42 reports or 18 per cent). In response to a small number of reports, Child Protection wrote to families, recommending that they contact Child FIRST (10 reports or 4 per cent). In total, 25 of the 35 children were referred to, or recommended to contact, Child FIRST at some point.

Child and family services are voluntary and so their utilisation requires agreement from families to participate. It is widely acknowledged that engagement with families facing multiple and complex issues can be a challenge for services.[111]

In the cases reviewed by this inquiry, approximately one-quarter of all families (n=9) expressed a persistent unwillingness to engage with community-based child and family services. Of these families, 89 per cent (n=8) were ultimately the subject of statutory intervention.

Nearly three-quarters of families (n=26) however, were recorded as expressing a willingness to engage (either consistently or intermittently) with community-based child and family services. Despite a relatively high number of families indicating a preparedness to engage, the inquiry found that none were successfully engaged.

Of the 25 children referred or recommended to Child FIRST, 12 died in the last five years (between 1 April 2014 and 1 April 2019). The Commission examined the cases of these 12 children in detail in order to assess the quality and effectiveness of early intervention services delivered through the Child FIRST and child and family service system.

For a full summary of the analysis, see Appendix D.

The inquiry found that in most cases, referrals were made in response to earlier reports (reports one to four). For those children and families referred in response to later reports (reports five onwards) the chronic and cumulative nature of concerns served as a considerable barrier to effective engagement.

For one-third of the children, the lack of successful community-based intervention resulted in subsequent reports to Child Protection and, ultimately, the initiation of protection proceedings (n=4).

Concerningly, none of the children and their families referred to (or recommended to contact) Child FIRST, were successfully engaged beyond the point of initial assessment, if at all. The Commission attributes this to a range of factors, including:

- delays in the allocation of families to particular services
- the intensity of services provided being inadequate to address the complexity of identified issues
- the handling of re-reports and re-referrals
- the practice of Child Protection recommending to families, by letter, that they contact Child FIRST.

The Commission assessed (in a less detailed fashion) the extent to which the themes identified for the 12 children who died in the last five years were present in the cases of the remaining children.[112]

111 VAGO Report, *Early intervention services for vulnerable children and families*, May 2015.

112 Unfortunately, detailed information concerning the quality of services provided by community-based child and family services was not available in all cases and so the rates are likely to represent an under-estimate.

Table 25: Themes identified related to ineffective engagement

Delays in commencement of services	Complexity of issues not matched by intensity of service	Refusal to engage by parent or child	Re-referrals from Child Protection	Recommendation via letter unsuccessful vehicle for engagement
7 (from 25)	12 (from 25)	9 (from 25)	14 (from 25)	8 (from 25)
28%	48%	36%	56%	32%

In summary:

- Approximately 70 per cent of families (71 per cent) were referred to, or recommended to contact, Child FIRST (n=25).
- Over half of those (56 per cent) were referred more than once to Child FIRST (n=14), with one family referred to Child FIRST eight times, across the course of 20 reports to Child Protection.
- In almost half of the cases reviewed (48 per cent), services provided by community-based child and family services were deemed by the Commission as inadequate to meet the complex and frequently chronic issues that families required help to address (n=12). The result of this mismatch was that families disengaged from child and family services with alarming regularity.
- Only 10 per cent (n=2) of families who were recommended to make contact with Child FIRST initiated contact and of those, neither were successfully engaged beyond an 'initial assessment'. Most families (80 per cent) who were recommended by Child Protection (by letter) to make contact with Child FIRST, did not (n=8).

Delays in allocation of child and family services

Delays in the commencement or allocation of child and family services were recorded in relation to seven families (28 per cent), although this is likely to be an under-estimation due to a lack of information regarding waitlists for all cases reviewed. Of those cases where waitlisting occurred, the delay in commencement of services ranged from eight weeks to four months.

For the 12 cases examined in detail, delays in allocation that resulted in families being 'waitlisted' was a factor for one-quarter of the families (n=3). The impact of delays in allocation are illustrated by the following example (based on a child death inquiry).

Case study

Referral 2

A child and their family were referred to Child FIRST for initial assessment. This was the family's second referral to Child FIRST and occurred in response to the third report. The protective concerns identified related to childhood sexual abuse (for the parent and child), substance misuse by the parent, neglect, exposure to family violence and disability.

The family was allocated a family service provider, who agreed to a 'long response' involving a 12-week intervention. Due to demand, the family were advised they would be waitlisted for three months before services could commence.

Further concerns were raised for the child while being 'waitlisted' and assessed in the context of 'services soon to commence'.

After three months, an initial visit occurred, goals were set (for the parent) that featured multiple service interventions and a schedule made for weekly visits. Visits failed to proceed weekly, due to illness and service refusal by the parent. None of the referrals intended for other services eventuated.

After six months of unsuccessful engagement, a new report was received. Child Protection consulted with the family service provider who confirmed the status quo. The report was closed with the family service provider agreeing to a joint home visit with the community-based child protection worker.

The joint home visit was attempted, but no-one was home. No further contact was made, and the referral closed.

Referral 3

Child Protection received a further report and another referral was made to the family service provider. There were further delays before the service could commence. This time the approach taken was to provide the family with an 'on-call service' for the next twelve months. The 'on-call service' allowed the family to reach out at times of crisis. No active case management was recorded during this period. After 12 months, the family's file was marked for closure.

Referral 4

Child Protection re-referred the family to Child FIRST 12 months later (following another three reports). A subsequent re-referral to the same family service provider was made. Soon after, protective proceedings were initiated.

This child was first reported to Child Protection as an infant. The risk indicators identified were serious and the level of help required to support this family, intensive. Delays in commencement of services led to a loss of intervention momentum. For this child, the result of this ineffective intervention was an escalation in concerns that resulted, ultimately, in protective intervention later in life.

Intensity of services inappropriately matched to address the complexity of concerns

The inquiry found that in one-quarter of the 12 cases reviewed (n=3), a significant barrier to effective intervention was a mismatching of complexity with the duration and intensity of services provided by community-based child and family services.

The issue was identified for almost half of the 25 children who were referred to Child FIRST (n=12).

One child was referred at report three to a family service. The referral was made to support their parents address a history of intergenerational abuse, drug use and severe family violence. The family received a total of four face-to-face visits across a 12-month period of intervention.

In another case, a child was referred at report six to a family service to support their parents to address significant attachment issues, physical abuse of the child and untreated parental mental illness. Involvement with the service was closed eight weeks later, noting 'goals were met'. Intervention involved two visits and a referral to a health service for the young child to have their 'behaviour assessed'. It was noted during intervention that the parents referred to the child as 'it'.

The experience of the following child who died in the last five years illustrates the impact of services lacking the ability to match the complexity of families needing help.

Case study

A child and their family were referred to Child FIRST for an 'initial assessment'. This was the family's first referral and occurred in response to the second report to Child Protection. The protective concerns identified related to intergenerational sexual abuse (for the parent), historical involvement of child protection services and abuse in care (for the parent), parental substance misuse and neglect.

Referral 1

The family was referred to a family service. They were waitlisted for three months before the service could commence.

The service attempted (without success) to work with the family for six months. At their last visit to the family home, the worker noted 'an overwhelming smell of urine in the house'. The case was closed due to 'lack of engagement'.

Referral 2

Four weeks later, and after a further report to Child Protection, the child and their family was re-referred to Child FIRST. Child FIRST allocated the family a family service provider. The family were waitlisted for two months before the provider could commence.

At the initial visit, goals were set (for the parent) and a schedule of weekly visits was fixed.

Visits didn't proceed due to parental illness and refusal. Attempts made to re-engage via utilisation of the community-based Child Protection worker proved unsuccessful.

The family service provider held open the case for a further 12 months before closing, citing in its closure summary '[parent] unable to be engaged, no referrals made to other services. Child now with [carer]'.

Referral 3

Within a year, the was back with their parent, and their family were re-referred to Child FIRST and reallocated to the same family service provider. The family were waitlisted by the service for three months. Following commencement, the family service kept the case open for six months. During that period, three attempted home visits were made, of which none were successful. The referral was subsequently closed.

This child was first reported to Child Protection as an infant. The risk indicators identified were serious and an intensive level of help was required to support this family. The service was unable to address the complex nature of these issues via utilisation of a standardised approach involving weekly appointments. For this child, the result of this ineffective intervention was an escalation in concerns that resulted, ultimately, in protective intervention later in life.

The handling of re-reports and re-referrals

All of the children referred to Child FIRST were the subject of subsequent re-reports to Child Protection and over half (56 per cent) were the subject of re-referrals to Child FIRST by Child Protection.

The inquiry identified a range of issues related to the handling of re-reports and re-referrals attributable largely, to poor coordination and information sharing between Child Protection and Child FIRST. See finding 2 for further discussion of re-reports and re-referrals.

The practice of Child Protection recommending via letter that families contact Child FIRST

For the 35 children reviewed, 14 letters were sent to 10 families recommending they contact Child FIRST. Of these, only two families initiated contact and they subsequently disengaged. Both families had contact from Child Protection prior to contacting Child FIRST.

For the majority of other families, letters were sent in circumstances where a report had been received by Child Protection and subsequently closed at intake, without contact between Child Protection and the family or child.

Case study

One child was the subject of a report that raised concerns relating to family violence (for parents and child) and untreated mental illness and suicidality (for child). The report was closed at intake, following contact with mental health services and the police. No contact was made with the family or child prior to closure.

Letter 1

Following closure, a letter was sent to the family recommending contact with Child FIRST, a child mental health service and a family violence service.

Letter 2

A further report was received within eight weeks, raising concerns relating to family violence (for parents). The report was closed at intake and a second letter sent to the family recommending contact with Child FIRST. No contact with the family or child was recorded prior to or after closure.

The family did not pursue contact with Child FIRST.

The Commission considers a lack of contact with families when recommending they initiate contact with Child FIRST means it is unlikely they will subsequently engage.

Finding 2: Child FIRST and family services – ineffective early intervention

There was no evidence that any of the 25 children and their families who were referred to Child FIRST were successfully engaged with family services. In all instances, the children and their families referred to Child FIRST were re-reported to Child Protection – in most cases, within quick proximity to referral.[113]

This led, in some cases, to multiple referrals being made to Child FIRST, who made multiple on-referrals to family services. This approach resulted, ultimately, in recurring concerns remaining unaddressed for children at risk of harm.

The ability of the Child FIRST and family service system to successfully engage the families reviewed was impeded by a range of factors, including:

- **delays in the allocation of families to particular services**
- **the intensity and duration of services were inadequate to meet the complexity of issues identified**
- **the handling of re-reports and re-referrals**
- **the practice of Child Protection recommending to families, by letter, that they contact Child FIRST for support.**

113 The Commission acknowledges that in some cases, re-reports were not made in quick proximity, but occurred across the course of a child's life, and occasionally with multiple years in between.

Lack of child-focussed practice

Absence of direct contact with children

Although the importance of seeing and listening to the child is a key aspect of the best interest principles and the associated Best Interest framework[114], there was overwhelming evidence that Child Protection services were not seeing and not speaking directly to children. Significantly, Child Protection practitioners were not always hearing what children were saying.

> *A feature of this case is the repeated contact with the parent and limited conversation with [child] who was the subject of reports.*[115]

> *Child Protection had regular contact with the mother or the mother and [child] together, but one-to-one contact between Child Protection and [child] was minimal, limiting the opportunities for engagement and to assess [child's] self-harming behaviour and suicidal ideation.*[116]

The lack of assessment of the whole family, including the child, resulted at times in a lack of understanding both of the experiences of the child and the parents' ability to meet their needs. This significantly reduced the capacity of Child Protection to assess the risk of cumulative harm posed to a child.

> *The amount of face-to-face contact with [the child] was often limited to enable adequate information to be obtained, to assess risk or safety factors and to plan for these.*[117]

> *For a child that had consistent mental health assessments that referred to her traumatic past and lack of connection to her family and siblings, ensuring that she was part of the decision making process is likely to have provided her with an opportunity to have a voice, be heard, be validated as a child growing up away from family and siblings.*[118]

In a number of cases, there was evidence that children had not been listened to with respect to issues central to their safety.

Inadequate evidence of participation by children in decision making

Ensuring that the voice of the child is heard is an important objective. It is also enshrined in the CYFA that a child's views and wishes, if they can be ascertained, should be given appropriate weight. This principle is consistent with Article 12 of the *Convention on the Rights of the Child.*

To ensure that the voice of the child is heard, Child Protection policy requires the participation of children, where appropriate, in case planning. Unfortunately, there was little evidence of these policies translating into practice. There were many examples of these children feeling unheard and unsupported by the services responsible for protecting them.

In one case, it was observed:

> *Of particular note in the management of this case was the lack of attendance and input from [the child] at family meetings and at critical decision-making points. This is despite it being noted on the file that [the child] expressed a wish to be involved in discussions, 'rather than have all decisions and choices made by my parents'.*[119]

Since the permanency amendments in March 2016, the Child Protection Manual has updated its advice regarding case planning, which confirms:

> *Giving children a voice in planning and decision making which affects them, in age appropriate ways, is at the heart of decision-making principles of the CYFA … if a child is of an age and able to understand, they should be encouraged to participate directly in case planning and be assisted to understand the importance of their role in the process. If a child chooses not to attend a case planning meeting, the practitioner should explore creative ways for the child's voice to be heard.*[120]

There are suggestions for how to help a younger child communicate their wishes without attending the meeting. Additional advice is provided to practitioners regarding the sorts of information needed to be conveyed to a child, including:

114 See Appendix C for further information.
115 Extract taken from a child death inquiry
116 Extract taken from a child death inquiry
117 Extract taken from a child death inquiry
118 Extract taken from a child death inquiry
119 Extract taken from a child death inquiry
120 http://www.cpmanual.vic.gov.au/advice-and-protocols/advice/case-planning/case-planning (accessed October 2019)

- The case manager should engage the child in discussions about the development, progress and review of the case plan.
- Special care must be taken to ensure that the child understands the decisions made and what the case planning process means.
- The case manager should talk with the child about day-to-day care issues as well as the permanency objective and the goals and actions required to achieve the objective.[121]

There is no advice provided that would help practitioners discuss relatively complex case planning practices (for example, how to explain the status of a case plan while there are active court proceedings). There are no suggestions for how practitioners should communicate with children about decision-making processes or internal review processes.

There is a separate section included in the advice entitled 'considerations for good practice' that lists a series of 'questions to elicit the family's safety goals', which are cited from a 1999 source (Turnell, A and Edwards, S). The questions are generic and distinctly adult or parent focussed. Development of similar content that is child-focussed and includes advice on how to describe the concept of 'permanency' may assist practitioners to translate policy into practice.

Multiple contacts involving multiple people

In some cases, there was evidence of children having multiple contacts with multiple people from Child Protection and other services. The Commission found that the greater the number of different interactions with different workers recorded on a child's file, the more disengaged a child became.

A child who had been in out-of-home care for most of her life, wrote of her experience:

> *Don't you remember people saying that friends are not always forever, but family is? What about children like me that are in foster care? We don't have the same stable life style as everyday children, we are owned by people we have never ever met, we have people in suits and fancy clothes come in and out of our lives. How are we supposed to feel normal when other children at school never have to experience what we go through?*[122]

Another child, who was the subject of eight reports, commencing at age seven, was described in the following terms:

> *[The child] was a hard to help child, who had experienced significant adverse life events and was reported to be emotionally detached and lacking in remorse. Workers found it very difficult to form a relationship with [the child].*[123]

Another child, who was the subject of nine reports, commencing at age two, was described in the following terms:

"All services contacted by this inquiry had found [the child] difficult to engage. The very experienced Student Wellbeing Counsellor at [the child's school] described [the child] as having 'severe attachment problems'".[124]

Another case quoted a mother as saying:

> *…there were so many workers, we would get to know one and then they would leave.*[125]

A child protection system that involves direct contact between a vulnerable child and multiple adults is not a system that can be described as child-focussed. Greater attention needs to be given to the importance of minimising the number of adults having direct contact with a child for the purposes of discussing protective matters. A number of the children reviewed were assessed to have problematic attachment issues with care-givers and associated difficulties forming trusting and safe relationships, yet these same children were required, in some instances, to speak about these matters to a revolving number of practitioners.

121 Ibid

122 Extract taken from a child death inquiry
123 Extract taken from a child death inquiry
124 Extract taken from a child death inquiry
125 Extract taken from a child death inquiry

Consistent, relationship-based practice is best practice for children

In order to adequately protect children, multi-agency work is required with an emphasis on relationship-based practices to engage children over a period of time. The significance of relationships between children and their families and carers and case workers cannot be overstated. Among the 35 files, there were a small number of cases where excellence in case management was acknowledged:

> *The case illustrates the value of relationship-based practice where qualified and experienced practitioners have the time and emotional space to engage with young people in crisis like [the child]. Those working directly with young people must have opportunities to read the past history and have access to the background information which enables them to place in context current behaviours and difficulties.*[126]

The Commission found that in all cases involving good practice, there was consistent case management, which enabled the child to form a relationship of trust with a key worker.

The department is currently structured so that responsibility for different 'case phases' are held by different teams, which results in families interacting with different workers depending on what stage a case is at. For children, this involves an in-built change in worker as their case progresses through each phase. This means that children who are deemed most at risk, who traverse each phase of intervention from intake to protective order, experience the greatest number of worker changes. It is the Commission's view that a case phased approach to case management is not child-focussed, nor is it consistent with promoting children's best interests.

Understanding, identifying and responding to adolescent vulnerability

In order to support children, their difficulties need to be recognised and understood. Perceptions of older adolescent children who were assessed as 'difficult to help' emerged as a key theme in many of the 35 cases reviewed.

In some reports, there was evidence that decision makers perceived older adolescents as able to take care of themselves, avoid harm and ask for help when needed. This was used as a basis for limited or no action by services.

Where evidence existed of the Best Interests framework being applied, the 'age and stage of life' component was prioritised above others, in combination with shallow assessments that considered immediate safety needs only. In one case, there was an unfounded presumption of resilience because the child was articulate and viewed as an adult rather than a vulnerable child.

A report involving a 15-year-old child, observed:

> *The assessment of Child Protection was that [the child] was 15 and [their] age meant that [the child] was more resilient to harm from [their] mother.*[127]

A report involving a 14-year-old child, similarly observed:

> *File notes frequently refer to [the child's] ability to 'remove [themselves] from harmful situations' and therefore [they were] not considered vulnerable. However, significant informants, including [the child], extended family, school were not contacted to ascertain actual resilience levels when exposed to constant stresses and dysfunction in [their] family situation.*[128]

For many of the children, previous life experiences and recurring safety concerns were mostly recognised, but not necessarily addressed, as professionals focussed on crisis-based intervention. For examples, exposure to family violence as a child was frequently noted but not necessarily connected with later behaviours, including the use of violence towards siblings.

126 Extract taken from a child death inquiry

127 Extract taken from a child death inquiry

128 Extract taken from a child death inquiry

The reports observed that for a number of the children, their age and behaviour led to services viewing them as young adults rather than vulnerable children.

> *The decision to move from a Custody Order to a Supervision Order was premature and appeared to put in train a process of increasing independence for [the child] that was not dependent on her demonstrating greater capacity to keep herself safe.*[129]

The Commission acknowledges that achieving a balance between respecting the autonomy and wishes of adolescents while recognising their vulnerability is not an easy task for professionals to achieve.

Finding 3: Statutory child protection – lack of child-focussed practice

The Commission found there was an absence of child-focussed engagement in response to the 35 children reviewed. This resulted in children's voices not always being heard by services, and their experiences often not being taken into account.

Children were rarely interviewed away from family members and rarely engaged in decision-making processes or participated in case planning.

For those children who had reached adolescence, they were rarely assessed or described as 'vulnerable' but frequently described as 'self-protective'. In some cases, the depth of sadness they experienced only revealed itself after their death, in the form of a suicide note or diary entry.

129 Extract taken from a child death inquiry

Chapter 8
Findings related to the mental health system

Ineffective early intervention

For children, intervention early in life at an early stage of mental health problems can reduce the duration and impact of the problems.[130] Mental health problems have many causes, including abuse and neglect in childhood, developmental disorders, and physical disability.[131]

Due to the scope of the inquiry, all 35 children had contact with the child protection system. Of these, 89 per cent also had contact with the mental health system (n=31). More than 80 per cent had a diagnosed or suspected mental illness (83 per cent) – of those, 39 per cent had received their diagnoses by the age of seven (n=12).

The Commission reviewed the provision of mental health services to children who died between 1 April 2014 and 1 April 2019 in order to identify any service system issues for these children and their families. Fifteen of the children received mental health services during the five-year period (43 per cent of the 35 children reviewed by the inquiry). Of these:

- 60 per cent were male (n=10) and 40 per cent female (n=6)
- 20 per cent were Aboriginal (n=3)
- 27 per cent were assessed as having an intellectual disability (n=4)
- 67 per cent of the children lived in regional or rural parts of Victoria (n=10) and the remaining 33 per cent lived in metropolitan areas (n=5).

For a full summary of analysis, please see Appendix E.

The inquiry identified multiple themes for the children reviewed, however three featured most prominently:

- an absence of specialised mental health services for children diagnosed with mental illness earlier in childhood, by the age of seven years
- a lack of targeted support to help children to recover from childhood abuse and trauma
- an inadequate focus on delivering integrated family-based interventions that supported the recovery of children experiencing mental illness.

The Commission also assessed (in less detail) the extent to which these themes identified for the 15 children who died in the last five years, were present in the cases of the other 20 children (who died before 1 April 2014).

Table 26: Themes identified related to mental health service provision

Absence of mental health services for children diagnosed with mental illness by the age of seven years	Lack of targeted support to help children recover from childhood abuse and trauma	Inadequate focus on delivering family interventions
11 from 12	20 from 31	20 from 31
92%	65%	65%

130 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 8
131 Ibid

In summary:

- For almost all of the children diagnosed by age seven (92 per cent) there was (or appeared to be) an absence of service intervention (beyond an annual or six-monthly medication review) until presenting issues escalated (usually at the point of adolescence) (n=11).
- Almost two-thirds of the children (65 per cent) were identified by the Commission to lack targeted support to help them recover from early childhood abuse or trauma (n=20).
- Almost two-thirds (65 per cent) were identified as receiving treatment that had an inadequate focus on integrated family-based interventions (n=20).

An absence of specialised mental health services for children diagnosed with mental illness by the age of seven years

The inquiry found that early contact with child protection services largely preceded or occurred simultaneously with contact from mental health services. This was particularly pronounced for the cohort of children who had contact with Child Protection before the age of three (n=15). For this group of children:

- 80 per cent had a diagnosed mental illness (n=12) and all of these children had received their diagnosis by the age of seven
- half of the children that were diagnosed had their first contact with a mental health service by the age of five years (n=6).

Despite receiving diagnoses early in their lives, none of the children received specialist therapeutic intervention (beyond annual or six-monthly paediatric appointments) until their presenting issues had escalated to the point of crisis – where they posed a significant risk of physical harm to themselves or others. It is not evident to the Commission why such a 'light touch' approach to the management of these children's mental health problems was taken, as none of the files recorded the rationale for this approach. What was clear, however, was that the approach was deeply problematic for many of the children reviewed.

Case study

A child had their first contact with Child Protection by the age of two and their first contact with a mental health service by the age of three. Their presenting issues included language problems and aggression. Reports to Child Protection detailed a history of exposure to severe family violence and neglect.

Information concerning the child's child protection history was not shared with the treating paediatrician. The focus of appointments was on addressing the child's 'challenging behaviours'.

The child was suspected as having ADHD and prescribed medication.

Six-monthly appointments with the paediatrician weren't consistently kept but scripts were regularly filled via a GP.

By age seven, the child's aggression had worsened, and new symptoms had emerged. The child was diagnosed with ASD, medications were changed, and a referral made to an Autism Program, for which there was a lengthy waitlist.

By age nine, the child was experiencing new symptoms. The child was rediagnosed and new medications prescribed. A referral was made to CAMHS. The referral was accepted, and the child was placed on a lengthy waitlist.

By 10, the child was reported as 'violent' and also the victim of family violence. A community-based child and family service was recommended.

By 12 years of age, the child had commenced fire-lighting and had attempted suicide. The child was treated by CAMHS as an outpatient for six months before withdrawing with safety plans in place. Information concerning the child's Child Protection history was not shared with CAMHS – even when new concerns arose and were reported during the period of treatment.

During the child's final mental health intervention – an in-patient admission – a report was made to Child Protection. It was closed at intake. At discharge, the hospital closure summary described ongoing family issues, noting 'no value in continuing to see the child at this stage. Will continue to provide secondary consultation to families working directly with [child]. Urgent need for respite.'

Like most of the children whose experiences were reviewed by this inquiry, this child was raised by parents with their own mental health challenges and history of trauma.

The child was the subject of seven reports to Child Protection, six of which were closed at intake and one at investigation. Despite two service systems having repeated contact with this child in early childhood, neither remained connected for long enough to effect positive and sustained change. And like most cases reviewed by this inquiry, there was a notable lack of information sharing between service systems, which meant there were times where neither system had complete knowledge of the child's circumstances.

Case study

A child had their first contact with Child Protection at six and their first contact with a mental health service at seven. Safety concerns related to family violence, neglect and parental alcoholism.

Concerns for the child's mental health had first been raised in kindergarten. By six, the child was displaying aggression at home. As a young child, they were referred to CAMHS. A short period of intervention with CAMHS followed, although was unable to be sustained due to the family 'moving around'. At eight, the child was diagnosed with ADHD and anxiety and prescribed medication. A plan was set for six-monthly paediatric review.

At nine, the child was reported to have experienced sexual abuse and referred for counselling but wasn't taken to the appointments.

By 10, further aggression at home resulted in a referral to CAMHS. By this time, the family was experiencing acute family violence. The child's mother reported to Child Protection that CAMHS had told her the child's aggression was 'behavioural … due to what's happening at home'.

At 12, the child was seen again by the paediatrician and anti-depressants prescribed.

At 13, the CAT team were regularly called in response to the child's 'behaviour'. The consistent assessment was: 'no mental health concerns … child displaying behavioural issues'.

By 14, the child was a client of Youth Justice.

For this child, contact with both systems occurred almost simultaneously. The child was the subject of eight reports to Child Protection, seven of which were closed at intake or investigation. The family received two referrals to Child FIRST, neither of which resulted in successful engagement with a family service. The difficulties successfully engaging this child's parents were identical across both Child Protection and mental health services, yet these difficulties were never shared between the two systems and no attempts at coordination were made.

It is unclear how representative the sample of children reviewed by this inquiry is, in terms of their concurrent contact with the child protection and mental health systems. For these children, however, where contact was concurrent, the focus of each system was quite different. Child Protection largely assessed the circumstances of young children in terms of mitigating parental risks, without necessarily taking steps to address how exposure to these risks may have impacted the child. This was especially the case for children exposed to significant family violence. Mental health interventions, on the other hand, were child-focussed – in that they focussed on addressing the mental health issues the children were experiencing – but were not always well-informed regarding family history or the child's exposure to parental risks.

Inadequate focus on helping children recover from childhood abuse and trauma

The majority of children reviewed by this inquiry had experienced a range of harms, often over the course of many years. These harms, in most instances, had a profound impact on the children and their mental health. In tracing the course of these children's lives, in some cases from birth to death, the inquiry found mental health services often lacked comprehensive information concerning the child's protective history. This impacted on the ability of services to implement longer-term interventions to address earlier abuse or trauma.

Where this information was available to mental health services, for many children the focus of mental health intervention appeared to remain largely episodic and reactive, without a focus on addressing the underlying trauma. The reasons for this were not always straightforward. In some cases, reactive management arose in the context of unsuccessful engagement with a child while in others it was due to treatment being unable to proceed while a child's condition remained 'unstable'.

For the children in out-of-home care, 'unstable' placements sometimes impacted upon their ability to access therapeutic mental health treatment.

Case study

A child was first reported to Child Protection at age three due to their recurring exposure to family violence, in the context of parental substance misuse.

The parents separated and commenced new relationships. As a young child, they witnessed their father seriously assault his new partner, before strangling her to unconsciousness. This report, like others, was assessed in the context of the other parent's ability to 'act protectively'. Impact on the child was never professionally assessed.

In total, seven reports were received during the child's primary school years, all closed at intake. Two referrals were made to Child FIRST – neither resulted in the family engaging with services.

At 13, the child's school referred them to a mental health service for counselling. The child attended all sessions, but the intensity of intervention wasn't able to address the escalation in presenting issues, which included substance misuse and deliberate self-harming.

Following an attempted suicide, a referral was made to CAMHS. CAMHS diagnosed depression in the context of childhood trauma.

A worsening in presenting issues, substance misuse and associated aggression led to the child being placed in out-of-home care. The child's parent indicated to Child Protection their view that substance misuse was at the

core of the child's difficulties and rehabilitation was urgently required. Child Protection never confirmed with CAMHS whether this was in fact, an accurate interpretation.

By this stage, Child Protection and CAMHS were both actively involved with the child.

The child was moved from placement to placement, each ending quickly, as carers struggled to provide safe care.

Appointments at CAMHS were being missed in the context of placement changes and with it, increasingly unchecked substance misuse by the child.

Child Protection never confirmed with CAMHS the child's diagnosis or treatment plan (beyond his medication needs). This meant that prospective carers were equally ill-informed about the child, their mental illness and plan for treatment (beyond their medication needs).

In terms of CAMHS involvement, the instability created by multiple placement changes meant 'there was very little work we could do at that time'.

For this child, placement instability impacted upon their ability to engage in urgently needed therapeutic mental health treatment. Their experience highlights the interdependencies between these two important systems. Children who are unable to live safely at home are reliant on the child protection system to provide them with suitable placements and equally, reliant on the mental health system to provide appropriate therapeutic intervention. When these two systems fail to align, children like those reviewed by this inquiry, face the full force of that misalignment.

Children who are known to have experienced childhood abuse and trauma are likely to require help to recover from this exposure. This was not however, identified as a consistent focus of mental health intervention for the children reviewed by this inquiry. It is unclear the extent to which this was attributable to a lack of available and appropriate service providers or because engagement with many of these families was particularly challenging.

Case study

A child had their first contact with Child Protection by age one and their first contact with a paediatrician at two years of age. Safety concerns related to intergenerational sexual abuse, intergenerational Child Protection involvement, substance misuse and neglect.

Contact with the paediatrician occurred in the context of the child presenting with delayed speech, aggression and reduced social skills. Advice was provided and follow-up appointments made.

By four years, the child continued to present with increased aggression. A referral was made to a community-based disability support service. The service was unable to successfully engage the family.

At five years, the child was diagnosed with ASD and intellectual disability. By this stage, a further report had been made to Child Protection and referrals made for the family to engage with a child and family support service. The service was unable to successfully engage the family.

At seven, follow-up with the paediatrician occurred and it was observed that the child was 'anxious, aggressive and increasingly difficult to manage'. The child was referred to a clinical psychologist, however, no appointments were made, and no follow-up provided to the paediatrician.

At 10, the child was trialled on anti-anxiety medication. Follow-up appointments with the paediatrician were missed for almost two years.

At some point during this period, the child's school made a referral to CAMHS for 'assessment of a possible emerging psychosis'. The assessment proceeded and the child's parent indicated the family was managing 'okay' but would value further advice and support relating to the child's diagnosis of ASD. On that basis, a full mental health assessment never proceeded. Instead, advice was provided to parent and school regarding behavioural management. No information was sought with respect to the child's family history or contact with Child Protection.

When appointments resumed with the child's paediatrician, it was assessed that the medication prescribed at age 10 continued to be helpful and a plan was made to re-refer the child to a clinical psychologist 'if anxiety increased or behaviour worsened'.

This was the final contact before the child died. Child Protection had received a total of six reports with respect to this child; five were closed at intake. Two referrals were made to Child FIRST. There was no record of any communication between Child Protection and the paediatrician in this case.

Child Protection and the paediatrician both had information that this child had a difficult family history, which included (among other things) trauma and disability. What was missing, however, was a plan for how best to address the child's exposure to and experience of that trauma in the context of failed attempts at service intervention. Complicating matters further, the child's disability tended to overshadow other aspects of risk assessment relating to both mental health and protective interventions. The child death inquiry found:

> *… a failure to refer [the child] to an intensive therapeutic support service to address their anxiety, extreme aggression, sexualised behaviours, trauma and cumulative harm.*[132]

Inadequate focus on integrated family-based interventions

Children in contact with mental health and child protection systems are likely to present with multiple issues, some related to the child and their mental illness and others related to their family and other life circumstances.

Almost all of the children reviewed (94 per cent) had a parent or parents with a diagnosed or suspected mental illness (n=33). Each of these children were recorded to have experienced family violence. More than 60 per cent of families (63 per cent) had a known and recorded history of trauma that was both entrenched and unresolved (n=22). Over half of the families were known to Child Protection as a result of earlier interventions involving a parent of the child (n=20).

The children reviewed by this inquiry existed in the context of their family circumstances and yet, frequently, their resulting 'behaviours' were understood by those outside of the mental health profession as principally a manifestation of mental illness. In the case of Child Protection, a child's diagnosis might be understood as an isolated risk indicator, unconnected from or impacted by family circumstances. This was not always helped by the individualised nature of treatment plans for children that in many cases failed to include integrated family-based interventions.

Where family-related issues were identified by mental health services, the assumption was that such issues were social in nature and required a response from Child Protection. Where that response was not provided (and in most cases, it was not), mental health services expressed growing frustration at the impact that unaddressed safety issues had on their ability to provide therapeutic intervention to the child.

132 Extract taken from a child death inquiry

Case study

A child was the subject of a report to Child Protection at age 12 and had their first contact with mental health services at the same time. Protective concerns related to a history of exposure to parental mental illness, including parental attempts at suicide.

Child Protection closed the report, with a referral to Child FIRST. No referrals were made on behalf of the child to mental health services as the risk was identified as being addressed by the parent receiving mental health treatment.

Additional reports to Child Protection were received after the child refused to return home. An alternate placement with a family member was arranged and a second referral to Child FIRST made.

Over the course of the next six months, the child presented six times to emergency departments, each time having attempted suicide. The child was referred to an in-patient facility but following discharge refused to engage with mental health services.

All mental health services identified '[the parent's] mental health and the difficult parent-child relationship were preventing [the child's] effective engagement with services'.

The child was the subject of six reports to Child Protection, five of which were closed at intake and one at investigation. At no stage was Child FIRST able to successfully engage the family via on-referral to a family service.

This child needed a coordinated service response. What they received was a fragmented response that failed to understand or resolve the interplay between their mental health diagnosis and accumulated exposure to harm. An integrated family-based intervention may have helped identify the impact that parent-related issues were having on the child's ability to successfully engage in therapeutic intervention.

For a large number of children reviewed by this inquiry, their parents or carers were identified as impeding their children's successful engagement with mental health services. For the children who had a recorded contact with a mental health service (n=31):

- 45 per cent of parents were recorded as failing to take their children to appointments (n=14)
- 26 per cent of parents were recorded as actively discouraging their children's engagement with mental health services due to their belief the intervention was unnecessary or unhelpful (n=8)
- where families were offered family-based interventions (such as family therapy) as part of the child's treatment plan (n=10), 90 per cent of parents refused to participate (n=9).

The inquiry found that in some cases, these issues posed a significant protective concern for children and yet these issues were almost never assessed as such. They were seen as a service issue to be remedied by the mental health system, rather than one requiring a collaborative service response between mental health services and Child Protection.

Case study

A child had their first contact with Child Protection before the age of two. The child was involved in a serious family violence incident. Safety concerns related to a history of intergenerational abuse, including intergenerational Child Protection involvement.

Reports to Child Protection detailed the parents' difficulties attaching to the child, struggling to contain their aggression and their use of physical restraints to assert

control. The core issue of family violence was assessed as being resolved when the parents separated and reports were closed.

The child had their first contact with mental health services at age seven. The child was reportedly violent and suicidal. An in-patient admission followed.

Following discharge, the out-patient mental health service noted '[parent] difficult to engage and hasn't kept recent appointments'.

At age eight, a further report was made, and Child Protection met with the parent and child. Child Protection also contacted CAMHS who confirmed that engagement with the family remained an issue and 'parental capacity to care [was] diminishing'.

Child Protection made a referral to an 'intensive' child and family support service. The service refused to accept the referral, indicating their view that 'the family does not require such an intensive service response'. The family was re-referred to a generic community-based child and family service and the referral was closed.

Three weeks later, the parent disengaged the child from CAMHS, citing the service as 'useless'.

The child was relocated to the home of their other parent and had no further engagement with CAMHS until re-presenting as suicidal at age 13. During the intervening period, the child had been the subject of two further reports to Child Protection, detailing multiple placements with extended family members, a dozen school changes and escalating behavioural issues.

The child was the subject of six reports to Child Protection and one referral to a child and family service. Four reports were closed at intake, one closed at protective intervention (without further action) and the final report resulted in protective proceedings. Multiple service systems were unsuccessful in engaging the family of this child. Attempts at involving the parents in the child's treatment plan were not made – it is unclear from the records whether consideration had been given to pursuing family-inclusive intervention.

Finding 4: Ineffective early intervention

For the majority of children reviewed, there was an absence of effective early mental health intervention. The inquiry found a range of systemic barriers to the provision of early mental health intervention, including:

- **an absence of specialised mental health services for children diagnosed with mental illness or other mental health presentations, by the age of seven years**
- **a lack of targeted support to help children recover from childhood abuse and trauma**
- **an inadequate focus on delivering integrated family-based interventions to support the recovery of children experiencing mental illness.**

Chapter 9
Findings related to collaboration and information sharing

Inadequate information sharing and collaborative practice

Information sharing is central to effective child safeguarding. Of the 35 child death inquiry reports, there was only one report in which the failure to share information was not specifically mentioned as an issue. Reports identified issues that ranged from a direct failure to identify risk or protect a child due to lack of information sharing, to the identification of information sharing as an area for service improvement.

Effective intervention requires careful assessment of the child's vulnerability and ensuring the child's rights, views and experiences remain central. Child Protection is often critiqued in child death inquiries for failings in communication and information sharing.

Effective information sharing requires practitioner skills, good systems and a culture that promotes information sharing for the protection of children. This must fit into a wider information-handling process whereby information is critically appraised and used to guide decision making and planning. As one inquiry found:

> *A key learning [from this child death inquiry] is the value of information sharing at the earliest possible stage in a complex case such as this. It was highly problematic that community-based workers who were trying to engage and work with [the child] who was exhibiting very high-risk suicidal behaviour, did not have knowledge of their family history or background experiences, beyond sketchy and at times inaccurate information.*[133]

For the children reviewed by this inquiry, their contact with Child Protection preceded, or coincided with, their contact with mental health services. Despite this, in the majority of cases, there were extremely limited exchanges of information between the two systems, which frequently led to neither system holding 'the complete picture'.

The inquiry also found that the different service systems tended to hold different, but equally significant, information concerning a child and their family.

Child Protection was more likely to hold information relevant to:

- parental history
- parental contact with police for family violence related issues
- parental risks relating to mental illness and substance misuse
- concerns raised by a child's school.

Mental health services were more likely to hold information relevant to:

- a child's presenting issues
- family history of disability or mental illness
- a child's treatment plan, including referrals to mental health services and prescribed medication.

For the children reviewed by this inquiry, mental health services generally had much more direct contact with children, while Child Protection tended to rely on other information sources – particularly when assessing risk at the intake or investigation stages. However, paediatricians and other mental health professionals were rarely used as a source of important information about children.

133 Extract taken from a child death inquiry

Case study

A child was the subject of their first report to Child Protection by the age of three months. They had contact with a paediatrician and received their first mental health service by the age of two.

The child was reported to Child Protection 20 times. Fifteen of those reports were closed at intake. At no stage did either system make assertive contact with the other.

For the children reviewed, paediatricians and other mental health service providers frequently held important information relevant to Child Protection's understanding of a child and their circumstances. By the same measure, in many instances, Child Protection held information that would have been worthwhile and relevant for mental health providers.

For these reasons, it was concerning to see so few examples of information sharing between service systems.

Role clarity and assumptions regarding the role of service systems

As well as sharing information, services and systems also need to be clear about their roles and an understanding of the roles of other services. As one child death inquiry highlighted:

> *Over time, many services attempted to provide support to the family and engage [the child], however, despite these efforts, service provision often appeared to be fragmented, with not all services being fully aware of the role of other agencies.*[134]

It is essential, however, that role delineation does not result in a disjointed service response. The points of intersection between systems are critical for children at risk of suicide. All service systems in contact with vulnerable children have an important role to play in suicide prevention.

A number of case studies referenced in Chapter 8 highlighted that services' assumptions regarding the differing roles of Child Protection and mental health services led to ineffective service intervention across both systems. There was a clear disconnect between issues that were identified as 'protective' versus those characterised as 'mental health', which resulted in a largely disjointed service response for children.

The different approaches and sometimes different lexicon between the statutory child protection and mental health systems reinforce the importance of good multi-agency practice, whereby the respective professionals involved with a family or child share knowledge and expertise and clearly understand each other's priorities.

For these reasons, the Commission recommends that for children at risk of suicide, an overall coordinating lead agency is required to manage the different perspectives and prioritise the child's best interests. If Child Protection is involved, the Commission suggests it appears best placed to assume that coordinating lead role.

The Commission acknowledges the recent, vital reforms to Victoria's child information sharing laws and the development of Child Link.[135] Legislative reform supported by training, combined with Child Link, offer the potential to transform practice and deliver significant benefits to children. At this stage, Child Link is legislated to become operational by 31 December 2021.

134 Extract taken from a child death inquiry

135 Child Link is a digital register that will enable authorised professionals to access specific and limited information related to children in their care or service.

Finding 5: Inadequate information sharing and collaborative practice

Children in contact with the statutory child protection and mental health systems benefit from a coordinated service response, which recognises the need to explore the intersection between protective and mental health issues. The inquiry identified a range of barriers to effective information sharing and collaborative practice, including:

- an absence of assertive information sharing by both service systems
- a failure to understand the significance of information potentially held by the respective service systems
- a lack of clarity or understanding regarding the role of each service system in respect of child safeguarding.

There were opportunities for services to engage and provide a coordinated response but this did not occur.

Finding 6: A shared responsibility for suicide prevention

Service systems in contact with vulnerable children have a shared responsibility to promote suicide prevention in children by ensuring they deliver a service response that prioritises the children's particular circumstances and experiences and their recovery from harm and abuse.

Shared responsibility for suicide prevention

Service systems in contact with vulnerable children have a shared responsibility to prevent suicide in children by ensuring they deliver a service response that prioritises children's particular circumstances and experiences and their recovery from harm and abuse.

The inquiry found that such an approach would have been particularly helpful for those children identified by the inquiry as flying 'under the radar'.

As outlined in Chapter 6, just under one-fifth (n=6) of the children reviewed were identified as having flown 'under the radar' prior to their deaths, amongst family members and services. As discussed, however, these children had contact with Child Protection and a range of other agencies, but there was a notable absence of information recorded about them.

Chapter 10
Recommendations

Recommendation 1

That, in line with *Roadmap to Reform*, the Victorian Government develop, resource and implement an integrated and whole-of-system **investment model and strategy** for the child and family system, focussed on:

- earlier intervention and prevention services to reduce risks to children and build child and family wellbeing
- reducing the rate of entry to care
- meeting the distinct needs of children who need to live away from the family home.

The **investment model** should recognise the drivers of demand and the need for coordinated service responses. It should use client data, analytics and service evidence to identify the:

- resource levels needed to meet demand for safe, quality services for vulnerable children and their families
- most efficient and effective investment options to achieve maximum impact.

The **investment strategy** should increase and improve safe, quality services in line with demand, by targeting early intervention and prevention, prioritising the most vulnerable cohorts, including families with chronic and complex issues and children exposed to cumulative harm.

Recommendation 2

That the Department of Health and Human Services develop, resource and implement a set of standard analytical data sets for Child FIRST/The Orange Door and IFS to monitor and report on the timeliness and effectiveness of their engagement with children and families, including:

- time between initial assessment and commencement of case management
- rates of unsuccessful engagement
- referral outcomes
- re-referrals
- re-reports.

Recommendation 3

That the Department of Health and Human Services review and revise all foundational practice guidance, training and tools to embed children's participation in decision making during the investigation, protective intervention and protection order phases of Child Protection intervention.

Recommendation 4

That the Department of Health and Human Services develop practice advice in relation to children involved with Child Protection who are identified as at risk of suicide. Practice advice should confirm the importance of information gathering, information sharing and service coordination, and include requirements to gather and consider:

- information regarding the child's involvement with different mental health services
- a child's mental health diagnosis
- any known history of exposure to abuse, harm or trauma
- a child's treatment plan and (where relevant) any actions taken or planned to address any history of exposure to abuse, harm or trauma
- the existence of any parent-related issues that may be impacting a child's ability to successfully engage in therapeutic intervention
- the existence of any placement-related issues that may be impacting a child's ability to successfully engage in therapeutic intervention
- identifying which service or agency involved is able to co-ordinate a child's access to mental health and other relevant services.

Recommendation 5

That the Victorian Government commit to proceeding with, and investing in, the Child Link Register, with a view to ensuring commencement of its operation by 31 December 2021.

Recommendation 6

That the Department of Health and Human Services develop and implement a suicide prevention strategy for children known to Child Protection that incorporates any relevant findings and recommendations made by the Royal Commission into the Victorian Mental Health System.

For noting

The Commission will provide a copy of the inquiry to the Royal Commission into the Victorian Mental Health System, and ask that consideration be given to its findings, particularly those relevant to:

- the points of intersection between the child protection, child and family service and mental health systems
- the need for greater levels of specialist early intervention mental health services for children known to have experienced harm and abuse.

Appendices

Appendix A

Table 27: Summary of Child Protection Phases

Phase	Duration	Details
Intake	Receipt of report through to decision about appropriate response	• Begins 'with a report about a child and concludes when the report is transferred for investigation or closed with or without the provision of advice' to the person who made the report and/or the child or their family, or referral to a community-based child and family service or other agency • Involves 'receiving reports and determining the appropriate response, providing advice to reporters, helping children and families access support services and where appropriate making referrals'
Investigation	Classification of report as 'protective intervention report' through to decision about whether report is substantiated	• A matter is investigated if a report is assessed as being a 'protective intervention report' • An investigation is undertaken to determine whether a child is in need of protection, as defined in s 162 • It 'determines: – the extent and nature of reported concerns, or any other concerns – whether the child has suffered or is likely to suffer significant harm – whether the parents have protected or are likely to protect the child from harm – whether statutory intervention is needed to meet the best interests of the child – whether other interventions are needed to assist the family' • The investigation phase ends 'when a decision is made on whether the report is substantiated' • If a report is not substantiated, the case may be closed

Table 27: Summary of Child Protection Phases continued

Phase	Duration	Details
Protective intervention	Intervention following substantiation through to protection order or closure	• Follows substantiation of a protective intervention report • Involves 'intervention with a child and family' including assessment, service engagement and case management focussing 'on establishing ongoing protection and supporting [the child's] best interests without seeking a protection order where possible' • Child Protection might make a protection application to the Children's Court if satisfied on reasonable grounds that a child is in need of protection – this could include placing the child in emergency care[136] • Three 'possible outcomes' from this phase: – 'Child protection intervention is no longer required and the case is moved to the closure phase' – The Children's Court makes a protection order 'following a protection application being [made]', 'and the case is moved to the protection order phase' – 'A protection application does not result in [the Court making a] protection order and the case is moved to the closure phase'.
Protection order	Children's Court makes protection order through to end of order	• '[B]egins when the Children's Court makes a protection order' • Involves 'administering and monitoring compliance with the court order in accordance with a [child's] case plan'
Case closure	When the decision is made to close a case	• 'It is appropriate to close a case when child protection involvement is either no longer possible, or no longer necessary'. • Cases are closed when (for example): – 'a report has not been classified as a protective intervention report, and necessary actions during intake phase are complete' – 'despite taking all reasonable steps it is not possible to complete an investigation' – 'a protective intervention report is not substantiated' – 'protective intervention by agreement is concluded with protective concerns being sufficiently addressed' – 'further protective intervention is not possible and follow-up is complete' – a protection application is made to the Court but the Court does not grant a protection order – a protection order 'ends and no further order is made'. • The Manual states that the aims of closure include: – finalising 'case practice, implement exit plans and confirm sufficient protection, care and support will continue, through negotiating a closure plan' – completing 'necessary procedures associated with ending child protection involvement including contacting and advising clients, services and others'.

Source: Child Protection Manual[137]

136 CYFA, sections 240–243.
137 The Child Protection Manual is available at https://www.cpmanual.vic.gov.au/.

Appendix B

The following laws relevant to vulnerable children were reviewed:

- *Children, Youth and Families Act 2005*
- *Child Wellbeing and Safety Act 2005*
- *Charter for Human Rights and Responsibilities Act 2006*
- *United Nations Convention on the Rights of the Child*

The following Department of Health and Human Services policies regarding vulnerable children were reviewed:

- *The Best interests principles: a conceptual overview*
- *The Best Interests framework for vulnerable children and youth*
- *Best interests case practice model summary guide*
- *Cumulative harm: a conceptual overview*
- *Cumulative harm specialist practice resource*
- *Adolescents and their families specialist practice resource*
- *Adolescents with sexually abusive behaviours and their families specialist practice resource*
- *Families with multiple and complex needs specialist practice resource*
- *Child Protection Manual*, 1 December 2015
- *Child development and trauma specialist practice resource: 12-18 years*

Appendix C

This section examines the legal framework used when making decisions about children under the CYFA.

Children, Youth and Families Act

The *Children, Youth and Families Act 2005* (CYFA) is the legal framework guiding DHHS in child protection.

Best interests of the child

The CYFA is clear that the best interests of the child must always be paramount when making a decision or taking action with regard to a child or young person.[138]

The CYFA doesn't offer a specific definition but does outline guiding principles for decision makers to use when determining a child or young person's best interests. These principles require that Child Protection, family services and placement services must take action to:

- protect children from harm
- protect the rights of children
- promote the development of children.

Decision-making framework

The CYFA ascribes a series of decision-making principles. They derive from accepted principles of natural justice or procedural fairness, and are designed to strengthen the participation of children, young people and family members.

Decision-making principles apply to decision making by courts, family services, out-of-home care services and Child Protection services.

In summary, decision-making principles should:

- be fair and transparent
- be collaborative
- be empowering
- assist children, young people and families to participate in a meaningful way
- promote Aboriginal self-management and self-determination

138 CYFA 2005, s.10; Family Law Act 1975 (Cth), s.60CA; United Nations, *Convention on the Rights of the Child*, opened for signature 20 November 1989, *Treaty Series*, vol. 1577 (entered into force 2 September 1990), Article 3. CYFA 2005, s.10(2).

Additional decision-making principles for Aboriginal children

In addition to the overarching best interest principles, the CYFA also provides guidance about additional decision making principles for Aboriginal children. These principles give recognition to the distinct and cultural attributes of Aboriginal people and to the importance of maintaining a child's Aboriginal identity.

In summary, the additional decision-making principles relate to:

- recognition of Aboriginal self-management and self-determination in seeking the views of Aboriginal community members to inform decision making
- the need to prioritise the placement of an Aboriginal child requiring out-of-home care within a hierarchy, whereby placement with Aboriginal extended family or relatives is the highest order consideration
- the cultural needs and rights of an Aboriginal child.

The Aboriginal Child Placement Principle

The ACPP is a specific extension of the best interest principles applicable to Aboriginal children. The ACPP prioritises and specifies the criteria for placement of Aboriginal children who are unable to remain safely at home. The hierarchy is specified as follows:

- it is a priority that, wherever possible, an Aboriginal child must be placed with the Aboriginal extended family or with relatives and where this is not possible, with other extended family or relatives
- if, after consulting with an Aboriginal agency, placement with extended family or relatives is not feasible or possible, the child may be placed with:
  - an Aboriginal family from the local community and within close proximity to the child's natural family
  - an Aboriginal family from another Aboriginal community
  - as a last resort, a non-Aboriginal family living in close proximity to the child's natural family
- any placement with a non-Aboriginal family must ensure the maintenance of the child's culture and identity through contact with the child's community.[139]

139 CYFA, section 13

Achieving the principles enshrined by the CYFA, with respect to the protection of children, relies on the relevant services translating best interests principles into effective practice.

Charter of Human Rights and Responsibilities

The Victorian *Charter of Human Rights and Responsibilities Act 2006* (the Charter) sets out the basic rights, freedoms and responsibilities for all people in Victoria and how government should interact with people.

The Charter creates an obligation on all public authorities to act consistently with human rights and to take all human rights into consideration when making decisions.[140]

Of relevance to decision making by family services, out-of-home care services and Child Protection services:

- Families are the fundamental group unit of society and are entitled to be protected by society and the State.[141]
- Every child has the right, without discrimination, to such protection as is in his or her best interests and is needed by him or her by reason of being a child.[142]
- Aboriginal persons hold distinct cultural rights and must not be denied the right, with other members of their community to enjoy their identity and culture.[143]
- Every person has the right to recognitions before the law.[144]
- Every person has the right to life.[145]

The Child Protection Manual requires decision-makers to integrate human rights into Child Protection work and to actively 'think Charter'.[146]

140 *Charter of Human Rights and Responsibilities Act 2006*, s.38
141 *Charter of Human Rights and Responsibilities Act 2006*, s.17(1)
142 *Charter of Human Rights and Responsibilities Act 2006*, s.17(2)
143 *Charter of Human Rights and Responsibilities Act 2006*, s.19(2)
144 *Charter of Human Rights and Responsibilities Act 2006*, s.8(1)
145 *Charter of Human Rights and Responsibilities Act 2006*, s.9
146 http://www.cpmanual.vic.gov.au/our-approach/roles-responsibilities/human-rights-and-child-protection#h3_0 (accessed March 2018)

Convention on the Rights of the Child

Australia ratified the United Nations Convention on the Rights of the Child in December 1990. The convention established the rights of children. It describes in clearest terms what every child and young person needs to survive, thrive and prepare for 'responsible life in a free society', including:[147]

- the best interests of the child shall be a primary consideration in all actions affecting children[148]
- right to protection from abuse, exploitation and neglect, and the importance of the physical and intellectual development of the child[149]
- right to be heard in all matters affecting the child, their views being given due weight in accordance with the child's age and level of maturity[150]
- right to culture[151]
- right to the enjoyment of health, including access to treatment and rehabilitation services[152]
- right to education[153]
- right to recovery and social integration for the child who has experienced neglect, exploitation or abuse.[154]

The CYFA incorporates many of the rights recognised by the Convention and protected by the Charter, including the promotion of:[155]

- children's 'best interests' as paramount
- intervention that is limited to the level necessary to secure the safety and wellbeing of children
- earlier intervention and prevention services for families in need
- improved planning, coordination and delivery of services to families by increased emphasis on partnership and collaboration across and within the service systems
- children's right to be heard, participate and access information
- a strong focus on children and young person's cultural identity and culturally appropriate service delivery
- a commitment to maintaining Aboriginal children's cultural connectedness.

147 United Nations, *Convention on the Rights of the Child*, opened for signature 20 November 1989, *Treaty Series*, vol. 1577 (entered into force 2 September 1990), Article 29
148 Article 3
149 Article 19
150 Article 12
151 Article 20 and 29
152 Article 24
153 Article 28
154 Article 39
155 http://www.dhs.vic.gov.au/__data/assets/pdf_file/0005/449213/the-best-interests-framework-for-vulnerable-children-and-youth.pdf

Appendix D

Table 28: Engagement with Child FIRST (between 1 April 2014 and 1 April 2019)

Total reports	No. of referrals to Child FIRST	No. of letters recommending Child FIRST	Report no.	Age of child	Complexity of issues	Quality and effectiveness of engagement
2	–	2	Report 1 Report 2	15 years 16 year	• exposure to recurring and severe family violence between parents • child at high-risk of suicide	No record family contacted Child FIRST.
3	1	–	Report 2	14 years	• perpetration of severe family violence by child • contact with criminal justice system • lengthy history of trauma	Contact initiated by parent. Referral closed due to lack of subsequent engagement.
6	2	1	Report 1 Report 3 Report 4	12 years 13 years 13 years	• child at high-risk of suicide • parent with severe mental illness	Parent did not engage beyond initial assessment. All further contact refused.
6	1	–	Report 3	8 years	• history of severe family violence between parents • child at risk of suicide • parent with history of trauma, threatening to relinquish care	Child FIRST refers family to 'family preservation service' but referral not accepted as family deemed not to meet threshold for intensive level of service. Family waitlisted. No engagement achieved by alternative family support service. Complexity of issues not matched to intensity of service.
3	–	2	Report 2 Report 3	16 years 16 years	• child at high-risk of suicide • perpetration of family violence by the child	No record family contacted Child FIRST.

Table 28: Engagement with Child FIRST (between 1 April 2014 and 1 April 2019) continued

Total reports	No. of referrals to Child FIRST	No. of letters recommending Child FIRST	Report no.	Age of child	Complexity of issues	Quality and effectiveness of engagement
9	3	1	Report 1 Report 3 Report 6 Report 8	1 years 7 years 8 years 10 years	• parent with history of trauma, mental illness and substance abuse issues • child displaying sexualised behaviours and aggression • child with disability and PTSD • high-level neglect	Lengthy waitlists for commencement of services. Parent consistently willing to accept supports, no subsequent engagement achieved. Complexity of issues not matched by intensity of service.
6	2	–	Report 4 Report 5 Report 6	7 years 8 years 8 years	• parent with history of trauma, mental illness and substance abuse issues • child displaying sexualised behaviours and aggression • child with disability • high-level neglect	Parent consistently willing to access supports, no subsequent engagement achieved. Complexity of issues not matched by intensity of service.
4	1	–	Report 2	16 years	• child at high-risk of suicide • perpetration of family violence by the child	Parent willing to engage. Child refusing to engage, service closed.
3	1	–	Report 3	14 years	• history of severe family violence between parents • child at risk of suicide • perpetration of family violence by the child	Family waitlisted for allocation. Referral subsequently withdrawn after new concerns raised for child.
3	–	1	Report 1	14 years	• disengaged from school • running away from home • perpetration of family violence by the child • contact with criminal justice system	No record family contacted Child FIRST.
8	1	1	Report 7 Report 8	13 years 13 years	• history of severe family violence between parents • parent threatening to relinquish care	Parent expressed unwillingness to engage.

Appendix E

Table 29: Quality and effectiveness of mental health service intervention

Diagnosis	Age first report to CP	No. of reports to CP	Mental health services involved	Complexity of issues	Quality and effectiveness
Yes	2 years	2	CAMHS Hospital	• Intergenerational trauma • Childhood sexual abuse • Suicidal	Clinically unnecessary inpatient stay No available Aboriginal mental health service Assessed using adult triage as 'low risk' No plan to support recovery from sexual abuse
Yes	18 months	6	Paediatrician CAMHS Hospital Private counsellor School counsellor In-patient admission	• Exposure to severe family violence between parents • Intergenerational trauma • Parental mental illness • Insecure attachment to parent • Longstanding suicidality and attempts at suicide	No plan to support recovery from childhood trauma Failure to successfully engage parents in treatment and recovery plan
Yes	18 months	9	Paediatrician School counsellor CAMHS Clinical therapist CYMHS	• Childhood sexual abuse • Chronic protective concerns • Parental mental illness and substance abuse issues • Dual diagnoses (intellectual disability) • Suicidal	Multiple providers, lack of coordination and information sharing Lack of attendance at appointments – lack of assertive outreach Response to threats of suicide by young children No plan to support recovery from trauma
Yes	9 months	6	Paediatrician Early intervention mental health service Hospital	• Childhood sexual abuse • Intergenerational trauma • Chronic protective concerns • Parental mental illness and substance abuse issues • Dual diagnosis (intellectual disability)	Lack of attendance at appointments Ineffective early intervention Lack of coordination and information sharing
Yes	3 years	8	School counsellor CAMHS	• Exposure to severe family violence between parents • History of trauma • Care experience • Substance misuse	Lack of coordination and information sharing No plan to support recovery from trauma

Table 29: Quality and effectiveness of mental health service intervention continued

Diagnosis	Age first report to CP	No. of reports to CP	Mental health services involved	Complexity of issues	Quality and effectiveness
No	4 years	3	School counsellor Headspace	• Exposure to severe family violence between parents • History of trauma • Parent with significant mental illness • Suicidal	Did not meet the threshold for tertiary mental health support Lack of information sharing
No	7 years	7	School counsellor Psychologist	• Intergenerational child sexual abuse • History of familial suicide • Risk of sexual abuse • Grief	Commenced engagement with a private psychologist but unable to afford cost Did not meet the threshold for tertiary mental health support
Yes	12 years	6	Hospital Early intervention mental health service In-patient admission Orygen	• Recent sexual assault • Parental mental illness • Suicidal • Disengagement from school	Impact of parent-child relationship on effective engagement with child Reactive intervention
No	12 years	3	School counsellor headspace	• Exposure to severe family violence between parents • Perpetration of family violence by child • Parental mental illness and substance misuse	Lack of accessible mental health services No plan to support recovery from trauma
Yes	15 years	2	GP Hospital Telephone triage CAMHS Crisis Assessment Team headspace	• Exposure to severe family violence between parents • Family violence in current relationship with older male • Disengaged from school • Suicidal	Did not meet the threshold for tertiary mental health services Lack of assertive outreach Fragmented response that failed to combine protective and mental health aspects
Yes	13 years	3	GP Psychiatrist Hospital	• Perpetration of family violence by child • Contact with criminal justice system • History of trauma	Lack of coordination and information sharing Unable to successfully engage child

Table 29: Quality and effectiveness of mental health service intervention continued

Diagnosis	Age first report to CP	No. of reports to CP	Mental health services involved	Complexity of issues	Quality and effectiveness
Yes	5 years	3	GP Hospital Youth substance abuse service Psychiatrist CAMHS Private clinic	• Acrimonious relationship between separated parents • Substance misuse by child • Disengaged from school • Suicidal	Reactive engagement by the child Failure to successfully engage parents in treatment and recovery plan Multiple service providers, lack of cohesion regarding diagnosis or treatment
Yes	14 years	4	Psychologist CYMHS headspace In-patient admissions Hospital	• Perpetration of family violence by child • Contact with criminal justice system • Disengaged from school • Substance misuse by child • Suicidal	Lack of coordination and information sharing Assessed using adult triage as 'low risk' Multiple providers, lack of cohesion regarding diagnosis or treatment Use of seclusion Inadequate support for parents as 'carers'
Yes	13 years	2	Early intervention mental health service School psychologist headspace	• History of early childhood trauma • Dual diagnosis (intellectual disability) • Suicidal	Excellent coordination and information sharing by service providers Good example of family inclusive practice
Yes	14 years	3	GP Paediatrician CAMHS Outreach worker	• Contact with criminal justice system • Substance misuse by child • Running away from home • Situational stressors • Suicidal	Triaging of suicide risk as 'low risk' leading to delayed intervention Unable to successfully engage the child Inadequate support for parents as 'carers'

COMMISSION FOR CHILDREN
AND YOUNG PEOPLE

Commission for Children and Young People logo

The logo represents our vision for all children to be strong in health, education, culture and identity, and face the world with confidence.

The people are connected, equal in size and importance, and there is a fluidity that binds them together.

The mission of the Commission is for all young Victorians to achieve these goals.

The symbol is a Koorie design created by Marcus Lee for the Commission.

The Commission respectfully acknowledges the Traditional Owners of the country throughout Victoria and pays respect to the ongoing living cultures of First Peoples.

COMMISSION FOR CHILDREN
AND YOUNG PEOPLE

DOH.0003.0001.0224

Part 1:

Aboriginal and Torres Strait Islander cultural safety framework

For the Victorian health, human and community services sector

VICTORIA State Government | Health and Human Services

Acknowledgement of Aboriginal peoples in Victoria

The Victorian Government proudly acknowledges Victoria's Aboriginal communities and their rich culture and pays respect to their Elders past and present. We acknowledge Aboriginal peoples as Australia's first peoples and as the Traditional Owners and custodians of the land and water on which we live, work and play. We recognise and value the ongoing contribution of Aboriginal people and communities to Victorian life and how this enriches our society more broadly. We embrace self-determination and reconciliation, working towards equality of outcomes and ensuring an equitable voice.

Victorian Aboriginal communities and peoples are culturally diverse, with rich and varied heritages and histories both pre- and post-invasion. The impacts of colonisation – while having devastating effects on traditional life – have not diminished Aboriginal peoples' connection to Country, culture or community. Aboriginal nations continue to strengthen and grow with the resurgence of language, lore and cultural knowledge. These rich and varied histories need to be understood and acknowledged by all Victorians, to truly understand the resilience and strength of previous generations, as well as the history of the fight for survival, justice and Country that has taken place across Victoria and around Australia.

As we work together to ensure Victorian Aboriginal communities continue to thrive, the government acknowledges the invaluable contributions of generations of Aboriginal warriors that have come before us, who have fought tirelessly for the rights of their people and communities towards self-determination. We are now honoured to be part of that vision.

This document honours the work of Aboriginal and Torres Strait Islander community leaders and staff in the health, human and community services sector for their tireless work in improving cultural safety and the delivery of high-quality services over many decades. This framework attempts to strengthen, reiterate and amplify their wisdom and expertise.

Please note

The department acknowledges the diverse and distinct cultures of Aboriginal peoples and Torres Strait Islanders. This cultural safety framework is intended for both Aboriginal peoples and Torres Strait Islanders living in Victoria or accessing Victorian health, human or community services. In this framework, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koorie' is retained when part of a report, program or quotation.

DOH.0003.0001.0226

Secretary's foreword

Cultural safety is everyone's business

I am pleased to present the *Aboriginal and Torres Strait Islander cultural safety framework*.

Cultural safety means creating environments where people feel safe – where there's no challenge to their identity, and where their needs can be met.

It's clear that racism and discrimination can significantly impact upon an individual's health and wellbeing. Aboriginal Victorians tell us that a lack of cultural safety, racism and fear are the main barriers to accessing essential services.

As a department, we believe that cultural safety is everyone's business. We are committed to investing the time, energy and resources to improve the cultural safety of our services – to increase the life expectancy of Aboriginal Victorians and improve their quality of life.

This framework marks our department's commitment to reform. To achieve this, it guides Victorian health, human and community services - and the department - to work together to deliver more culturally diverse and safe environments, services and workplaces.

The framework builds on the actions of *Korin Korin Balit-Djak*, our 10-year Aboriginal health, wellbeing and safety strategic plan.

It also contributes to the Victorian Government's commitment within the *Victorian Aboriginal Affairs Framework* to advance Aboriginal self-determination and cultural safety.

This cultural safety framework was developed in collaboration with Aboriginal communities, Aboriginal organisations and Aboriginal staff across the department.

We believe that it will help us, and our partners, move beyond cultural awareness by placing a strong importance on reflecting how one's own beliefs, values and behaviours impact upon the safety of others.

For the department, the framework offers a new approach to how we can we can deliver and regulate services using a continuous quality improvement model.

For our mainstream partner organisations, it will support the strengthening of cultural safety through improved accountability requirements included in existing standards and service agreements.

The framework is more than a compliance exercise. The key to success is its application in every service and every workplace.

We will partner with Aboriginal organisations to lead on the delivery of training and support for all Victorian organisations, helping them to truly deliver on the intentions of this work.

This framework is an important catalyst for change – and through a shared commitment from the department, mainstream services and Aboriginal organisations – we can together make a positive impact on the health, wellbeing and safety of Aboriginal Victorians.

Kym Peake
Secretary

Artwork

Korin Korin Balit-Djak **Artwork**

Artist – Dixon Patten

The artwork for the Aboriginal and Torres Strait Islander cultural safety framework *uses a section of the artwork from* Korin Korin Balit-Djak, *the Aboriginal health, wellbeing and safety strategic plan (2017–2027) and has been adapted with the artist's permission and depicts the Aboriginal community and our connection to culture and each other.*

Within the detailed circles, the Department of Health and Human Services and community work together to help with system reform across the health and human services sector with the ultimate goal of physical, social and emotional wellbeing for all Aboriginal people. The ripples represent the positive impact on community that this strategy will have and that Aboriginal culture and community is a priority.

The hands represent individuals, couples and families. The white circles represent various tribes/families/regions. The various paths with the footprints depict our life journeys and transference of knowledge, history and culture.

Dixon Patten was commissioned by the Department of Health and Human Services to produce the artwork for *Korin Korin Balit-Djak*.

Permission to use *Korin Korin Balit-Djak* for this policy was provided by the Wurundjeri Tribe Land Council.

To receive this publication in an accessible format please email Aboriginal Strategy and Oversight <aboriginalstrategyandoversight@dhhs.vic.gov.au>

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Contents

Part 1: Introduction **6**

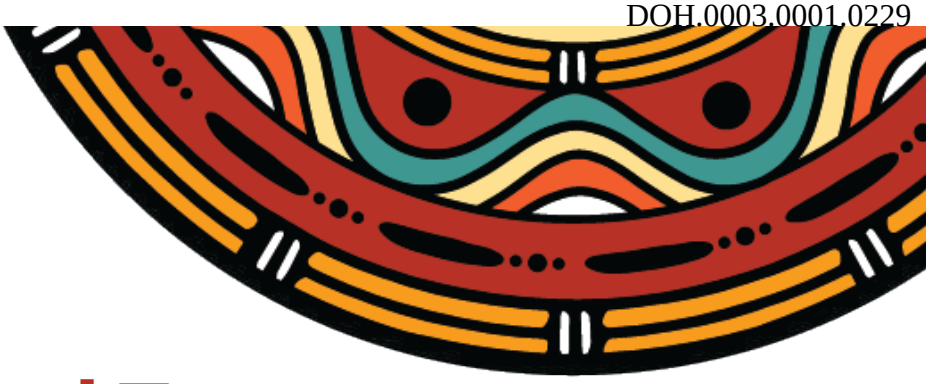
What is Aboriginal and Torres Strait Islander cultural safety? **7**

The cultural safety framework **7**

1. Vision 8
2. Principles 9
3. Domains 10
4. Cultural safety continuum 10

Reflective tool **10**

References **11**



Aboriginal and Torres Strait Islander cultural safety framework

Introduction

Aboriginal and Torres Strait Islander cultures are the oldest living cultures in the world. Cultural factors, such as identity, language and spirituality, as well as connection to Country, to family and to community, can positively impact on the lives of Aboriginal people.

Aboriginal communities are culturally diverse, with rich and varied heritages and histories both pre- and post-colonisation. Aboriginal communities in Victoria were heavily affected by colonisation and past discriminatory policies such as the policy of assimilation. Unequal power relationships and inequities continue to exist between Aboriginal peoples and the dominant non-Aboriginal population.

The Victorian Auditor-General's 2014 report *Accessibility of mainstream services for Aboriginal Victorians* identified lack of cultural safety as a significant barrier to accessing services. It also highlighted the critical importance of Victorian Aboriginal peoples and their communities being authentically engaged in the design and delivery of health and community services, policies and programs.

Despite concerted efforts to address racism and discrimination through policies and legislation, both remain systemic issues across the health, human and community services sector.

Cultural safety is a fundamental human right. Public agencies are required by legislation to provide safety in the workplace. If we do not invest the time, energy and resources required to improve cultural safety, our health, human and community services sector will not increase life expectancy and improve the quality of Aboriginal people's lives.

The development of the *Aboriginal and Torres Strait Islander cultural safety framework* is a key commitment in the department's *Aboriginal employment strategy 2016–2021* and in *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027*. The framework will support *Korin Korin Balit-Djak* to achieve the Victorian Government's vision of 'self-determining, healthy and safe Aboriginal communities'.

This framework has been developed as the first phase of a continuous quality improvement approach.

- Phase 1, 2019: launch the Aboriginal and Torres Strait Islander cultural safety framework – aimed at **reflection** and planning.
- Phase 2, 2020: key standards and measures will be developed to help individuals and organisations track their growth – aimed at **improvement and development**.
- Phase 3, 2021: individuals and organisations will be required to meet and be measured against cultural safety standards – aimed at **accountability** and compliance.

The Aboriginal and Torres Strait Islander cultural safety framework has been developed to assist the department and mainstream Victorian health, human and community services to create culturally safe environments, services and workplaces.

The cultural safety framework is for:

- every person and every mainstream organisation to take responsibility and work together to create culturally safe services and workplaces
- Aboriginal and Torres Strait Islander staff and clients, who have a right to culturally safe workplaces and services.

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What is Aboriginal and Torres Strait Islander cultural safety?

Professor Gregory Phillips, PhD

Aboriginal and Torres Strait Islander cultural safety is defined as an environment that is safe for Aboriginal people and Torres Strait Islanders, where there is no assault, challenge or denial of their identity and experience (Williams 2008)

Cultural safety is about:

- shared respect, shared meaning and shared knowledge
- the experience of learning together with dignity and truly listening
- strategic and institutional reform to remove barriers to optimal health, wellbeing and safety outcomes for Aboriginal people. This includes addressing unconscious bias, racism and discrimination, and the ability to support Aboriginal self-determination
- individuals, organisations and systems taking responsibility for ensuring their own cultural values do not negatively impact on Aboriginal peoples, including a responsibility to address their potential for unconscious bias, racism and discrimination
- individuals, organisations and systems taking responsibility to support self-determination for Aboriginal peoples – this includes sharing power (decision making and governance) and resources with Aboriginal communities, and is especially relevant for the design, delivery and evaluation of services for Aboriginal peoples (Phillips 2015).

Figure 1 outlines the key features of a culturally safe workplace.

Figure 1: Key elements of culturally safe workplaces and services

Adapted from (Phillips 2015).

The cultural safety framework

The cultural safety framework is designed to improve cultural safety for:

- Aboriginal employees working within the Victorian health, human and community services sector
- Aboriginal clients accessing services within the Victorian health, human and community services sector.

The framework aims to assist the department and mainstream health and community services to strengthen their cultural safety by participating in a process of continuous learning and practice improvement. The model is designed to guide the department and mainstream organisations as they develop strategies, policies, practices and workplace cultures that address unconscious bias, discrimination and racism.

The cultural safety framework has been informed by evidence and consultations including:

- a series of consultations with Aboriginal Victorians, including staff and organisations
- consultation with the department's Aboriginal Strategic Governance Forum and its Koorie Caucus
- a series of pilots with departmental staff to test and validate the framework and reflective tool
- material received in response to a call for written submissions from the health, human and community services sector
- a literature review on cultural safety
- existing government and sector standards, policies, procedures and strategic documents.

This framework does not specifically address the issue of lateral violence for Aboriginal workers, but it is acknowledged that this is a significant issue relating to their cultural safety. Addressing lateral violence requires supervisors and organisations having advanced cultural safety knowledge, skills and attitudes. Organisations may need to assist Aboriginal employees to engage specialist expertise and support to address issues of lateral violence in the workplace.

1. Vision

The Victorian health, human and community services sector provides culturally safe practices and service provision that enable optimal health, wellbeing and safety outcomes for Aboriginal and Torres Strait Islanders (Figure 2).

Figure 2: Cultural safety framework

REFLECTION TOOL

The four stages of learning	→ TOWARDS CULTURAL SAFETY →			
	1ST STAGE: UNAWARE	2ND STAGE: EMERGING	3RD STAGE: CAPABLE	4TH STAGE: PROFICIENT
	'Unconsciously incompetent' learning stage	'Consciously incompetent' learning stage	'Consciously competent' learning stage	'Unconsciously competent' learning stage
Overall reflection	I am unaware of how my unconscious biases and behaviours affect the cultural safety of the workplace and services delivered	I recognise the need to unlearn and build my skills and knowledge to improve cultural safety	I consciously apply my learnings and improve cultural safety practice	My work practices are culturally safe and do not require a conscious correction. I am open to and enact ongoing learning and improvement

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2. Principles

The cultural safety framework is supported by an agreed set of guiding principles. Table 1 outlines the principles to be applied across the three domains of the framework.

Table 1: Cultural safety framework principles

Principle	Explanation
Leadership	Organisations provide meaningful leadership opportunities to design, deliver and evaluate culturally safe policies, programs, initiatives and services. Organisations have leadership at all levels that understand and champion the organisation's role in cultural safety.
Self-determination	Aboriginal staff, people and communities have meaningful leadership and decision-making roles, and are involved in designing, delivering and evaluating Aboriginal health, wellbeing and safety policies, programs and initiatives.
Human rights approach	The rights-based approach that drives this framework is an essential part of Victorian Aboriginal service delivery and sector development. The United Nations *Declaration on the Rights of Indigenous Peoples* recognises both the principle of self-determination (Article 3) and the right to culture (Articles 11 and 31). *The Victorian Charter of Human Rights and Responsibilities Act 2006* also recognises culture as a right.
Support and sustainability	Staff at all organisational levels are supported to undertake ongoing cultural safety professional and personal development. Workplaces have processes to build individual and organisational capacity, provide mentoring opportunities and establish culturally safe spaces for Aboriginal staff and clients.
Culturally safe systems	Embed culturally safe practice into recruitment and retention processes, as well as into existing policies, programs, procedures, procurement and services.
Ongoing learning	A continuous process of reflection and quality improvement to identify and reflect on individual and organisational practice, and implement the actions required for ongoing learning and self-reflection at all levels of the organisation.
Accountability and transparency	Individuals reflect on their own level of competency in cultural safety and identify required improvements. Organisations reflect on their current policies, practices and procedures and reflect on their organisational competency. Organisations demonstrate accountability by implementing key performance indicators.
Respect and trust	Individuals and organisations establish a relationship of trust and respect with Aboriginal staff, clients and local Aboriginal communities.

3. Domains

The cultural safety framework has three key domains for action:

1 Creating a culturally safe workplace and organisation

This domain focuses on changing workplaces and organisations to be culturally safe by reforming strategies, policies, procedures and accountabilities. It helps individuals and organisations build on their cultural safety through professional development, reforming governance, policies, procedures and evaluation measures.

2 Aboriginal self-determination

This domain is closely aligned to changing workforce and organisational practice. It focuses on building our ability to hear the Aboriginal client and community voice and support the decisions of Aboriginal people, families and communities.

3 Leadership and accountability

This domain highlights the importance of leaders being accountable for driving quality improvement to affect behavioural and systemic changes so that cultural safety becomes embedded in everyday practice.

4. Cultural safety continuum reflective tool

The framework includes a continuous quality improvement approach and uses the 'Johari window' approach to the four stages of learning a new skill (Figure 3).

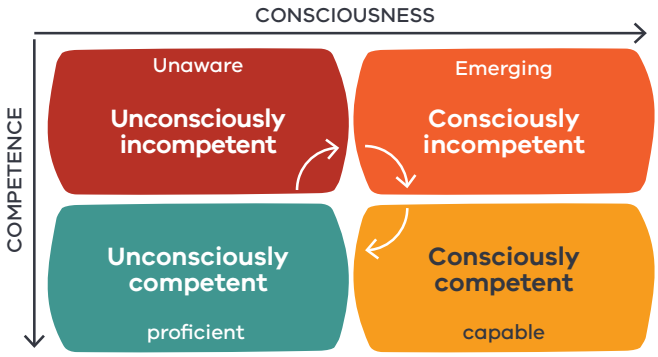
Competence continuum model

The competence continuum model describes the four stages of competency in cultural safety as:

1. **unaware** – unconsciously incompetent
2. **emerging** – consciously incompetent
3. **capable** – consciously competent
4. **proficient** – unconsciously competent and open to continual learning and improvement

The continuum acknowledges coming into consciousness along the learning journey (Getha-Taylor et al. 2013; Luft & Ingham 1955; Pateros 2001). These terms relate to the competency level of learning a new skill, rather than the competency of an individual.

Figure 3: The four stages of learning a new skill



Adapted from Getha-Taylor et al. 2013.

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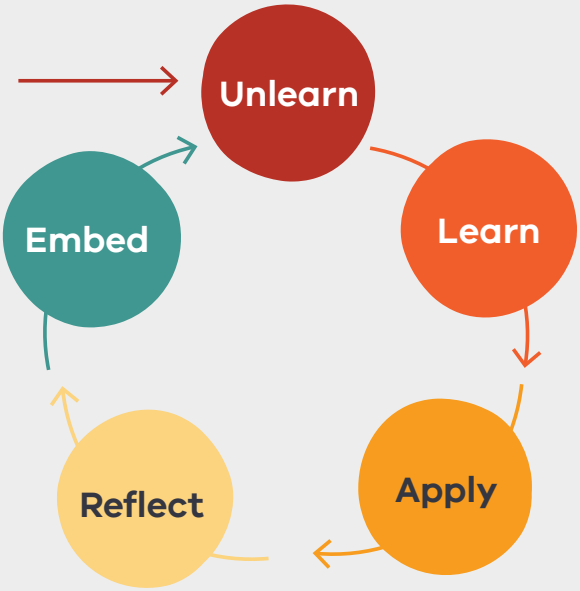
Continuous learning and improvement

Improving cultural safety is an ongoing learning process. Proficiency will be achieved when individuals and organisations commit to improving their knowledge of cultural safety and changing their attitudes, beliefs and behaviours.

The cultural safety continuum reflective tool intends to support a continuous quality and practice improvement approach. Figure 4 outlines the continual learning journey from 'unlearn' to 'embed'.

Figure 4: Continual learning journey



Unlearn – Challenge what is established as 'the norm' and question what is accepted so a non-biased and more balanced set of shared values and ways of doing things can be learnt.

Learn – Understand why 'established' or 'usual' practice is not always the best way to learn. Learn other, more balanced ways to learn as part of everyday practice.

Apply – Implement what is learnt to create positive interactions and environments.

Reflect – Continually challenge assumptions, which may require returning to the unlearning and learning stages to gain more knowledge.

Embed – Implement continuous quality improvement to reform systems, procedures, policies, strategies, programs, procurement, workplace culture, accountability and monitoring.

The aim is for individuals and organisations in the Victorian health, human and community services sector to continuously improve cultural safety proficiency by adopting the *Aboriginal and Torres Strait Islander cultural safety framework*.

References

Department of Health and Human Services 2017, *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027*, State Government of Victoria, Melbourne.

Getha-Taylor H, Hummert R, Nalbandian J and Silvia C 2013, 'Competency model design and assessment: findings and future directions', *Journal of Public Affairs Education*, vol. 19, no. 1, pp. 141–171.

Luft J and Ingham H 1955, *The Johari window, a graphic model of interpersonal awareness: Proceedings of the western training laboratory in group development*, University of California, Los Angeles.

Pateros J 2001, *The four stages of learning*, Process Coaching Centre, San Rafael, viewed 22 February 2019, <https://www.processcoaching.com/fourstages>.

Phillips G 2015, *Dancing with power: Aboriginal health, cultural safety and medical education*, PhD thesis, School of Psychological Sciences, Monash University, Clayton.

Williams R 2008, 'Cultural safety: what does it mean for our work practice?' *Australian and New Zealand Journal of Public Health*, vol. 23, no. 2, pp. 213–214.

Victorian Auditor-General 2014, *Accessibility of mainstream services for Aboriginal Victorians*, State Government of Victoria, Melbourne.

Victorian Government 2006, *Charter of Human Rights and Responsibilities Act 2006*, no. 43 of 2006, Victorian Government, Melbourne, <http://www.legislation.vic.gov.au/ Domino/Web_Notes/LDMS/ LTObject_Store/LTObjSt8.nsf/DD E300B846EED9C7CA257616000A 3571/87318807B8E7A33ACA257D07 00052646/$FILE/06-43aa013%20 authorised.pdf>.

United Nations (UN) 2008, United Nations Declaration on the Rights of Indigenous Peoples, UN, Geneva, <https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf>.

DOH.0003.0001.0236

Part 1:

Aboriginal and Torres Strait Islander cultural safety framework

For the Victorian health, human and community services sector

(accessible version)

VICTORIA State Government | Health and Human Services

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Contents

Acknowledgement of Aboriginal peoples in Victoria **4**

Secretary's foreword **5**

Artwork **6**

Introduction **6**

What is Aboriginal and Torres Strait Islander cultural safety? **7**

Professor Gregory Phillips, PhD 7

The cultural safety framework **8**

1. Vision 9
2. Principles 10
3. Domains 11
   1. Creating a culturally safe workplace and organisation 11
   2. Aboriginal self-determination 11
   3. Leadership and accountability 11
4. Cultural safety continuum reflective tool 11

Competence continuum model 11

Continuous learning and improvement 12

References **12**

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Korin Korin Balit-Djak Artwork

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Cultural safety is a fundamental human right. Public agencies are required by legislation to provide safety in the workplace. If we do not invest the time, energy and resources required to improve cultural safety, our health, human and community

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What is Aboriginal and Torres Strait Islander cultural safety?

Professor Gregory Phillips, PhD

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- individuals, organisations and systems taking responsibility for ensuring their own cultural values do not negatively impact on Aboriginal peoples, including a responsibility to address their potential for unconscious bias, racism and discrimination
- individuals, organisations and systems taking responsibility to support self-determination for Aboriginal peoples – this includes sharing power (decision making

and governance) and resources with Aboriginal communities, and is especially relevant for the design, delivery and evaluation of services for Aboriginal peoples (Phillips 2015).

Figure 1 outlines the key features of a culturally safe workplace.

Figure 1: Key elements of culturally safe workplaces and services

Knowledge and respect for self

Awareness of how one's own cultural values, knowledge, skills and attitudes are formed and affect others, including a responsibility to address their unconscious bias, racism and discrimination

Knowledge of and respect for Aboriginal people

Knowledge of the diversity of Aboriginal peoples, communities and cultures, and the skills and attitudes to work effectively with them

A commitment to redesigning organisations and systems to reduce racism and discrimination

Strategic and institutional reform to remove barriers to optimal health, wellbeing and safety outcomes for Aboriginal people

Cultural safety is an ongoing learning journey

An ongoing and responsive learning framework that includes the need to unlearn unconscious bias and racism and relearn Aboriginal cultural values

Adapted from (Phillips 2015).

The cultural safety framework

The cultural safety framework is designed to improve cultural safety for:

- Aboriginal employees working within the Victorian health, human and community services sector
- Aboriginal clients accessing services within the Victorian health, human and community services sector.

The framework aims to assist the department and mainstream health and community services to strengthen their cultural safety by participating in a process of continuous learning and practice improvement. The model is designed to guide the department and mainstream organisations as they develop strategies, policies, practices and workplace cultures that address unconscious bias, discrimination and racism.

The cultural safety framework has been informed by evidence and consultations including:

- a series of consultations with Aboriginal Victorians, including staff and organisations
- consultation with the department’s Aboriginal Strategic Governance Forum and its Koorie Caucus
- a series of pilots with departmental staff to test and validate the framework and reflective tool
- material received in response to a call for written submissions from the health, human and community services sector
- a literature review on cultural safety

- existing government and sector standards, policies, procedures and strategic documents.

This framework does not specifically address the issue of lateral violence for Aboriginal workers, but it is acknowledged that this is a significant issue relating to their cultural safety. Addressing lateral violence requires supervisors and organisations having advanced cultural safety knowledge, skills and attitudes. Organisations may need to assist Aboriginal employees to engage specialist expertise and support to address issues of lateral violence in the workplace.

1. Vision

The Victorian health, human and community services sector provides culturally safe practices and service provision that enable optimal health, wellbeing and safety outcomes for Aboriginal and Torres Strait Islanders (Figure 2).

Figure 2: Cultural safety framework

Vision:

The Victorian health, human and community service sector provides culturally safe practices and service provision that enables optimal health, wellbeing and safety outcomes for Aboriginal people.

Domains:

1. Creating a culturally safe workplace and organisation
2. Aboriginal self-determination
3. Leadership and accountability

Principles that inform the domains:

- Leadership
- Self-determination
- Human rights approach
- Support and sustainability
- Culturally safe systems
- Ongoing learning
- Accountability and transparency
- Respect and trust

Reflection tool – the four stages of learning towards cultural safety

1st stage: unaware ‘Unconsciously incompetent’ learning stage	**2nd stage: emerging** ‘Consciously incompetent’ learning stage	**3rd stage: capable** Consciously competent’ learning stage	**4th stage: proficient** ‘Unconsciously competent’ learning stage
`Overall reflection: I am unaware of how my unconscious biases and behaviours affect the cultural safety of	Overall reflection: I recognise the need to unlearn and build my skills and knowledge to improve	Overall reflection: I consciously apply my learnings and improve cultural safety practice	Overall reflection n: My work practices are culturally safe and do not require a conscious correction. I am open to and enact

1st stage: unaware 'Unconsciously incompetent' learning stage	2nd stage: emerging 'Consciously incompetent' learning stage	3rd stage: capable Consciously competent' learning stage	4th stage: proficient 'Unconsciously competent' learning stage
the workplace and services delivered			ongoing learning and improvement

2. Principles

The cultural safety framework is supported by an agreed set of guiding principles. Table 1 outlines the principles to be applied across the three domains of the framework.

Table 1: Cultural safety framework principles

Principle	Explanation
Leadership	Organisations provide meaningful leadership opportunities to design, deliver and evaluate culturally safe policies, programs, initiatives and services. Organisations have leadership at all levels that understand and champion the organisation's role in cultural safety.
Self-determination	Aboriginal staff, people and communities have meaningful leadership and decision-making roles, and are involved in designing, delivering and evaluating Aboriginal health, wellbeing and safety policies, programs and initiatives.
Human rights approach	The rights-based approach that drives this framework is an essential part of Victorian Aboriginal service delivery and sector development. The United Nations Declaration on the Rights of Indigenous Peoples recognises both the principle of self-determination (Article 3) and the right to culture (Articles 11 and 31). The Victorian Charter of Human Rights and Responsibilities Act 2006 also recognises culture as a right.
Support and sustainability	Staff at all organisational levels are supported to undertake ongoing cultural safety professional and personal development. Workplaces have processes to build individual and organisational capacity, provide mentoring opportunities and establish culturally safe spaces for Aboriginal staff and clients.
Culturally safe systems	Embed culturally safe practice into recruitment and retention processes, as well as into existing policies, programs, procedures, procurement and services.
Ongoing learning	A continuous process of reflection and quality improvement to identify and reflect on individual and organisational practice, and implement the actions required for ongoing learning and self-reflection at all levels of the organisation.

Principle	Explanation
Accountability and transparency	Individuals reflect on their own level of competency in cultural safety and identify required improvements. Organisations reflect on their current policies, practices and procedures and reflect on their organisational competency. Organisations demonstrate accountability by implementing key performance indicators.
Respect and trust	Individuals and organisations establish a relationship of trust and respect with Aboriginal staff, clients and local Aboriginal communities.

3. Domains

The cultural safety framework has three key domains for action:

1. Creating a culturally safe workplace and organisation

This domain focuses on changing workplaces and organisations to be culturally safe by reforming strategies, policies, procedures and accountabilities. It helps individuals and organisations build on their cultural safety through professional development, reforming governance, policies, procedures and evaluation measures.

2. Aboriginal self-determination

This domain is closely aligned to changing workforce and organisational practice.

It focuses on building our ability to hear the Aboriginal client and community voice and support the decisions of Aboriginal people, families and communities.

3. Leadership and accountability

This domain highlights the importance of leaders being accountable for driving quality improvement to affect behavioural and systemic changes so that cultural safety becomes embedded in everyday practice.

4. Cultural safety continuum reflective tool

The framework includes a continuous quality improvement approach and uses the ‘Johari window’ approach to the four stages of learning a new skill (Figure 3).

Competence continuum model

The competence continuum model describes the four stages of competency in cultural safety as:

1. unaware – unconsciously incompetent
2. emerging – consciously incompetent
3. capable – consciously competent
4. proficient – unconsciously competent and open to continual learning and improvement

Figure 3: The four stages of learning a new skill

The continuum acknowledges coming into consciousness along the learning journey (Getha-Taylor et al. 2013; Luft & Ingham 1955; Pateros 2001). These terms relate to the competency level of learning a new skill, rather than the competency of an individual.

Continuous learning and improvement

Improving cultural safety is an ongoing learning process. Proficiency will be achieved when individuals and organisations commit to improving their knowledge of cultural safety and changing their attitudes, beliefs and behaviours.

The cultural safety continuum reflective tool intends to support a continuous quality and practice improvement approach. Figure 4 outlines the continual learning journey from 'unlearn' to 'embed'.

Figure 4: Continual learning journey

Unlearn – Challenge what is established as 'the norm' and question what is accepted so a nonbiased and more balanced set of shared values and ways of doing things can be learnt.

Learn – Understand why 'established' or 'usual' practice is not always the best way to learn. Learn other, more balanced ways to learn as part of everyday practice.

Apply – Implement what is learnt to create positive interactions and environments.

Reflect – Continually challenge assumptions, which may require returning to the unlearning and learning stages to gain more knowledge.

Embed – Implement continuous quality improvement to reform systems, procedures, policies, strategies, programs, procurement, workplace culture, accountability and monitoring.

The aim is for individuals and organisations in the Victorian health, human and community services sector to continuously improve cultural safety proficiency by adopting the Aboriginal and Torres Strait Islander cultural safety framework.

References

Department of Health and Human Services 2017, *Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027*, State Government of Victoria, Melbourne.

Getha-Taylor H, Hummert R, Nalbandian J and Silvia C 2013, 'Competency model design and assessment: findings and future directions', *Journal of Public Affairs Education*, vol. 19, no. 1, pp. 141–171.

Luft J and Ingham H 1955, *The Johari window, a graphic model of interpersonal awareness: Proceedings of the western training laboratory in group development, University of California*, Los Angeles.

Pateros J 2001, *The four stages of learning*, Process Coaching Centre, San Rafael, <https://www.processcoaching.com/fourstages> viewed 22 February 2019,.

Phillips G 2015, *Dancing with power: Aboriginal health, cultural safety and medical education*, PhD thesis, School of Psychological Sciences, Monash University, Clayton.

Williams R 2008, 'Cultural safety: what does it mean for our work practice?' *Australian and New Zealand Journal of Public Health*, vol. 23, no. 2, pp. 213–214.

Victorian Auditor-General 2014, *Accessibility of mainstream services for Aboriginal Victorians*, State Government of Victoria, Melbourne.

Victorian Government 2006, *Charter of Human Rights and Responsibilities Act 2006*, <http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/LTObject_Store/LTObjSt8.nsf/DDE300B846EED9C7CA257616000A3571/87318807B8E7A33ACA257D0700052646/$FILE/06-43aa013%20authorised.pdf > no. 43 of 2006, Victorian Government, Melbourne.

United Nations (UN) 2008, *United Nations Declaration on the Rights of Indigenous Peoples*, <https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf> UN, Geneva.

Seeing the Clear Light of Day:

Expert Reference Group on Decriminalising Public Drunkenness

Report to the Victorian Attorney-General

August 2020

Table of Contents

Seeing the Clear Light of Day: ... 1

Report to the Victorian Attorney-General ... 1

About this report ... iii

Glossary of key terms ... iv

Executive Summary ... 1

List of recommendations ... 4

1. Introduction ... 14

1.1 Appointment of the Expert Reference Group ... 14

1.2 Methodology ... 15

1.3 Acknowledgements ... 15

2. Vision and design principles ... 16

2.1 Outcomes ... 16

2.2 Outcomes ... 16

2.3 Principles ... 17

3. The journey to decriminalisation ... 18

3.1 Royal Commission into Aboriginal Deaths in Custody ... 18

3.2 A sustained case for change ... 18

3.3 Inquest into the Death of Tanya Day ... 19

3.4 Need and imperative for change ... 21

3.5 Consistency with current policy priorities ... 21

4. Victorian context ... 23

4.1 Current Legislative Scheme ... 23

4.2 Current service system responses ... 23

4.3 What the data told us ... 24

4.4 Feedback from consultations ... 28

5. Experiences of decriminalisation in other jurisdictions ... 33

6. A public health response to public intoxication ... 39

7. Stage 1: First response ... 41

7.1 Role and functions of First Responders ... 42

7.2 First response services and agencies ... 42

7.3 Guaranteeing coverage and availability ... 44

7.4 Consent and powers ... 45

7.5 Tailored local responses ... 51

7.6 Safety of First Responders ... 51

7.7 Summary of First Responders ... 51

8. Stage 2: Transport to a place of safety ... 54

8.1 Role of transportation ... 54

8.2 Transport options ... 55
8.3 Assessment of transport options ... 55
8.4 Guaranteeing transport coverage and availability ... 59
8.5 Consent and powers ... 59
8.6 Transport safety ... 60
9. Stage 3: Places of safety ... 61
9.1 Home/private residences ... 62
9.2 Health infrastructure overview ... 62
9.3 Sobering services ... 65
9.4 Assessment of options for places of safety ... 70
9.5 Differentiated service system responses ... 71
9.6 Guaranteeing coverage and availability ... 72
9.7 Consent to medical treatment ... 78
9.8 Workforce requirements ... 81
10. Stage 4: Health and social care pathways ... 83
10.1 Investment in Aboriginal alcohol and other drug services ... 86
11. Stage 5: Broader prevention strategies ... 88
12. Implementation considerations ... 90
12.1 A phased transition ... 90
12.2 Trial sites ... 91
12.3 Governance arrangements ... 92
12.4 Ongoing monitoring, evaluation and adaptability ... 94
12.5 Cultural safety framework ... 95
12.6 Further consultation and co-design ... 103
12.7 Local Government ... 104
12.8 Resourcing ... 105
Appendix 1: Terms of reference ... 106
Appendix 2: Community consultation and engagement ... 111
Appendix 3: Recommendations from the Inquest into the Death of Tanya Day ... 114
Appendix 4: Public drunkenness by Local Government Area (2014-2019) ... 117

About this report

This report has been prepared by the Expert Reference Group appointed to advise the Victorian Government on the decriminalisation of public drunkenness and the development of an alternative health-based response.

Our report comprises two parts:

Part 1 provides background and context to the work of our Expert Reference Group, including the current Victorian context and journey to decriminalisation. It summarises the key data and evidence demonstrating the need and imperative for changes to Victorian laws, policies and services, as well as provides an examination of the experiences of decriminalisation of public drunkenness in other jurisdictions.

Part 2 outlines our Expert Reference Group's advice and recommendations on the adoption of a public health response to public drunkenness, based on the insights outlined in Part 1. It contains a detailed discussion of the various phases required to adopt a public health response, as well as key implementation considerations relating to the successful transition away from the current criminal justice response.

Glossary of key terms

The following key terms are used throughout this report:

ACCOs is a broad umbrella term that is inclusive of Aboriginal Community-Controlled Organisations including Aboriginal Community-Controlled Health Organisations (ACCHOs)

ACJP means Aboriginal Community Justice Panels, a volunteer-based community initiative that provides cultural and practical support to Aboriginal people in police custody

AHLO means Aboriginal Hospital Liaison Officer

AOD means alcohol and other drugs

CALD means culturally and linguistically diverse

DHHS means Department of Health and Human Services

DJCS means Department of Justice and Community Safety

ERG means this Expert Reference Group on public drunkenness

ESTA means the Emergency Services Telecommunications Authority

First Responder means the agency or service who has first contact with a person who is intoxicated in public and requires assistance

Heath practitioner means an individual who practises a health profession

Intoxication means affected or apparently affected by alcohol or a drug or other substance to such an extent that there is a significant impairment of judgement or behaviour

LEAP means Law Enforcement Assistance Program, a Victoria Police database

LGA means Local Government Area

Medical practitioner means a person who is registered in the medical profession as set out in the Health Practitioner Regulation National Law

OPCAT means the Optional Protocol to the UN Convention against Torture

Places of safety means a place where people who are intoxicated can be safe and have their immediate health needs met to sober up. This includes private homes (where appropriate) and the various health and community services identified throughout this report.

PSOs means Protective Services Officers

Proposed Health Model means the recommended health-based model outlined by the Expert Reference Group throughout this report

RAJACs means Regional Aboriginal Justice Advisory Committees

WIES means Weighted Inlier Equivalent Separation, which is a cost weight that measures resource use in an episode of care in a hospital.

Executive Summary

There is a clear, compelling and urgent imperative to overhaul Victoria's current approach to people who are intoxicated in public. The current punitive, criminal justice led response to intoxicated people is unsafe, unnecessary and inconsistent with current community standards. A safer, sensible health-based approach is required that ensures the health and safety of all Victorians, particularly our most vulnerable.

Ever since the Royal Commission into Aboriginal Deaths in Custody, calls for the decriminalisation of public drunkenness in Victoria have been strong, sustained and spirited. Numerous reports during the past 30 years have added to the Royal Commission's clear call for decriminalisation, including the Drugs and Crime Prevention Committee's Inquiry into Public Drunkenness in 2001 and the Victorian Parliament's Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody in 2005.

While the numerous recommendations have been gathering dust, the devastating human impacts of the criminalisation of public drunkenness have continued. The death in police custody of Tanya Day – a much-loved mother, grandmother and a proud Yorta Yorta woman – has been a clarion call for change. Ms Day's story embodies the tragic human consequences of the continuing criminalisation of public drunkenness in Victoria – a punitive scheme that has widespread unjust, discriminatory and intergenerational impacts on vulnerable Victorians.

Very regrettably, Ms Day's story reflects a much larger, systemic issue across Victoria. The human impacts of the criminalisation of public drunkenness are borne out clearly in the data. What the data tells us is that the criminalisation of public drunkenness discriminates against vulnerable people, and in particular Aboriginal and/or Torres Strait Islander people, Sudanese and South Sudanese communities, people experiencing homelessness, substance abuse and people experiencing mental health.

What the data also tells us is that this reform is eminently achievable. It paints a clear picture that:

- the total numbers of incidences of public intoxication are very low, at 159 per week
- there is a significant 'low intensity' cohort of people, with the vast majority of people (84 percent) entering custody in these circumstances only once. However, there is also a small 'high intensity' cohort (6.5 percent) who are responsible for over a quarter of all public intoxication offences; and
- there are a small number of 'high demand' Local Government Areas (LGAs) where a higher number of public intoxication offences occur.

While the imperative for change is overwhelming, we are convinced that the changes required to give effect to a health-based response are not. Our work over the last year tells us that there is a clear path away from criminalisation and towards an effective health-based response to public intoxication.

Based on data, consultations with the community and experts and drawing on the salient lessons of decriminalisation in other jurisdictions, this report outlines our Proposed Health Model for the decriminalisation of public drunkenness in Victoria.

The design of a new health-based model to respond to public intoxication must begin with the fundamental premise that no one should be placed into a police cell simply because they are intoxicated in public.

In order to eliminate the use of police cells for public intoxication, there must be safe places available that are accessible and appropriate to meet the health and safety needs of people who are

intoxicated. We adopt a 'supply and demand' framework to identify the service system response that is required, based on current data on public drunkenness offences being the most appropriate indicator of expected demand for placements.

This report outlines the public health approach that is required to achieve this transition. Our Proposed Health Model comprises five key stages:

- First response
- Transportation to a place of safety
- Meeting the immediate health needs of an intoxicated person
- Providing health and social care pathways for high needs individuals
- Broader prevention strategies.

First response

An effective health-based approach demands a cultural shift in the characterisation of intoxication as a health rather than a law enforcement issue. The primary First Responders should be personnel from health or community services organisations, such as outreach services (including existing outreach programs associated with homelessness services), alcohol and other drugs (ADO) services and Aboriginal Community Controlled Organisations (ACCOs). While emergency services such as Victoria Police and Ambulance Victoria will play an important role, a range of health-based services must be supported to meet the levels of expected demand across the state.

Transport

The preferred and default position is that an intoxicated person organises his/her own transport or does so with the assistance of family or friends. In situations where this is not possible due to health or safety risks, a range of new transport options will be required. Victoria Police will only have a role to play in the transportation of an intoxicated person when there are no other options available. The new range of transport options, in combination, will need to be capable of responding to the expected demand based on geography, time distribution and particular individual circumstances, including health needs and cultural safety.

Places of safety

Places of safety are essential to ensuring the health and wellbeing needs of intoxicated people are addressed. Depending on the circumstances, intoxicated people who pose a safety risk to themselves and/or others should, in general, be transported to a private residence, an emergency department or urgent care centre if they require urgent medical care, or a sobering service if they require a short recovery period and cannot be cared for elsewhere.

New sobering services are integral to our Proposed Health Model. Based on the data, seven new sobering services in high demand areas will provide the capacity to meet the variances in demand across the state. In regional and rural locations where there is much lower demand, the best health response solutions should be locally devised involving engagement of health services and the communities they serve.

The expansion of the sobering services network should be combined with modular 'pop-up' services to expand capacity in a rapid and flexible manner to respond to demand associated with specific sporting or cultural events.

Health and social care pathways and broader prevention strategies

A significant minority of people who present intoxicated in public more frequently are likely to be experiencing complex health and welfare challenges that are contributing to their drinking patterns. Increased access to follow-up or ongoing support is a key element of an effective public health approach to public intoxication. This requires improved service pathways and targeted approaches, such as filling the gaps in AOD services for Aboriginal and/or Torres Strait Islander people.

Under a public health approach, broader prevention strategies also play a valuable and effective role in reducing the impacts of high-risk drinking by addressing underlying causes.

The path forward

The major thrust of our recommendations is clear – an effective health-based service system response to public intoxication is absolutely essential for the proposed reforms to be effective. Cultural safety considerations must be at the core of both design and implementation. This requires ongoing consultation and co-design with health services and their staff and with particularly affected communities, such as Aboriginal and CALD communities, to ensure that localised responses are developed that are tailored and effective.

In light of the complexity involved in the development of the Proposed Health Model, we recommend that a phased implementation take place over a two-year transition period. This will enable the model to be trialled and statewide service infrastructure put in place before full decriminalisation takes effect.

With detailed attention given to implementation of our Proposed Health Model, we are confident that a shift from a criminal justice approach to a health-based model is both realistic and attainable.

While the journey to decriminalisation in our state has been long and painful, Victoria now has the opportunity to leapfrog other Australian states and territories and be at the forefront with the development of an innovative and transformative health-based approach to public intoxication.

Once the shackles of a criminal justice approach to public intoxication have been shed, there can be no going back. The path ahead lies in a comprehensive health-led response that recognises public intoxication for what it is – a public health issue and not one that can be addressed by a blunt and reactive criminal justice approach.

There is strong community support.

The Victorian Government's commitment is clear.

Now is the right time for this long overdue reform to begin.

Now is the time to see the clear light of Day.

List of recommendations

The ERG's recommendations for a public health response to public intoxication cover the following:

- a public health response to public intoxication
- various phases required to adopt the ERG's Proposed Health Model; and
- key implementation considerations relating to the successful transition away from the current criminal justice response.

The recommendations listed below follow the structure of this report.

The journey to decriminalisation

1. The Expert Reference Group acknowledges the Victorian Government's acceptance of the coronial findings made by the Deputy State Coroner in the Inquest into the Death of Tanya Day and strongly encourages their full implementation by the Attorney-General, Chief Commissioner of Victoria Police, CEO of V/Line and Secretary of the Department of Justice and Community Safety (DJCS).

Implementing a public health approach to public intoxication

2. The Victorian Government repeals the offence of public drunkenness in sections 13, 14 and 16 of the *Summary Offences Act 1966* to achieve the decriminalisation of public drunkenness.
3. The Victorian Government ensures no person is detained in a police cell solely for being intoxicated in public.
4. The Victorian Government should adopt a 'supply and demand' approach that identifies the current number of public drunkenness offences as the most likely indicator of the number of placements that that will be required in sobering and other health services under the Proposed Health Model.
5. The Victorian Government ensures the implementation of the Proposed Health Model takes into account the need for holistic health-based responses that are also capable of responding to drug use and experiences of mental health, including dual diagnosis, where possible.
6. The Victorian Government undertakes further consultation to ensure that the management of intoxicated people, who have committed criminal offences, and are incarcerated in police cells can be more effectively supported and comply with the mandatory terms of Victoria Police's governing policy and procedures, including proper medical supervision and access to health treatment where required.

Stage 1: First responders

Roles and functions of first responders

7. All first responders under the public health model (whether justice-based or health-based first responders) perform their respective roles and functions in such a way as to ensure the health and safety of individuals who are intoxicated in public, consistent with the principles underpinning the public health model.

First response services and agencies

8. The Victorian Government considers how the Emergency Services Telecommunications Authority (ESTA) process can change regarding determining what tasks can be referred to certain response agencies in order to promote a health-based response to incidents of public intoxication. This should include how such alternate agencies can be facilitated through such a process – having regard to the contractual arrangements ESTA has with emergency services agencies.

Consent and powers of Victoria Police

Threshold for police powers

9. The Victorian Government establishes a legislative basis for Victoria Police to detain an intoxicated individual in strictly limited circumstances, including that:
   a) the Victorian Government defines intoxication within the legislation as 'affected or apparently affected by alcohol or a drug or other substance to such an extent that there is a significant impairment of judgement or behaviour'
   b) the Victorian Government limits the threshold for police with regards to someone who is intoxicated to 'serious and imminent risk of significant harm to the intoxicated individual or other individuals'
   c) the Victorian Government explores the appropriate assessment of this threshold which should have an objective element, such as a reasonable person test.

Strict limits to police powers

10. The Victorian Government establishes a legislative basis for Protective Services Officers (PSOs) within Victoria Police be given the power to detain an intoxicated individual in an existing designated place and is at serious and imminent risk of significant harm to themselves or others, recognising the safeguards contained in other recommendations.
11. The Victorian Government does not extend the power to detain an intoxicated individual who is at serious and imminent risk of significant harm to themselves or others to any other cohort.
12. The Victorian Government legislates to ensure detention ceases at the moment that the threshold of serious and imminent risk is no longer met, whether this is due to a change in the environment or the person's personal circumstances (e.g. their degree of intoxication has sufficiently decreased).
13. The Victorian Government limits the power to detain an intoxicated individual who is at serious and imminent risk of significant harm to themselves or others for no longer than 60 minutes. Any exception to this time limit required to arrange a safe placement should require the authority of a Divisional Patrol Supervisor or Inspector.
14. The Victorian Government does not establish a specific offence as a result of the establishment of police powers to detain for the purpose of making inquiries to identify a place of safety for an intoxicated person.
15. The Victorian Government implements a review process for any charges laid in relation to assault police arising from attempts to escape by a superior officer, such as an Inspector.

Conditions of detention and use of force

16. The Victorian Government takes steps to ensure that in accordance with the *Victorian Charter of Human Rights and Responsibilities Act 2006*, Victoria Police exercise their powers to give effect to the least restrictive means of achieving their objective, in terms of both the decision to detain and the nature of restraint employed.
17. The Victorian Government ensures Victoria Police takes steps to ensure the full protection of the health of persons in their custody and in particular, shall take immediate action to secure medical attention whenever required.
18. The Victorian Government explores and consults with relevant stakeholders on how to ensure treatment during and conditions of detention of intoxicated people are consistent with relevant state and international human rights obligations and principles. This includes ensuring effective independent oversight of the detention of intoxicated people that is consistent with the Optional Protocol to the UN Convention against Torture (OPCAT).
19. Victoria Police takes steps to ensure officers use force only when strictly necessary, and the force used must be proportionate to the circumstances. The degree and nature of the force used must account for the fact that the purpose of the power to detain is to keep the person safe from harm. Thus, any use of force must be used by exception and the force used itself minimal.

Limits on police discretion

20. The Victorian Government creates comprehensive regulations, guidelines, policies and procedures on the operationalisation of the legislation, to ensure police discretion is applied appropriately and reasonably to all members of the community.
21. The Victorian Government establishes legislation to ensure police discretion in assessing whether a location is a safe place is limited, including but not limited to risk of family violence and instances where the intoxicated person is behaving or is likely to behave so violently that a responsible person would not be capable of taking care of and controlling them.

Training

22. Victoria Police provides police officers and PSO with training on the legislative amendments, regulations, guidelines, policies and procedures and be provided ongoing refresher training.
23. Victoria Police provides police officers and PSO with training on systemic racism, unconscious bias, culturally appropriate service delivery, effective communication, de-escalation and conflict resolution, and be provided ongoing refresher training.
24. Victoria Police provides police officers and PSO with training on mental health and disability and be provided with ongoing refresher training.

Record keeping obligations of police

25. Victoria Police keeps detailed records of the enquiries they make in relation to locating a safe place for the person, including any reasons for concluding that the location is not a safe place, such as risk of family violence.

Publicly available information

26. Victoria Police ensures guidelines, policies, procedures and training and other similar materials are publicly available.

27. The Victorian Government considers making disaggregated data relating to police assistance provided with consent, and police intervention without consent, publicly available. This information should include, but not be limited to, information with regards to whether people are Aboriginal and/or Torres Strait Islander, CALD status, homelessness, gender, disability and age.
28. The Victorian Government implements public reporting on the exercise of new police powers and other relevant powers that may be used more frequently subsequent to the reform (e.g. move on powers), as well as arrests for other minor offences.

Internal police oversight

29. Victoria Police ensures authorisation of any charges that arise from an incident of public intoxication should be authorised by an Inspector.

Independent oversight

30. Victorian Government, in consultation with the Victorian Aboriginal Legal Service and Victoria Police, considers the introduction of a mandatory requirement that where an intoxicated Aboriginal and/or Torres Strait Islander person is detained and/or transported for their safety by Victoria Police they be subject to sections 464AAB and 464FA of the *Justice Legislation Miscellaneous Amendment Act 2018.*
31. The Victorian Government empowers an oversight body, such as the Victorian Ombudsman, to adjudicate complaints and conduct investigations in relation to the implementation and operation of these reforms by police. This should include oversight of up-charging practices by police, and the treatment of people detained and conditions of detention during transport.

Accountability for police negligence and abuse of power

32. The Victorian Government ensures any abuse of power by police to circumvent the limitations on powers to detain an intoxicated person must be treated seriously and they should be held accountable.
33. The Victorian Government undertakes further research and consultations to establish an offence in relation to negligent conduct when detaining an individual who is intoxicated.

Stage 2: Transport to a place of safety

Guaranteeing transport coverage and availability

34. The Victorian Government supports outreach teams and sobering services to have a transport capability attached to their service or work together with separate transport teams to achieve the most effective and efficient management of demand.
35. The Victorian Government ensures that the proposed implementation phase gives local areas an opportunity to test a range of low-demand transport models, including the identification and development of local partnerships.
36. The Victorian Government ensures that the implementation phase monitors the impact on police and ambulance emergency services, including impact on response time performance measures.

Consent and powers

37. The Victorian Government establishes a legislative basis for Victoria Police to transport an intoxicated individual to a place of safety in strictly limited circumstances, including that:
    a) there be a legislative obligation that police exhaust all other avenues by which an intoxicated person could be transported to a safe place, and that police transport be a last resort
    b) the Victorian Government does not establish a specific offence as a result of the establishment of police powers to transport intoxicated individuals to a place of safety
    c) the Victorian Government ensures that all limits, thresholds and accountability measures in relation to the power to apprehend and detain, as outlined in Part 7 of this report, apply to the exercise of the limited power to transport intoxicated individuals to a place of safety.

Transport safety

38. The Victorian Government establishes a transport safety standard to ensure the safe transport of intoxicated people.

Stage 3: Places of safety

39. The Victorian Government ensures intoxicated people who pose a safety risk to themselves and/or others should, in general, be transported to one of three safe place locations to sober up, including to:
    a) their home or other private residence where it is determined that the individual is at low-risk and can be adequately and safely cared for by family or friends
    b) an emergency department or rural trauma and urgent care centre where it is determined the individual requires urgent medical assessment and/or care; or
    c) a health or sobering service where it is determined the individual does not require emergency care but still requires a short period of recovery and detoxification and/or cannot be cared for safely elsewhere.
40. The Victorian Government ensures that a home or other safe private residence remain the preferred and default safe place option to assist people with sobering needs. Wherever possible and appropriate, an intoxicated person should be safely cared for by family or friends in order to minimise the impost on health services. Additionally, people who reside alone should not by default be taken to a sobering service simply because they do not have someone to care for them.
41. The Victorian Government ensures the key elements of intake, assessment, monitoring, further assessment and intervention form the model of care for sobering services in Victoria that comprises:
    a) outreach and transport services as a key element of a model of care for sobering services in Victoria
    b) the workforce for sobering services should be multidisciplinary and at a minimum including a health practitioner, such as a registered nurse, and reflect the profile and the needs of the population and region it serves

c) a staff to client ratio between 1:6 and 1:8, which would be a reasonable starting point subject to detailed implementation planning for each location and any variations to a core model.

42. The Victorian Government considers modular health spaces as an infrastructure approach to trialling heath responses as part of the proposed implementation phase, given they are an increasingly accepted part of the health infrastructure mix, offering expanded capacity that can be deployed rapidly and flexibly to meet need.
43. The Victorian Government expands the Mental Health and Alcohol and Other Drug (ADO) Hubs model of care to enable them to provide sobering services as part of their model of care. This may require additional government investment above that initially allocated.
44. The Victorian Government supports the re-location and substantial expansion of Ngwala Willumbong Sobering Service to service Melbourne's northern region which will require additional government investment.
45. The Victorian Government considers whether the rural trauma and urgent care centres could be an effective option for provision of sobering services, and if so, infrastructure may need to be boosted to provide dedicated sobering up placements, where required.
46. The Victorian Government enhances the capability of the existing health system in areas of low demand in regional and rural Victoria to enable medically supervised sobering up placements.
47. The Victorian Government establishes both permanent and 'pop-up' sobering services in LGAs with high demand. The permanent services should operate 24-hours a day seven days a week, with capacity to scale up services at peak times.

Consent to medical treatment

48. The Victorian Government establishes a legislative basis for medical practitioners to apprehend or detain an intoxicated individual, where they do not consent to treatment, in strictly limited circumstances, including that:
    a) the Victorian Government defines intoxication within the legislation as 'affected or apparently affected by alcohol or a drug or other substance to such an extent that there is a significant impairment of judgement or behaviour'
    b) the Victorian Government ensures that limits for the threshold for medical intervention with regard to someone who is intoxicated is serious and imminent risk of significant harm to the intoxicated individual or other individuals
    c) the Victorian Government explores the appropriate assessment of this threshold which should have an objective element, such as a reasonable person test.

Safeguards

49. The Victorian Government legislates to ensure detention ceases at the moment that the threshold of serious and imminent risk is no longer met, whether this is due to a change in the environment or the person's personal circumstances (e.g. their degree of intoxication has sufficiently decreased).
50. The Victorian Government ensures health practitioners are required to regularly assess the ongoing need for detention, including upon admission if detained during transport and through regular assessments of whether informed consent can be secured.

51. The Victorian Government ensures detention for the purposes of the sobering up of an intoxicated person should be a last resort and is limited by appropriate safeguards.
52. The Victorian Government considers the matters highlighted in the *Restrictive Interventions in Victorian Emergency Departments: A Review of Current Clinical Practice* commissioned by the Department of Health and Human Service must be addressed by the Victorian Government.
53. The Victorian Government ensures medical practitioners exercise their powers to give effect to the least restrictive means of achieving their objective, in terms of both the decision to detain and the nature of the restraint, in accordance with the *Victorian Charter of Human Rights and Responsibilities Act 2006.*
54. The Victorian Government implements robust safeguards, including comprehensive legislation, regulations, and guidelines, policies and procedures on the operationalisation of the legislation. This is to ensure, for example, that medical practitioners use sedation and other chemical and mechanical restraints on intoxicated people appropriately.
55. The Victorian Government ensures that medical practitioners:
    a) maintain appropriate written records, including the reasons for the order, the period for which the person is ordered to be detained, the monitoring regime, treatment provided, restraints used and reasons, and discharge
    b) to the extent reasonably possible inform the person of the reasons for the detention and their applicable rights
    c) take reasonable steps to notify the person's nominated person, guardian or carer of their admission or detention; and
    d) provide the reasons for detainment and/or the use of restraint in writing to the person upon their discharge/release.

Independent oversight

56. The Victorian Government empowers an oversight body, such as the Victorian Ombudsman, to adjudicate complaints and conduct investigations in relation to the implementation and operation of these reforms in health service. This should include oversight of detention conditions and treatment of detained people, as well as use of mechanical and chemical restraints.
57. The Victorian Government, in accordance with OPCAT obligations, enables the National Preventive Mechanism to have oversight when intoxicated people are deprived of their liberty, including when they are detained and/or restrained in hospitals.

Stage 4: Health and social care pathways

58. The Victorian Government ensures that a comprehensive service system is capable of supporting the broader health and wellbeing needs of the high intensity cohort of people, who very often experience quite complex health and welfare challenges that contribute to their drinking patterns.

Investment in Aboriginal alcohol and other drug services

59. The Victorian Government establishes a specific adult AOD program for Aboriginal and/or Torres Strait Islander Victorians prior to the end of the implementation phase, with Wotha Daborra considered for further development as part of this process.

60. The Victorian Government ensures that all Social and Emotional Wellbeing teams include AOD expertise (a position outlined by the Royal Commission into Victoria's Mental Health System) and that the role of the teams be expanded to support the government's public intoxication reforms for Aboriginal and/or Torres Strait Islander Victorians where appropriate.

Stage 5: Broader prevention strategies

61. The Victorian Government continues to support and expand where necessary public awareness campaigns focused on primary prevention health initiatives that relate to the prevention of public intoxication, including the work of VicHealth.

Implementation considerations

Phased transition

62. The Victorian Government ensures the Proposed Health Model is phased in over a 24-month period to enable an adequate transition from the current justice-based response to public intoxication.

Trial sites

63. The Victorian Government establishes at least three trial sites during the 24-month transition period to inform the development of the statewide implementation of the ERG's Proposed Health Model.

Governance

64. The Victorian Government establishes a dedicated implementation office to operationalise the public intoxication reform agenda.
65. The Victorian Government establishes a dedicated oversight committee to oversee the overall implementation of the public health approach to public intoxication and to ensure that implementation is consistent with, and gives effect to, the intention of the proposed reforms.

Ongoing monitoring, evaluation and adaptability

66. The Victorian Government works with affected communities, including Aboriginal and/or Torres Strait Islander, Sudanese and South Sudanese communities to develop an evaluation framework including outcomes, reporting by agencies and services, provision of data to affected communities and the involvement of affected communities in the governance model.
67. The Victorian Government undertakes a statutory review of the reforms related to decriminalisation of public drunkenness.
68. The Victorian Government develops a monitoring and evaluation framework in consultation with relevant stakeholders including representatives from Aboriginal and/or Torres Strait Islander and CALD communities.
69. The Victorian Government ensures that Aboriginal Community Controlled Organisations evaluate the cultural appropriateness of the implementation and operation of the reforms.

Cultural safety framework

70. Consistent with its commitment to self-determination and co-design principles, particularly for Aboriginal and/or Torres Strait Islander people, the Victorian Government consults with

affected communities and work wherever possible with community-controlled organisations in the design, delivery and evaluation of the public health response to public intoxication.

71. The Victorian Government continues to support the implementation of a new funding and governance model across public health services to strengthen and improve approaches to delivery of culturally safe and responsive services for Aboriginal and/or Torres Strait community.

72. The Victorian Government continues to support further actions via health service statement of priority processes and funding and service agreements for funded organisations to progress Reconciliation Action Plans.

73. The Victorian Government continues to support and elevate the cultural safety planning undertaken by hospitals and the delivery of culturally safe sobering services provided in hospital settings, including:

    a) sobering services in hospitals are established in line with the identified six themes impacting cultural safety

    b) expanding the Aboriginal and/or Torres Strait Islander health workforce, including Aboriginal Health and Liaison Officers, fully utilising Weighted Inlier Equivalent Separation (WIES) loadings and other resources to adequately resource this function

    c) Aboriginal Health and Liaison Officers – or an appropriate equivalent - are available to support Aboriginal and/or Torres Strait Islander clients utilising sobering services, including access after-hours and on weekends; and

    d) undertake an audit of cultural safety in relation to both Aboriginal and/or Torres Strait Islander people and CALD communities at relevant emergency department and rural trauma and urgent care centres, and appropriate actions undertaken to address identified areas of concern.

74. The Victorian Government works in partnership with affected communities at a local level to develop culturally appropriate service responses as part of the public health response, including building on established partnerships with Aboriginal organisations and communities (e.g. Aboriginal Justice Caucus and Regional Aboriginal Justice Advisory Committees (RAJACs), and with Sudanese and South Sudanese communities under the African Community Action Plan, where appropriate.

75. The Victorian Government support comprehensive cultural safety training to be developed for all first responder agencies (in the justice and health systems), with localised input from, and delivery by, ACCOs and other affected community-controlled organisations, including training on:

    a) Aboriginal cultural awareness

    b) unconscious bias

    c) trauma-informed care

    d) mental health and disability

    e) human rights under the Victorian Charter of Human Rights.

76. The Victorian Government supports the development and delivery of cultural safety training by ACCOs and other affected communities for all staff in services in the public health model.

77. The Victorian Government ensures that training is provided to all first responders and services on localised service pathways and access for affected communities, including for ACCOs. This will be particularly important during the implementation phase.
78. The Victorian Government requires that all first responders and staff in services under the public health model undergo cultural safety training, including ongoing, localised and refresher training.
79. The Victorian Government continues to build the capacity of ACCOs and other community-controlled organisations to deliver cultural safety training in mainstream organisations, including appropriate resourcing and funding of these as professional development activities.
80. The Victorian Government ensures that culturally appropriate safeguards and service pathways are developed for Aboriginal and/or Torres Strait Islander people coming in to contact with police, including exploring options with the Aboriginal Community Justice Panels (ACJP).
81. The Victorian Government extends the role of Aboriginal Hospital Liaison Officers (AHLOs) to after-hours and/or implement an on-call model so hospital based sobering services also have access to Aboriginal support persons for relevant clients (noting this could also benefit all Aboriginal and/or Torres Strait Islander clients) ensuring any non-hospital services operate consistent with the eight cultural safety domains now in place at hospitals. This could include consideration of block grants for cultural safety to other health services with a primary direct role in public intoxication (i.e. Ambulance Victoria).
82. The Victorian Government ensures that interpreters are available across the range of service system responses identified by the ERG for the proposed reform.

Further consultation & co-design

83. The Victorian Government ensures that detailed consultation and co-design occurs as it is critical to the successful establishment and implementation of a public health model.

Local government

84. The Victorian Government undertakes a review of relevant local laws in partnership with local government. The scope of such a review might include consideration of amendments as well as operational protocols to support the reform principles underpinning decriminalisation of public drunkenness.
85. The Victorian Government analyses data relating to enforcement of local laws be monitored to track any unintended consequences associated with the enforcement of local laws.

Resourcing

86. The Victorian Government adequately resources all components of the Proposed Health Model, reflecting the interdependency between all components identified in this report.

Part 1: Background and context

1. Introduction

On 22 August 2019, the Victorian Government announced it would "decriminalise public drunkenness and replace it with a health-based response, in order to provide vulnerable Victorians with appropriate help and support".[1] This will involve the repeal of three offences relating to public drunkenness in the *Summary Offences Act 1966* and the related power of arrest.

The decision was made in the context of the coronial inquest into the death of Yorta Yorta woman Tanya Day, who died after being held in police custody in Castlemaine in December 2017 on a charge of being drunk in public.

The decriminalisation of public drunkenness is consistent with recommendations of the Royal Commission into Aboriginal Deaths in Custody made in 1991 and aligns with the findings and recommendations made by the Deputy State Coroner in April 2020 following the Inquest into the Death of Tanya Day.

1.1 Appointment of the Expert Reference Group

This ERG was established in late August 2019 to provide strategic advice and recommendations to the Victorian Government on the decriminalisation of public drunkenness and the development of an alternative health-based response.

The ERG consists of:

- **Helen Kennedy**, former Chief Operating Officer of the Victorian Aboriginal Community Controlled Health Organisation
- **Tony Nicholson**, former Executive Director of the Brotherhood of St Laurence
- **Jack Blayney**, former Assistant Commissioner and Chief Information Officer of Victoria Police
- **Nerita Waight**, Chief Executive Officer of the Victorian Aboriginal Legal Service

The Terms of Reference for the ERG identify that:

- the ERG is to ensure that its advice reflects the importance of promoting the health and safety of vulnerable Victorians and providing them with appropriate help and support, while ensuring that the safety of the community, first responders, health workers and the broader public is protected
- the ERG's advice is to be developed in consultation with the Aboriginal and/or Torres Strait Islander community, Victoria Police, health services, alcohol and other drugs experts, local government and operators of licensed premises
- the new health-based model will promote therapeutic and culturally safe pathways to assist alcohol-affected people in public places, who may be facing other challenges including homelessness, mental illness, family violence, and substance dependency; and
- a health-based approach will be particularly significant for the Aboriginal and/or Torres Strait Islander community, who are disproportionately affected by the current laws.

A copy of the full Terms of Reference for the ERG is provided in **Appendix 1**.

[1] Attorney-General, Media Release, 22 August 2019.

1.2 Methodology

Guided by the Terms of Reference, the ERG has engaged in a detailed consultation process to progress our understanding of the issues associated with adopting a public health approach to public intoxication and prepare our advice and recommendations to government. Within the time limitations provided for us to provide our report, this process has included:

- **community consultations –** a series of community forums and workshop-style consultations
- **representative forums –** meetings and workshops with key representative groups to discuss the progress of our work, including the Justice Stakeholder Forum, Aboriginal Justice Forum and Health Services and Health Partnership Implementation Committee
- **meetings with key experts –** metropolitan and regional forums, workshops and small group meetings with key experts, including peak organisations, police, ambulance, legal services, public health experts, academics and advocates. This includes experts involved in experiences in other jurisdictions, such as Aboriginal Legal Services (Ontario), National Sobering Collective (United States) and the Kununurra Sobering Up Centre (Western Australia)
- **government briefings –** presentations from government, briefing papers and responses to requests from the ERG for specific information and data
- **consultations with health services –** one-on-one, small group interviews and targeted workshops with specialist services, including health services, clinicians, and Aboriginal Community-Controlled Health Organisations (ACCHOs)
- **data and evidence review –** briefings and papers from key agencies and data sources, including the Crime Statistics Agency, Ambulance Victoria, Law Enforcement Assistance Program (LEAP) data and DHHS data
- **other key stakeholders –** one-on-one meetings with other key stakeholders, including local government and operators of licensed premises, as well as engagement with existing stakeholder forums
- **ERG meetings –** the ERG met on a regular basis to progress our work. Other stakeholders and experts attended these meetings from time to time.

1.3 Acknowledgements

We are extremely grateful to those who shared their advice and insights throughout this process and whose expertise will also be drawn upon during the implementation phase.

A list of organisations and agencies who were engaged with in the development of this report is provided at **Appendix 2**.

We are particularly indebted to the dedicated and expert staff from DJCS and DHHS for their tireless assistance and advice to support the work of the ERG. Similarly, we also want to recognise contributions provided by staff from the Victorian Aboriginal Legal Service, including Isabel Robinson and Andreea Lachsz as well as Jane Andrews from the Victorian Aboriginal Community Controlled Health Organisation We also wish to recognise the stellar contributions of our writer Ben Schokman.

Finally, we wish to acknowledge the unique challenges presented by the coronavirus (COVID-19) pandemic in the final stages of the preparation of this report, which has led to significant challenges in sourcing data and advice, drastically altered timeframes and difficulties presented for individual ERG members.

2. Vision and design principles

As we highlight in Section 3, the need and imperative for a major change to current responses to public intoxication in Victoria is clear, compelling and urgent. We outline below the vision, intended outcomes and principles that we have used to guide the design of a public health response to public intoxication. These parameters for our advice and recommendations have been developed based on the Terms of Reference and informed by the evidence and feedback received from community consultations, service providers, experts, government departments and agencies, and other key stakeholders.

2.1 Outcomes

People in Victoria who are intoxicated in public and are at risk to themselves or others will be safe, they will have access to culturally-appropriate care and support if they choose it, their contact with the criminal justice system will be minimised, and the safety of the community and responders will be assured.

2.2 Outcomes

In delivering on the ERG's terms of reference, the Victorian community should experience the following broad outcomes, including:

- reduced incarceration and deaths in custody
- decreased contact with the criminal justice system
- increased access to a culturally responsive service system that is capable of addressing both immediate short-term needs and longer-term health and social care pathways
- reduced harm from risky drinking and related behaviours by individuals
- maintenance of community safety and perceptions of community safety in relation to public intoxication.

We wish to recognise at the outset that particular communities and cohorts of people are disproportionately impacted either as a result of existing law enforcement of public drunkenness, or their experiences in the justice, health and law enforcement systems more broadly, including:

- Aboriginal and/or Torres Strait Islander people
- Sudanese and South Sudanese people
- children and young people
- people at risk of being a victim and/or perpetrator of family violence
- people with a disability
- people with a mental health issue
- people experiencing homelessness
- Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex (LGBTQI) people.

Improved outcomes for these communities have been front of mind throughout our considerations and the work that we have undertaken to design the Proposed Health Model outlined in this report.

2.3 Principles

Our advice and recommendations on the design of a public health response is guided by the following principles:

- **human-rights informed –** the new model will reflect the human rights for which Victorians have protection in the *Charter of Human Rights and Responsibilities Act 2006* – in particular freedom of movement, liberty and security, and equality before the law
- **self-determination –** Aboriginal and/or Torres Strait Islander Victorians will be empowered to make decisions about how the new model can best support Aboriginal communities
- **engagement and collaboration –** engaging and collaborating with communities, service users, service providers and researchers will help ensure the new model is fit for purpose and service responses are integrated and supported by strong relationships
- **locally tailored and consistent with overarching scheme –** while service and operational responses should vary and adapt according to local conditions, there will be fair and consistent procedures for determining an intoxicated person's risk of harm and health and safety needs. Agency roles and responsibilities will be clear, with connected referral pathways
- **scalable –** the model design can be scaled and adjusted according to changing needs, including responding to seasonal demand variation. Where appropriate, new programs and services can be trialled in one area and expanded across the state
- **safety –** cultural and psychological safety will be essential to meet the needs of Aboriginal and/or Torres Strait Islander Victorians and a range of other groups who may be at greater risk of public intoxication-related harm, including: people experiencing mental illness; harmful substance use and/or homelessness; survivors and perpetrators of family violence; young people; culturally and linguistically diverse communities; and people with disabilities
- **evidence-informed –** the new model will be informed by the best available evidence on problems, solutions and opportunities, while being adaptive and innovative
- **feasible and implementable –** make the most of all of Victoria's existing strengths – including protective factors, efforts, expertise and service infrastructure – and be adequately and sustainably resourced
- **sustainable –** funding models predictably allow services to deliver care and support in line with these principles, with consideration to changing demand levels, costs of service delivery and availability of other funding sources
- **ongoing evaluation and adaptability –** finally, given the nature of the proposed reforms, service system responses designed to implement a public health approach must be reviewed, evaluated and adapted on an ongoing basis, based on clearly identified service system parameters and quality available data.

3. The journey to decriminalisation

This section outlines the historical context leading to the Victorian Government's decision to repeal the offence of public drunkenness.

3.1 Royal Commission into Aboriginal Deaths in Custody

Nearly 30 years ago, the Royal Commission into Aboriginal Deaths in Custody investigated 99 deaths of Aboriginal and Torres Strait Islander people in custody over a nine-year period. The Royal Commission found that the disproportionate rate at which Aboriginal and Torres Strait Islander people were arrested was the major and most immediate cause of these deaths. The Royal Commission also reported on the complex, intergenerational impacts of dispossession, colonisation and institutional racism on Aboriginal and Torres Strait Islander peoples.

The Royal Commission made 339 recommendations relating to improvements in the criminal justice system and measures to reduce the number of Aboriginal and Torres Strait Islander peoples coming into contact with the criminal justice system. The key recommendations relating to responses to public intoxication are:

- abolition of the offence of public drunkenness (recommendation 79)
- establishment of non-custodial facilities for the care and treatment of intoxicated people (recommendation 80); and
- creation of a statutory duty that police must consider and use alternatives to the detention of intoxicated people in police cells (recommendation 81).

We are particularly moved by the Royal Commission's examination of the death in custody of Harrison Day – Ms Day's uncle. In re-visiting the Royal Commission's work, we are struck by the unnerving parallel between the circumstances of Mr Day's death in police custody in 1982 and his niece's death 35 years later.

Since the Royal Commission's report in 1991, the number of Aboriginal and Torres Strait Islander people who have died in custody around Australia is 438. As we discuss further below, Victoria and Queensland remain the only Australian states not to have abolished the offence of public drunkenness. As is made abundantly clear in the Royal Commission's report, there will continue to be devastating human impacts unless and until Victoria's current criminal justice approach to public intoxication is discarded and replaced with a health-based response that ensures the safety and wellbeing of individuals who require support.

3.2 A sustained case for change

We acknowledge the community groups, service providers, experts and academics who have long advocated for a change to Victoria's criminalisation of public intoxication. This includes strong, sustained and spirited advocacy by Aboriginal and Torres Strait Islander leaders, organisations and communities given the over-representation of Aboriginal and/or Torres Strait Islander people detained in police custody for public intoxication, as well as the harmful impacts of detention. For Aboriginal and Torres Strait Islander communities, experiences associated with public intoxication are inherently linked to the broader operation of the criminal justice system and the disproportionate impacts of criminal laws, policing practices and sentencing. These disproportionate impacts have enormous costs

and consequences for Aboriginal and/or Torres Strait Islander people and the broader Victorian community.

Since the Royal Commission, numerous inquiries and reports have repeated the calls for decriminalisation of public intoxication, including the Drugs and Crime Prevention Committee's 2001 *Inquiry into Public Drunkenness* and the Victorian Parliament's 2005 *Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody*. The family of Tanya Day observed that "if the Victorian Government had done what the Royal Commission into Aboriginal Deaths in custody recommended 30 years ago and abolished the offence of public drunkenness, our mum would still be alive today".[2] We echo their call that whilst the decision to decriminalise public intoxication is just the beginning and "this country has so much further to travel. For as long as Aboriginal and/or Torres Strait Islander people are targeted by police, are locked up and mistreated, and continue to die in police custody, the fight for true and complete justice for our people will be ongoing".[3]

Recently, the global impact of the Black Lives Matter movement has sharpened awareness of the overrepresentation of, and adverse outcomes experienced by, Aboriginal and Torres Strait Islander people in the justice system and the suffering of the many Aboriginal and Torres Strait Islander families whom have lost loved one to deaths in custody and continuous cycles of incarceration. The Black Lives Matter movement is also shaping community expectations of the systemic and cultural change that is required to improve health and justice outcomes for Aboriginal and Torres Strait Islander people and other vulnerable groups. We believe that everyone in our community deserves fair and equal treatment, regardless of ethnicity, socioeconomic status, or education – and that by listening and implementing reforms that heed of the calls of generations of marginalised communities we can go a long way to creating a more equal and fair society.

We recognise that the principal thrust of advocacy by community groups is the demonstrable need for a comprehensive health-based response to replace the current criminal justice approach. This requires an integrated public health approach that is capable of addressing the often multiple, intersecting challenges experienced by the high intensity cohort of people who come into contact with police when intoxicated in public. This includes culturally appropriate and tailored responses for people who are over-represented in this cohort, such as people experiencing homelessness, Aboriginal and/or Torres Strait Islander people and people with Sudanese background.

We outline more specific detail about the information received during consultations in Section 3.4 below.

We also recognise that further consultation needs to be undertaken to inform the implementation phase of the public health model addressing public intoxication (which we address in Part 2).

3.3 Inquest into the Death of Tanya Day

The Victorian Government's commitment to abolish the offence of public drunkenness was made on the eve of the coronial Inquest into the Death of Tanya Day. Ms Day died after being removed from a train and taken into police custody for being intoxicated in public. She sustained a serious head injury after falling in a police cell and died 17 days later, on 22 December 2017.

Ms Day was a much-loved mother and grandmother, and a proud Yorta Yorta woman. Her children – Belinda Stevens, Warren Stevens, Kimberly Watson and Apryl Watson – have publicly and fiercely

[2] Available at https://www.hrlc.org.au/news/2020/4/9/family-of-tanya-day-statement
[3] Available at https://www.hrlc.org.au/news/2020/4/9/family-of-tanya-day-statement

advocated for justice for their mother, as well as provided detailed submissions to the Deputy State Coroner about the need for major, systemic reform and cultural change.[4]

The Day family's submission requests that the Coroners Court of Victoria make a number of recommendations that are relevant to the approach to the decriminalisation of public intoxication and consideration of the powers of Victoria Police and other first responders. Key recommendations include:

- that the Victorian Government prohibit the placement of intoxicated people – charged solely with an offence (or offences) under the Summary Offences Act 1966 – in police cells (Recommendation 2)
- that the Victorian Government work in partnership with Aboriginal and Torres Strait Islander organisations and communities, legal and health experts, Ambulance Victoria and Victoria Police to design, resource and implement a range of non-custodial public health alternatives for the care and treatment of intoxicated persons (Recommendation 3)
- that the Chief Commissioner of Victoria Police review the adequacy of legislation, the Victoria Police Manual, Standard Operating Procedures (SOPs) and training/refresher modules regarding dealing with intoxicated persons to require that police officers:
    - consider and utilise alternatives to custody
    - consider arrest as a last resort and consider all alternatives before arresting a person, particularly for minor offences
    - undertake individual health and risk assessments to determine whether the person requires medical attention or accommodation prior to taking a person into custody
    - if the intoxicated person is an Aboriginal and/or Torres Strait Islander person, consider that they may have experience of intergenerational trauma, be more likely to have more complex health needs, and may experience being detained in custody in a particularly negative and traumatic way; and
    - provide adequate care and supervision of persons taken into custody to maintain their health, safety and wellbeing (Recommendation 18).

On 9 April 2020, the Deputy State Coroner handed down her findings and made 10 recommendations directed towards the Attorney-General, Department of Justice and Community Safety and Victoria Police. The findings included that Ms Day's death was preventable and referred Victoria Police officers for criminal investigation. These recommendations and the Victorian Government responses are provided at **Appendix 3**.

For the ERG, the Day family's submission and their long fight for truth and justice, supported by the coronial findings, has formed a strong basis for the content of this report and our recommendations.

As observed by the former Minister for Aboriginal Affairs Gavin Jennings, on 22 August 2019, "Since Tanya Day's death in 2017, her family has been committed to law reform and better support services. The courage and determination they have shown to prevent other families from experiencing their pain has been remarkable and truly inspiring."

[4] Available at https://www.hrlc.org.au/news/2019/11/10/family-of-tanya-day-call-for-police-accountability.

Recommendation

1. The ERG acknowledges the Victorian Government's acceptance of the coronial findings made by the Deputy State Coroner in the inquest into the death of Tanya Day and strongly encourages their full implementation by the Attorney-General, Chief Commissioner of Victoria Police, CEO of V/Line and Secretary of DJCS.

3.4 Need and imperative for change

We are acutely aware that the history and context briefly outlined above demonstrates a clear need and urgent imperative for change that is long overdue. The circumstances of Ms Day's death and the coronial inquest has become a tipping point for change in Victoria.

While this reform will bring Victoria in line with almost all other states and territories across Australia, there is a vital opportunity for Victoria to learn from the experiences of other jurisdictions. As we outline in Section 4 below, approaches to decriminalisation elsewhere have largely failed to eliminate the incarceration of people who are intoxicated. The absence of adequately resourced health-based responses has had the unintended consequence of perpetuating, and in some instances exacerbating, major issues relating to the overuse of detention and safety and wellbeing of people who are detained. In the Australian context, this failure is most clearly and dramatically highlighted by the number of continued deaths in custody, particularly of Aboriginal and Torres Strait Islander people around the country.

The advice and recommendations we provide throughout this report present a significant opportunity for Victoria to lead domestically and internationally by implementing reforms that create an ongoing legacy that promotes the safety, wellbeing and dignity of all Victorians.

3.5 Consistency with current policy priorities

The Victorian Government's commitment to decriminalise public drunkenness and adopt a public health approach is consistent with a number of current key policy priorities, including:

- delivery of the Burra Lotjpa Dunguludja - The Aboriginal Justice Agreement Phase 4
- delivery of the Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan – 2017-2027
- delivery of the Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027
- delivery of the Public Health and Wellbeing Plan 2019-23
- establishment of the DJCS Youth Justice Strategic Plan 2020-2030
- Community Crime Prevention, including the establishment of place-based interventions, new research and resources to assist in reducing crime at the local level
- DJCS's Statement of Direction outcome 'a fair and accessible justice system for Aboriginal people' and commitment to reducing over representation of Aboriginal Victorians in the justice system.

In addition, there is significant work underway on emerging reforms including:

- responses and recovery measures related to the coronavirus (COVID-19) pandemic
- amendments to the Summary Offences Act 1966

- the review of the *Liquor Control Reform Act 1998*, including consideration of current approaches to harm reduction
- upcoming recommendations of the Royal Commission into Victoria's Mental Health System
- expansion of AOD services, including residential rehabilitation services.

These priorities recognise a range of significant issues within Victoria, including the need to improve outcomes for people in contact, or at risk of contact with justice services through improved early intervention and prevention and development of service responses that meet the needs of vulnerable people and improve outcomes for rehabilitation and recidivism.

We note a Victorian Parliamentary Inquiry into Homelessness is also currently underway.

4. Victorian context

This section provides an overview of the operation of the current response to public drunkenness in Victoria. We outline the current legislative scheme and service system response. A high-level summary of the key findings from available data, stakeholder consultations and available literature is also presented.

4.1 Current Legislative Scheme

Public drunkenness in Victoria is captured by several offences contained in the *Summary Offences Act 1966*, namely:

- being found drunk in a public place (section 13)
- found drunk and disorderly in a public place (section 14)
- behaving in riotous or disorderly manner while drunk (section 16)

The mere fact that a police officer considers a person to be intoxicated is sufficient to give rise to the charge under section 13. A person does not need to be violent, disturbing the peace or at risk of harm to themselves or others to be arrested. Public intoxication offences require discretionary assessments by police about a person's intoxicated state based on their appearance and behaviour. However, alcohol levels do not necessarily correlate with the person's behaviour. People with relatively low alcohol levels can engage in behaviours that place them or others at risk. An individual may also appear intoxicated, but in fact be experiencing an underlying health condition.

4.2 Current service system responses

Under the current system, there are a number of First Responders that undertake a range of roles and functions when responding to an intoxicated person in public. These include:

- **Victoria Police –** Victoria Police have powers to maintain community safety under a range of legislation, including the current public drunkenness offences (outlined above), move on powers, banning notices and other summary offences to maintain community safety[5]
- **Ambulance Victoria –** Ambulance Victoria paramedics deliver medical care and transport to intoxicated people who need urgent medical attention. This care is mostly voluntary and is not based on any statutory power[6]
- **health services –** a range of health services respond to medical and other health needs of intoxicated people, including in particular AOD services. Support is provided where a person presents to that health service, as well as through outreach and mobile services. There are no express statutory powers for health workers to require or regulate health interventions in relation to a person's intoxication except where that intoxication requires an urgent medical response
- **welfare and community services –** a number of community organisations provide health, alcohol and other drug, and welfare services, including outreach services such as Koori Night Patrols and Ngwala Willumbong Sobering Centre and outreach services to people experiencing

[5] See general powers and functions under the *Victoria Police Act 2013*, *Crimes Act 1958*, *and Summary Offences Act 1966*.
[6] Ambulance officers do have powers under the *Mental Health Act 2014* to enable apprehension and transport to a mental health service: section 351 of the *Mental Health Act 2014*.

homelessness. These services range from professional services with medical staff to voluntary services

- **liquor licensees' –** operators of licensed premises have powers to respond to intoxication and a range of alcohol related behaviour under the *Liquor Control Reform Act 1986*. This includes refusing entry, barring and banning people from licensed venues. (The *Liquor Control Reform Act 1986* is currently under review through a separate process)
- **authorised officers –** various authorised officers enforce regulations and local laws[7] in public places and on public transport.[8] These officers may be the first to respond to a person who is intoxicated, respond to related behaviour and detect any relevant offences related to public drinking and related behaviour.

4.3 What the data told us

The ERG has received detailed data from a number of sources including police, ambulance and other health and human services data. This includes data recorded in the Victoria Police LEAP database relating to the offences of 'drunk in a public place' and 'drunk and disorderly in a public place' under the *Summary Offences Act 1966*.

Whilst the data indicates that overall numbers are quite small, it does reveal definite patterns concerning the demographics of individuals charged with public drunkenness and the time and place they were charged, all of which are critical to designing an appropriate new service response.

Based on data sourced from DJCS and DHHS, we have identified the following key findings.

Total Numbers

Total numbers are quite low. Between April 2014 and March 2019 there were a total of 41,347 alleged offences recorded in LEAP for public drunkenness. Of these, 88 percent were recorded as drunk in a public place, whilst the remaining 12 percent were drunk and disorderly in a public place. This equates to an average of 8,269 per annum or 159 per week.

Age and sex

The majority of offenders were relatively young males, with 86 percent of offences recorded against men. Further, 42 per cent of men and 34.5 percent of women were aged between 18 and 29 years. Just one percent of both males and females were aged less than 18 years.

Country of birth

Approximately 70 percent of attendances related to people who identified as born in Australia. The most common country of birth for offences relating to people born overseas was Sudan (four percent), with the next most common being the United Kingdom and Ireland (three percent), and New Zealand (two percent).

[7] Section 111 of the *Local Government Act 1989* provides that a council may make local laws for or with respect to any act, matter or thing in respect of which the Council has a function or power under this or any other Act. A local law must not be inconsistent with any Act or regulation. A local law is inoperative to the extent that it is inconsistent with any Act or regulation. The making of local laws is governed by a Ministerial Guideline that is published in the Government Gazette (see section 111A).

[8] See, for example, *Local Government Act 1986* which permits the making and enforcement of local laws; Transport (Compliance and Miscellaneous) (Conduct on Public Transport) Regulations 2015

High intensity and low intensity cohorts

The contribution by individual offenders to the total number of offences is uneven. Two distinct categories can be identified:

- **low intensity cohort*:*** During the five-year period analysed, the vast majority of people (84 percent) entered custody in these circumstances only once, with a further 9.5 percent doing so twice. Whilst this cohort represented 93.5 percent of offenders, they accounted for 74 percent of offences
- **high intensity cohort:** Whilst people entering custody on three or more occasions represented only 6.5 percent of all offenders, they were responsible for 26 percent of all offences. This cohort tend to be significantly older than those in the low intensity cohort. Almost half (47.5 percent) were aged 40 or older, compared to just over a quarter in the low intensity cohort. LEAP data matched with DHHS data indicates that they were also more likely to experience significant health and welfare difficulties. For example, in the 2017/18 financial year, 46 percent made use of homelessness services compared to 17 percent of the low cohort, 30 percent received help from AOD services compared to 12 percent in the low cohort, and 72 percent had an emergency room presentation compared to 39 percent of the low cohort.

Aboriginal and/or Torres Strait Islander people

Aboriginal and/or Torres Strait Islander people are significantly overrepresented amongst those charged with breaching public drunkenness laws. Whilst they make up 0.8 percent of the Victorian population, overall 6.5 percent of all public drunkenness offences were recorded against Aboriginal and/or Torres Strait Islander people. This may be an underestimate given that the Aboriginal and/or Torres Strait Islander status of the person offending was recorded as unknown for between 9 and 11 percent of attendances each year. In 2017, Aboriginal and/or Torres Strait Islander people were significantly overrepresented in both cohorts representing 5.3 percent of the low intensity cohort and 7.9 percent of the high intensity cohort.

People from Sudan and South Sudan

People from Sudan and South Sudan tended to be younger than others charged with public drunkenness offences and are overrepresented in the high intensity cohort. Their offending was less prone to weekend spikes and they had relatively high use of health and welfare services.

People experiencing homelessness

People who were homeless at the time of breaching public drunkenness laws contributed disproportionately to offences recorded in LEAP data. Whilst they made up only 1.9 percent of all offenders, they were responsible for 9.9 percent of all offences. Almost half were recorded as having offended four times or more. The matching of LEAP data with data held by DHHS concerning the use of health and welfare services suggested that homelessness, or the imminent risk of it, may be having a large role in the phenomenon of public drunkenness offending. For example, in 2017/2018 almost 19 percent (1,042) of the 5,545 offenders were recorded as having accessed a homelessness service.

Intersectionality with other issues

Family violence

There is a reasonably high correlation between public drunkenness offences and recorded incidents of family violence. The most significant lies with those who have been perpetrators of family violence. The data showed 28 percent of the low intensity cohort and 45 percent of the high intensity cohort had been recorded as perpetrators of family violence. Victim-survivors of family violence were also present in the data, making up 12 percent of the low intensity cohort and 16 percent of the high intensity cohort.

Presence of drugs other than alcohol

Whilst the combined presence of alcohol and other drugs was often reported during consultations the data sets available did not enable this phenomenon to be quantified.

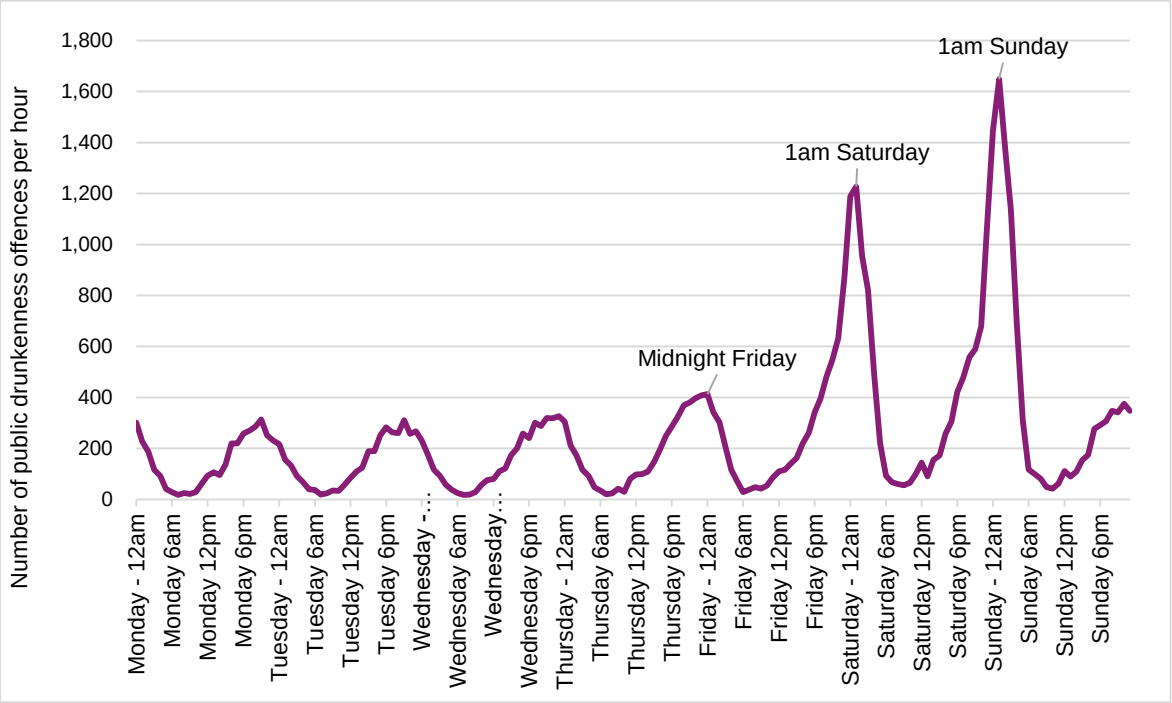
Time distribution

Public drunkenness offences take a predictable pattern across the week and the year.

Weekly pattern

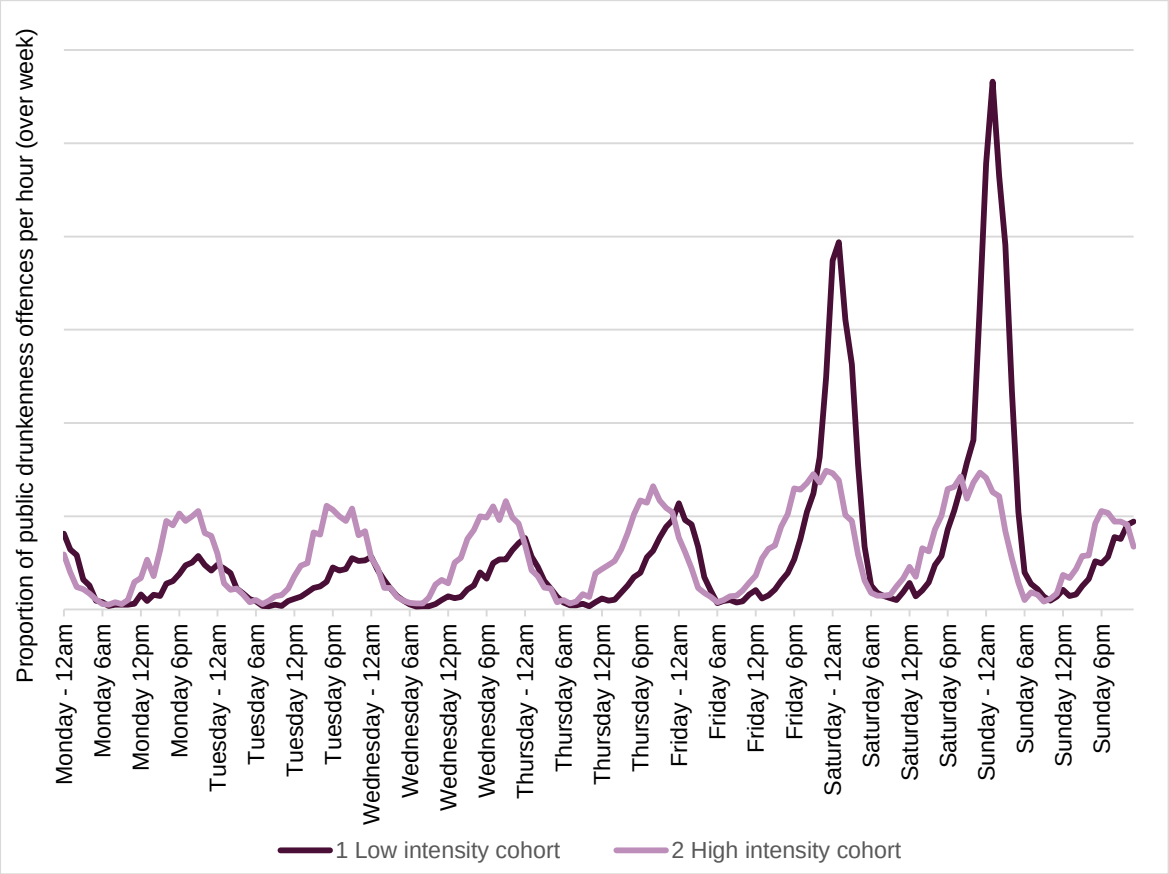
Whilst offences take place on all days of the week, major spikes occur in the early hours of Saturday and Sunday mornings.

Figure 1: Hourly number of public drunkenness offences for each day of the week



These spikes are almost exclusively caused by people from the low intensity cohort. Offences recorded by the high intensity cohort occur extremely consistently across each day of the week.

Figure 2: Hourly number of public drunkenness offences for each day of the week, by intensity cohort

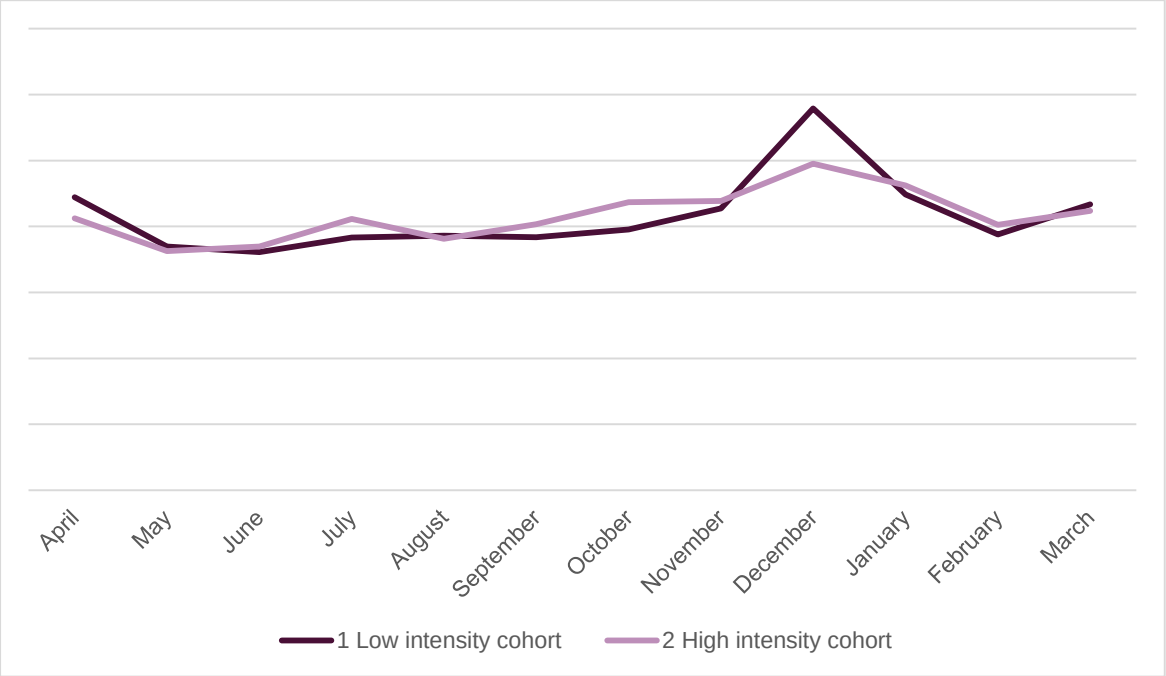


For the low intensity cohort, offences peak on Friday and Saturday nights, as well as at times of high-profile sporting and cultural events and during certain holiday periods.

Yearly pattern

A significant spike in low intensity cohort offences occurs over the summer holiday period and to a lesser extent during major sporting and cultural events. This occurs for high intensity cohort offences, but not to the same degree.

Figure 3: Distribution of public drunkenness offences over the year, by intensity cohort



Geographical distribution

There is also a very definite pattern to the geographic distribution to the recorded offences. Approximately 50 percent of all offences occur within eight local government areas (LGAs) in metropolitan Melbourne and in Greater Geelong: City of Melbourne, Greater Dandenong, Mornington Peninsula, City of Port Phillip, City of Yarra, Greater Geelong, City of Frankston and City of Stonnington. When these “high demand” LGAs are set aside, the average weekly rate of offences occurring across all the remaining seventy-one LGAs, is approximately 80.

There are several regional locations such as Mildura, Greater Bendigo, Latrobe, Ballarat and Greater Shepparton that record moderate numbers of offences, but for whom the rate of offending for their population size is disproportionately high. This is suggestive of broader problems with alcohol consumption in these communities that may not be reflected in the public drunkenness offence numbers. In many other LGAs in rural Victoria the record of offences is sparse. In as many as 33 LGAs, offences occur less than once a fortnight.

Appendix 4 contains data sourced from DHHS on the number of public drunkenness offences by Victorian local government area from 1 April 2014 to 31 March 2019, which provides the basis for the above analysis.

4.4 Feedback from consultations

Throughout the consultation process, we heard from a range of experts, agencies, service providers and community organisations. The following key themes emerged.

Model design

- Stakeholders broadly noted that a public health response is required in order to respond to immediate health and safety concerns posed by public drunkenness, and that shorter-term

interventions offer the opportunity to engage with people on any medium to longer term health needs

- Flexible responses are required as there is no one-size-fits-all approach, yet there is also a need for a consistent and equitable approach
- Any model will require a response that meets the individual needs of the person. This will depend on their immediate clinical needs and any underlying health and wellbeing issues. Social and cultural dimensions are also likely to shape both the immediate and longer-term needs
- There is no existing model than can apply across the state. Localised responses will need to be designed and implemented that are developed using agreed best practice evidence informed principles
- While the law and health elements require consideration, the social element also needs to be addressed, including stigma and discrimination
- A public health model should focus on harm minimisation approaches that consider the health and social consequences of public intoxication on both the individual and the community. This approach acknowledges that alcohol use is an inevitable part of society and occurs across a continuum ranging from occasional use to dependent use
- Self-determination principles should drive service design, planning and delivery for Aboriginal and/or Torres Strait Islander people. It's also important to remember that not all Aboriginal and/or Torres Strait Islander people want to utilise an Aboriginal service. The need to ensure a culturally responsive health, human service and justice system is paramount in this regard.

Alcohol combined with other drugs

- Intoxicated people in public places are often found to be affected by a combination of alcohol and other drugs
- Whether a person is affected by alcohol or drugs or a combination of both may not be readily identifiable to First Responders.

Places of safety

- For the majority of people who are intoxicated, all that is required is a place of safety to sober up. For many people this place of safety is with friends and family
- The hospital emergency department is the appropriate place for people with acute alcohol intoxication who require medical supervision and/or intervention. People with acute health needs who are intoxicated, including those with complex needs related to long-term alcohol and other drug use, are also likely to continue to require emergency department assistance
- For those unable to be safely transported home, or who are homeless, sobering up centres may provide an alternative service type to custody and were recommended by the Royal Commission into Aboriginal Deaths in Custody for this purpose. Sobering services can cater for chronically intoxicated people with more complex needs, for episodic and one-off binge drinkers, and can be provided by both mainstream and ACCOs
- Almost universal interest in sobering services that provide a holistic response, such as both medical and counselling services. Individuals should also be linked into the broader service system where needed, such as homelessness or mental health services

- Sobering services would not need to operate 24-hours per day, seven days per week, especially in regional areas
- There is potential to start providing brief interventions at places of safety once people have sobered up (for example, at a pop-up chill out zone or medical unit).

System capacity

- While the reform is universally supported, there is concern that demand for already stretched services will increase without a corresponding capacity increase being put in place.
- Implementing a public health response may place greater demand on already stretched services, particularly when responding to people with more complex needs. For example, safe housing is a major issue for people who are coming into contact with the justice system regularly through public drunkenness, however there is a scarcity of housing and homelessness services.
- Better to build on existing services and infrastructure rather than build new services.
- Some First Responders may need additional training in order to provide an appropriate first response for people who are intoxicated in public. This could include training in clinical assessment, triage and the provision of culturally safe services.
- Better referral pathways and connections between services need to be established and funded – not enough housing, mental health and AOD services.
- Safety for workforce – including at sobering up centres and for outreach services – needs careful planning and support.

Role of police as First Responders

- Stakeholders noted that Victoria Police's primary role is to maintain community safety, including in the context of alcohol and drug consumption. However, different views exist in relation to the functions Victoria Police should have, if any, in a public health-based response, and the powers that might support such a function (including powers for authorised officers or PSOs)
- Issues raised include the potential of the repeal of the public drunkenness offences to result in the alternative use of associated powers (such as move-on powers) and other offences relating to the maintenance of community safety, for example, obscene, indecent or threatening language or behaviour in a public place, common assault, and wilful damage of property.

Role of first responders other than police

- A number of outreach services and mobile/pop-up services run by community organisations offer First Responder options. This includes the Koori Night Patrol, field officers, AOD workforce and other Aboriginal community-controlled services
- Other key First Responders noted in discussions include paramedics, health workers, local government authorised officers and operators of licensed premises and their staff
- Occupational violence for paramedics and emergency department staff is an increasing issue associated with people who are seriously affected by alcohol. Some stakeholders stressed that a public health response must ensure occupational safety.

Legislative framework and civil detention powers

- There are varying views on whether civil apprehension and detention powers that are a feature of other jurisdictions that have decriminalised public drunkenness would be appropriate in Victoria. In other jurisdictions they are considered as 'last resort' powers where there is a threat to individual or community safety posed solely by a person's intoxication, and there is no option to release a person into safe custody
- Concerns were identified about the disproportionate use of detention powers resulting in higher number of Aboriginal and/or Torres Strait Islander people detained for public drunkenness
- Consultations have highlighted the need to carefully consider potential perverse outcomes of repealing legislation. Some other states have reported an increase in people being charged with other more serious offences following the repeal of public drunkenness laws.

Clinical issues

- Health and safety assessments on first contact are essential for triaging people into the right care pathways. However, follow up assessment once a person is sober will provide the best indication of a person's health needs
- Further education and training are required to assist First Responders and clinical staff to recognise other factors such as disability, mental health and drug use that may appear like drunkenness and/or co-exist for a person who is intoxicated
- Careful consideration needs to be given to issues of consent when people are drunk.

Cultural issues

- To ensure that a response is safe and appropriate for Aboriginal and/or Torres Strait Islander people and other CALD communities, the public health-based response needs to be developed collaboratively with those communities
- AOD services run by Aboriginal people for Aboriginal people come with their own sets of histories, values and strategies. These are all influenced by Aboriginal and/or Torres Strait Islander perspectives that are unique and continually evolving to meet the needs of the people those organisations seek to help
- Recommendations from previous work outlining best practice in Aboriginal AOD services suggests that the following key elements are critical:
    - Aboriginal community control
    - clearly defined management structures and procedures
    - trained staff and effective staff development programs
    - multi-strategy and collaborative approaches
    - adequate funding; and
    - clearly defined and realistic objectives aimed at the provision of appropriate services that address community needs.

Role of broader prevention strategies

- The problem of public intoxication also requires a broader approach, which includes community awareness, education of frontline workers and responsibility of venues that supply alcohol
- The ‘public health response’ alone cannot reduce risky drinking and underlying alcohol cultures. Government could consider strengthening its prevention response, including addressing licensing, responsible service of alcohol, promoting safe environments, education campaigns about risky drinking and alcohol advertising
- Acknowledgment that alcohol dependence is also linked to poor mental health, poverty, homelessness, intergenerational trauma and a range of interrelated issues – and that these issues also need to be addressed in order to respond effectively to public intoxication.

5. Experiences of decriminalisation in other jurisdictions

Key points

- A primary lesson we have learned is that in Australian jurisdictions that have decriminalised public drunkenness the use of police cells for such cases has continued.
- Of major concern is the significant over-representation of Aboriginal and Torres Strait Islander people still being held in police cells in jurisdictions that have decriminalised.
- Protective custody regimes adopted in other jurisdictions following the decriminalisation of public intoxication have largely failed to address the risk of death in police custody.
- A significant reason for the failure in other jurisdictions to address the risk of death in police custody has been the failure to provide an effective health-based service system response that makes places of safety available as an alternative to police cells.
- The decriminalisation of public drunkenness in Victoria is at risk of continuing to incarcerate intoxicated persons in police cells should a protective custody regime allow for this to occur and a health system response is not in place to address the care needs of such persons.

In considering the proposed health-based approach outlined in Part 2 of this report, we have examined the experience of decriminalisation of public intoxication in other jurisdictions. Public drunkenness offences have been repealed in most English-speaking countries around the world. In Australia, most states and territories have abolished public drunkenness as a criminal offence, with the exception of Victoria and Queensland.

This section outlines our assessment of the strengths and weaknesses of various responses that could inform the development of public health model for Victoria.

Continued use of police cells

The primary lesson we take from the decriminalisation of public intoxication laws in other Australian states and territories – and our major concern – is their continued use of police cells for instances of public drunkenness. Following decriminalisation, most states and territories introduced a form of protective custody legislation. While these reforms were introduced with the aim of ensuring police had powers to apprehend individuals as a last resort in order to keep them and the community safe, it is clear that decriminalisation approaches still result in large numbers of people being taken into police cells, as demonstrated in Table 1.

Table 1: Use of police cells for public drunkenness in other Australian states and territories

	Total number of people taken into custody over previous 12-month period*	Proportion of total number of people taken into custody who identify as Aboriginal or Torres Strait Islander (%)	% of general population that Aboriginal or Torres Strait Islander (2016 Census))
NSW	1802	18.1%	3.56%
SA	330	41.5%	2.52%
Tas	447	17.4%	5.84%
ACT	829	13.5%	1.9%
NT	8247	92.8%	43.56%
WA	Not available	Not available	4.09%
QLD	Not available	Not available	4.79%

* 12-month period varies slightly between jurisdictions but included data obtained from 2014 to 2019.

The continued high rates of placement of intoxicated people into police cells indicates that powers granted to police under protective custody regimes are not used as a last resort. Where the option remains to place an intoxicated person into a police cell, police continue to use the power to a significant extent. In our view, the continued use of police cells in relation to public intoxication points to a failure by governments to develop and implement effective health-based responses that are capable of providing more appropriate places of safety for people who are intoxicated and have immediate health needs.

In addition to the continued use of police cells, several issues and risks arise under the operation of protective custody regimes in other jurisdictions, including:

- disproportionate impacts on particular groups, including people experiencing homelessness, Aboriginal and/or Torres Strait Islander people, First Nations communities and particular ethnic groups9
- the failure to establish an effective health-based response through the provision of places of safety as an alternative to police cells means that intoxicated people still find themselves the subject of police scrutiny; and
- relatedly, an ineffective health-based response fails to address the underlying causes of public intoxication, leading to continued reliance on emergency services and tertiary health interventions.

Finally, and most significantly in light of the reason for the ERG's establishment, the impact of the continued use of police cells means that unacceptably high numbers of people continue to die after being taken into police custody for public intoxication, particularly Aboriginal and Torres Strait Islander people. For the Day family, this unfortunate reality has ongoing intergenerational impacts going back to the death of Ms Day's uncle, Mr Harrison Day, in 1982.

[9] See generally Pennay (2012) citing (Dyb, 2006) Brady, 2010 Galloway et al., 2007

Ultimately, while various policy responses implemented in other jurisdictions have purported to decriminalise public drunkenness, in practice the measures that have been adopted have perpetuated a punitive, criminal justice approach that conceives of people intoxicated in public as antisocial, dangerous and a risk to public safety. There has not been the requisite shift in systems and attitudes to move away from a criminal justice approach to public intoxication.

The ERG has given appropriate consideration to the above insights when developing the proposed framework for a public health response in Victoria, which we outline in Part 2 of this report.

Part 2: Implementing a Public Health Approach to Public Intoxication

We have concluded that there is an urgent need to replace the criminal justice model of dealing with public intoxication. As we outlined in Part 1, a criminal justice approach has proved to be unsafe, has led to avoidable deaths, has been ineffective in reducing the recurring public intoxication of individuals and has unnecessarily entangled people in the legal system.

In Part 2 of this report we detail our framework for implementing a public health approach to public intoxication (our ***Proposed Health Model***). The key service system responses required are outlined along with consideration of their implementation.

Implementation Themes

The following key themes provide the starting point for the development of our Proposed Health Model.

Police cells not safe or appropriate

- Our strong view is that detaining an intoxicated person in a police cell is unsafe and cannot be an option in a health-based response. No one should be placed into a police cell simply because they are intoxicated in public. The design of a new health-based model to respond to public intoxication must start from this premise.

Availability of places of safety

- In order to eliminate the use of police cells for public intoxication, there must be safe places available that are accessible and appropriate to meet the health and safety needs of people who are intoxicated (places of safety). Places of safety include going home with or to family or friends where possible and a variety of health and community-based services depending on the health needs of the intoxicated person
- In undertaking the development of our Proposed Health Model, we have used a 'supply and demand' approach to identify the likely number of placements that will be required in sobering and other health services following the decriminalising of public drunkenness offences. We believe that the most appropriate indicator of expected demand for placements is the current data on public drunkenness offences. Current data also provides a helpful basis on which to design the most effective and appropriate service system response under a health-based model.

Consent and voluntariness

- A consent-based model is central to an effective health response to public intoxication at all stages of possible intervention within the public health approach. This includes engagement by first responders, transport to a place of safety, admission to a health or sobering service and the provision of longer-term health and social care supports. In some extremely limited circumstances, it will be necessary to limit the principle of based, providing that appropriate safeguards in place.

Culturally responsive service system

- An appropriate and effective health-based response to public intoxication requires a service system that is capable of supporting people with diverse cultural backgrounds, including Aboriginal and Torres Strait Islander people and CALD communities. The need for tailored, appropriate solutions requires effective engagement and participation, respect for self-determination and locally developed solutions, and the implementation of a clear and comprehensive cultural safety framework.

Intersection with drug intoxication

- As identified in our Terms of Reference, we have been asked to consider how a new health-based model to public intoxication is sensitive to intersecting issues presenting in the lives of people accessing the new health-based response. While the focus of the ERG's report is drunkenness, the on-the-ground reality (confirmed in consultations) is that public intoxication very often co-occurs with drug use. For this reason, we prefer the term 'intoxication' rather than 'drunkenness'. This also reflects contemporary health-based language and is consistent with the premise that an intoxicated person should be subject to a health-based response.
  The considerations outlined in this report necessarily take in to account appropriate health-based responses to drug use and dependence.

Intersection with mental health

- In addition to the high interdependencies between alcohol and drug use, the data also confirms the high correlation between public intoxication and mental health. Consistent with the Terms of Reference relating to intersectional issues, this report gives appropriate consideration to how the health-based response can best respond to and support people experiencing mental illness.

Community and cultural change

- In addition to the necessary service system change, a transition to a health-based approach to public intoxication requires a shift in community and cultural attitudes about public intoxication. This involves increased awareness and understanding that fundamentally public intoxication is a public health issue that requires holistic responses that are capable of addressing the underlying causes of public intoxication.

Each of these themes is explored in further detail throughout the remainder of this report.

We consider that one related matter warrants comment at the outset. As emphasised throughout this report, our strong view is that police cells are unsafe and inappropriate for people who are intoxicated. This raises the related question of intoxicated people who are detained in a police cell on other charges and not solely due to their intoxication. The Deputy State Coroner in the Tanya Day inquest made a number of findings in relation to the management of an intoxicated person in custody, including a "culture of complacency regarding intoxicated detainees" within Victoria Police and found that there is a systemic failure to recognise the medical dangers of intoxication. The Deputy State Coroner also found that the physical checks conducted by the police on Ms Day were "illusory" and that the police officers did not take proper care of Ms Day's safety, security, health and welfare as required by the VPM and SOPs.

In our view, an appropriate health-based response to public intoxication also encompasses the health and safety needs of intoxicated people in police cells. Consistent with the findings of the Deputy State Coroner, we recommend that further consultation be undertaken to ensure how intoxicated people in

police cells can be more effectively supported, including proper medical supervision and access to health treatment when required.

Based on the implementation themes outlined above, we make the following recommendations at the outset.

Recommendation

2. The Victorian Government repeals the offence of public drunkenness in sections 13, 14 and 16 of the *Summary Offences Act 1966* to achieve the decriminalisation of public drunkenness.
3. The Victorian Government ensures no person is detained in a police cell solely for being intoxicated in public.
4. The Victorian Government should adopt a 'supply and demand' approach that identifies the current number of public drunkenness offences as the most likely indicator of the number of placements that that will be required in sobering and other health services under the Proposed Health Model.
5. The Victorian Government ensures the implementation of the Proposed Health Model takes into account the need for holistic health-based responses that are also capable of responding to drug use and experiences of mental health, including dual diagnosis, where possible.
6. The Victorian Government undertakes further consultation to ensure that the management of intoxicated people, who have committed criminal offences, and are incarcerated in police cells, can be more effectively supported and comply with the mandatory terms of Victoria Police's governing policy and procedures, including proper medical supervision and access to health treatment where required.

6. A public health response to public intoxication

Key points

- The current unsafe criminal justice-focused model of dealing with public intoxication must be replaced with an approach that comprises interventions designed to ensure the safety and wellbeing of individuals, as well as promoting access to appropriate services and supports to minimise the incidences of public intoxication in the first place
- The aim of a public health approach to public intoxication is to shift the focus away from a narrow and reactive criminal justice intervention towards a universal approach that makes sure that individuals at risk of public intoxication have the information, supports and services they need. A public health approach comprises three levels of intervention: primary/universal interventions; secondary early interventions and tertiary interventions targeted to high-risk individuals who are identified as having needs or concerns
- Our focus has been mainly focused on the tertiary element – where an incident of public intoxication has already occurred – it is also important that an effective health-based response takes a comprehensive approach.

We are convinced of the need for the development of an integrated health-based approach that is capable of responding appropriately to public intoxication. The current unsafe criminal justice-focused model of dealing with public intoxication must be replaced with an approach that comprises interventions designed to ensure the safety and wellbeing of individuals, as well as promoting access to appropriate services and supports to minimise the incidences of public intoxication in the first place.

The aim of a public health approach to public intoxication is to shift the focus away from a narrow and reactive criminal justice intervention towards a universal approach that makes sure that individuals at risk of public intoxication have the information, supports and services they need.[10] A public health approach comprises three levels of intervention:

- **primary/universal interventions**, which usually target the general public or a whole population groups to provide education and support before problems occur
- **secondary early intervention** programs and services for risk groups where there is an identified risk, in order to alleviate problems before they escalate; and
- **tertiary interventions** targeted to high-risk individuals who are identified as having needs or concerns.

While our Terms of Reference focus predominantly on the tertiary element – where an incident of public intoxication has already occurred – we consider that a continuum of strategies and responses will be necessary to reduce the number of incidences of public intoxication.

[10] The World Health Organisation (WHO) has defined a public health approach as the involvement of the entire health system and the broadest possible intersectoral and inter-institutional collaboration in developing policies and plans and executing activities that reduce the public health impact of public drunkenness on individuals, families and communities. http://www.emro.who.int/

Proposed Health Model

Applying the principles of a public health approach, Figure 4 outlines the ERG's Proposed Health Model to ensure that an immediate health and safety response by First Responders to public intoxication is integrated into a broader health and wellbeing approach.

The remainder of Part 2 of our report is structured around the five stages of the public health model identified in Figure 4.

Figure 4: ERG's Proposed Health Model to public intoxication

	Immediate response			Secondary response	Universal response
Stage	1. First response, initial screening and triage	2. Immediate transportation	3. Place of safety & initial service period	4. Assessment of longer term needs and provision of services	5. Broader prevention strategies
Purpose	Initial identification of person's health and safety needs and associated risks. Triage for appropriate response	Safely transport the individual to a place of safety	To provide a safe place where the individual can rest and recover (sober-up)	Identify health and social needs and appropriate care pathways to reduce harm and improve people's wellbeing over the longer term	Address the underlying causes to prevent problematic drinking occurring in the first place
Types of responses	Late night entertainment outreach, complex needs outreach, multidisciplinary emergency response, police / ambulance	Private transport of friends or family, Uber / taxi, outreach van, Police / ambulance van	Sobering services, fixed place sobering-up centre, after-care transport home	E-referrals, voluntary AOD services, state wide Aboriginal specific withdrawal service	Education and support services targeted towards the general public as well as specific population groups
Factors to determine appropriate response	• Health needs • Safety risk (ind, community) • Consent to receive initial assistance • Available services • Geographic location • Identity / cultural safety	• Health needs • Safety risk (ind, community) • Cooperation of individual; state of consciousness • Available services • Geographic location • Identity / cultural safety	• Health needs • Safety risk (ind, community) • Consent to be taken to place of safety • Available services • Geographic location • Identity / cultural safety	• Health needs • Consent to receive / engage with services • Available services • Broader wellbeing needs • Geographic location • Identity / cultural safety	• Broder wellbeing and health needs • Policy framework and setting • Engagement with target population groups • Local and tailored approaches • Intersection with other prevention strategies (eg AOD, homelessness)

7. Stage 1: First response

Key points

- This reform demands a cultural shift in the characterisation of intoxication as a health rather than a law enforcement issue
- The primary role of First Responders under a health-based response is to ensure the health and safety of any person found intoxicated in public. This involves assessment of both health and safety risks and the risk category will determine the response required
- Where the health risk is high, transport to a hospital or another place where health treatment is a priority. Where the health risk is low, in many cases the person may not require health or emergency services. The first consideration should be whether the intoxicated person can return to their home, or to friends or family while they sober up
- The primary First Responders should be health services personnel and/or personnel from community services organisations, such as outreach services (including existing outreach programs associated with homelessness services), alcohol and other drugs services and ACCOs
- An assessment of the safety risk will need to be made as to whether the person poses a threat to themselves or to others. In situations where an intoxicated person is a serious and imminent risk to themselves or to others, there is an appropriate role for Victoria Police to play
- Police officers and PSOs, as a last resort, should have a limited power to detain intoxicated persons to prevent harm. This power should be strictly limited with appropriate safeguards, monitoring and oversight, and should not apply to any other category of First Responder.

A public health response to public intoxication will require changes to law, policy and service delivery. Overwhelmingly, however, it demands a cultural shift in the characterisation of intoxication as a health rather than a law enforcement issue. Done effectively, this shift will be most significant in the way that First Responders support a person who is intoxicated in public.

In considering what a public health model to address public intoxication should look like, we examined a range of scenarios to test how a health model would respond to typical on-the-ground situations following the decriminalisation of public drunkenness offences. These scenarios identified a range of different factors are relevant to determining the most appropriate first response, including:

- the role and functions of First Responders
- which agencies or services should undertake the role of First Responders
- guaranteed coverage and availability of services
- consent and powers of First Responders
- tailored local responses.

Each of these issues is discussed below based on our review of the available data and evidence as well as consultations with key stakeholders.

7.1 Role and functions of First Responders

The primary role of First Responders under a health-based response is to ensure the health and safety of any person found intoxicated in public.

In responding to an intoxicated person in public, the first step should be an initial assessment as to whether health treatment is urgently required. This requires undertaking the following needs and risk assessment:

- ***health risk:*** The level of risk to an intoxicated person's health outcomes (for example, the likelihood of choking, injury)
- ***safety risk***: The risk to the safety of the intoxicated individual or others (for example, the likelihood of an accident, assault).

In different situations, each of these risks will range in severity from low to high and will require a proportionate response. The nature of the first response will often be shaped by the location of the person, what risks have been identified and what services are available to respond.

In situations where the health risk is high, transport to a hospital or another place where health treatment can be provided (for example, a sobering-up place that includes health professionals) will be necessary. Where the health risk is lower, in many cases the person may not require health or emergency services. The first consideration should be whether the intoxicated person can return to their home, or to friends or family while they sober up. Where this is possible, we consider that this should be the preferred and default position. In this instance, an assessment of the safety risk will need to be made as to whether the person poses a threat to themselves or to others if returned home or to another private residence, including any family violence threat. Where required, the intoxicated person may need the assistance of friends or family or the First Responder to identify an appropriate transport option.

Local responses, specific to some communities, will need to be developed under the new model, including Aboriginal led responses. Where a local response is available, it is expected that the First Responder would contact that service to determine whether and how they could assist. This assistance might include transport and/or placement in a safe place (each discussed in further detail under Stage 2: Transport to a place of and Stage 3: Places of).

In situations where the safety risk is assessed as high, Victoria Police may have an appropriate role to play – this is discussed further below.

Recommendation
7. All First Responders under the public health model (whether justice-based or health-based First Responders) perform their respective roles and functions in such a way as to ensure the health and safety of individuals who are intoxicated in public, consistent with the principles underpinning the public health model.

7.2 First response services and agencies

As identified in Section 4.2 above, there are currently a number of First Responders that possess a range of roles and functions when responding to an intoxicated person in public, including Victoria Police (and various authorised officers), ambulance officers, health and community services and

operators of licensed premises. A wider range of services will necessarily be required to replace the current criminal justice-led response to public intoxication with an effective health-based system.

The role and functions of First Responders under a health-based approach requires a service system response that is complementary, intersecting and overlapping. This will require a range of services and agencies with different functions and powers that are capable of providing the most appropriate first response to a person who is intoxicated in public. The nature, orientation and duration of a First Responder's engagement will depend in any given situation on the factors involved in undertaking the needs and risk assessment discussed above.

While Victoria Police will inevitably be the First Responder to public intoxication in limited situations, the effective operation of a health-based response means that police officers should not be relied on as primary First Responders. Wherever possible, First Responders should be health services personnel and/or personnel from community services organisations, such as outreach services (including existing outreach programs associated with homelessness services), AOD services and ACCOs.

With the proposed establishment of a number of sobering services (discussed further under Stage 3: Places of), particularly with transport capacity, we expect that there will be enhanced capacity amongst the cohort of outreach workers. This is a critical element of the Proposed Health Model response to ensure that, to the greatest extent possible, health-base services are the primary category of First Responder options rather than police or ambulance services.

In situations where an intoxicated person is a serious and imminent risk to themselves or to others, there is an appropriate role for Victoria Police to play based on the safety risk considerations identified above. In these cases, the role of Victoria Police within a health-based response should involve:

- engaging with the individual to make an assessment of whether immediate medical assistance is required and to call an ambulance if needed
- if the person does not need immediate medical assistance, making inquiries to identify a safe place for the person, including contacting a responsible person (family/ friend of the intoxicated person) or a sobering up centre or other similar support service; and
- where required, ensuring that there is appropriate transport to take the person to the safe place.

Powers to undertake this role effectively and appropriately within a health-based response are discussed in further detail below.

First contact

The question of how First Responders are contacted in situations of public intoxication is important in the context of ensuring a health-based response. Under the current criminal justice-based approach, Victoria Police are predominantly the default option as a result of police patrols or calls to Triple Zero (000) from members of the public or from specific groups such as operators of licensed premises.

We consider that particular attention should be given to how calls from the public can best ensure that appropriate health and community organisations are First Responders, rather than Victoria Police. For example, protocols could be established within ESTA to determine how calls from the community in relation to incidences of public intoxication are managed and directed to identified local health and community organisations in particular areas. This triaging role would serve an important function in promoting health-based responses to public intoxication rather than the dispatch of Victoria Police and a police-led response. This would also be important to ensure that the resources of emergency services are directed appropriately.

Another consideration is whether a separate contact number should be established. For example, ESTA also provides call-taking and dispatch services via a separate number (132 500) for non-life-threatening emergencies involving storm or flood. Consideration should be given to whether a separate number could be established that is dedicated to instances of public intoxication. This approach could play an especially useful role in ensuring that the most appropriate heath based First Responder is contacted to provide support and a referral pathway to an appropriate place of safety. A separate number that is not associated with emergency situations would potentially also play an important cultural change piece in promoting a change of thinking about public intoxication requiring an appropriate health-based response rather than a police-led response.

With the proposed expansion of sobering services, it is also expected that work can be done to increase awareness among operators of licensed premises of local services in the area.

Recommendation

8. The Victorian Government considers how the ESTA process can change regarding determining what tasks can be referred to certain response agencies in order to promote a health-based response to incidents of public intoxication. This should include how such alternate agencies can be facilitated through such a process – having regard to the contractual arrangements ESTA has with emergency service agencies.

7.3 Guaranteeing coverage and availability

An effective health-based response to public intoxication must be capable of meeting the levels of expected demand across the state. This requires appropriate First Responders to be available on a statewide basis 24-hours a day, seven days a week. Table 2 provides an overview of the ability of identified First Responders under a health-based response to respond to expected levels of demand.

Table 2: Summary of identified First Responders

First Responder option	Service parameters			
	Individual's health risk	Safety risk	Geographic location	Hours of operation
Ambulance Victoria	High	Med	State-wide	24/7
Victoria Police	Low	High	State-wide	24/7
Health outreach services	Medium	Low	State-wide	24/7
Foot patrols and community outreach services, including Koori Night Patrols	Low	Low	CBD, inner suburbs and regional towns	Peak, event specific
Protective Services Officers	Low	High	CBD, suburbs and regional centres	Peak
Private providers of medical/first aid services e.g. St John Ambulance	High	High	State-wide	Event specific
Liquor licensees*	Low	Low	Licensed Premises	Peak

* Operators of licensed premises are included in this table given the range of legal and regulatory obligations relating to the responsible service of alcohol and interactions with people who may be intoxicated and/or disorderly.

Under the proposed health-based model, outreach services, such as sobering and other health services, have a central role to play to ensure adequate coverage and availability of First Responders, particularly in relation to areas of high demand and during peak times. The role of these services and recommended expansion under the Proposed Health Model is discussed in further detail under Stage 2: Transport to a place of and Stage 3: Places of .

7.4 Consent and powers

As identified above, an underlying principle of our Proposed Health Model is that any intervention to assist an intoxicated person must be with the individual's informed consent and respect their right to reject treatment or assistance where they have capacity to do so.

In relation to health treatment, consent is required for medical professionals (who may also be First Responders) to provide treatment to an individual, unless the person requires emergency assistance. Anecdotal evidence highlights that most people will be willing to receive health treatment (and/or transport to a safe place), however there will be instances where an individual may refuse to consent to treatment or assistance for a variety of reasons. This can be due to the person not having capacity or being unable to comprehend the situation where they need support or treatment. There may also be situations where a person does not understand the nature of the treatment or is resistant to the First Responders.

For health services acting as First Responders, a consent-based approach is already adopted to encourage an intoxicated person to a place of safety. We consider that no discrete additional statutory powers would be required for health based First Responders to undertake their functions under the Proposed Health Model.

Where a person has capacity but refuses to consent (an informed refusal), then First Responders may consider the involvement of police where there are serious risks to the person's health. However, with the decriminalisation of the offence of public drunkenness, the role of Victoria Police (and other justice-based first providers such as PSOs) as First Responder raises important considerations in the implementation of a health-based response that require careful consideration.

Last resort powers for Victoria Police

The effect of the decriminalisation of public intoxication means that existing powers of Victoria Police to detain an individual for public intoxication are removed. The question therefore arises about what happens in situations where Victoria Police consider that an intoxicated person poses a risk to themselves or to other people. We have given very careful consideration to whether any discrete additional powers are required for First Responders to intervene to provide support and assistance to an intoxicated person. In doing so, our primary concern is to ensure that an intoxicated person who requires health treatment does not end up entangled in the justice system.

Following an extensive consultation process and detailed consideration, we recognise that Victoria Police will need an additional statutory power to support them to intervene to assist where there is a serious and imminent risk and an intoxicated person does not consent to intervention or assistance.

Before turning to a discussion of the scope and nature of this additional statutory power, we wish to make the following important observations, including that:

- the overarching purpose of this reform is to move away from a police-led response to a health-based response – proposed reforms, including the scope of any new police powers, should therefore be designed to minimise or avoid police involvement to the greatest possible extent
- with adequate resourcing of the Proposed Health Model, Victoria Police should not be relied on as a First Responder, but rather a last resort responder
- Victoria Police already possesses a range of broad powers to detain and transport people. It is vital that Victoria Police do not feel compelled to resort to more restrictive powers where they perceive that apprehension of an intoxicated person is necessary
- it is understood that the public drunkenness provisions to be repealed have been used on occasion by police as a means to resolve public order incidents, without recourse to charging people with more serious public order related offences
- in this context careful consideration has been given to striking the right balance to provide police with appropriate power to address the challenges faced in protecting the community whilst also promoting the adoption of a health-based response
- in circumstances where police powers of apprehension or detention are engaged, they must only be used where strictly necessary and in the least restrictive way; and
- effective safeguards and oversight must be in place to ensure that police powers are used as intended in only the strictest of circumstances.

In the context of these observations, we consider that under the Proposed Health Model, Victoria Police should only have the power to apprehend or detain an intoxicated individual in strictly limited circumstances.

Our views on the scope and nature of an additional statutory power are outlined below, together with a range of safeguards and oversight mechanisms.

High threshold for police intervention

The ERG considers that two high thresholds must be satisfied in order for the police exercise any power to detain an intoxicated person in public, including:

- ***significant impairment –*** firstly, 'intoxicated' should be defined as 'affected or apparently affected by alcohol or a drug or other substance to such an extent that there is a significant impairment of judgement or behaviour'. This definition is based on section 3 of the *Protective Custody Act 2000* (WA)
- ***serious and imminent risk –*** secondly, an individual who is intoxicated in public could only be detained if that individual presents a serious and imminent risk to themselves or others. Assessment of this threshold should be objective and based on the "reasonable person" test. Examples of the serious harm risks we believe would meet this threshold include a significantly impaired person walking onto a busy roadway and being at risk of being struck by a vehicle; or impaired to such an extent that they are stumbling and at risk of falling and potentially striking their head on a hard surface or otherwise seriously injuring themselves; or being unable to adequately assess risk to themselves in circumstances where they are at risk of being physically or sexually assaulted. The risk of damage to property was considered in the context of this threshold and it was determined that it should not be included.

Strict limits to statutory police powers

In addition to the high threshold discussed, there must be strict limits to the use of the police power to detain. These limits include:

- a strict requirement that the purpose of the additional statutory power must only be to:
  - detain an intoxicated person who poses a safety risk (as above) for the purposes of identifying a place of safety; and/or
  - provide transport to a place of safety (discussed below as well as under Stage 2: Transport to a place of).
- a requirement to release an individual if they no longer pose a serious and imminent risk of significant harm, acknowledging that the nature of what is 'imminent' can change rapidly. Detention should cease if the circumstances change and the grounds for detaining the person lo longer apply. In this context it is understood that this is a decision that involves assessment of the person's demeanour and other related risks that may fluctuate between calmness and volatility
- PSOs often encounter intoxicated people in their patrols at designated places. They are confronted with the same challenges as police officers in terms of ensuring the safety of those people and others that may be at risk of harm. They presently have a power to arrest persons for public drunkenness and so consideration has been given to providing a limited detention power. Otherwise they will not be able to detain an intoxicated person when a serious and imminent risk of significant harm is posed, as will be the case for police officers. We consider that PSOs should also have a statutory power to detain as do police, similarly subject to the same limitations and oversight requirements but have enhanced training to address the requirements of this reform
- The ERG is also especially concerned to ensure that the creation of an additional power does not result in the creation of any new criminal offences, such as alternate offences to offending that are already addressed in law.

Detention for the purposes of transport

To ensure that Victoria Police is only a transport provider as a last resort and in the most of limited circumstances, there must be a legislative obligation that police exhaust all other avenues by which an intoxicated person could be transported to a safe place. For example, inconvenience to police, such as waiting times for other First Responders to attend, should not be a reason to default to police transport. Police must only transport an intoxicated person when other transport options have been reasonably discounted.

Conditions of detention and use of force

Under the Proposed Health Model, the use of detention and any related police powers, such as the use of force, must be consistent with the fundamental purpose of keeping the intoxicated person safe from harm, including securing immediate medical attention where required. The use of powers and detention by Victoria Police must be consistent with established human rights standards, including relevant rights enshrined in the *Charter of Human Rights and Responsibilities Act 2006*. Furthermore, any use of force should only be proportionate to the threat and be the minimal force possible to achieve the objective of addressing the threat.

Guidelines and training

To support the intended purpose of the additional police power in relation to intoxicated people, there should be comprehensive regulations, guidelines, policies and procedures on the operationalisation of the legislation, to ensure discretion is applied appropriately and reasonably to all members of the community. This should be supported by appropriate training for police officers and PSOs on the purpose and scope of the additional power.

Oversight and accountability

Given the nature of the additional power, appropriate oversight and accountability processes and mechanisms must be established. This includes:

- detailed record-keeping, particularly in relation to enquiries made to identify a place of safety and appropriate transport option
- making publicly available relevant policies, procedures and training materials
- public reporting on the use of the additional power, including disaggregated data
- internal police oversight of any charges arising from an incident of public intoxication
- independent, external oversight by a body such as the Victorian Ombudsman
- powers to conduct visits to places of detention, consistent with the principles contained in OPCAT; and
- clear accountability mechanisms for any abuse of power by a police officer to circumvent the purpose and operation of the additional power – for example, South Australian legislation makes it an offence that a ”person having the oversight, care or control of a person detained under [the Public Intoxication Act] who ill-treats or wilfully neglects that person.”

Recommendation

Threshold for police powers

9. The Victorian Government establishes a legislative basis for Victoria Police to detain an intoxicated individual in strictly limited circumstances.
   a) The Victorian Government defines intoxication within the legislation as ‘affected or apparently affected by alcohol or a drug or other substance to such an extent that there is a significant impairment of judgement or behaviour.’
   b) The Victorian Government limits the threshold for police with regards to someone who is intoxicated to ’serious and imminent risk of significant harm to the intoxicated individual or other individuals’.
   c) The Victorian Government explores the appropriate assessment of this threshold which should have an objective element, such as a reasonable person test.

Strict limits to police powers

10. The Victorian Government establishes a legislative basis for PSOs within Victoria Police to be given the power to detain an intoxicated individual in an existing designated place and who is at serious and imminent risk of significant harm to themselves or others, recognising the safeguards contained in other recommendations.

11. The Victorian Government does not extend the power to detain an intoxicated individual who is at serious and imminent risk of significant harm to themselves or others to any other cohort.
12. The Victorian Government legislates to ensure detention ceases at the moment that the threshold of serious and imminent risk is no longer met, whether this is due to a change in the environment or the person's personal circumstances (e.g. their degree of intoxication has sufficiently decreased).
13. The Victorian Government limits the power to detain an intoxicated individual who is at serious and imminent risk of significant harm to themselves or others for no longer than 60 minutes. Any exception to this time limit required to arrange a safe placement should require the authority of a Divisional Patrol Supervisor or Inspector.
14. The Victorian Government does not establish a specific offence as a result of the establishment of police powers to detain for the purpose of making inquiries to identify a place of safety for an intoxicated person.
15. The Victorian Government implements a review process for any charges laid in relation to assault police arising from attempts to escape by a superior officer, such as an Inspector.

Conditions of detention and use of force

16. The Victorian Government takes steps to ensure that in accordance with the *Victorian Charter of Human Rights and Responsibilities Act 2006,* Victoria Police exercise its powers to give effect to the least restrictive means of achieving their objective, in terms of both the decision to detain and the nature of restraint employed.
17. The Victorian Government ensures Victoria Police takes steps to ensure the full protection of the health of persons in their custody and, in particular shall take immediate action to secure medical attention whenever required.
18. The Victorian Government explores and consults with relevant stakeholders on how to ensure treatment during and conditions of detention of intoxicated people are consistent with relevant state and international human rights obligations and principles. This includes ensuring effective independent oversight of the detention of intoxicated people that is consistent with the Optional Protocol to the UN Convention against Torture.
19. Victoria Police takes steps to ensure officers use force only when strictly necessary, and the force used must be proportionate to the circumstances. The degree and nature of the force used must account for the fact that the purpose of the power to detain is to keep the person safe from harm. Thus, any use of force must be used by exception and the force used itself minimal.

Limits on police discretion

20. The Victorian Government creates comprehensive regulations, guidelines, policies and procedures on the operationalisation of the legislation, to ensure police discretion is applied appropriately and reasonably to all members of the community.
21. The Victorian Government establishes legislation to ensure police discretion in assessing whether a location is a safe place is limited, including but not limited to risk of family violence and instances where the intoxicated person is behaving or is likely to behave so violently that a responsible person would not be capable of taking care of and controlling them.

Training

22. Victoria Police provides police officers and PSOs with training on the legislative amendments, regulations, guidelines, policies and procedures and be provided ongoing refresher training.
23. Victoria Police provides police officers and PSOs with training on systemic racism, unconscious bias, culturally appropriate service delivery, effective communication, de-escalation and conflict resolution, and be provided ongoing refresher training.
24. Victoria Police provides police officers and PSOs with training on mental health and disability and be provided with ongoing refresher training.

Record keeping obligations of police

25. Victoria Police keeps detailed records of the enquiries they make in relation to locating a safe place for the person, including any reasons for concluding that the location is not a safe place, such as risk of family violence.

Publicly available information

26. Victoria Police ensures guidelines, policies, procedures and training and other similar materials are publicly available.
27. The Victorian Government considers making disaggregated data relating to police assistance provided with consent, and police intervention without consent, publicly available. This information should include, but not be limited to, information with regards to whether people are Aboriginal and/or Torres Strait Islander, CALD status, homelessness, gender, disability and age.
28. The Victorian Government implements public reporting on the exercise of new police powers and other relevant powers that may be used more frequently subsequent to the reform (e.g. move on powers), as well as arrests for other minor offences.

Internal police oversight

29. Victoria Police ensures authorisation of any charges that arise from an incident of public intoxication should be authorised by an Inspector.

Independent oversight

30. Victorian Government, in consultation with the Victorian Aboriginal Legal Service and Victoria Police, considers the introduction of a mandatory requirement that where an intoxicated Aboriginal and/or Torres Strait Islander person is detained and/or transported for their safety by Victoria Police they be subject to sections 464AAB and 464FA of the *Justice Legislation Miscellaneous Amendment Act 2018* .
31. The Victorian Government empowers an oversight body, such as the Victorian Ombudsman, to adjudicate complaints and conduct investigations in relation to the implementation and operation of these reforms by police. This should include oversight of up-charging practices by police, and the treatment of people detained and conditions of detention during transport.

Accountability for police negligence and abuse of power

32. The Victorian Government ensures any abuse of power by police to circumvent the limitations on powers to detain an intoxicated person must be treated seriously and they should be held accountable.

33. The Victorian Government undertakes further research and consultations to establish an offence in relation to negligent conduct when detaining an individual who is intoxicated.

7.5 Tailored local responses

It is intended that local responses will be developed under the Proposed Health Model. This should include community-led responses by groups such as the Aboriginal community, CALD communities and the Sudanese and South Sudanese community in areas where there are populations of these groups. Where a local response is available and appears to the First Responder to be applicable to the person, it is envisaged that the First Responder would contact that service to determine whether and how they could assist. Assistance may involve a range of functions including transport or providing a place of safety.

There will be a range of First Responders under the Proposed Health Model, including potential new channels such as outreach services from sobering services, health workers and expanded night patrols. These responses should differ based on the tiered response to high and low demand areas and development of community driven solutions (existing examples include establishment of Koori Night Patrols or partnerships such as the 'chill out zone' established in Queensland).

It is intended that the Proposed Health Model will be responsive to individual need. At a practical level, this means that there will be a cascading response based on the circumstances and needs of an individual.

The available data suggests that people who are found intoxicated in public may require support to return to a place of safety and address any immediate health and safety issues, but that most people will not require a longer-term health response under a public health model. For the high intensity cohort, defined as people who have intersecting needs, or who may frequently be found to be intoxicated in public, the new model may provide a greater level of ongoing support beyond their immediate needs through better links with housing, community mental health services in addition alcohol and drug rehabilitation programs.

7.6 Safety of First Responders

The safety of First Responders is an important consideration and the needs and risk assessment referred to above plays an important part in the identification of appropriate First Responders and the actions they undertake. Further discussion relating to workforce safety under the Proposed Health Model is contained in Workforce requirements under Stage 3: Places of Safety.

7.7 Summary of First Responders

Table 3 provides an overview of the roles of the various First Responders under our Proposed Health Model.

Table 3: Overview of proposed First Responders

First Responder – overarching role	Functions under Proposed Health Model
Victoria Police Powers and duties to maintain community safety	• Continue to provide a statewide 24/7 service, including respond to calls from the public, or other agencies • Continue to engage with people who are drunk in public where necessary for the purpose of identifying health, safety and/or other needs of people drunk in public • Victoria Police already have powers to maintain community safety under a range of legislation and common law • No power to arrest (or charge) for public drunkenness (or being drunk and disorderly) alone • Detainment in a police cell will no longer be an option merely for being drunk in public • An additional statutory power to be created to detain people and/or transport them to a place of safety in strictly limited circumstances • The additional statutory power created for Victoria Police to detain people and/or transport them to a place of safety in strictly limited circumstances to be extended to PSOs within existing designated areas
Ambulance paramedics & non-emergency patient transport	• Will continue to attend where person has acute health needs • Statewide, 24/7 response (though more limited service capacity in rural and regional areas) • Ambulance paramedics will continue to deliver emergency care to people who are intoxicated in public, including transport to hospital emergency departments for further assessment where necessary • They may also have a role in transporting a person to an alternative safe place (such as a sobering-up centre) with the person's consent, subject to clear operational guidelines
Koori Night Patrol & community-led services	• Under the proposed model, the Koori Night Patrol and/or other Aboriginal-led services responses would be enhanced to provide greater capacity to respond in a holistic public health model

	• They would continue to have a range of flexible functions and culturally safe services, as determined by the local communities consistent with self-determination, which could include transport to a safe place
Outreach workers (incl associated with Sobering Up Centre) services Provide health and other social and outreach services	• In addition to emergency health workers (paramedics and those working in emergency departments), the model will involve a range of other outreach and health workers delivering the proposed range of services to manage non-acute health harms that cannot be managed at home or with friends and family • The primary role of outreach workers under the model will be to offer assistance to address health or other risks associated with a person's intoxication.
Operators of licensed premises Respond to intoxication and other behaviours at licensed venues	• Licensees will continue to have powers and responsibilities under the *Liquor Control Reform Act 1986* (subject to any reforms which arise from the recent governmental review). • It will be important that licensees are informed of the reforms for responding to public intoxication.
Authorised officers Enforcement of regulations and local laws in designated areas such as local council areas and public transport	• Continuation of all functions and powers as currently authorised in a particular area.

8. Stage 2: Transport to a place of safety

Key points

- Under the Proposed Health Model, whilst the preferred and default position where possible is that an intoxicated person organises their own transport or does so with the assistance of family or friends, a range of new transport options will be required. Victoria Police will only have a role to play in the transportation of an intoxicated person when there are no other options available
- The new range of transport options, in combination, will need to be capable of responding to the expected demand based on geography, time distribution and particular individual needs, including health needs and cultural safety
- To achieve the most effective and efficient management of demand for transportation, outreach teams and sobering services will need to have an associated transport capability
- Different operational models for transport should be varied across locations and should be tested during the proposed implementation phase.

A range of transport services are capable of taking people found intoxicated in public to a place of safety. Possible places of safety under the Proposed Health Model, including individuals' private homes, emergency departments and health and sobering services, are explored in further detail in the next section Stage 3: Places of .

This section discusses the role of transportation and identifies our views on the proposed transport services under a health-based model.

8.1 Role of transportation

Transporting a publicly intoxicated individual to a designated place of safety is an integral component of the Proposed Health Model. The identification of the most suitable transport option is inherently linked with the specific needs of the intoxicated person and the identification and availability of the most appropriate place of safety.

Many people who are intoxicated in public will require assistance with transport to a safe place in a range of different situations, such as:

- being separated from family/friends and needing information about local transport
- in need of a safe place because of vulnerability/state of consciousness
- at imminent risk of harm to themself or others
- in need of medical assessment and/or treatment
- after being discharged from a sobering service or emergency health service
- being homeless and having no ready access to a safe place.

Clearly, the type of transportation required will depend on the individual’s circumstances and immediate health and safety needs.

8.2 Transport options

A range of options exist to transport an intoxicated person to a place of safety. The identification of appropriate transport options depends on a number of factors, including the specific health and safety needs of the individual, the availability of an appropriate place of safety and additional relevant considerations such as cultural safety. Appropriate and adaptable transport options will need to be available in both high and low demand areas that are capable of meeting expected levels of demand.

As identified elsewhere in this report, the preferred and default position, where possible, is that people organise their own transport or do so with the assistance of family or friends. Transport options include private vehicles with family/friends or the use of public transport or taxis and ride-sharing services.

For individuals who are not in a position to arrange their own transport, there are various options for transport of an intoxicated person to a place of safety, including:

- by emergency services, such as an ambulance
- standalone transport services
- integration of transport into various outreach services
- integration of transport into health and sobering services
- private paramedic and first aid services to support major events or venues; and
- specialist taxi or rideshare services.

Following the recommendations of the Deputy State Coroner to the Tanya Day inquest, the Victorian Government's review of the ACJP model also presents an opportunity to consider and refine the role of the ACJP in the context of a public health response to public intoxication.

As discussed in relation to first response options, Victoria Police should not be a primary First Responder. Nor are police intended to be a primary transport provider under the Proposed Health Model. However, we acknowledge that there may be some circumstances, particularly in regional and rural areas, where no other transport option is available, and Victoria Police will have a role to play. The role and powers of Victoria Police with respect to transport under the Proposed Health Model are discussed in further detail under the Consent and powers section below.

8.3 Assessment of transport options

Table 4 presents an exploration of various transport options with a preliminary assessment of the suitability of each option for the range of circumstances that are likely to occur within a health-based response to public intoxication.

Table 4: Assessment of transport options

Transport option	Adaptation to health response	Advantages	Disadvantage	Suitability and assessment
Family/friends	• Suitable for cohorts who consent to this option (responder needs to assess family violence or other safety risks) • Use of family and friends is consistent with arrivals at emergency departments – only approx. 25% of emergency presentations arrive by ambulance	• Minimal or no investment. • Minimal disruption to the individual • Encourages personal responsibility	• Without careful assessment could lead to health or safety risk to both the individual and friends/family • May require time and effort to locate and short-term supervision until family/friends arrive	• Yes – subject to assessment by First Responder • Suitable in all areas unless there are significant health or safety concerns • Will not be available to all persons – family/friends may not be available or not able to offer a safe environment
Public transport (P/T)	• Suitable for low risk cohorts – people who are not violent/ agitated and reasonably capable of taking care of themselves (e.g. intoxicated and lost wallet/friends) • Could be given Myki • May not support transport to sobering service	• Reasonable availability in metro Melbourne • Encourages personal responsibility. • Minimal or no investment. • Sobering-up services staff or outreach workers can assist people to access P/T	• Potential for violence, harassment and aggression may occur on P/T when there is no police or PSO presence • Limited in outer suburban Melbourne and little or none in regional and rural areas	• Good option where available, unless there are significant health or safety concerns • Suitable in high and low demand LGAs • Less suitable for rowdy, unwell, disruptive and potentially violent people
Taxis/rideshare	• Suitable for low risk cohorts – people who are not agitated or potentially violent and reasonably capable of taking care of themselves (e.g. intoxicated and lost wallet/friends) • Could be given transport voucher/credit • Safety could be enhanced with use of family or friends to support relocation to a place of safety • Handover to sobering service may be low-quality • No additional training and often lack cultural safety/awareness	• Available in metro and regional centres • People able to use their own agency to manage the consequences of their intoxication • Minimal or no investment, unless supported by vouchers • Sobering service staff or outreach workers can assist people to access taxis/ridesharing service	• Some drivers will not be willing to transport alcohol-affected persons	• Good option where available, unless there are significant health or safety concerns • Suitable in high and low demand LGAs • Less suitable for rowdy, disruptive and potentially violent people
Event paramedics & private transport and first aid providers	• Provide a high-level clinical response to individual's health needs • Staff profile can be flexible to reflect care needs of cohort – includes paramedics, Emergency Medical Technicians or other medical staff	• Private paramedic and first aid services to support major events or venues	• Event paramedics and first aid providers may not have existing transport capability	• Potentially have a role to play particularly around seasonal events and peak periods.in areas of high demand • Cost relative to other options may be high

	• Provides existing fully equipped ambulances and experience in delivering mobile health services • Unknown interest in market for providing response and transport for intoxicated individuals • May lack cultural awareness, or experience working with vulnerable people			
Outreach and sobering services with dedicated or flexible transport	• Opportunity to create a fit for purpose model • Ensures immediate transport availability for outreach teams	• Expanding/ establishing new safe services to respond and transport people to place of safety permits local services/partnerships to draw on local resources to provide a transport solution • Evidence from other jurisdictions that it can be an effective way of organising transport for intoxicated individuals • Can transport more than one person at a time if necessary. • Potential for flexible, 'on-call' model.	• Requires two staff per van • Requires assessment capacity to ensure safety for client and staff • May require special fit outs to ensure safety	• Yes • Invest in areas of high demand • Provides flexibility to outreach /workers who can use the funds at their discretion) to provide transport options (e.g. taxi/uber vouchers as part of local solutions). • Suitable in high and low demand LGAs. May be particularly attractive in rural and regional areas • Appropriate for people with low health and safety risk
Standalone flexible transport services (no outreach or service provision)	• Opportunity to create a fit for purpose model • Separation from outreach teams provides scope for more flexibility (i.e. can link to other sobering service options such as hospitals) • Enables outreach teams to focus on first response needs	• New safe transport option	• Requires assessment of capacity to ensure safety • Costly but less expensive than transport investment options (below) • Risk of over-reliance or unnecessary transports from those able but unwilling to make their own arrangements • Reporting and monitoring may be administratively burdensome	• Yes • Most suited areas of high demand and areas with variable seasonal demand
Specialist taxi/rideshare	• Option to provide additional training and support to taxi and share ride providers to help transport intoxicated individuals	• Drivers purpose trained	• Cost and provider business model feasibility unknown	• Yes • Explore for areas of low demand or areas with variable/seasonal demand

	• Target at lower risk clients who do not have other transport options or family or friends for support • Could involve additional payments to drivers per transport above standard fees to encourage uptake of service • Will need regulation			
Ambulance Victoria	• Provides a high-level clinical response for clients requiring emergency treatment, but will provide an excessive response for low risk clients • Diversion of resources to respond to intoxication reduces capacity to respond to other emergencies • Custodial sentence applicable for violence against paramedics • Fees are payable for transportation ($1,265 for metro & $1,866 for regional; $546 for treat without transportation) or requires coverage by ambulance insurance	• Statewide, 24-hour, demand-responsive • Provides emergency clinical assessment treatment, transport for those requiring it • A safe default option when there is uncertainty about an individual's medical condition	• Increase in demand would require investment • Unnecessary transports are a significant drain on resources (particularly in rural & regional areas where ambulance services are limited)	• Last resort only or for genuine emergencies • Appropriate for people with high immediate health needs who require assessment in an emergency department • Suitable in high and low demand LGAs
Victoria Police	• Only as a last resort • Police not responsible or appropriately trained to manage health issues • Diversion of resources to respond to intoxication reduces capacity to respond to other policing work • Possible risk of escalation resulting in criminal charges	• Statewide, 24-hour, demand-responsive service • Experience in transporting intoxicated people	• Resource-intensive • Discretionary • Not always appropriate in a health-based model • Holding and detaining powers are required	• Last resort only • Suitable in high and low demand LGAs • Appropriate for people with a high safety risk but not people with high health needs

8.4 Guaranteeing transport coverage and availability

To ensure an effective health-based response on a statewide basis, appropriate transport options must be available to meet the levels of expected demand. This requires a diversity of transport options that, combined, are capable of responding to expected demand based on geography, time distribution and specific individual needs, including health needs and cultural safety.

In areas of high demand, it is clear that additional investment in specific transport options will be required. The availability of increased transport services will ensure that intoxicated people receive appropriate care and that emergency services such as ambulance and Victoria Police are only used as a last resort, leaving them free to respond to other emergencies.

It is therefore critical that outreach teams and sobering services have a transport capability attached to their service or work together with separate transport teams to achieve the most effective and efficient management of demand. We consider that different operational models for transport, whether they be attached to a sobering service, or be more flexible demand-led options, should be tested during the proposed implementation phase. Amongst these could be the use of specially trained taxi or ridesharing services for low risk cohorts.

In addition to independent transport capacity attached to sobering facilities, transport in regional areas and/or for people with complex, co-occurring presentations, will require differing and adaptable approaches outside of the scope and/or locale of a sobering services centre.

In areas where the demand for transport will be low, local solutions will need to be developed, particularly in regional and rural areas. This will need to be considered in relation to our recommendations concerning the use of hospitals and other health services to provide sobering services in key rural locations. The proposed implementation phase would give local areas an opportunity to test a range of low-demand transport models, including the identification and development of local partnerships.

The implementation phase should also monitor the impact on police and ambulance emergency services, including impact on response time performance measures.

Recommendation

34. The Victorian Government supports outreach teams and sobering services to have a transport capability attached to their service or work together with separate transport teams to achieve the most effective and efficient management of demand.
35. The Victorian Government ensures that the proposed implementation phase gives local areas an opportunity to test a range of low-demand transport models, including the identification and development of local partnerships.
36. The Victorian Government ensures that the implementation phase monitors the impact on police and ambulance emergency services, including impact on response time performance measures.

8.5 Consent and powers

Under the Proposed Health Model, consistent with the nature of consent in the context of the provision of health care, in all but a few exceptional instances consent of an intoxicated person to be

transported to a suitable place of safety is fundamental, As identified earlier, many health and community services who are First Responders already rely on the consent of an intoxicated person to be transported to an appropriate place of safety. However, we acknowledge that in some circumstances Victoria Police will be the only or last resort option to provide transport, particularly given their availability, both in terms of geography (statewide) and time (24-hours a day, seven days a week) and the fact that the availability of other transport options may vary depending on the service system in a particular area and the specific needs of the intoxicated person requiring transportation.

We acknowledge that the role Victoria Police as a transport option raises several concerns, including the potential drain on Victoria Police resources and that, in some circumstances, the involvement of police may lead to escalation of the situation.

In the limited circumstances where Victoria Police is the only available transport option and an individual does not consent to being transport, we recognise that Victoria Police will require powers that enable them to transport people to a safe place. However, police are not intended to be the primary transport provider in this model. For legal reasons, a specific power will be required for police to transport an individual to a safe space, whether consent is present or not.

Any powers given to police to transport an intoxicated person should be strictly limited to ensure that police are not the primary method of transport under the new health response. A detailed discussion in relation to the nature and scope of additional statutory powers for Victoria Police is contained in Section 7.4: Consent and powers, including our recommendations for an additional statutory power in relation to transport and associated safeguards and oversight.

Recommendation

37. The Victorian Government establishes a legislative basis for Victoria Police to transport an intoxicated individual to a place of safety in strictly limited circumstances.
    a) There be a legislative obligation that police exhaust all other avenues by which an intoxicated person could be transported to a safe place, and that police transport be a last resort
    b) The Victorian Government does not establish a specific offence as a result of the establishment of police powers to transport intoxicated individuals to a place of safety
    c) The Victorian Government ensures that all limits, thresholds and accountability measures in relation to the power to apprehend and detain as outlined in Part 7 of this report apply to the exercise of the limited power to transport intoxicated individuals to a place of safety.

8.6 Transport safety

We are very concerned to ensure the safety of an intoxicated person who is transported to a place of safety. We recommend that a transport safety standard be established to ensure the safe transport of intoxicated people.

Recommendation

38. The Victorian Government establishes a transport safety standard to ensure the safe transport of intoxicated people.

9. Stage 3: Places of safety

Key points

- Places of safety are essential to ensuring the health and wellbeing needs of intoxicated persons are addressed
- Depending upon their personal circumstances, under the Proposed Health Model intoxicated people who pose a safety risk to themselves and/or others should, in general, be transported to a private residence, an emergency department or urgent care centre if they require urgent medical care, or a sobering service if they require a short recovery period and cannot be cared for elsewhere
- New sobering services are integral to the Proposed Health Model. In effect, they will replace the current use of police cells and will have the capacity to meet the variances in demand according to location and time. This should include the capacity to respond to demand associated with cultural and sporting events through the provision of 'pop-up' services. Modular health spaces provide the opportunity to expand capacity in a rapid and flexible manner
- The workforce for sobering services needs to be multidisciplinary, at a minimum include a health practitioner, such as a registered nurse, and reflect the profile and needs of the population and region it serves
- In higher demand areas, it is recommended that sobering services be incorporated into the proposed Mental Health and AOD Hubs and that the existing Ngwala Willumbong Sobering Service be expanded. In regional and rural locations where there is much lower demand, the best health response solutions should be locally devised involving engagement of health services and the communities they serve
- Under the Proposed Health Model, provision of health services takes a consent-based approach, with strictly limited exceptions.

Under our Proposed Health Model intoxicated people who pose a safety risk to themselves and/or others should, in general, be transported to one of three safe place locations to sober up, including to:

- their home or other private residence where it is determined that the individual is at low risk and can be adequately and safely cared for by family or friends
- an emergency department or rural trauma and urgent care centre where it is determined the individual requires urgent medical care; or
- a health or sobering service where it is determined the individual does not require emergency care but still requires a short period of recovery and detoxification and/or cannot be cared for safely elsewhere.

This section outlines our views on the service system response required to provide places of safety for people who are intoxicated under a health-based model.

9.1 Home/private residences

In many instances of public intoxication, a person can be assisted by friends or family without any intervention needed from health or emergency services. An intoxicated person can be assisted to return to their home, or to friends or family while they sober up.

Wherever possible, we consider that a home, or other safe private residences, remain the preferred and default safe place option to assist people with sobering-up needs. This has the benefit of minimising the impost on health services.

This option requires a range of risk assessments to be undertaken, including whether the person:

- can be safely supervised while they sober up – for example, are there responsible people at home who can provide food and hydration?
- will pose a threat to others if returned home or to another private residence – for example, is the person at risk of perpetrating or being the victim of family violence?

If a person cannot be transported home or to friends and family, First Responders will need to undertake further consideration of what the most appropriate place of safety for the person is, having regard to a range of factors, including whether:

- the person currently at risk, or a risk to others
- they be safely supervised to sober up within a local sobering or health service
- they need a specific service response to address their needs, such as the support of an Aboriginal community organisation
- they are experiencing concurrent needs which should be addressed, such as homelessness or other vulnerabilities.

9.2 Health infrastructure overview

This section outlines the current types of health infrastructure available including their purpose, function and potential suitability to incorporate into a sobering service which utilises existing infrastructure.

In addition to these existing service types, we have considered the suitability of modular, prefabricated/pop-up infrastructure as part of the Public Health Model. Modular health spaces are an increasingly accepted part of the health infrastructure mix, offering expanded capacity that can be deployed rapidly and flexibly to meet need. It may be particularly well suited to trialling health responses and infrastructure needs as part of the proposed implementation phase.

Emergency departments

Emergency departments provide care for people who have life-threatening or other conditions that require urgent medical care. Staffing mix and operating hours make them well placed to provide an immediate medical response in cases of acute intoxication. However, emergency departments are not the best location to support intoxicated individuals with non-urgent medical care needs. Emergency resources should not be diverted towards providing lower-acuity sobering supports.

Nevertheless, hospitals with emergency departments are available 24-hours a day, seven days a week for client triaging and admission and deliver a high level of clinical governance and oversight. We consider that emergency departments have an important role to play as part of the service system response to public intoxication. We anticipate that this role will continue in regard to providing urgent

medical care for those suffering acute intoxication. We also consider that this does not require any new investment from government in respect of this reform.

Mental health and alcohol and other drug hubs

As part of the 2018-19 State Budget, the Victorian Government announced funding for six mental health and AOD responses in six public hospital emergency departments. The six public hospitals were Monash Health (Monash Medical Centre Clayton), Peninsula Health (Frankston), Western Health (Sunshine), Barwon Health (University Hospital Geelong), St Vincent's Hospital, and Melbourne Health (Royal Melbourne Hospital).

The hubs aim to enhance the emergency treatment and experience for those presenting with mental health and AOD issues. It is expected these clients will receive more timely assessment and specialist treatment, with access to a dedicated physical space and workforce that is more conducive to therapeutic interventions than a conventional emergency department.

The hubs response will operate 24-hours a day, seven days a week to provide an integrated care pathway to respond to people presenting to the emergency department with urgent physical health and mental health or alcohol and other drug needs.

The three key components of the hub response are:

- **non-admitted service** – a multidisciplinary assessment and treatment service within the emergency department. Initially this will be within existing infrastructure until capital works are completed that will deliver a dedicated space. Clients will have access to a collaborative and multidisciplinary assessment across physical, mental health and AOD domains followed by appropriate treatment, including:
    - brief (where clinically indicated) therapeutic interventions
    - peer support
    - referral to appropriate inpatient and/or community-based services with the involvement of families and carers where applicable and appropriate.
- **the short stay unit, the hub** – a 4-6 bed facility, the short-stay unit (the physical refurbishment referred to as the 'hub') within the emergency department for clients who require stabilisation and intensive support for a period of time that is clinically appropriate. Short-stay beds will be included in building works to be undertaken in line with the capital development plan for each health service. Once completed, staff will work across both the non-admitted and short stay units.
- **assertive outreach** – a 28-day post-discharge follow-up service where required. This will facilitate comprehensive assessment for clients, provide appropriate linkages and referrals in response to presenting needs and provide follow-up engagement for those discharged from the hub response into the community.

We are of the view that the hubs represent an excellent opportunity to address the sobering-up needs of clients and that consideration of extending the remit of these hubs to incorporate sobering services should occur. This proposal is particularly strengthened when the service orientation of the hubs is understood. The services intended for the hubs will complement the service requirements for a sobering service.

We consider the hubs should provide sobering services as part of their model of care. This may require additional investment above government's initial investment in the hubs.

Rural trauma and urgent care centres

Rural urgent care centres are local health services for people in small rural communities providing 24-hour care and treatment, with the option of transfer to larger services when required. Rural urgent care centres are expected to undertake initial assessments of clients and initial treatment of any type of presentation. Rural urgent care centres also receive ambulances for definitive treatment, assessment of client needs or stabilisation before transfer to a larger health service. We consider that rural trauma and urgent care centres may be an effective option for provision of sobering services, and if so, in some circumstances, infrastructure may need to be boosted to provide dedicated sobering up placements.

Public hospitals

Public hospitals provide a variety of inpatient and outpatient services, with unplanned admissions generally triaged through the emergency departments. Most hospitals have social workers available to help with personal, emotional and practical concerns relating to clients, including connecting clients to relevant community supports. Hospitals in LGAs identified as having high demand or highly complex cohorts for sobering services are generally already familiar with managing the needs of this cohort and will be well placed to establish dedicated sobering service supports.

Most hospital services are delivered during business hours, meaning that peak time periods for instances of public intoxication do not usually coincide with these hours. Additional investment and support would therefore be required for staff to be available to triage and admit clients and support escalation of care where needed, particularly in smaller rural public hospitals where there is limited or no capacity to admit clients for care outside of normal business hours.

Residential alcohol and other drug and health services

A range of existing residential services for AOD treatment operate across Victoria. They generally do not provide 24-hour accessibility. People with high needs experiencing AOD dependence and related social issues (as distinct from people who are merely intoxicated) are referred to residential treatment services through catchment-based intake services and other alcohol and other drug treatment providers.

Residential withdrawal services provide support for people to safely withdraw from alcohol and other drugs in a supervised residential or hospital facility, usually in a short-term stay. Residential rehabilitation provides a longer-term (typically three or more months), structured residential program for people who require that level of support.

We consider that the role of residential services may be better suited to integration as part of a secondary response (discussed further under Stage 4: Longer Term Needs) where a person is assessed as needing these interventions. The role of non-residential AOD services would likely be more aligned with secondary response integration.

Aboriginal-specific health and support services

There are a number of Aboriginal-specific services and initiatives, which are delivered by ACCOs as well as ACCHOs based on the principle of self-determination. ACCOs are controlled by and accountable to Aboriginal and/or Torres Strait Islander people in those areas which they operate. They deliver diverse holistic, comprehensive and culturally appropriate health and care to the community. We consider that ACCOs have a central role to play in the provision of health and sobering services as safe places for Aboriginal and/or Torres Strait Islander people who are intoxicated in public.

Implementation of an effective health-based response will require investment in ACCOs to develop new and expand existing responses to public intoxication as both First Responders and in the provision of Places of Safety. Further detail on the role of ACCOs is provided in our discussion on the expansion of Sobering services.

Community health services

Victoria has a comprehensive network of community health services that deliver a range of primary health, human services and community-based support to meet local community needs. Community health services provide universal access to services as well as targeted services for vulnerable population groups. We consider that community health services may be suited to providing sobering services given their existing focus on supporting vulnerable cohorts and experience in AOD treatment. Individuals in the highly complex cohort are likely to be already connected with these services.

However, because they are generally not open overnight and on weekends, consideration would need to be given to the additional infrastructure they would need to provide a suitable sobering service.

Homelessness support services

Homelessness services provide various forms of housing, welfare and health support for people experiencing homelessness or at imminent risk of doing so. Whilst several of the large services are accessible 24-hours a day, we consider the role of homeless services to best fit with the secondary response in a health model of responding to public intoxication.

9.3 Sobering services

The ERG is of the view that sobering services must be a core part of their recommended model. Sobering services are intended to provide a short-term recovery and detoxification response to acute alcohol or other drug intoxication.

The purpose of this section is to provide more detail on a good practice model of care and workforce and infrastructure requirements for sobering services.

It is expected that a more detailed and responsive model of care will be required for sobering services in areas of high demand or services supporting Aboriginal and/or Torres Strait Islander people or people of other cultural backgrounds. In areas of low demand, a more simplified model may be appropriate, with referral pathways in place for clients with highly complex needs.

Key issues for *n*ew sobering services

Scalability

The type of sobering service models should ‘fit’ with the target population and area. This can involve mobile units with outreach capacity for temporal demand associated with cultural and sporting events, and fixed site services for higher demand regions with more complex needs. Effective implementation of sobering services should consider a core model of care and workforce requirements, associated services pertaining to outreach and transport, and scalability options to ensure capacity meets the local demand.

Integrated care

Some reviews and evaluations note that sobering services may act as a ‘band aid’ to the immediate issues, resulting in the repeated use of these services by more complex clients. Sobering services are

by design a short-term solution intended to provide safety and immediate care but are often not equipped to address longer term needs, such as chronic substance use, mental health issues and homelessness.

Consequently, strong integration of sobering services with local health and human services is key to the success of long-term harm reduction. This requires a response that is co-designed across government and the community to ensure a holistic response to public intoxication. This will ensure the provision of immediate safe and health informed responses to intoxicated individuals, whilst engaging early intervention and support programs.

Establishing safety

All service elements and personnel involved in responding to public intoxication should maximise Aboriginal, cultural, linguistic, gender and sexuality safety.

This is consistent with the design principles for the public health model, and will increase the likelihood of effective engagement, trust-building, disclosure and service uptake. Local communities need to be engaged in and control the development and delivery of sobering services, and core workforce competency training should include cultural awareness and safety. This includes conforming to the six LGBTQI-inclusive practice guidelines.

Evaluation of services

Frequently highlighted in service reviews and evaluations of sobering services are the limitations due to the diversity of approaches (lack of a programmatic approach) and paucity of service and client data resulting from the absence of a data system and/or the lack of a systematic approach to data collection.[11] A systematic approach to evaluation for these services will ensure that effectiveness of the public health response can be measured and early identification of any unintended effects during the implementation phase.

History of sobering services in Victoria

In 1990, the Victorian Government funded eight ACCHOs to establish sobering-up centres to provide information, support and a crisis response for intoxicated clients. The centres were in response to the Royal Commission into Aboriginal Deaths in Custody recommendations that imprisonment should be used as a last resort, non-custodial facilities should be made available for the care and treatment of intoxicated persons, and the offence of drunkenness should be abolished. The Royal Commission supported the establishment of sobering-up centres in Victoria, South Australia, the Northern Territory and Western Australia.

In 2008, a review of Koori Community Alcohol and Drug Resource Services, which included sobering services, was undertaken to understand the program's implementation and strengthen the model of service delivery. At the time there were five sobering- services in Victoria, including four rural and one metropolitan. These comprised:

- Ngwala Willumbong Cooperative in Melbourne
- Gippsland and East Gippsland Aboriginal Cooperative interim service in Morwell
- Gippsland and East Gippsland Aboriginal Cooperative in Bairnsdale
- Rumbalara Aboriginal Cooperative in Shepparton
- Mildura Aboriginal Cooperative.

[11] Miller, P et al, 2018.

The review highlighted a range of concerns with the program, such as:

- difficulties in addressing the full range of client needs
- the need for DHHS to support locally developed strategies addressing public intoxication issues in their community
- addressing occupational health and safety issues for the staff and clients; and
- building workforce capacity.

A number of systemic issues were highlighted by stakeholders throughout the review of the services. The issues highlighted included:

- cultural competence of mainstream AOD services
- lack of coordination by services sharing common clients
- the geographical reach required, particularly in rural settings
- limited funds leading to limitations on staff available for rosters
- workforce issues including recruitment & retention of staff
- limited prevention and early intervention services in the area
- limited medical/nursing support.

Following review processes, most ACCHOs decided to move away from the then 'sobering-up service' model. This included:

- three rural ACCHOs developing local action plans to respond to the availability of new AOD rural nursing program funding and to address areas of program, clients, workforce, and collaboration and partnership. This resulted in reconfigured service responses with a stronger focus on prevention, AOD treatment, integrated service delivery, and workforce training and support
- one rural ACCHO decided to cease the operation of the sobering-up service and use the funding to employ an additional Aboriginal and/or Torres Strait Islander AOD worker
- Ngwala Willumbong Aboriginal Corporation remains the only sobering service available in Victoria, providing an on-call service at a property in Northcote and covering the metropolitan area. However, few intoxicated people are electing to be taken to the Northcote site and consequently the service is mainly focussed on providing transport support. When people have wanted to go back to the Northcote property it is often due to needing emergency accommodation.

Significant changes in the AOD service system since 2008 would place any new sobering services in a different context, which would address some of the previous operational concerns. Those changes include, the growing role of outreach and peer workers, strengthened role for ACCHOs in service delivery and partnerships with mainstream services, and a stronger authorising environment for harm minimisation approaches to AOD use. With appropriate resourcing, use of evidence-informed models of care and integrated service pathways, new sobering services could provide a catalyst to delivering culturally safe, client-centred approaches for clients with multiple and complex needs.

Sobering-up centres – other jurisdictional experiences

The ERG examined the sobering services that have operated or that are in operation today in other Australian jurisdictions. In summary, these sobering services differed significantly in service-offering, staff mix and ratio and scale. Sobering services did not provide a whole of jurisdiction solution and

were generally confined to locations of high demand. In these jurisdictions, the sobering services do not replace protective custody powers and operations whereby some intoxicated persons are incarcerated in police cells. The sobering services, particularly in the Northern Territory and Western Australia, did indicate that such services are sustainable and have experienced ongoing government support.

Models of care

Our examination of sobering services in Australia and internationally found significant variation between centres in terms of opening hours, co-location with detoxification facilities, availability of trained Aboriginal and/or Torres Strait Islander workers and the presence of security rooms for aggressive clients. Individual variation often reflects the local need of the area, as well as the philosophical, religious or cultural beliefs of the organisation that manages it. However, there are key elements that are shared by most sobering-up centres in the literature. These include:

- **intake –** referrals to sobering services are most commonly made by police or community-based patrols that deliver clients to the centre. Emergency department and self-referrals are also accepted by some services, as well as referrals by family, friends or legal representatives. Staff are skilled at engaging and winning the trust and co-operation of the intoxicated person.

  Clients of these services are not detained against their will and are free to leave at any time. If requested, a nominated contact may come collect them. Data is gathered on the individual to register their attendance, and client belongings are removed and recorded for their safe keeping.

- **assessment –** clients are assessed for their level of intoxication, using either physical assessments (e.g. walking in straight line), or a breathalyser test to determine blood alcohol concentration level. A health assessment is performed to identify any clients with medical issues that need to be attended to, and transport to hospital is arranged as necessary.

- **monitoring –** clients are observed at regular intervals in their attendance by staff trained in first aid and in the identification of withdrawal symptoms, with transport to hospital arranged as necessary. Clients with behavioural issues following intake are monitored to ensure the health and safety of personnel, with conflict resolution protocols as required for any disputes between residents.

  Basic needs attended to, including a shower, washed clothes, a clean bed, rehydration/refreshments and an appropriate meal. Clients are often recommended to ‘sleep it off’ but are not obliged to do so. Services that accept both male and female clients have separated dormitories, with a mixed gender workforce to ensure personal care can be provided in a safe environment for the client.

- **further assessment and intervention –** once the client is sober and ready to leave the service, they may be screened using tools such as the Alcohol Use Disorders Identification Test (AUDIT). AUDIT is a 10-item screening tool developed by the World Health Organisation to assess alcohol consumption, drinking behaviours and alcohol-related problems. General health and wellbeing issues are assessed, with brief interventions and referrals for further assistance provided if required. Determination of the operating hours should ensure that all clients receive assessment and intervention services upon departing the service.

  This model of care is the approach that sobering services across Australia and internationally have adopted to deliver effective immediate care for clients. It is recommended that these key elements form the model of care for sobering services in Victoria.

Outreach and transport

Some sobering services provide an ancillary service of street-based outreach teams for the purposes of locating intoxicated people and providing immediate health support. This First Responder role will often offer an associated transport service.

The model of care outlined above incorporates the elements of best practice for sobering services across Australia and internationally. It is recommended that these key elements form the model of care for sobering services in Victoria.

Workforce requirements

Staffing models vary between services, from volunteers with minimal training to multi-disciplinary teams that are led by a nurse practitioner and/or paramedic. Some services have police and/or ambulance staff on duty which may reflect emergency service involvement in the governing partnership.[12] However, all members of staff in a sobering service should as a minimum have qualifications in first aid and cultural competence[13]. Other skills, such as a caring environment with non-judgemental staff was also identified as key for building trust and rapport.[14]

Evaluations of sobering services in Australia and elsewhere highlight the need for effective workforce supports.[15] Effective workforce supports include capacity for de-briefing, formal supervision (individual and/or group) and usual staff development opportunities. Staff employed in the Northern Territory sobering services have identified that regional fora assist in building and strengthening the workforce identity, sharing of good practice and assist with skill development.[16]

The workforce for sobering services should be multidisciplinary and specific to the population and region it serves. Workers may include a mixture of AOD and mental health clinicians, medical practitioners, community and health workers with specialist AOD or social and emotional wellbeing skills, cultural support workers, peer workers and security services. The staffing profile should be considered within the specific context of the service, and with considerations for any implementation challenges, but at a minimum it should include a medical practitioner such as a registered nurse.

The *Victoria's Alcohol and Other Drugs Workforce Strategy 2018-2022*, while focused on AOD services, provides a useful framework to assess these challenges. The strategy considers availability, capabilities, diversity, worker health and safety, leadership and collaboration, and person-centred integrated care as relevant considerations.[17]

Size and capacity

The size and capacity of sobering services in other jurisdictions vary significantly. However, in establishing a new health-based response to public intoxication, Victoria has the opportunity to tailor the size and capacity of its sobering services to anticipated demand in various locations and across

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[12] Moore, SC et al. pre-publication, 2020.

[13] Allen-Kelly K, McArthur M, Thomson L (2006) Evaluation of Centacare sobering up shelter. Australian Catholic University.

[14] Parliament of Victoria (2000) Inquiry into Public Drunkenness. Discussion paper. Drugs and Crime Prevention Committee, October. Available at: https://www.parliament.vic.gov.au/80-dcpc/inquiry-into-public-drunkenness

[15] Department of Human Services, *Review of Koori alcohol and drug services*, Drug Treatment Services Unit, Aged, Community and Mental Health Division, 1997; Department of Health, Victoria, 'Koori Community Alcohol and Drug Resource Service Review: Key Findings'. 2010; Department of Health, NT, 'Review of the Northern Territory Sobering Up Shelters', PwC, 2018; Ward BM, O'Sullivan B & Buykx P 'Evaluation of a local government 'shelter and van' intervention to improve safety and reduce alcohol-related harm' *BMC Public Health*, 18:1370, 2018; Miller, P. et al, 2018.

[16] Department of Health, NT, 'Review of the Northern Territory Sobering Up Shelters', PwC, 2018

[17] Department of Health and Human Services, Victoria (2018) Victoria's Alcohol and Other Drugs Workforce Strategy 2018–2022. Available at: https://www2.health.vic.gov.au/about/publications/researchandreports/victoria-alcohol-other-drugs-workforce-strategy-2018-2022.

the days of the week. The physical size of each will need to accommodate the peak periods and the staffing regime will need to have the ability to scale up and down according to the variations in daily demand which we know to be reasonably predictable.

Critical to designing an appropriate staffing model is the establishment of staff to client ratios that ensure the quality and safety of the service. Whilst we could find no definitive staffing ratio for a sobering service, on the basis of literature and examples from other jurisdictions we recommend that a range between 1:6 and 1:8 would be reasonable starting point, subject to detailed implementation planning for each location and any variations to a core model. This assumes the presence at all times of a health practitioner such as a registered nurse.

The indicative size of the sobering up services that we recommend is addressed below in the discussion of their coverage and availability.

9.4 Assessment of options for places of safety

Table 5 provides a summary and our assessment of possible options for safe places.

Table 5: summary of health infrastructure

Leverage suitability	Option	Geographic location	Operating hours	Staffing mix
Yes*	Hospital Emergency Departments	CBD, suburbs, some regional	24/7	Doctors, nurses, social workers, AOD workers and psychologists available for consults though hours of availability vary
Yes*	Rural trauma and urgent care services (UCS)	Rural and regional	Varies, ranging from seasonal service to 24/7	Varies, the majority do not have designated nursing or medical staff, with nurses coming off the ward as needed. They may or may not have on-call medical support which are local GPs. Larger UCSs (>5000 presentations) have dedicated nurses. Phillip Island, Colac, Djerriwarrah and Portland have designated medical staff.
Yes**	MH/AOD Hubs	Future plan for 6 hubs: CBD, suburbs, Geelong	24/7	Mental health and AOD workers
Maybe	Community Health Services	CBD, suburbs, regional	Extended business hours	Broad range of workers depending on services delivered, can include both health and social worker supports.
Maybe	Public hospitals	CBD, suburbs, regional	Staffed 24/7 Admission generally 9am-5pm	Broad range of medical (including specialists), nursing and allied health staff Regional medical staff may only be available on-call
No	Residential AOD services	CBD, suburbs, regional	Staffed 24/7 Admission 9am-5pm	AOD workers and nurses. Psychologists, social workers and doctors available as required
No	Non-residential AOD services	CBD, suburbs, regional	9am-5pm, some open outside business hours	AOD workers, nurses, psychologists and social workers

Maybe	ACCOs	CBD, suburbs, regional	9am-5pm, some open outside business hours	Varied mix – including doctors, nurses, AOD workers, Aboriginal health practitioners and social workers
No	Homelessness support services	CBD, suburbs, regional	Mix of 24/7 and business hours	Housing support workers, social workers

** Subject to consultation – services/infrastructure may need to be separate from the ED or UCC.*

*** May require additional investment, to ensure capacity (especially at peak times for public intoxication).*

9.5 Differentiated service system responses

The data outlined in Part 1 of this report indicates that differentiated service responses will be required to meet the needs of people who are intoxicated. Key data, such as geographic and time distribution of public drunkenness offences, provide a useful indication of the service system responses that are necessary to meet the variability in demand for safe places.

The Proposed Health Model design should be scalable and adjusted according to changing needs, including responding to seasonal demand variation. Locally developed solutions with engagement of local area stakeholders to determine arrangements considering demographics, timing, location and trends.

As identified above, transporting a person home or to other safe private residences should remain the preferred and default option to help intoxicated people who are low risk.

It is essential that service systems are flexible, cultural appropriate and responsive to individual needs and circumstances.

We recommend the following differentiated approach to the availability and provision of safe places.

Low demand areas

In the vast majority of LGAs (85 percent), the average weekly demand is less than three placements. These low demand LGAs are found within the Melbourne metropolitan area and across regional and rural areas of the state. We propose that low demand LGAs in the Greater Melbourne area can be accommodated by sobering services proposed for neighbouring or close by LGAs.

Our strong view is that in areas of low demand in regional and rural Victoria, the capability of the existing health system can be enhanced to enable medically supervised sobering-up placements.

A new model of care will be required for regional and rural hospitals and other health services to support delivery of sobering services in areas of low demand when it is needed.

A hub-and-spoke network approach could also connect these services to a dedicated sobering service provided in an area of high demand to ensure model fidelity and quality and safety of care. Hub-and-spoke network models are often used in the health sector to increase access to high quality care. Under this approach, one organisation will act as the 'hub' providing a central base for activity and playing a support and coordination role for the spokes. Effective corporate and clinical governance structures and communication strategies promote and support integration between the hub and spokes.

The hub-and-spoke model is often used in rural settings, where larger regional hospitals provide clinical support and leadership to smaller nearby hospitals. This model is particularly useful for services that require a degree of specialisation or where variability in demand means a hospital cannot maintain expertise in certain services.

A hub-and-spoke approach to sobering services should be considered in regional areas to ensure hospitals feel supported in managing intoxicated clients in areas of low demand.

High demand areas

In areas of high demand, there is a lack of capacity in the existing system to offer 24-hour, flexible services to meet the nature of the expected demand. New service options must therefore be developed in order to implement an appropriate health-based response.

We consider that both permanent and temporary or pop-up health services need to be available in LGAs with high demand.

For permanent facilities providing sobering services, these should operate 24-hours a day, seven days a week with capacity to scale up services at peak times. These should be supplemented by pop-up up services responding to demand associated with specific sporting or cultural events.

Tailored, community-based services

Victoria does not have a formal health service role delineation framework. This means that individual health services are relatively autonomous in respect of the services provided to their communities. This also means that a universal approach to the state is not available and a solution for one particular locality may not work in others. In this context, we are of the view that sobering service solutions, particularly for regional and rural locations need to be developed in collaboration with the relevant local health services and communities. Such local collaboration should be an integral component of an implementation approach and be aligned to the approved intent of the reform.

Further development and consultation with each local area will be required on the appropriate location and model of care, including additional infrastructure/equipment, workforce and training needs, and security issues.

There also may be a need for place-based grants for smaller and remote regional areas which cannot readily access a nearby sobering service to develop localised solutions.

9.6 Guaranteeing coverage and availability

To analyse the potential sobering service coverage and availability we utilised geo-spatial and temporal data and advice received from the Crime Statistics Agency coupled with data and advice received from DHHS regarding existing health services, the services that they provide, and their respective locations across the state. The analysis also involved separate examination of the service locations for Greater Melbourne and regional Victoria. This enabled a better appreciation of the service response opportunities and challenges, for the higher demand locations, particularly in Greater Melbourne, as distinct from the lower demand areas in some regional and rural services.

The ERG considered that an indicative benchmark should be applied to determine potential solutions for geographic location of sobering services based on demand and existing health services and related infrastructure. It was considered that a goal of a sobering service being geographically accessible within a vehicular travel time of approximately 30 minutes should be used as a guide to determine the suitability of existing service facility locations. This means that if an intoxicated person was to be transported from the public location they are in, to a sobering services facility, that trip should not exceed approximately 30 minutes. It is accepted that this should not be a hard and fast rule but should be considered as a planning guide that would demand further analysis and consideration in circumstances where the estimated travel time would be considerably more than the 30-minute guide.

We examined the range of existing and proposed health services that could have a role in providing a sobering service. For the high demand LGAs we were of the view that the proposed Mental Health and AOD Hubs represent the most suitable sobering service option. The ERG considers the proposed hubs intended for Melbourne and Geelong public hospitals present as excellent opportunities to incorporate a sobering service function under this reform. In furtherance of this consideration, the locations of these proposed hubs were examined to determine relative proximity and suitability to meet the demand arising from community locations in Greater Melbourne and Greater Geelong.

Greater Melbourne

In Greater Melbourne, hubs are proposed for hospitals in Melbourne CBD (Royal Melbourne and St Vincent's), Western, Monash and Frankston. LGAs in Greater Melbourne were mapped to these hubs on the basis of applying the 30-minute travel guide. This analysis indicated that the hubs were well placed in terms of proximity to meet the anticipated demand, with the exception of the northern metropolitan area. This area covers the north and north east of Melbourne, which includes the LGAs of Hume, Darebin, Whittlesea, Banyule and Nillumbik.

Also included are major growth corridors to the north and north-east. Here, in the absence of a hub being established in this region, we see the opportunity to substantially expand and relocate the existing Ngwala Willumbong Sobering Service into a major sobering service catering to this part of Melbourne. The ERG recommends that sobering services should be established in each of the six new Mental Health and AOD Hubs and that the Ngwala Willumbong Sobering Service be relocated and substantially expanded to service Melbourne's northern region. This would provide for a network of sobering services that would meet the anticipated service demand and proximity guide for sobering services across Greater Melbourne.

Table 6 describes the mapping of LGAs to specific hubs in Greater Melbourne and Greater Geelong. From a demand perspective the average annual, weekly and daily caseloads for LGAs are attributed to those hubs. The Melbourne CBD demand has been evenly split between the Royal Melbourne and St Vincent's hospitals. It is considered that collaborative arrangements should exist between hubs to provide relief to hubs experiencing high demand through spreading some caseload to other hubs where travel times and other circumstances suit. However, hubs should be established to be capable of meeting reasonably predictable surge demands.

As previously described, Friday and Saturday nights represent peak demand for sobering services. In the context of resourcing and demand implications, the total weekly caseload was attributed to Friday and Saturday nights, and Saturday night alone. It is not anticipated that the weekly caseload would represent the demand for a Saturday night. However, it does give insights into what may be reasonably expected as an absolute maximum demand for a hub. It is considered that attributing the weekly caseload to Friday and Saturday nights alone would be more a more reliable and insightful indicator of demand limits. On this basis, we calculate that the daily maximum service capacity will vary between 10 and 25 contemporaneous placements, according to the anticipated demand in each location.

Table 6: Mapping of LGAs to specific hubs

	Annual cases	Av weekly	Av daily	All split between Fri/Sat	All on Saturday
MONASH					
Greater Dandenong	490				
Maroondah	136				
Casey	133				
Monash	97				
Yarra Ranges	95				
Knox	90				
Cardinia	62				
Manningham	20				
Whitehorse	71				
	1194	22.9	3.27	11.48	22.96
FRANKSTON					
Mornington Peninsula	364				
Frankston	307				
Bayside	60				
Kingston	164				
	895	17.21	2.45	8.61	17.22
St VINCENTS					
Melbourne (half)	889				
Port Phillip	347				
Yarra	319				
Stonnington	264				
Glen Eira	127				
Boroondara	75				
	2021	38.87	5.54	19.43	38.86
NORTHERN					
Hume	113				
Darebin	95				
Whittlesea	45				
Banyule	51				
Nillumbik	11				
	315	6.06	0.86	3.03	6.06
ROYAL MELBOURNE					
Melbourne (half)	890				
Moonee Valley	111				
Moreland	107				
	1108	21.31	3.04	10.65	21.3
WESTERN					
Maribyrnong	140				
Brimbank	140				
Wyndham	113				
Melton	42				
Hobsons Bay	62				
	497	9.56	1.36	4.78	9.56

	Annual cases	Av weekly	Av daily	All split between Fri/Sat	All on Saturday
GEELONG					
Geelong	322				
Surf Coast	18				
Queenscliff	1				
	341	6.56	0.9	3.27	6.56

Transition arrangements discussed later in this report should include more analysis of demand with the view to refining infrastructure and resourcing decisions for broader implementation.

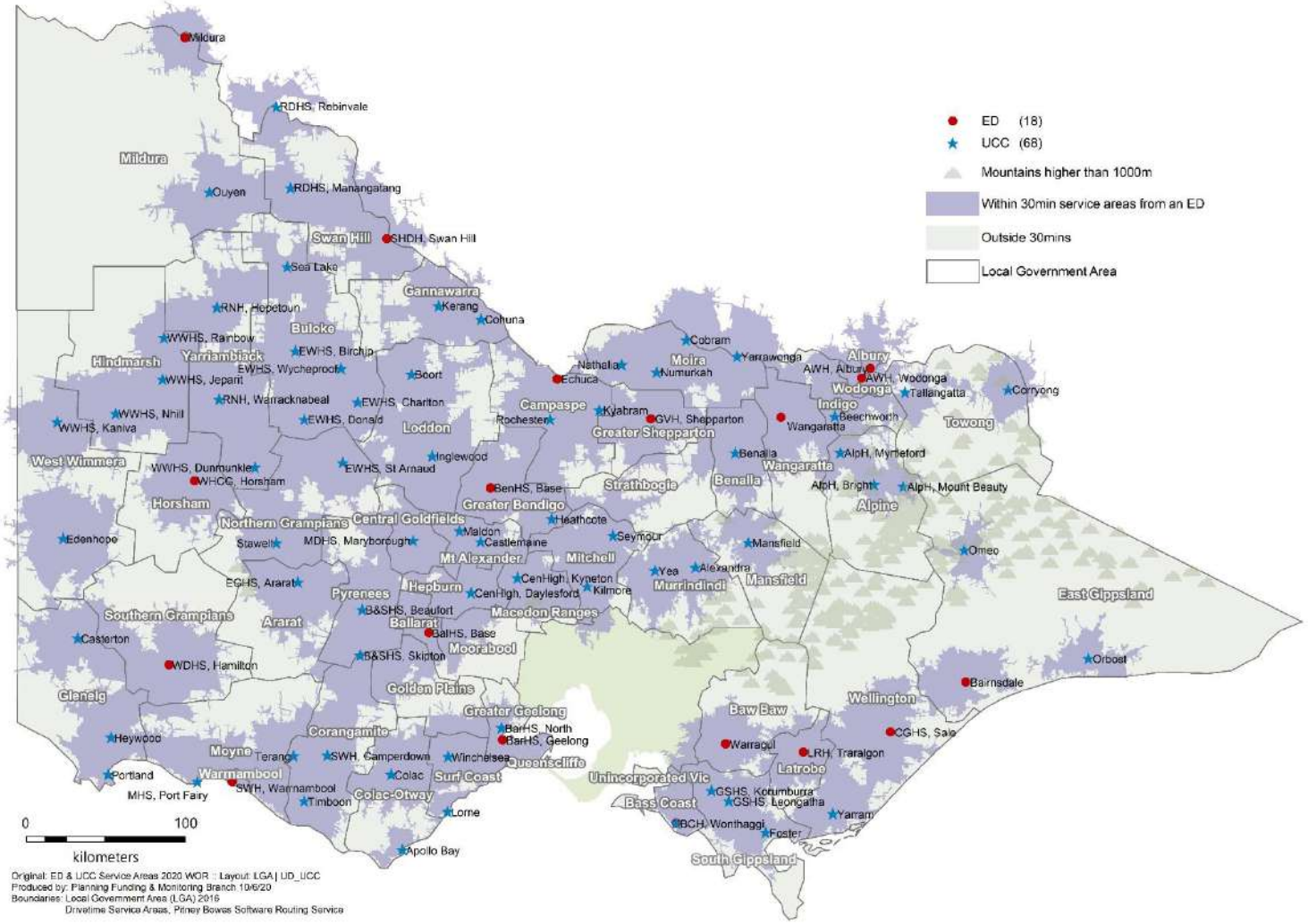
Regional and rural Victoria

It is understood that expansion of Mental Health and AOD Hubs more broadly across the state, including regional and rural locations, provide an opportunity to address sobering service needs.

We also understand from data provided to us by DHHS that many regional areas are within 30 minutes of an emergency department or urgent care centre (see Figure 5). Utilising these health networks would ensure that the vast majority of people in regional and rural Victoria would have reasonable access to a sobering service. East Gippsland and the west of Mildura are key areas that would require more localised solutions.

In summary, we believe that the Mental Health and AOD Hubs model needs to be extended to incorporate a sobering service function and that the existing Ngwala Willumbong Sobering Service be expanded to service Melbourne's northern region. This represents a solution to address the high demand locations. In time, any extension of Mental Health and AOD Hubs to regional centres should consider the incorporation of sobering services. For regional and rural locations, a range of service options exist that are achievable. The regional and rural locations are also well placed to develop sobering service solutions through collaboration between relevant local health services and communities. Such local collaboration should be an integral component of an implementation approach and be aligned to the approved intent of the reform.

Figure 5: Travel times to nearest emergency departments and urgent care centres in regional Victoria: LGA (2020)



Recommendation

39. The Victorian Government ensures intoxicated people who pose a safety risk to themselves and/or others should, in general, be transported to one of three safe place locations to sober up, including to:
    a) their home or other private residence where it is determined that the individual is at low risk and can be adequately and safely cared for by family or friends
    b) an emergency department or rural trauma and urgent care centre where it is determined the individual requires urgent medical assessment and/or care; or
    c) a health or sobering service where it is determined the individual does not require emergency care but still requires a short period of recovery and detoxification and/or cannot be cared for safely elsewhere.
40. The Victorian Government ensures that a home or other safe private residence remain the preferred and default safe place option to assist people with sobering needs. Wherever possible and appropriate, an intoxicated person should be safely cared for by family or friends in order to minimise the impost on health services. Additionally, people who reside alone should not by default be taken to a sobering service simply because they do not have someone to care for them.
41. The Victorian Government ensures the key elements of Intake, Assessment, Monitoring, Further Assessment and Intervention form the model of care for sobering services in Victoria that comprises:
    a) outreach and transport services as a key element of a model of care for sobering services in Victoria.
    b) the workforce for sobering services should be multidisciplinary and at a minimum including a health practitioner, such as a registered nurse, and reflect the profile and the needs of the population and region it serves
    c) a staff to client ratio between 1:6 and 1:8, which would be a reasonable starting point subject to detailed implementation planning for each location and any variations to a core model.
42. The Victorian Government considers modular health spaces as an infrastructure approach to trialling heath responses as part of the proposed implementation phase given that they are an increasingly accepted part of the health infrastructure mix, offering expanded capacity that can be deployed rapidly and flexibly to meet need.
43. The Victorian Government expands the Mental Health and AOD Hubs model of care to enable them to provide sobering services as part of their model of care. This may require additional government investment above that initially allocated.
44. The Victorian Government supports the re-location and substantial expansion of Ngwala Willumbong Sobering Service to service Melbourne's northern region which will require additional government investment.
45. The Victorian Government considers whether the rural trauma and urgent care centres could be an effective option for provision of sobering services, and if so, infrastructure may need to be boosted to provide dedicated sobering up placements, where required.

46. The Victorian Government enhances the capability of the existing health system in areas of low demand in regional and rural Victoria to enable medically supervised sobering up placements.
47. The Victorian Government establishes both permanent and pop-up sobering services in LGAs with high demand. The permanent services should operate 24-hours a day, seven days a week with capacity to scale up services at peak times.

9.7 Consent to medical treatment

Informed consent is considered the cornerstone of the clinical-patient relationship and a patient's right to autonomy should be respected and steps taken to ensure consent is truly informed.

The ERG has extensively considered the issue of consent in the context of receiving a service. This issue is considered above in relation to the provision of health treatment at the First Responder stage but also arises in the context of receiving a health service at the safe place options considered in this section.

Sobering services

In moving to a public health model for public intoxication, we recognise that there may be some circumstances where an individual may refuse treatment at a sobering service. This may be due to both the individual being unable to make an informed decision due to intoxication or where there is a legitimate concern expressed by the individual. For example, some Aboriginal and/or Torres Strait Islander clients may refuse to be treated at a local health facility due to distrust of mainstream services.

It is important that First Responders and sobering services establish a model of care which strongly encourages clients to use sobering services and provides a welcoming and safe environment. All necessary steps should be taken to minimise the number of individuals who may refuse treatment.

Consistent with the consent-based model we propose, our strong view is that admission to a sobering up facility should be voluntary. Providing detention powers for sobering-up centre staff may jeopardise trust and the relationship between staff and a person who needs care and treatment, including fundamentally changing the power dynamics. Furthermore, people may become apprehensive of sober-up centres where there is a possibility they will be detained against their will. Staff and management at sobering-up centres have generally expressed a reluctance to the creation of powers to detain.

Emergency departments and hospitals

Consent is required to provide medical support services to publicly intoxicated individuals unless they need emergency treatment. Health services (except in cases of emergency medical treatment) rely on an individual's voluntary engagement. Under the *Medical Treatment Planning and Decisions Act 2016*, emergency treatment is medical treatment that is necessary as a matter of urgency to:

- save the person's life
- prevent serious damage to the person's health or
- prevent the person from suffering or continuing to suffer significant pain or distress.

For individuals that continue to refuse treatment, involuntary measures may need to be taken for the safety of the person and the community. We consider that cases involving intoxicated persons refusal

of care will be rare. However, we have recommended earlier in this report that police cells will not be an option for detaining intoxicated person. Consistent with that recommendation, we are of the view that should an intoxicated person refuse treatment at a sobering service, police should not be engaged for the purpose of finding a detention solution. We are of the view that this problem should be addressed in a health setting.

We understand that the detention of involuntary people in a health context is a significant issue and will involve some level of cultural concern. We are aware that the issue of the compulsory treatment is provided for in some serious settings, for example, a provision in the *Mental Health Act 2014* that allows for detention for the purpose of treatment. Such precedents apply to the most serious circumstances and are considered a last resort option to enable critical care. We have given significant consideration to the range of risks that could exist in a sobering up setting and how they may be mitigated. We have formed the view that, if an intoxicated person does not consent to treatment and poses a serious and imminent risk to themselves or others should they leave the health setting, then a power to detain them is necessary.

We are of the view that the threshold for the power to detain should be to address a serious and imminent risk posed by intoxicated persons to their own safety or the safety of others.

As previously discussed, sobering services should be aligned to emergency departments and public hospitals under hub-and-spoke arrangements that are used in the health sector. They are particularly suited to rural locations where a comprehensive and specialised suite of health services may be less accessible. It is considered that, as a last resort, in circumstances where consent is not provided and there exists a serious and imminent risk of harm to the intoxicated person or the public, that a sobering service should be able to apply to an emergency department, public hospital or other local health service for an order permitting the detention of the intoxicated person. Such a power should be subject to strict safeguards and oversight.

Discharge

Discharge against medical advice is a small but common problem in hospitals. Clients may choose to discharge themselves if they do not agree with the treatment proposed by the hospital. Hospitals should have policies and procedures in place covering the steps that should be taken to ensure clients have adequate information regarding the risk of discharge.

In scenarios where a competent client discharges themselves and consequently suffers adverse outcomes, part of the blame for any medical negligence would be attributed to the client. The extent of this contribution would be determined based on the capacity of the client to make an informed decision at the time and documentation by the hospital of steps taken to ensure the client understood the risks.

Proposed approach

As identified above, informed consent is central to the clinical-patient relationship and to the ERG's Proposed Heath Model. Detention and the use of restraint in the context of providing health care to an intoxicated person should always occur as a last resort.

A clear framework must be developed on the use of restraint in support of the decriminalisation of public intoxication. The framework should be developed with input from clients, organisations and staff, and include a focus on continuous quality improvement to minimise its use.

The framework should consider the following elements:

- restraint is only used in line with the definition of an emergency under the *Medical Treatment Planning and Decisions Act 2016*

- hospitals require tools to ensure adequate documentation for the reason and authorisation of restraint
- clinical guidelines to support decision making for use of restraint, including guidance as to the level of intoxication which may suggest a client has lost their capacity for consent
- recognition that the client's inability to consent will be temporary, and consent may be withdrawn or change where a client has sobered to the point that they can make an informed decision
- rates of use of restriction for public intoxication are monitored and reported to appropriate oversight committees
- development of a review mechanism to assess decision making in relation to the use of restraint
- respect the rights of clients to make informed decision that may be detrimental to their health
- include proactive strategies to de-escalate aggressive situations, encourage consent for treatment or seek consent from an appropriate guardian or next of kin.

Recommendation

Consent to medical treatment

48. The Victorian Government establishes a legislative basis for medical practitioners to apprehend or detain an intoxicated individual, where they do not consent to treatment, in strictly limited circumstances.
    a) The Victorian Government defines intoxication within the legislation as 'affected or apparently affected by alcohol or a drug or other substance to such an extent that there is a significant impairment of judgement or behaviour.'
    b) The Victorian Government ensures that limits for the threshold for medical intervention with regard to someone who is intoxicated is serious and imminent risk of significant harm to the intoxicated individual or other individuals.
    c) The Victorian Government explores the appropriate assessment of this threshold which should have an objective element, such as a reasonable person test.

Safeguards

49. The Victorian Government legislates to ensure detention ceases at the moment that the threshold of serious and imminent risk is no longer met, whether this is due to a change in the environment or the person's personal circumstances (e.g. their degree of intoxication has sufficiently decreased).
50. The Victorian Government ensures health practitioners are required to regularly assess the ongoing need for detention, including upon admission if detained during transport and through regular assessments of whether informed consent can be secured.
51. The Victorian Government ensures detention for the purposes of the sobering of an intoxicated person should be a last resort and is limited by appropriate safeguards.
52. The Victorian Government considers the matters highlighted in the *Restrictive Interventions in Victorian Emergency Departments: A Review of Current Clinical Practice* commissioned by the Department of Health and Human Service must be addressed.
53. The Victorian Government ensures medical practitioners exercise their powers to give effect to the least restrictive means of achieving their objective, in terms of both the decision to detain

and the nature of the restraint, in accordance with the *Victorian Charter of Human Rights and Responsibilities Act 2006.*

54. The Victorian Government implements robust safeguards, including comprehensive legislation, regulations, guidelines, and policies and procedures on the operationalisation of the legislation. This is to ensure, for example, that medical practitioners use sedation and other chemical and mechanical restraints on intoxicated people appropriately.

55. The Victorian Government ensures that medical practitioners:

    a) maintain appropriate written records, including the reasons for the order, the period for which the person is ordered to be detained, the monitoring regime, treatment provided, restraints used and reasons, and discharge

    b) to the extent reasonably possible inform the person of the reasons for the detention and their applicable rights

    c) take reasonable steps to notify the person's nominated person, guardian or carer of their admission or detention; and

    d) provide the reasons for detainment and/or the use of restraint in writing to the person upon their discharge/release.

Independent Oversight

56. The Victorian Government empowers an oversight body, such as the Victorian Ombudsman, to adjudicate complaints and conduct investigations in relation to the implementation and operation of these reforms. This should include oversight of detention conditions and treatment of detained people, as well as use of mechanical and chemical restraints

57. The Victorian Government, in accordance with OPCAT obligations, enables the National Preventive Mechanism to have oversight when intoxicated people are deprived of their liberty, including when they are detained and/or restrained in hospitals.

9.8 Workforce requirements

Evaluations of sobering services in Australia and elsewhere highlight the need for effective workforce supports. Effective workforce supports include capacity for de-briefing, formal supervision (individual and/or group) and usual staff development opportunities. Staff employed in Northern Territory sobering services have identified that regional fora assist in building and strengthening the workforce identity, sharing of good practice and assist with skill development.

The workforce for sobering services should be multidisciplinary, at a minimum include one health practitioner such as a registered nurse and reflect the population and region it serves. Workers may include a mixture of AOD and mental health clinicians, health practitioners, community and health workers with specialist AOD or social and emotional wellbeing skills, cultural support workers, peer workers and security services. The staffing profile should be considered within the specific context of the service, with considerations for any implementation challenges.

Safety for the workforce must remain paramount, including at sobering services and during outreach, which need careful planning and support. Safe work practices for staff and volunteers are critical within sobering services, especially at night-time or in volatile situations. Most sobering services, both in Australia and internationally, do not make use of security staff. Given the nature of services, we consider that staff should have adequate training in de-escalation, cultural competency and the

general needs and behaviours of their client cohorts. Within hospital settings, existing security arrangements should be capable of meeting the needs of any “bolt on” services associated with hospitals and emergency departments.

The *Victoria’s Alcohol and Other Drugs Workforce Strategy 2018-2022,* while focused on alcohol and other drug services, provides a useful framework to assess these challenges. The strategy considers availability, capabilities, diversity, worker health and safety, leadership and collaboration, and person-centred integrated care as relevant considerations.

10. Stage 4: Health and social care pathways

Key points

- A significant minority of people who present intoxicated in public more frequently are likely to be experiencing complex health and welfare challenges that are contributing to their drinking patterns
- A key element of an effective public health approach to public intoxication is access to follow-up or ongoing support. Service pathways including AOD, mental health, Aboriginal social and emotional wellbeing, family violence, and homelessness services could be supported by 24-hour support lines, local arrangements and/or a dedicated service navigator
- Targeted approaches to support particular individuals and groups to address underlying issues that contribute to drinking patterns is a key component of a health-based approach.
- There are major gaps in AOD services for Aboriginal and Torres Strait Islander people.
- A specific adult AOD program under the Wotha Daborra model will be established providing an Aboriginal-specific adult withdrawal and rehabilitation service which aims to provide a culturally responsive, family supported, place-based response to alcohol and other drug use in other Aboriginal communities
- New Aboriginal Social and Emotional wellbeing teams being established under the Royal Commission into Mental Health include AOD expertise with team functions expanded to support the new public health reform for Aboriginal and Torres Strait Islander people where appropriate.

A key element of an effective public health approach to public intoxication is access to follow-up or ongoing support. As outlined in the data Section in Part 1, a significant minority of people who present intoxicated in public more frequently are likely to be experiencing co-occurring wellbeing or social challenges. This points to the need and imperative to support the broader health and wellbeing needs of the high intensity cohort of people experiencing public intoxication, who very often experience quite complex health and welfare challenges that are contributing to their drinking patterns.

Targeted approaches to support particular individuals and groups to address underlying issues that contribute to their drinking patterns is a vital component of a health-based approach to public intoxication that seeks to minimise the need for tertiary interventions.

We make a number of observations and recommendations designed to support individuals to access follow-up or ongoing support after they have left a place of safety following an occurrence of being found intoxicated in public, including:

- **AOD, mental health, Aboriginal social and emotional wellbeing, family violence, and homelessness services are the core potential service needs explored in this paper –** these are consistent with the government's August 2019 announcement. Other services are likely to be identified as worthwhile pathways for inclusion at the local level and through the proposed transition phase
- **safety and non-judgement will make pathways attractive –** all services and personnel involved in responding to public intoxication should maximise Aboriginal, cultural, linguistic,

gender and sexuality safety (particularly in a manner responsive to their local area). This will increase the likelihood of effective engagement, trust-building, disclosure and service uptake, and is consistent with agreed design principles for the public health model.

Shame and stigma are often felt by people experiencing issues such as acute intoxication, addiction, mental health problems, family violence, homelessness or poverty. A public health model for public intoxication should recognise the real impact of these phenomena, eliminating them from service practice without assuming their effect can be nullified.

- **all core personnel and services should be able to identify and respond to need –** this includes undertaking health, safety and wellbeing assessments, and taking appropriate action. Core personnel are outreach, transport and sobering services workers, as well as Victoria Police (which has an established e-referral system) and Ambulance Victoria.

  While each geographic area should have minimum capability, at the local level, some personnel or service elements will be better placed to undertake assessment, information and referral activities. This may be for operational reasons – e.g. critical demand pressures on police or ambulance services – or because of enhanced cultural safety or practice specialisation within other elements of the service model.

  In relation to AOD needs, it is recognised that some people use alcohol with other drugs, (e.g. illegal substances or medication prescribed or otherwise). The identification of people who are intoxicated in public – and therefore in scope for the public health model – will be based on observation and engagement; it will not be possible to ascertain precisely what someone has consumed. The public health model will need to incorporate poly-substance responses into all elements, noting that this may alter health, safety or wellbeing assessments and therefore the support provided to a given client

- **engagement and trust-building is the first priority –** the potential diversity of need is significant, but clear information may be challenging to obtain while a person remains intoxicated. For a voluntary service the focus should be on maintaining safety and trust, minimising undue pressure on clients, and avoiding escalation of risk.

  This will be particularly true as Victoria's new approach to public intoxication becomes known and established in communities across the state

- **identification of need should be based on engagement, observation and handover, and may be ultra-brief –** a flexible and adaptive approach to identifying need will be required to reflect the variable service settings, personnel and duration of interactions. For example, where a person is being transported home instead of to a sobering service, only information provision (e.g. printed, text-message or online information, if safe to provide) may be feasible.

- **needs should be triaged pragmatically and collaboratively with a client, wherever possible –** a service oriented around public intoxication should not necessarily prioritise AOD or even mental health needs (unless these are acute, in which case transport to hospital may be necessary). Finding a place of safety – for example for someone who is homeless or escaping family violence – may well be a person's primary interest.

  The triaging of any support needs should ultimately be determined by the client; this may be influenced by the client's own priorities or previous experience with services, which should be respected and drive decision-making

- **service pathways could be supported by 24-hour support lines, local arrangements and/or a dedicated service navigator –**

  <u>24-hour support lines</u>

Public intoxication services are likely to experience the overwhelming majority of demand outside of usual business hours. Where a health, safety or wellbeing need is identified and the client agrees to some form of further action – e.g. receipt of information, passive referral, warm referral – a number of 24-hour support lines will be available, including:

- AOD: Directline: screening, intake and referral for AOD support (including Aboriginal AOD services)
- Mental health services: Psychiatric triage – mental health assessment and referral (area-based)
- Homelessness: Salvation Army Crisis Services (out-of-hours)
- Family Violence: Safe Steps Family Violence Response Centre
- Djirra: Family violence support for Aboriginal and/or Torres Strait Islander people.

Each of these services has the benefit of being a state-wide, 24-hour service with specialist expertise.

Local arrangements – outreach and sobering services

Local outreach and sobering services may prefer to establish direct connections with services at the local level. This approach may be most feasible and appropriate:

- for sobering services, which could accommodate people overnight and then, once a person has sobered up, support them to access critical services (especially homelessness and family violence, and potentially also residential withdrawal)
- for Aboriginal and/or Torres Strait Islander Victorians seeking access to specialist support via a local Aboriginal community-controlled organisation
- to help reconnect people with any existing, positive service or practitioner relationships (if volunteered by the client).

Dedicated service navigation function

Given the diversity of support needs and service pathways potentially required for higher-intensity clients, we consider a navigation service (likely telephone-based) that would work with on-the-ground services to undertake service referral and coordination functions. This could allow outreach and sobering services to focus on immediate demand (transport, safety and engagement) rather than 'back office' functions such as arranging service pathways. If recommended, this function would require effective information-sharing and coordination protocols with existing 24-hour support lines and other intake services.

A key factor in whether this kind of service is needed will be the gap between identified follow-up need and actual uptake by clients. It may be that the immediate post-intoxication period is not a valuable window of opportunity for engaging people (the experience in hospital emergency departments varies in this regard). This could be tested as part of the transition phase, with a future recommendation made about the need for a service navigation function

- **a bespoke, comprehensive workforce support package could be developed to support this model of care and ensure consistent minimum standards –** we consider that a bespoke practice and training package – including clinical, social and operational components – be developed to support both minimum and specialist capability. The training package should be adaptive, incorporating lessons identified through the proposed transition phase.

Recommendation

58. The Victorian Government ensures that a comprehensive service system is capable of supporting the broader health and wellbeing needs of the high intensity cohort of people, who very often experience quite complex health and welfare challenges that are contributing to their drinking patterns.

10.1 Investment in Aboriginal alcohol and other drug services

In moving to a public health model for public intoxication, demand for AOD services is expected to flow from new outreach teams, sobering services, and First Responders such as Victoria Police and paramedics. In the context of Ms Day's death in custody, and the over-representation of Aboriginal and/or Torres Strait Islander people in both the high and low intensity cohorts of people placed in custody for public drunkenness offences, there is high community expectation for the delivery of Aboriginal-specific sobering-up capacity and Aboriginal-specific AOD drug treatment services to support these reforms deliver improved outcomes for the community.

DHHS currently funds a range of alcohol and other drug activities for Aboriginal and/or Torres Strait Islander Victorians, including approximately 90 Aboriginal AOD workers who provide assessment, counselling, care coordination, group work including therapeutic cultural groups, health promotion, education, information, referral, advocacy and liaison services.

However, gaps in AOD services for Aboriginal and/or Torres Strait Islander Victorians remain, including the lack of a dedicated adult AOD program for Aboriginal Victorians, poor youth diversion pathways and the need to expand prevention and harm reduction approaches to drug use of primary concern to the Aboriginal community, such as alcohol and ice. A Victorian based service would enable clients to undertake rehabilitation, whereas in existing circumstances they are often prevented from doing this due to personal circumstances such as being subject to Community Corrections Order, parole, bail and involvement in the child protection system.

DHHS has provided financial support to the Koori AOD Withdrawal and Rehabilitation Consortia to establish a business case for a new and culturally informed model of care for AOD services for the Victorian Aboriginal Community, known as the Wotha Daborra model. The business case supports the development of Victoria's first Aboriginal-specific adult withdrawal and rehabilitation service which aims to provide a culturally responsive, family supported, place-based response to alcohol and other drug use in the Aboriginal community. It will offer holistic support and a wrap-around response, which includes AOD treatment, as well as access to life skills, parenting skills, health care, family therapy, education, training and employment, and housing options for individuals and families. Clients will experience improved social and emotional wellbeing by integrating cultural values, spirituality and healing with a range of evidence-based treatment interventions.

The Wotha Daborra model aligns with the upcoming expansion of multidisciplinary Social and Emotional Wellbeing teams in ACCHOs as part of recommendations from the Royal Commission into Victoria's Mental Health System.

During the next five years, social and emotional wellbeing teams will be expanded across the state and provide integrated care which addresses clients' social and emotional wellbeing. Social and Emotional Wellbeing teams are expected to include a range of specialist expertise as relevant to local community needs, including AOD workers.

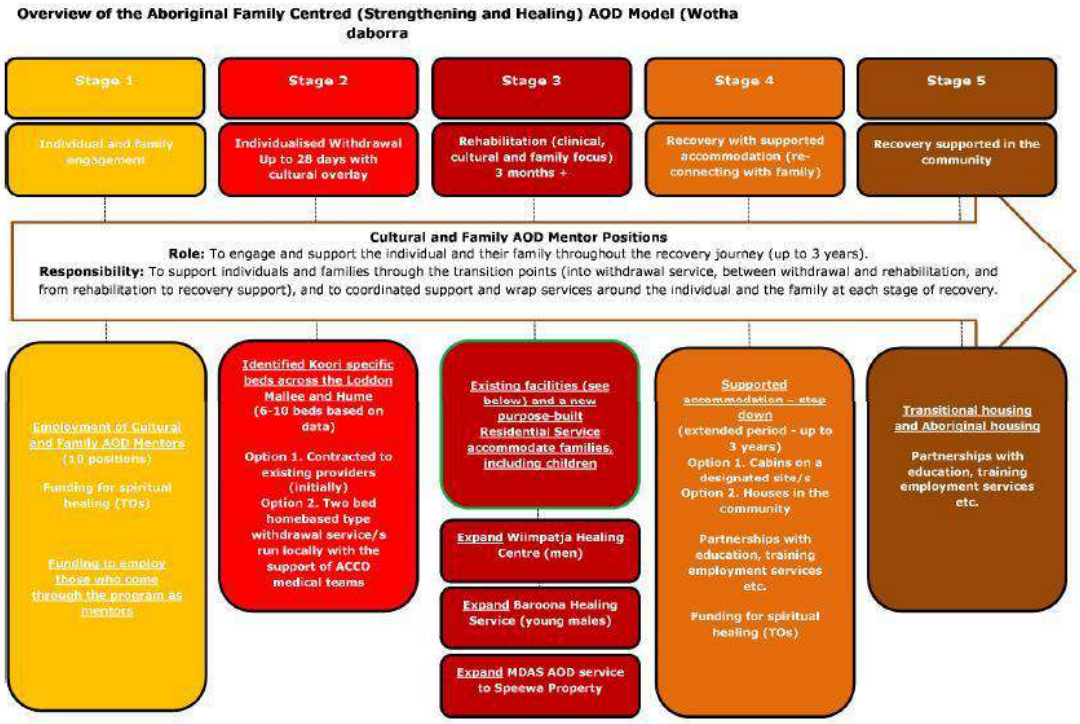
There are opportunities to leverage off the government's commitment to invest in Social and Emotional Wellbeing teams to also achieved improved outcomes for Aboriginal and/or Torres Strait

Islander Victorians engaged in public intoxication. A strong commitment to incorporating alcohol and other drug workers into the new Social and Emotional Wellbeing teams, with practices aligning to the family centred, traditional values approach in the Wotha Daborra model, will provide a high quality referral option for Aboriginal and/or Torres Strait Islander sobering service clients to address their alcohol and mental health needs.

DHHS continues to work with the consortia to develop and cost the model for government's consideration.

The ERG recognises that reforms to public intoxication also requires the development of pathways into treatment for clients who are identified as having problematic alcohol use (that is, the high intensity cohort).

Figure 6: Wotha Daborra model



Recommendation
59. The Victorian Government establishes a specific adult AOD program for Aboriginal and/or Torres Strait Islander Victorians prior to the end of the implementation phase, with Wotha Daborra considered for further development as part of this process.
60. The Victorian Government ensures that all Social and Emotional Wellbeing teams include AOD expertise (a position outlined by the Royal Commission into Victoria's Mental Health System) and that the role of the teams be expanded to support the government's public intoxication reforms for Aboriginal and/or Torres Strait Islander Victorians where appropriate.

11. Stage 5: Broader prevention strategies

Key points

- Broader prevention strategies to address the underlying causes of high-risk drinking and harm minimisation approaches form a key part of a public health approach to public intoxication
- Public awareness campaigns focused on primary prevention health initiatives that relate to the prevention of public intoxication play an important role in a public health approach
- Community strengthening programs are important to support local communities and specific groups and their leaders to develop tailored place-based solutions, particularly in high demand areas.

In addition to measures to address the longer-term needs of people experiencing problematic drinking, we consider that a range of broader prevention strategies form a key part of a public health approach to responding to public intoxication.

Victoria's *Public Health and Wellbeing Plan 2019-23* sets the direction for action across state and local government, the health and wellbeing sector and the community at large to achieve sustained improvements in the health and wellbeing of all Victorians.

The plan identifies a reduction in harmful alcohol and other drug use as one of 10 priorities for achieving the objects of the *Public Health and Wellbeing Act 2003*, and specifically targets:

- changing risky drinking cultures and delivering environments that support low-risk drinking
- better outcomes for those who access treatment, reducing harm (such as overdose, drug-related illness) and improving social outcomes (such as employment, stable housing and family reunification)
- improved capability of primary care providers to assist people to manage alcohol and other drug-related issues before treatment is required or complexity develops
- increased capability in all service systems including mental health, housing, child protection and family violence to assist people with alcohol and other drug-related issues.

We recognise that VicHealth as an independent statutory authority also plays an important role in health promotion. 'Preventing harm from alcohol' is one the five strategic imperatives in VicHealth's three-year Action Agenda for Health Promotion, with key activities including working with partners in state and local government, universities and community and sporting groups to highlight the harms of alcohol, the benefits of drinking less and the evidence for why and how. In the four years between 2019 and 2023, VicHealth's aim is to prevent harm from alcohol products with a focus on changing risky drinking cultures and enabling environments to support low-risk drinking.

This includes:

- supporting organisations and local communities to design interventions for high-risk drinking social worlds
- providing councils with tools and evidence to add value and support their efforts to reduce alcohol-fuelled harm at the local level

- providing legal policy capacity to the alcohol harm-prevention sector
- engaging the public and stakeholders to harness community support for better regulation of alcohol marketing and sales
- consulting with its advisory body, the VicHealth Alcohol Taskforce, and other stakeholders to identify priority research required to inform our future strategies and deliver this with research partners.

Clearly, many of these important initiatives play a critical role as part of a comprehensive public health approach to public intoxication, including by addressing the underlying causes of problematic drinking and minimising its potential impact in public spaces. While the focus of our work has been on public intoxication, we also wish to acknowledge the significant impact on the community of problematic drinking in private, including the role that alcohol plays in family violence as well as the broader health impacts of harmful drinking. In this respect, broader prevention strategies play an important role in minimising the dangerous consequences of both public and private intoxication.

We also make specific reference to the fact that operators of licensed premises have a range of legal and regulatory obligations relating to the responsible service of alcohol and interactions with people who may be intoxicated and/or disorderly. The ERG considers that liquor licensees' have an important role to play with respect to avoiding, as well as minimising, the risks associated with public intoxication, particularly given the majority of public intoxication occurs in entertainment precincts on weekends and during one-off events such as festivals.

In addition to specific health promotion activities, we recognise that a range of other strategies can contribute to addressing the underlying causes of public intoxication and reducing harm in high demand areas. These include:

- supporting people experiencing multiple and intersecting problems, such as homelessness, drug dependency and mental health (as discussed throughout this report, including in Stage 4: Health and social care above); and
- community strengthening programs to support local communities and specific groups and their leaders to develop tailored place-based solutions to the prevention of public intoxication, particularly in high demand areas.

Recommendation
61. The Victorian Government continues to support and expand where necessary public awareness campaigns focused on primary prevention health initiatives that relate to the prevention of public intoxication, including the work of VicHealth.

12. Implementation considerations

Key points

- To ensure that the failures that occurred when other jurisdictions decriminalised public drunkenness do not occur under these reforms, great attention will need to be given to their implementation
- In light of the complexity involved in the development of the Proposed Health Model a phased implementation over two years is appropriate. This will enable the model to be trialled and state-wide service infrastructure put in place before full decriminalisation takes effect
- Two new governance arrangements are important for effective implementation including: an implementation office to drive the operationalisation of the model and a specialist oversight committee to ensure the implementation and ongoing operation of the model reflects the intent of these reforms
- A key task during implementation will be to ensure that cultural safety considerations are at the front and centre of the design and operation of all service responses
- As highlighted throughout our report, an effective health-based response necessitates appropriate resourcing of all components of the model that reflects the essential interdependency of the Proposed Health Model.

The decriminalisation of public drunkenness is a significant reform that requires major cultural and service change to the way First Responders and health services support intoxicated people. Successful implementation of any reform is a major challenge for government.

We are especially concerned to ensure that the health-based model outlined by the ERG is implemented in a way that is consistent with the reform's intended purpose. As identified in Section 5: Experiences of decriminalisation in other of this report, experience in other Australian jurisdictions demonstrates that decriminalisation of public drunkenness without the necessary health system responses in place can and has led to unintended and significantly detrimental consequences.

This section outlines a number of key considerations relating to the effective implementation of our proposed reforms.

12.1 A phased transition

In light of the scale and complexity involved in the development of a health-led response to public intoxication, we consider that a phased implementation approach would be the most practical and effective way to transition from the current justice-based model of public intoxication. We understand that a 24-month transition period following the passage of legislation decriminalising public drunkenness would be required for the public health model outlined in this report to take full effect.

We recognise that this is a long period of time, particularly given the impacts of the existing justice-based approach and clear imperative for urgent change. However, given the complexity of the transition involved, it is essential that service system responses are capable of delivering the intended reforms. In this respect, a phased approach is designed to ensure the success of the public intoxication reforms by:

- supporting trials of sobering services in areas of high demand to test different models of care to inform a state-wide roll out
- enabling co-design to occur with the Aboriginal communities, CALD communities, local communities, organisations, workforce and people with lived experience on matters – such as where sobering services are located and the model of care they provide
- providing time to develop a detailed statewide plan for sobering services which establishes the optimal design and investment for a network of sobering services throughout Victoria, taking into account models of care, capital investment, workforce arrangements and any service gaps
- reflecting current limitations arising due to the coronavirus (COVID-19) pandemic and provide time for affected health services to consider and support the reforms. Notwithstanding the current and likely continuing impacts of coronavirus (COVID-19) on the capacity of DHHS and the health sector, the implementation of this important reform must remain an ongoing government priority
- providing time to develop any detailed legislative, regulatory or policy changes necessary to ensure the success of the reforms (i.e. identify any unintended consequences or unexpected issues)
- establish a robust quality and safety framework for the care of intoxicated individuals that covers police, ambulance and health and sobering services; and
- enabling time to develop appropriate governance, resourcing and commissioning of services.

Recommendation
62. The Victorian Government ensures the Proposed Health Model is phased in over a 24-month period to enable an adequate transition from the current justice-based response to public intoxication.

12.2 Trial sites

Under the phased implementation approach, we recommend the immediate establishment of a large, multi-site, multi-model trial of various health responses to help inform the development of the statewide scheme. Trial sites should commence in some form within six months of the passage of legislation to decriminalise public intoxication.

Under this approach, three to four areas should be selected that represent suitably varied volume and intensity of demand, geographic and social characteristics, and with a relative advanced state of readiness. For example:

- the Melbourne CBD represents high volume and both low and high intensity metropolitan needs
- Dandenong represents high volume and high intensity outer metropolitan needs; and
- Mildura represents moderate volume and high intensity rural needs with focus on support for the local Aboriginal community.

During the trial phase, trial sites should have de-facto decriminalised arrangements in place so that no person will be placed in a police cell for public intoxication. We recognise that this will require agreements to be sought with Victoria Police and other relevant services and agencies at a local level not to exercise current public intoxication powers given that Victoria Police would still retain the legal authority to take enforcement action up until decriminalisation takes effect. Local agreements should

include clear written protocols and rapid data monitoring in place to ensure ongoing assessment of the implementation of the trial sites (discussed further below under Ongoing monitoring, evaluation and adaptability).

Outside of the identified trial sites, during the transition phase Victoria Police would still be empowered to lodge people in a police cell if there were no other option available, but we strongly recommend that no fines should be issued, nor charges laid in the event that detention in a police cell is deemed absolutely necessary. Furthermore, Victoria Police should be encouraged to give effect to the intention of this reform by broadly practising aspects of the reform including working collaboratively with outreach and other alternate First Responders, utilising alternate safe places for intoxicated persons and use of police cells for incarceration only as a last resort.

As expanded on in more detail below, dedicated governance and implementation arrangements will need to be established to provide intensive oversight and accountability. This would help maximise good practice and learning.

Recommendation
63. The Victorian Government establishes at least three trial sites during the 24-month transition period to inform the development of the state-wide implementation of the ERG's Proposed Health Model.

12.3 Governance arrangements

We are especially keen to see the development of strong governance arrangements to ensure the effective coordination and oversight of the ERG's Proposed Health Model. While we assume that existing performance and governance arrangements for health and emergency services and police responses within DHHS and DJCS respectively will continue to monitor the operational aspects of the reforms, we consider that additional governance measures will be required to ensure success. This is especially the case given the importance and complexity of the proposed reforms and the fact that they span across both DJCS and DHHS. Both departments have a considerable role to play to provide the commitment, expertise, dedicated resources and collaboration required to deliver the systems and cultural change necessary to achieve the intended outcomes.

The roles of implementation and oversight are two distinct functions that should be undertaken under separate governance arrangements. Both the Royal Commission into Family Violence and the Royal Commission into Victoria's Mental Health System have highlighted that a degree of independence from the day to day operations of departments and service delivery agencies is needed to implement and embed major reforms.

We consider that two new governance mechanisms, within the existing frameworks at DHHS and DJCS, should be established to ensure successful implementation of the Proposed Health Model. In finalising the establishment details for these governance mechanisms, further consideration of the extent of independence required should occur.

Reform implementation office

A separate implementation office should be established to operationalise the public intoxication reform agenda on a day-to-day basis. Appropriate governance arrangements would need to be established

between DJCS and DHHS to ensure delivery of initiatives within each portfolio, such as a Memorandum of Understanding (MOU). The functions of the implementation office should include:

- designing, commissioning and delivering the new sobering services
- building new alliances and collaborative partnerships between key stakeholders at the local level
- early and regular data analysis, including the monitoring of any adverse consequences associated with implementation
- early and regular implementation reporting.

We consider that the implementation office could be modelled on Mental Health Reform Victoria, although the office need not necessarily be a separate administrative body. The entity should be time-limited and established over a short timeframe to cover the initial implementation phase of the reforms (approximately two to three years). This would cover:

- development and delivery of initiatives during the trial period, including supporting evaluation of the trials
- roll out of services throughout the state once decriminalisation officially commences and activities transition into standard department processes; and
- support the oversight committee (see below) and provide regular reports on implementation.

Specialist oversight committee

We consider that a dedicated oversight committee should be established to oversee the overall implementation of the decriminalisation of public intoxication and establishment of the Proposed Health Model. The primary function of the oversight committee is to ensure that implementation is consistent with and gives effect to the proposed reforms and service system models as identified in this report.

The entity should be a committee comprised of key representatives. The entity would need to include representation/partnerships with the Aboriginal community and CALD community, and adhere to the principles of self-determination.

The oversight committee role could include:

- defining the data and information needed to ensure departments and service delivery agencies can effectively account for their actions in decriminalising public drunkenness and establishing a new public health model
- maintaining regular surveillance and review over the implementation and delivery of public intoxication initiatives to ensure their success; and
- reporting regularly to government on the status of the reforms and make recommendations on future actions required to ensure the desired outcomes are achieved.

The entity should be time-limited but established over a longer timeframe to ensure the reforms are effectively embedded into standard service operations well beyond the transition period. This would cover:

- oversight of the implementation phase and assessment of the effectiveness of the two-year trial period, including making recommendations to government on additional measures required to support full roll-out; and
- oversight of the initial stages of decriminalisation and ensure reforms are successfully embedded into standard operational practice.

The entity should be independent from departments and report directly to the Attorney-General and the Minister for Health or Minister for Mental Health.

Recommendation

64. The Victorian Government establishes a dedicated implementation office to operationalise the public intoxication reform agenda.
65. The Victorian Government establishes a dedicated oversight committee to oversee the overall implementation of the public health approach to public intoxication and to ensure that implementation is consistent with, and gives effect to, the intention of the proposed reforms.

12.4 Ongoing monitoring, evaluation and adaptability

During the transition phase, we recommend that a range of data sources be collected and analysed in order to monitor the trial sites and inform the statewide roll out of the Proposed Health Model. Monitoring of the implementation of the decriminalisation of public intoxication is consistent with recommendation 85 of the Royal Commission into Aboriginal Deaths in Custody. Possible data may include recognising that further consideration and collaboration is required among relevant agencies to develop a full set of data requirements. Possible data sources include:

- any changes in demand for emergency services, including Victoria Police and emergency departments
- reporting on the use of the additional statutory power, including the frequency of its use and the characteristics of people who are detained and/or provided with transport; and
- any shift in the enforcement of more serious offences (such as offensive conduct) and exercise of other police powers (such as move on powers).

Comprehensive data analysis will be imperative to track the impact of the reforms. Monitoring and evaluation of the response should include working with DHHS, DJCS, the Crime Statistics Agency and Victoria Police.

We also consider that there should be a statutory review of the decriminalisation of public drunkenness. This could also consider Aboriginal-led data analysis to track the impact of the reforms, consistent with the *Victorian Aboriginal Affairs Framework 2018-2023*. Any such accountability measures should be accompanied by publicly accessible data, as identified earlier in this report.

Delivering a culturally safe response

Monitoring and evaluation of decriminalisation and the effectiveness of justice services in addition to the wider health response should be underpinned by the principles of self-determination and cultural recognition outlined in *Burra Lotjpa Dunguludja – The Aboriginal Justice Agreement Phase 4* (AJA4) and the *Koori Cultural Respect Framework*. AJA4 promotes progressing self-determination towards a justice system which values, promotes and requires greater involvement of Aboriginal communities in decision-making, program design and delivery which in turn results in culturally safe and appropriate initiatives. The *Koori Cultural Respect Framework* works alongside the *Koori Inclusion Action Plan - Yarrwul Loitjba Yapaneyepuk – Walk the Talk Together*. The framework was established to achieve fundamental changes to DJCS's practices, planning and policies in order to be responsive to the

cultural needs of Koori people in addition to ensuring staff have the knowledge and skills to deliver services in a culturally competent way.

A health model that is culturally safe should be developed and further evaluated in consultation with the Aboriginal Justice Caucus and other Aboriginal stakeholders.

Recommendation

66. The Victorian Government works with affected communities, including Aboriginal, Sudanese and South Sudanese communities to develop an evaluation framework including outcomes, reporting by agencies and services, provision of data to affected communities and the involvement of affected communities in the governance model.
67. The Victorian Government undertakes a statutory review of the reforms related to decriminalisation of public drunkenness.
68. The Victorian Government develops a monitoring and evaluation framework in consultation with relevant stakeholders including representatives from Aboriginal and/or Torres Strait Islander and CALD communities.
69. The Victorian Government ensures that Aboriginal Community Controlled Organisations evaluate the cultural appropriateness of the implementation and operation of the reforms.

12.5 Cultural safety framework

As identified earlier in this report, establishing an effective health-based response to public intoxication will require a cultural shift not only in the characterisation of intoxication as a public health rather than a law enforcement issue, but also in the way in which all First Responders – whether justice or health-based – support a person who is intoxicated in public.

Establishing a culturally safe and appropriate public health model is a critical aspect of an effective response. This is particularly relevant for Aboriginal and/or Torres Strait Islander people and people in the Sudanese and South Sudanese community, for whom public intoxication has a disproportionate impact.

In this section, we discuss key considerations relating to cultural safety and competence across both the health and justice systems.

Cultural safety in the health system

The DHHS Aboriginal and Torres Strait Islander cultural safety framework was developed to help DHHS and mainstream Victorian health, human and community services to create culturally safe environments, services and workplaces. The model is designed to guide DHHS and mainstream organisations as they develop strategies, policies, practices and workplace cultures that address unconscious bias, discrimination and racism

Aboriginal and Torres Strait Islander cultural safety is defined as an environment that is safe for Aboriginal and/or Torres Strait Islander people, where there is no assault, challenge or denial of their identity and experience. Cultural safety is about:

- strategic and institutional reform to remove barriers to the optimal health, wellbeing and safety of Aboriginal and/or Torres Strait Islander people

- individuals and organisations ensuring their own cultural values do not negatively impact on Aboriginal and/or Torres Strait Islander people. This includes addressing unconscious bias, racism and discrimination, and supporting Aboriginal and Torres Strait Islander self-determination
- individuals, organisations and systems ensuring self-determination for Aboriginal and/or Torres Strait Islander people. This includes sharing power (decision-making and governance) and resources with Aboriginal communities. It is especially relevant for the design, delivery and evaluation of services for Aboriginal and/or Torres Strait Islander people.

Figure 7: Cultural safety in the health system

Cultural safety in Victorian public hospitals

From 1 July 2020 Victorian public hospitals are expected to address eight domains of cultural safety. The introduction of the new governance approach to cultural safety stems from a 2016 review into Victorian hospitals' efforts to improve the cultural responsiveness and cultural safety for Aboriginal and/or Torres Strait Islander people.[18] For many Aboriginal and/or Torres Strait Islander people hospitals had been sites of trauma, they had not been "places of healing or where you got better". In providing a culturally safe environment, the review noted the following:

- **leadership and commitment –** at the Board, CEO and executive level is a necessary though not sufficient factor in enhancing culturally responsive care and cultural safety so that hospital staff and the Aboriginal community are enabled and experience change
- **relationships with ACCHOs –** are a necessary though not sufficient factor to guaranteeing culturally responsive care and cultural safety for Aboriginal community members. They provide value in hospitals accessing local cultural knowledge, supporting the AHLO and building cultural competency/safety in the hospital
- **AHLOs –** are deemed critical to enhancing culturally responsive care and ensuring the cultural safety of clients. However as critical roles within the hospital experience and as bearers of important knowledge and expertise, AHLOs mostly feel undervalued and neglected. AHLOs are the subject and object of community trauma and as such their roles are highly stressful and stress leave was common. Without sufficient support, legitimacy and acknowledgement of these roles,

[18] Social Compass (2016) Improving Cultural Responsiveness of Victorian Hospitals Final Report

culturally responsive care and cultural safety become highly vulnerable for Aboriginal and/or Torres Strait Islander clients

- **a welcoming environment –** is important and Aboriginal and/or Torres Strait Islander people place great importance on the display of flags outside the hospital and Acknowledgement of Traditional Owner plaques and local Aboriginal and/or Torres Strait Islander artwork inside hospitals. This has the effect of enabling people to feel they are still connected to land, community and culture. However, they can also feel tokenistic if the service system does not support them
- **cultural safety training –** is important, however there is no evidence of particular standards that programs need to meet, though most hospitals have a preference for local providers. The results of such training are only anecdotal as there was no evidence[19]
- **rigorous monitoring or reporting –** is not conducted at the hospital or statewide level for cultural responsiveness or cultural safety. The mechanisms for reporting that are in place are ad hoc, non-mandatory and provide an incomplete story at the sector level with regard to cultural responsiveness or cultural safety.

The role of the AHLOs is seen as key to achieving culturally safe services. Overall, the review into cultural safety at hospitals found that increasing the support and capacity of the AHLOs would have the biggest impact. While there has been considerable improvement in expanding the number of AHLOs and increasing support for their roles in organisations, problems still remain.

The 2016 review noted many AHLOs were not available due to stress leave, Sorry Business and illness. All AHLOs expressed that they found their roles deeply challenging, often feeling under-valued, under-resourced and overburdened by community need and community trauma. This was mostly due to a perceived inability to meet the demand for their services, lack of recognition of their role and expertise, and in working Monday to Friday 9am to 5pm not being present at the hospital when most clients present (after hours and on the weekend).

This latter point regarding Aboriginal and/or Torres Strait Islander hospital staff availability is critical when considering the needs of a sobering service where most demand is expected to fall after hours. The review noted the following proposals from community to address this issue including using third-party (Aboriginal community) agencies to deliver on-call AHLO equivalent services after-hours and establishing a locum AHLO pool.

Case Study: Bairnsdale regional health cultural safety initiatives

"They just make you feel welcome and have trained Aboriginal staff"

Bairnsdale Regional Health Service is located on the lands of the Gunaikurnai people. Aboriginal and/or Torres Strait Islander people make up 3.2 percent of the regional population (1,332 persons).

The hospital is seen as a leader in cultural safety and has successfully established core elements of a culturally safe service, with strong CEO leadership, integrated health services, a large Aboriginal staff and an Aboriginal employment plan.

A 2016 review into cultural responsiveness of Victorian hospitals noted the success of Bairnsdale's Aboriginal health program and community engagement, attributed to a combination of committed leadership and highly committed, community connected and capable ACHOs. The local Aboriginal

[19] Note the National Aboriginal Community Controlled Health Organisation has developed standards for cultural safety.

community itself noted that Bairnsdale had not been known for its inclusive attitudes in the past and acknowledged the work underway to change attitudes both within the hospital and more broadly in the community.

"The town has come a long way. Staff and community involvement has come a long way"

Elements supporting a culturally safe environment at Bairnsdale include:

- long standing relationship with Gippsland and East Gippsland Aboriginal Cooperative and developing relationships with other local Aboriginal health organisations
- footprints designed by a local Aboriginal artist show the way to the Aboriginal Meeting and Resource Room; and the Blue Wren (a culturally significant icon) is now a well-known and recognised symbol of the hospital
- the hospital pharmacy providing self-funded medication to all discharged Aboriginal clients
- monthly collaborative meetings with local ACCHOs
- cultural training and information for all staff
- policies and procedures to identify and support Aboriginal clients.

The allocation of resources to establish the Warrawee Room – a dedicated space for Aboriginal clients, family and AHLOs to meet in comfort – has been critical in making Aboriginal staff and clients feel welcome. Additional physical elements such as Aboriginal flags and gardens also support this.

The hospital tracks their improvement through the use of continuous quality improvement tools and holds annual meetings to monitor progress and ensure the tools is utilised through the service to assess cultural safety.

Source: Social Compass (2016) *Improving Cultural Responsiveness of Victorian Hospitals Final Report*

Funding for Aboriginal and/or Torres Strait Islander cultural safety

The Aboriginal WIES loading is a key policy lever for improving Aboriginal and/or Torres Strait Islander outcomes from hospital care. The WIES (or Casemix) funding model is the mechanism used to fund the treatment of admitted clients in public hospitals. It is an activity-based funding approach which allocates a payment to hospitals for each client treated. This model accounts for approximately 60 percent of all funding provided to public hospitals.

In 1998, a 10 percent loading per Aboriginal and/or Torres Strait Islander client was introduced, which was increased to 30 percent in 2004. The loading was meant to cover both the cultural safety costs and the excess clinical costs for Aboriginal and/or Torres Strait Islander clients which are not fully covered by the Activity Based Funding model. In 2017-18, approximately $20 million was spent on this loading.

A review of this funding in 2018 demonstrated that the WIES loading was not achieving its goal to promote and embed cultural safety in health services. Few hospitals were found to have provided all the critical cultural safety elements and many hospitals report employing few AHLOs, especially after hours (when most Aboriginal and/or Torres Strait Islander clients are admitted), or within mental health wards.

Across the past few years, the Statement of Priority process (the establishment of priority actions and deliverables with health service boards) has endorsed health services to undertake the development

of Reconciliation Action Plans as promoted via Reconciliation Australia. A Reconciliation Action Plan formerly developed should occur via partnership with the local Aboriginal community, services and Elders as an advisory body. Enhancing such partnerships as continuous improvement is required for culturally safe services.

Following the 2018 review, a range of recommended reforms were proposed to Aboriginal and/or Torres Strait Islander client funding, monitoring and cultural safety guidance, which will be fully implemented in 2020–2021. The four broad recommendations relate to funding design, funding accountability, supporting reforms and Aboriginal and Torres Strait Islander self-determination.

In 2020–2021 the 30 percent Aboriginal loading has been be split into three distinct funding streams, including:

- a reduced WIES loading closer to the national pricing adjustment of four percent to cover excess clinical costs for Aboriginal and/or Torres Strait Islander clients
- a significant proportion of the remaining loading will be redirected into annual block grants to contribute to key workforce (e.g. AHLO) costs, and other recurrent costs associated with cultural safety and supplementary programs for Aboriginal and/or Torres Strait Islander clients. The size of the block grant will vary and will be calculated using a number of criteria which may include, but not limited to, the size of the health service and the Aboriginal and/or Torres Strait Islander population within the health services catchment
- funding grants that will be available through a competitive application process to cover the costs of one-off purchases for innovative projects (including research and evaluation) designed to improve cultural safety.

These changes to the Aboriginal WIES loading approach in effect means there is a significant pool of existing funding now specifically available to hospitals to address cultural safety.

Cultural safety in emergency departments

Emergency departments are often the first entry point for clients entering the hospital system and are expected to play a key role in the triaging and admission of clients into sobering services within the hospital setting. Providing a safe and welcoming environment in the emergency department is critical to clients having a positive experience of care. However, clients seeking care for AOD related issues and/or Aboriginal and/or Torres Strait Islander clients can face stigma and discrimination in the emergency department setting.

Anecdotally, emergency departments are considered a key area where more can occur to promote cultural safety. This view is reflected in client experience surveys - in 2018-19, 71 percent of Aboriginal and/or Torres Strait Islander Victorians said they had a positive overall experience of emergency department care compared to 84 percent of non-Aboriginal Victorians.[20] This gap is wider for ambulance care with 78 percent of Aboriginal and/or Torres Strait Islander Victorians having a positive overall experience of ambulance care compared to 96 percent of non-Aboriginal Victorians. This can also be shown in the number of clients leaving treatment prematurely - in 2019-20, more than 11 percent of Aboriginal and/or Torres Strait Islander clients either decided they did not wish to wait for care or left the emergency department at their own risk after being seen by a clinician, compared to more than six percent of non-Aboriginal and/or Torres Strait Islander clients.[21]

[20] Victorian Agency for Health Information (2020) *Adult experiences of emergency care in Victoria 2018-19*
[21] VEMD data 2019-20, DHHS internal analysis

Similar findings are reflected in the international literature on the treatment of First Nations people in emergency care.

We understand that from 2020-21, Victorian hospitals are required to report formally to DHHS on their performance in providing a culturally safe service. Hospitals are working to improve cultural safety, with some notable examples of best practice (see Bairnsdale case study above).

The eight cultural safety domains are DHHS's key directives to strengthening cultural safety and provide a basis for accountability. Hospitals are also required to report on the implementation of DHHS's Aboriginal cultural safety framework through the Statement of Priorities which is an agreement between hospitals and the Minister for Health.

Cultural safety in the justice system

The justice system has significant impacts on many Aboriginal and/or Torres Strait Islander people and their communities. These impacts in the context of public intoxication have been well-documented, in particular through the Royal Commission into Aboriginal Deaths in Custody and more recently in the coronial findings and recommendation in the Tanya Day inquest.

The scope of Ms Day's inquest also included consideration of the impact of systemic racism and the Deputy State Coroner found that the V/Line conductor's decision making was influenced by unconscious bias and that his decision to call police rather than pursue other options was influenced by Ms Day's Aboriginality. The subsequent recommendations to V/Line regarding training for its staff, including input from the Aboriginal and Torres Strait Islander community about unconscious bias and a review of compatibility with human rights under the Victorian Charter of Human Rights, provide relevant context to our consideration of cultural competence for all First Responders under the public health model.

As identified in *Burra Lotjpa Dunguludja - The Aboriginal Justice Agreement Phase 4* (AJA4), a culturally-responsive system is one in which "non-Aboriginal people take responsibility to understand the importance of culture, country and community to Aboriginal health, wellbeing and safety, by working with Aboriginal communities to design and delivery culturally-responsive services". AJA4 reflects the importance of embedding self-determination and the need to reflect the current aspirations of the Aboriginal and/or Torres Strait Islander community as the core policy approach that must sit alongside efforts to address the over-representation of Aboriginal and/or Torres Strait Islander people in the criminal justice system.

It outlines a vision for Aboriginal people having access to "an equitable justice system that is shaped by self-determination, and protects and upholds their human, civil, legal and cultural rights" with key goals under four domains, including:

- strong and safe Aboriginal families and communities
- fewer Aboriginal people in the criminal justice system
- a more effective justice system with greater Aboriginal control
- greater self-determination in the justice sector.

Several explicit outcomes within these four domains are of particular relevance to the ERGs consideration of measure to ensure implementation of an effective public health response to public intoxication, including service pathways from justice system First Responders.

For example, decriminalisation of public drunkenness and the enhancement of Aboriginal community-led responses such as Koori Night Patrols contributes to the outcomes of identifying and remedying policies and legislation which either currently do, or which may in future, have a disproportionate

impact on Aboriginal people (outcomes 2.1.1 and 2.1.2). Similarly, flexible, culturally safe service pathways is consistent with the AJA4 commitment to support community policing approaches that support crime prevention initiatives and evidence based programs delivered by ACCOs for young people, in order to achieve the outcome of fewer young people becoming involved with the criminal justice system (outcome 2.2.1).

Further, under the overarching goal of safer Aboriginal communities, AJA4's strategies include empowering Aboriginal communities to identify and determine solutions to the justice and community safety issues in their local areas. Existing initiatives cited in AJA4 include Victoria Police Aboriginal Community Liaison Officers as part of community engagement and relationship building.

Good access to culturally appropriate service responses for Aboriginal people highlighted in AJA4 is critical to improve justice outcomes. Ensuring that staff in justice agencies take human rights into account when making decisions is one example of the commitments identified by AJA4 to meet the needs of Aboriginal and/or Torres Strait Islander people in the justice system more broadly. Another such example is the development of cultural safety standards for health services in both adult and youth justice systems.

Developing a culturally appropriate and safe model will require ongoing consultation with the Aboriginal community, ensuring that the wider health response is underpinned by the principles of self-determination and cultural recognition outlined in AJA4.

Cultural safety for an inclusive multicultural community

While the nature and circumstances of the ERG's work in light of the death of Ms Day warrants particular attention to be given to cultural safety for Aboriginal and/or Torres Strait Islander people, we must not ignore other communities and cohorts of people who are disproportionately impacted either as a result of existing law enforcement of public intoxication, or their experiences in the justice, health and law enforcement systems more broadly. Appropriate cultural safety frameworks must also operate to ensure that vulnerable CALD communities, including Sudanese and South Sudanese people, are able to access the health supports and services they need, as well as to avoid any disproportionate impacts of a justice-led response.

The Victorian Government's multicultural policy statement sets out a vision to enable every Victorian to participate fully in society, remain connected to their culture and ensure we all have equal rights, protections and opportunities. The Whole of Government Multicultural Affairs Outcomes Framework works across the following domains to ensure Victorians are:

- safe and secure
- healthy and well
- able to participate fully
- connected to culture and community
- have equal rights and opportunities.

Relevant to the work of the ERG, this framework articulates examples to ensure safety and security including:

- resource investment, including with Victoria Police to enhance social cohesion in partnership with vulnerable multicultural communities
- identifying over-represented cultural groups in adult and youth justice programs.

It also outlines investment in the health system including building cultural competence in health services, with extra targeted assistance for refugees and asylum seekers to address the inequalities that particular communities face.

Additional relevant Victorian Government initiatives include the *Victorian African Communities Action Plan* (VACAP), developed by and for Victoria's African communities. The VACAP covers work through several domains including:

- employment
- education
- leadership
- health and Wellbeing.

Progress on implementation of the VACAP under the health and wellbeing domain outlines initiatives relating to AOD misuse, including specialist outreach workers and education programs, the design of which is being finalised with a VACAP sub-committee together with the DHHS and the Department of Premier and Cabinet.

Recommendation

70. Consistent with its commitment to self-determination and co-design principles, particularly for Aboriginal and/or Torres Strait Islander people, the Victorian Government consults with affected communities and work wherever possible with community-controlled organisations in the design, delivery and evaluation of the public health response to public intoxication.
71. The Victorian Government continues to support the implementation of a new funding and governance model across public health services to strengthen and improve approaches to delivery of culturally safe and responsive services for Aboriginal and/or Torres Strait community.
72. The Victorian Government continues to support further actions via health service statement of priority processes and funding and service agreements for funded organisations to progress Reconciliation Action Plans.
73. The Victorian Government continues to support and elevate the cultural safety planning undertaken by hospitals and the delivery of culturally safe sobering services provided in hospital settings, including:
    a) sobering services in hospitals are established in line with the identified six themes impacting cultural safety
    b) expanding the Aboriginal and/or Torres Strait Islander health workforce, including Aboriginal Health and Liaison Officers, fully utilising WIES loadings and other resources to adequately resource this function
    c) Aboriginal Health and Liaison Officers – or an appropriate equivalent - are available to support Aboriginal and/or Torres Strait Islander clients utilising sobering services, including access after-hours and on weekends; and
    d) undertake an audit of cultural safety in relation to both Aboriginal and/or Torres Strait Islander people and CALD communities at relevant emergency department and rural trauma and urgent care centres, and appropriate actions undertaken to address identified areas of concern.

74. The Victorian Government works in partnership with affected communities at a local level to develop culturally appropriate service responses as part of the public health response, including building on established partnerships with Aboriginal organisations and communities (e.g. Aboriginal Justice Caucus and RAJACs), and with Sudanese and South Sudanese communities under the African Community Action Plan, where appropriate.
75. The Victorian Government supports comprehensive cultural safety training be developed for all First Responder agencies (in the justice and health systems), with localised input from, and delivery by, ACCOs and other affected community-controlled organisations, including training on:
    a) Aboriginal cultural awareness
    b) unconscious bias
    c) trauma-informed care
    d) mental health and disability
    e) human rights under the Victorian Charter of Human Rights.
76. The Victorian Government supports the development and delivery of cultural safety training by ACCOs and other affected communities for all staff in services in the public health model.
77. The Victorian Government ensures that training is provided to all First Responders and services on localised service pathways and access for affected communities, including for ACCOs. This will be particularly important during the implementation phase.
78. The Victorian Government requires that all First Responders and staff in services under the public health model undergo cultural safety training, including ongoing, localised and refresher training.
79. The Victorian Government continues to build the capacity of ACCOs and other community-controlled organisations to deliver cultural safety training in mainstream organisations, including appropriate resourcing and funding of these as professional development activities.
80. The Victorian Government ensures that culturally appropriate safeguards and service pathways are developed for Aboriginal and/or Torres Strait Islander people coming into contact with police, including exploring options with the Aboriginal Community Justice Panels.
81. The Victorian Government extends the role of AHLO to after-hours and/or implement an on-call model so hospital based sobering services also have access to Aboriginal and/or Torres Strait Islander support persons for relevant clients (noting this could also benefit all Aboriginal and/or Torres Strait Islander clients) ensuring any non-hospital services operate consistent with the eight cultural safety domains now in place at hospitals. This could include consideration of block grants for cultural safety to other health services with a primary direct role in public intoxication (i.e. Ambulance Victoria).
82. The Victorian Government ensures that interpreters are available across the range of service system responses identified by the ERG for the proposed reform.

12.6 Further consultation and co-design

As identified in various places throughout this report, detailed consultation and co-design will be critical to the successful establishment of a public health model to respond to public intoxication.

Consultation with and the ongoing involvement of a range of diverse stakeholders is relevant in a number of different contexts, including:

- with local stakeholders and communities to ensure that place-based arrangements respond effectively to local needs and expected demand, particularly in low demand areas where there will be reliance on existing services and transport options
- with people with lived experience to ensure services reflect the needs of the people that will use them
- with health services and their staff to ensure that appropriate health-based responses and processes are developed to respond effectively to people who are intoxicated; and
- with particularly affected communities, such as Aboriginal and CALD communities, to ensure that local responses are tailored and effective.

Effective engagement, consultation and partnership building will also be required across the service system to ensure that a comprehensive statewide model works effectively to provide a health-based response to people who are intoxicated in public. We consider that, as much as possible, implementation of the Proposed Health Model should be incorporated within relevant existing arrangements, such as rural and regional health partnerships.

Recommendation
83. The Victorian Government ensures that detailed consultation and co-design occurs as it is critical to the successful establishment and implementation of a public health model.

12.7 Local Government

The removal of offences relating to public drunkenness in legislation will not interfere with the operation of existing local laws to regulate public drinking and related behaviour by local government. We understand that this may give rise to a tension between the delivery of a public health response to public intoxication and the continued enforcement of local laws.

Where a person is intoxicated in public in an area to which a local law applies, the response may be significantly different if the First Responder is acting under the authority of a local law as opposed to the framework of the Proposed Health Model. Enforcement of local laws relating to public intoxication, particularly through prosecution, will continue to reinforce a justice-based approach to public drinking.

The Royal Commission into Aboriginal Deaths in Custody recommended negotiation between police, local government bodies and representative Aboriginal organisations and Aboriginal legal services with a view to developing an acceptable plan with respect to public consumption of alcohol.

We consider that engagement with local government will be an important component of the development of localised responses. With improved service system responses and the increased availability of places of safety under the Proposed Health Model, local government has an important role to play in promoting the adoption of health-based approaches.

Recommendation

84. The Victorian Government undertakes a review of relevant local laws in partnership with local government. The scope of such a review might including consideration of amendments as well as operational protocols to support the reform principles underpinning decriminalisation of public drunkenness.

85. The Victorian Government analyses data relating to enforcement of local laws be monitored to track any unintended consequences associated with the enforcement of local laws.

12.8 Resourcing

The provision of adequate resourcing to assure the availability and quality of the various health-based service responses identified throughout this report is essential to the success of the proposed reforms. As we have highlighted, the experiences of discrimination of public drunkenness in other jurisdictions demonstrates that the failure to put in place effective health-based service system responses means that police cells will continue to be used.

Put simply, insufficient resourcing of an effective health-based response will inevitably lead to the continuation of a justice-led response to public intoxication. This has a range of resourcing implications due to the burden placed on emergency services and in particular Victoria Police. Most significantly, it has enormous human costs including, most tragically, entirely unnecessary and avoidable deaths in custody.

Adequate resourcing must be provided for the range of components that we have identified are necessary for the effective implementation of the Proposed Health Model, including:

- guaranteeing the availability and coverage of First Responders
- guaranteeing the availability and coverage of appropriate places of safety, including the expansion of sobering services and other community and health services as discussed under Stage 3; and
- focused work on the transition phase and the resource implications required for workforce change and effective governance, monitoring and evaluation.

Resourcing cannot be dedicated to one isolated component alone as there is an essential interdependency between all components. This will be critical for effective implementation. Our Proposed Health Model requires the operation of a range of integrated components designed to complement each other and contribute to the overall effectiveness of the health-based approach.

Recommendation

86. The Victorian Government adequately resources all components of the Proposed Health Model, reflecting the interdependency between all components identified in this report.

Appendix 1: Terms of reference

Background

The Victorian Government has announced its commitment in principle to decriminalise public drunkenness and develop a new health-based response to public drinking and intoxication, in order to provide vulnerable Victorians with appropriate help and support.

This reform will implement the recommendation of the Royal Commission into Aboriginal Deaths in Custody and submissions made to the Royal Commission into Victoria's Mental Health System. The Acting State Coroner, Caitlin English, has also foreshadowed that she would recommend the repeal of public drunkenness offences in the report of the coronial investigation into the death of Ms Tanya Day.

The Government has committed to report-back to the Coroner on the progress of this reform by the end of 2019.

Expert Reference Group

Members

The Expert Reference Group consists of the following members:

- Helen Kennedy, Chief Operating Officer of the Victorian Aboriginal Community Controlled Health Organisation
- Tony Nicholson, former Executive Director of the Brotherhood of St Laurence
- Jack Blayney, former Assistant Commissioner and Chief Information Officer, Victoria Police
- Nerita Waight, Chief Executive Officer of the Victorian Aboriginal Legal Service.

Role

The Expert Reference Group will provide strategic advice to government on the decriminalisation of public drunkenness and the design and development of a new health-based response.

In performing its role, the Expert Reference Group is requested to:

- ensure that its advice reflects the importance of promoting the health and safety of vulnerable Victorians and providing them with appropriate help and support, while also ensuring that the safety of the community, first responders[22], health workers and the broader public is protected
- focus on measures to support a new health-based response that is culturally safe and appropriate, informed by clinical best practice, and sensitive to intersecting issues presenting in the lives of people accessing the new health-based response.
- have regard to approaches and experiences in other Australian and international jurisdictions.

The Expert Reference Group is not required to consider or provide advice to the government on the following matters, which are beyond the scope of this project:

[22] First responders are those who provide a rapid response at the scene and include Victoria Police, Ambulance Victoria, community response teams and other service providers.

- the specific circumstances surrounding the death of Ms Tanya Day, which will be independently examined by the Coroner through the separate coronial inquest process
- other specific cases where individuals are alleged to have committed a public drunkenness offence, particularly cases that are subject to ongoing police investigations or court processes
- the form and content of draft legislation to give effect to a repeal of public drunkenness offences, which will be a matter for the Office of the Chief Parliamentary Counsel
- the training and specific duties of police officers to implement the policing policy and priorities of the government in responding to public drinking and intoxication.[23]
- broader responses to discrimination, human rights, mental illness (which is being considered by the Royal Commission into Victoria's Mental Health System) and homelessness.

The Expert Reference Group will meet monthly and be supported by a cross-government Executive Oversight Committee and Working Group. The project governance structure is at Attachment A.

Expert Reference Group members may bring a support person to Expert Reference Group meetings.

The Expert Reference Group will consider briefings prepared by the Working Group, including briefings on consultation and engagement with stakeholders led by the Working Group.

Executive Oversight Committee

Members

The Executive Oversight Committee will include representatives of the following government departments and agencies:

- Department of Justice and Community Safety (co-chair)
- Department of Health and Human Services (co-chair)
- Victoria Police
- Department of Premier and Cabinet
- Department of Treasury and Finance.

Role

The Executive Oversight Committee will support the Expert Reference Group, including by:

- overseeing the operation of the Working Group and providing coordinated strategic direction as required
- endorsing Working Group briefings ahead of their provision to the Expert Reference Group
- overseeing advice provided to government, other than the advice provided by the Expert Reference Group.

An Executive Oversight Committee representative from both the Department of Justice and Community Safety and the Department of Health and Human Services will attend Expert Reference Group meetings.

[23] The Victoria Police Act 2013 provides that the Chief Commissioner of Police (CCP) is responsible for implementing the policing policy and priorities of the Government. Training and education within Victoria Police is a matter for the CCP and determined by Victoria Police as a Registered Training Organisation, in compliance with a national framework and informed by an Independent Advisory Board.

Working Group

Members

The Working Group will include representatives from each of the agencies represented on the Executive Oversight Committee.

Role

The Working Group will convene monthly (or more regularly, if required), and will report to the Executive Oversight Committee.

Working Group members will also attend Expert Reference Group meetings by invitation.

The Working Group will be responsible for developing draft proposals (including by undertaking research, modelling and stakeholder consultation) for consideration by the Executive Oversight Committee and the Expert Reference Group on the:

1. design and implementation of a new health-based response
2. appropriate police powers under the new health-based response required to ensure community safety.

To inform the development of the draft proposals, the Working Group will:

- undertake research, including on data, evidence and best practice responses in other jurisdictions
- undertake preliminary modelling of the cost and resourcing requirements of the proposed reforms to inform consultation, and the development of legislative reform and funding proposals
- implement the consultation plan, including collaboration with the Victorian Aboriginal Community Controlled Organisations, Victoria Police, as well as justice, health and community service providers, to promote culturally safe and best practice reform.

Design and implementation of a health-based response

The design of a new health-based response to public drinking and intoxication will consider:

1. best practice approaches to responding to public drinking and intoxication in other jurisdictions, including opportunities to learn from experiences in these jurisdictions, and the results of evaluations and reviews of these approaches
2. legal requirements and duties under relevant legislation, including the *Occupational Health and Safety Act 2004* and *Liquor Control Reform Act 1998*
3. the particular needs of different communities across Victoria (including in rural and regional Victoria), and cohorts and cultural groups within those communities
4. workforce, training, infrastructure, transport and other resourcing requirements for the successful implementation of the model.

Approach to repealing public drunkenness offences

The development of a proposed approach to repealing public drunkenness offences will consider:

1. the need for an appropriate period to prepare for the decriminalisation of public drunkenness, provide guidance and training to first responders and others on the new health-based response, and the establishment of place-based support services
2. the adequacy of existing police powers and criminal offences to protect the community and respond effectively to threats to public safety and order arising from intoxication, particularly in the context of major events where there may be significant alcohol consumption

3. the role of first responders and others under the new health-based response to assist people who are drunk in a public place, but are not otherwise committing a criminal offence
4. workforce, training, infrastructure, transport and other resourcing requirements for the successful implementation of the new health-based response.

The Working Group will collaborate closely with first responders in developing this proposal.

Consultation

The proceedings and papers of the Expert Reference Group are confidential. Requests to share materials with community and stakeholders will be considered and agreed with the Expert Reference Group as the process and advice develops, noting that final approval is required by the Department of Justice and Community Safety (as per the terms of conditions of the engagement of members of the Expert Reference Group).

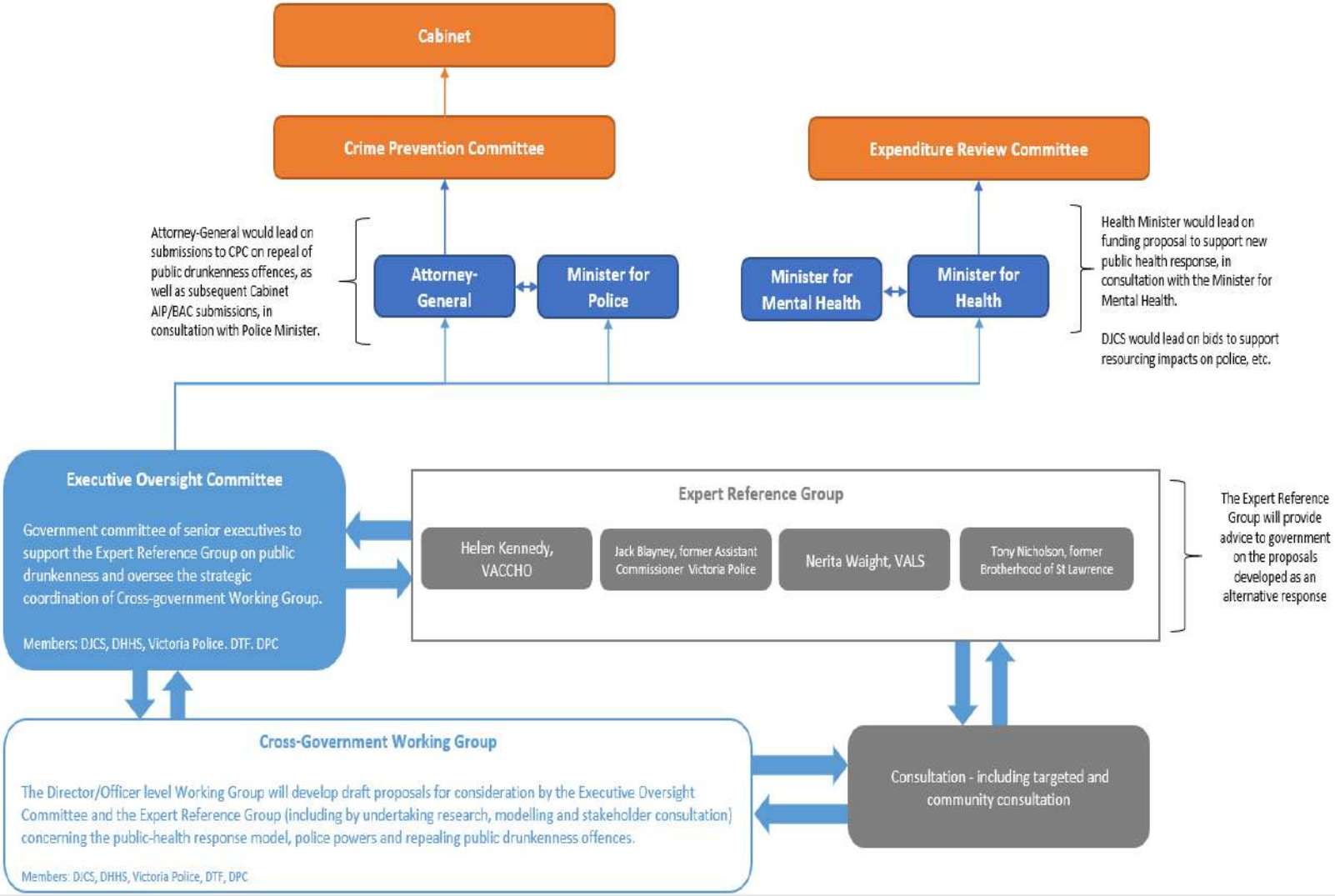
The Executive Oversight Committee and Working Group will coordinate and undertake consultation with key community groups and stakeholders to support the development of the reforms. The Expert Reference Group may attend stakeholder consultations meetings.

Report

The Expert Reference Group, supported by the cross-government Executive Oversight Committee and Working Group, will prepare a report to government with its advice and reform proposals.

The final report should be delivered to the Attorney-General and the Minister for Health by the end of **January 2020** to enable the Expert Reference Group to consider the interim report of the Royal Commission into Victoria's Mental Health System, and to allow for funding requirements arising from the implementation of the new health-based response to be considered as part of the 2020-21 Victorian Budget process.

Public Drunkenness Reform project governance



Appendix 2: Community consultation and engagement

The following table comprises the list of organisations which were invited to participate in consultations as part of the reform of public intoxication. Consultations were conducted by and large around October to December 2019 and in February 2020 as part of the process of preparing advice by DJCS and DHHS, and to support the work of the ERG.

Organisation	Organisation type
Aboriginal Justice Caucus	Aboriginal organisations
Ambulance Victoria	First Responders
Association of Participating Service Users (APSU) at the Self-Help Addiction Resource Centre (SHARC)	Consumer peak
Australian Hotels Association	Industry
Australian Medical Association, Victoria	Community peak bodies
Australian Nursing and Midwifery Federation	Unions/professional associations
Australian Security Industry Association Limited (ASIAL)	Industry
Bendigo Community Health	Community health
Bendigo Health	Health services
Bolton Clarke	Community/ health services
CAPR (Centre for Alcohol Policy Research)	Academic experts
Centre for Innovative Justice	Academic experts
Chill-out Zone, Queensland	First Responders / community organisation
City of Greater Bendigo Council	Local government
City of Greater Geelong Council	Local government
CoHealth	Community health
Commissioner for Children and Young People	Government & statutory agencies
Community Clubs Victoria	Industry
Council to Homeless Persons	Community peak bodies
Darebin City Council	Local government
Deakin University (Addiction Studies)	Academic experts
Dhelk Dja Koori Caucus	Aboriginal organisations
Djirra	Aboriginal organisations
Federation of Community of Legal Centres	Community peak bodies
Foundation for Alcohol Research and Education, ACT	Academic experts / community organisation
Goulburn Valley Health	Health services
Healing Foundation, ACT	Aboriginal organisations
Health Services Union	Unions/professional associations
Health Workers Union	Unions/professional associations
Human Rights Law Centre (HRLC)	Community peak bodies
Human Services Health Partnership Implementation Committee (HSHPIC)	Community peak bodies
Koori Youth Caucus	Aboriginal organisations
Koori Youth Council	Aboriginal organisations

Latrobe City Council	Local government
Latrobe Community Health Service	Community health
Latrobe Regional Hospital	Health services
Launch Housing	Other services
Law Council of Australia	Community peak bodies
Law Institute of Victoria (LIV)	Community peak bodies
Municipal Association of Victoria (MAV)	Local government
Melbourne City Council	Local government
Melbourne University (Alcohol research)	Academic experts
Mental Health Victoria	Community peak bodies
Mildura Base Hospital	Health services
Mildura Rural City Council	Local government
Mission Australia	Community peak bodies
Monash Health	Health services
Monash University (Law)	Academic experts
Monash University (Paramedicine)	Academic experts
National Drug Research Institute	Academic experts
Ngwala Willumbong	Aboriginal organisations
North Richmond Community Health	Community health
Penington Institute	Community peak bodies
Primary Health Network (PHN) Alliance	Community peak bodies
Port Phillip City Council	Local government
Regional Aboriginal Justice Advisory Committees (RAJAC)	Aboriginal organisations
Safer Care Victoria	Government & statutory agencies
Salvation Army	Community health
Small Business Mentoring Service Victoria	Government & statutory agencies
St John's Ambulance	First Responders
St Vincent's Hospital	Health services
Sunraysia Community Health	Community health
Turning Point	Other services
United Voice Victoria	Unions/professional associations
Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and members	Aboriginal organisations
VALiD	Community peak bodies
Victorian Council of Social Services	Community peak bodies
VicHealth	Government & statutory agencies
Victoria Legal Aid	Legal services
Victoria Police	First Responders
Victoria Police Association	Unions/professional associations
Victorian Aboriginal Health Service	Aboriginal organisations
Victorian Aboriginal Legal Service	Aboriginal Organisations
Victorian Alcohol and Drug Association (VAADA)	Community peak bodies
Victorian Ambulance Union	Unions/professional associations
Victorian Equal Opportunity and Human Rights Commission (VEOHRC)	Community peak bodies

Victorian Healthcare Association	Community peak bodies
Youth Affairs Council of Victoria (YAC Vic)	Community peak bodies
Youth Advisory Council	Community peak bodies
Youth Projects	Community health
Youth Support and Advocacy Service (YSAS)	Community health

Appendix 3: Recommendations from the Inquest into the Death of Tanya Day

The Deputy State Coroner Caitlin English handed down the findings from the Inquest into the Death of Tanya Louise Day on 9 April 2020.

The Deputy State Coroner found that an indictable offence may have been committed contributing to Ms Day's death and has referred the matter to the Director of Public Prosecutions to investigate. The Deputy State Coroner also made ten recommendations for improvements related to the circumstances of Ms Day's death. These recommendations are outlined below.

COMMENTS

Pursuant to section 67(3) of the *Coroner's Act 2008,* I make the following comment:

1. During the course of this inquest it became apparent to me that the Coroner's Court of Victoria should review the relevant recommendations from the Royal Commission into Aboriginal Deaths in Custody as they relate to coronial investigations. This review is currently underway.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroner's Act 2008*, the Deputy State Coroner made the following recommendations connected with the death:

To: The Attorney General, The Honourable Jill Hennessey

1. I Recommend that the offence of public drunkenness be decriminalised and that section 13 of the *Summary Offences Act 1966* be repealed.

   Summary of government response
   The government has committed in principle to decriminalise the offence of public drunkenness and has established an Expert Reference Group to provide advice on the development and implementation of a public health-based response.

2. I recommend legislative amendment to the *Coroners Act 2008* that the coroner in charge of coronial investigation may give a police officer direction concerning investigations to be carried out for the purpose of an inquest or investigation into a death being investigated by the coroner, thus legislatively recognising the role of the Coronial Investigator.

   I refer to both the Royal Commission into Aboriginal Deaths in Custody, Recommendation 29 and the Victorian Parliamentary Law Reform Committee Report regarding the *Coroner's Act* (1985) Recommendation 42.

   Summary of government response
   The Attorney General has instructed DJCS to undertake consultation on a legislative amendment to the *Coroners Act 2008.*

To: The Chief Commissioner, Victoria Police

3. I recommend that the Victoria Police Manual Rules and Guidelines be amended to include a falls risk assessment as part of the detainee risk assessment for each person in custody who appears to be affected by alcohol or drugs or illness.

   Summary of government response

   Victoria Police are reviewing options to include a falls risk assessment in the Victoria Police Manual and Guidelines.

4. I recommend that there be a review of training and education within Victoria Police regarding the findings and recommendations of the Royal Commission into Aboriginal Deaths in Custody to ensure knowledge and appropriate compliance.

   Summary of government response
   Victoria Police has accepted this recommendation and will review training in the context of the Royal Commission into Aboriginal Deaths in Custody recommendations and report on specific training that has been, or is planned to be implemented, that seeks to enhance members cultural awareness.

5. I recommend training be implemented for all Victoria Police custody staff regarding the Victoria Police Manual Rules, Guidelines and local police station Standard Operating Procedures (SOP) regarding the mandatory requirements applicable for safe management of persons in police care or custody.

   Summary of government response

   Victoria Police notes the courses on the Victoria Police Learning Hub (VPLH) regarding safe management of persons in police care or custody were updated in 2019 and made compulsory to all relevant staff in April 2020. The courses provide instruction for custody staff regarding the current VPM and VPMGs and Victoria Police will continue to monitor the completion rates. SOPs provide a more localised level of detail in line with the VPM and centralised training is incompatible with this approach, however Victoria Police will ensure SOPs are updated and align with the VPM.

6. I recommend training be implemented within Victoria Police regarding the medical risks of individuals affected by alcohol.

   Summary of government response
   Victoria Police notes that all police members receive training regarding risks of individuals affected by alcohol and the Chief Commissioner notes the Custodial Health Service (CHS) provide training to Police Custody Officers (PCOs). CHS will assess the specific training needs for police based on their roles and their future responsibilities under the health model following the decriminalisation of public drunkenness responses to understand and implement training requirements.

7. I recommend Victoria Police request the Victorian Equal Opportunity and Human Rights Commission to conduct a section 41(c) review of the compatibility of its training materials with the human rights set out in the Charter.

   Summary of government response
   Victoria Police accepts Recommendation 7 and will engage VEOHRC to conduct a review pursuant to s41(c) of the Charter to ensure training provided to Police and Police Custody Officers promotes the protection of human rights, particularly the protection of Aboriginal Cultural Rights and the right to humane treatment when deprived of liberty.

To: The Chief Executive Officer, V/Line

8. I recommend V/Line review training materials to include input from the Aboriginal and Torres Strait community about unconscious bias and to provide training to staff as to how to reduce the impact of unconscious bias in decision making.

9. I recommend V/Line request the Victorian Equal Opportunity and Human Rights Commission to conduct a section 41(c) review of the compatibility of its training materials with the human rights set out in the Charter.

   Summary of government response
   The CEO of V/Line has accepted all recommendations.

To: The Secretary, Department of Justice and Community Safety

10. I recommend that the current volunteer model for the Aboriginal Community Justice Panel be reviewed as to is effectiveness in providing protection for Aboriginal people in custody and that this review include a clarification of the services offered by the Aboriginal Community Justice Panel with both Victoria Police and the Victorian Aboriginal Legal Service.

Summary of government response

The Secretary of DJCS has also responded accepting recommendation 10 and has commenced the process to review the Aboriginal Community Justice Panel.

Appendix 4: Public drunkenness by Local Government Area (2014-2019)

Table: Public drunkenness offences by Victorian local government area (1 April 2014 to 31 March 2019) with demand and targeted response assessments

LGA	No. of public drunkenness offences 2014-2019 (%)	Average offences per year	Demand (high/low)	Proposed cohort response
Melbourne	8,893 (21.5%)	1,779	High	Homelessness High intensity Low intensity Sudanese
Greater Dandenong	2,450 (5.9%)	490	High	Homelessness Sudanese High intensity
Mornington Peninsula	1,821 (4.4%)	364	High	Aboriginal Low intensity
Port Phillip	1,735 (4.2%)	347	High	Homelessness
Yarra	1,593 (3.9%)	319	High	Homelessness Sudanese
Greater Geelong	1,612 (3.9%)	322	High	Aboriginal Low intensity
Frankston	1,536 (3.7%)	307	High	Aboriginal High intensity
Stonnington	1,322 (3.2%)	264	High	High intensity Low intensity
Mildura	1,236 (3.0%)	247	High	Aboriginal High intensity
Greater Bendigo	1,177 (2.9%)	235	High	Aboriginal
Latrobe	1,044 (2.5%)	209	High	Aboriginal Sudanese
Kingston	818 (2.0%)	164	High	High intensity
Ballarat	765 (1.9%)	153	High	Aboriginal
Greater Shepparton	731 (1.8%)	146	High	Homelessness Aboriginal Sudanese
Maribyrnong	700 (1.7%)	140	Low	

Brimbank	698 (1.7%)	140	Low	
Maroondah	678 (1.6%)	136	Low	
Casey	666 (1.6%)	133	Low	
Glen Eira	636 (1.5%)	127	Low	
Hume	567 (1.4%)	113	Low	
Wyndham	564 (1.4%)	113	Low	
Moonee Valley	553 (1.3%)	111	Low	
Moreland	536 (1.3%)	107	Low	
East Gippsland	501 (1.2%)	100	Low	
Monash	483 (1.2%)	97	Low	
Darebin	474 (1.2%)	95	Low	
Wangaratta	474 (1.2%)	95	Low	
Yarra Ranges	473 (1.1%)	95	Low	
Knox	448 (1.1%)	90	Low	
Warrnambool	387 (<1%)	77	Low	
Boroondara	375 (<1%)	75	Low	
Whitehorse	353 (<1%)	71	Low	
Hobsons Bay	312 (<1%)	62	Low	
Cardinia	309 (<1%)	62	Low	
Bayside	301 (<1%)	60	Low	
Swan Hill	275 (<1%)	55	Low	
Wellington	267 (<1%)	53	Low	
Banyule	255 (<1%)	51	Low	
Campaspe	253 (<1%)	51	Low	
Horsham	230 (<1%)	46	Low	
Whittlesea	227 (<1%)	45	Low	
Baw Baw	216 (<1%)	43	Low	
Bass Coast	209 (<1%)	42	Low	
Melton	209 (<1%)	42	Low	
Wodonga	183 (<1%)	37	Low	
Mitchel	161 (<1%)	32	Low	

Colac-Otway	152 (<1%)	30	Low	
Moira	125 (<1%)	25	Low	
Glenelg	118 (<1%)	24	Low	
Manningham	101 (<1%)	20	Low	
Surf Coast	90 (<1%)	18	Low	
Ararat	87 (<1%)	17	Low	
Southern Grampians	86 (<1%)	17	Low	
Mount Alexander	81 (<1%)	16	Low	
Macedon Ranges	80 (<1%)	16	Low	
Northern Grampians	69 (<1%)	14	Low	
Moorabool	67 (<1%)	13	Low	
Central Goldfields	61 (<1%)	12	Low	
Nillumbik	55 (<1%)	11	Low	
South Gippsland	48 (<1%)	10	Low	
Indigo	44 (<1%)	9	Low	
Benalla	43 (<1%)	9	Low	
Murrindindi	42 (<1%)	8	Low	
Alpine	41 (<1%)	8	Low	
Moyne	34 (<1%)	7	Low	
Gannawarra	33 (<1%)	7	Low	
Corangamite	24 (<1%)	5	Low	
Mansfield	24 (<1%)	5	Low	
Yarriambiack	17 (<1%)	3	Low	
Hepburn	15 (<1%)	3	Low	
Loddon	13 (<1%)	3	Low	
Buloke	11 (<1%)	2	Low	
Pyrenees	11 (<1%)	2	Low	
Strathbogie	11 (<1%)	2	Low	
Towong	10 (<1%)	2	Low	
Queenscliffe	7 (<1%)	1	Low	
Golden Plains	4 (<1%)	1	Low	

Hindmarsh	3 (<1%)	1	Low	
West Wimmera	2 (<1%)	0	Low	
Unknown/unspecified	32 (<1%)	6	Low	

Media Release

The Hon Jaclyn Symes MLC
Leader of the Government in the Legislative Council
Attorney-General
Minister for Resources

VICTORIA State Government

Friday, 19 February 2021

HISTORIC LAWS PASSED TO DECRIMINALISE PUBLIC DRUNKENNESS

People who are drunk in public will get the health support and help they need with laws to decriminalise public drunkenness passing Parliament today.

The *Summary Offences Amendment (Decriminalisation of Public Drunkenness) Bill 2020* will save lives by ensuring no one can be locked in a police cell just for being drunk in public. It paves the way for public drunkenness to be treated as a health issue, not a crime.

These laws have been informed by Aboriginal communities and health experts – who have advocated for this reform for decades – and enable the Government to move to culturally safe and appropriate model that prioritises the health and safety of individuals who are intoxicated in public, as well as the broader community.

This will include more outreach services, training for first responders and new sobering up services – making sure people are transported to a safe place where they can receive support if they need it.

The Bill builds on three decades of work and activism, including key recommendations from the Royal Commission into Aboriginal Deaths in Custody, and the Coronial Inquest into the tragic death of Tanya Day.

Over the next two years, the Government will continue to work closely with Aboriginal communities, health experts and key stakeholders – including Victoria Police – to design, trial and refine the public health model and develop local solutions that are safe and effective.

These reforms were developed following extensive consultation to ensure they strike the right balance between protection of people who are intoxicated and community safety.

The government is currently considering trial site locations in line with advice provided by an Expert Reference Group report.

Quotes attributable to Attorney-General Jaclyn Symes

"Today we have delivered a reform that is long overdue – public drunkenness laws have caused too much pain for too many and we acknowledge everyone who has fought tirelessly for this change."

"We'll continue to work closely with Aboriginal communities, health experts and other stakeholders, including police to establish a health model that focuses on support and safety, not punishment."

Quote attributable to Minister for Aboriginal Affairs Gabrielle Williams

"We have worked with and listened to the Aboriginal community to deliver real change. These reforms will save lives and provide fair and culturally appropriate care – that's the right thing to do."

Quote attributable to Minister for Health Martin Foley

"This important change wraps a culturally appropriate health response around vulnerable people who are drunk in public, giving them the immediate help they need."

Media contact: Stephanie Jones 0448 359 507 | stephanie.jones@minstaff.vic.gov.au

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Victoria's mental health and wellbeing workforce strategy 2021–2024

December 2021

VICTORIA State Government | Department of Health

We acknowledge Victoria's First Peoples and their rich culture.

We respectfully acknowledge all Countries of the Kulin Nation and pay respects to their Spiritual Ancestors, Elders, families, children and young people of past, current and future generations. This acknowledgement also extends to the Traditional Custodians protecting and nurturing its lands, waters and other significant sites.

We recognise their lived experiences of colonisation and the strength and resilience of their living cultures and connection to Country. We embrace the spirit of reconciliation and commit to working towards community-driven and self-determining outcomes that ensure equality of outcomes and an equal voice.

To receive this document in another format, phone 1300 650 172, using the National Relay Service 13 36 77 if required, or email Mental Health Workforce (MentalHealthWorkforce@health.vic.gov.au).

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

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Except where otherwise indicated, the images in this document show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. This document may contain images of deceased Aboriginal and Torres Strait Islander peoples.

In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

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Available at: https://www.health.vic.gov.au/strategy-and-planning/mental-health-workforce-strategy

Minister's foreword

Nine months ago, I stood up at an historic sitting of the Victorian Parliament alongside the Premier and made a commitment to rebuild Victoria's mental health system from the ground up.

Not just to improve things a little bit, but to reconsider every dimension of the care Victorians receive if they are living with a mental illness or supporting someone who is facing mental health challenges.

But providing better care requires people. People who are skilled and trained to do the jobs that will deliver that care, and who approach their work with compassion, empathy and dedication.

From social workers in community health, to mental health nurses in our acute units, we need a workforce that is built to support Victorians whether they are experiencing mental health challenges for the first time or dealing with chronic illness.

Victoria's mental health and wellbeing workforce strategy 2021–2024 sets out a clear and actionable plan to attract, train and support the workforce we need for our future. If we are to deliver on every recommendation of the Royal Commission, as promised, we must start by strengthening and expanding our mental health workforce.

This strategy identifies the gaps and the challenges we face in getting workers skilled up and into jobs – and provides a pathway towards building a workforce that is capable of delivering the care Victorians need and deserve.

We have already made significant progress on many of the workforce initiatives recommended by the Royal Commission into Victoria's Mental Health System, including a record $228 million investment since the 2020-21 Victorian State Budget. But we acknowledge that we are at the start of a long process to build the foundations for change, and to ensure we stay on track we will review and update the strategy every two years, so it reflects the needs of the mental health and wellbeing workforce as we build the new system from the ground up.

To all members of our mental health and wellbeing workforce, I want to thank you on behalf of the Victorian community for your dedication, perseverance and the important work you do to care for our state each day as we create a better system of care for every single Victorian.

The Hon James Merlino MP
Deputy Premier
Minister for Mental Health

Contents

Minister's foreword **3**

1. Reforms to promote mental health and wellbeing for all Victorians **6**
- A bold vision for reform 6
- Better mental health for Victoria leading to better opportunities for jobs 7
- A different approach to change 7
- The workforce's role in system reforms 7

2. Overview of Victoria's mental health and wellbeing workforce strategy 2021–2024 ..... **8**
- Purpose of the strategy 8
- Stakeholder input 9
- Vision for the mental health and wellbeing workforce 10
- Key priorities 11

3. Spotlight: Lived and living experience workforces **14**

4. Workforce profile **16**

5. Spotlight: Supporting workforce capability to provide integrated care **18**

6. Priority 1: Building workforce supply **19**
- **Action area 1a:** Attracting people to mental health careers 23
- **Action area 1b:** Growing graduate, post-qualifying and transition training pathways 24
- **Action area 1c:** Building emergent and new workforces 26
- **Action area 1d:** Ensuring workforce meets regional needs 27

7. Spotlight: Capability Framework **28**

8. Priority 2: Building workforce skills, knowledge and capabilities **29**
- **Action area 2a:** Ensuring education and training meets the needs of the community 30
- **Action area 2b:** Embedding a system wide capability focus 32
- **Action area 2c:** Improving capability through ongoing training opportunities 34
- **Action area 2d:** Ensuring workforce reflects and responds to diverse communities 35

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9. Spotlight: Aboriginal social and emotional wellbeing workforce **37**

10. Priority 3: Supporting the safety, wellbeing and retention of the mental health and wellbeing workforce **38**

Action area 3a: Establishing workforce wellbeing monitoring and supports 42

11. Spotlight: Rural and regional incentive **45**

12. Priority 4: Building system enablers for excellence in workforce **46**

Action area 4a: Improving system planning and sustainability 47

Action area 4b: Shaping the workforce for the future 48

13. Spotlight: Collaborating with the Commonwealth and other partners **50**

14. Implementation **53**

15. Appendices **58**

Stakeholder engagement 58

Members of the Workforce Technical Advisory Group 59

Glossary 60

1. Reforms to promote mental health and wellbeing for all Victorians

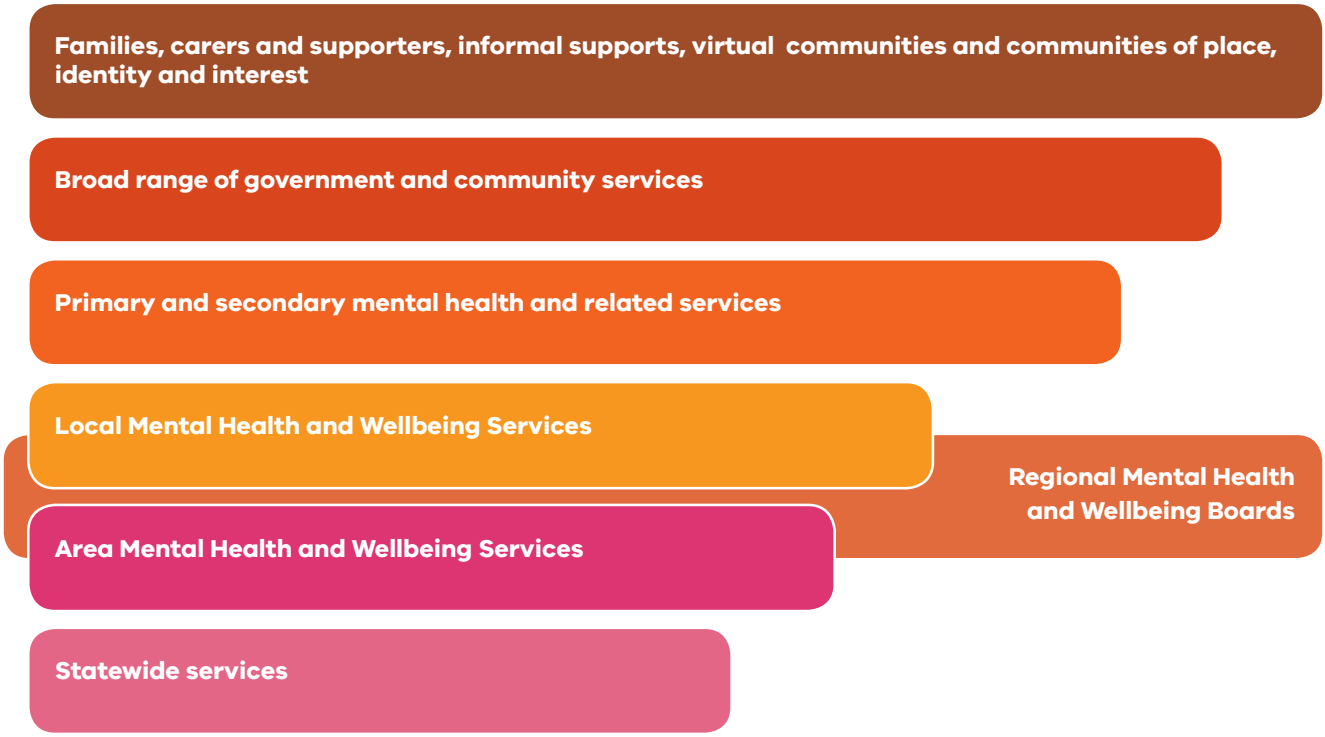
A bold vision for reform

The Royal Commission released its final report in March 2021, setting out its vision for the future mental health and wellbeing system. The 65 recommendations of the final report, along with nine recommendations in the interim report, lay the foundations for a future where more people needing mental health and wellbeing support will receive services in the community. The system will be responsive and integrated, and people will be able to access a mix of treatment, care and support options as set out in Figure 1.

The ten-year reform program is ambitious, and will see:

- community-based services at the core of the new system
- services that are responsive to people's level of need
- promotion of good mental health and wellbeing where people live, work and learn
- support for all Victorians to experience their best mental health and wellbeing
- new system foundations underpinned by lived experience leadership and supported by a strengthened workforce
- a commitment to research and innovation
- evidence-based service planning and contemporary, fit-for-purpose infrastructure.

Figure 1: Victoria's new responsive and integrated system



Royal Commission into Victoria's Mental Health System, Final Report, Volume 1, p. 297

Better mental health for Victoria leading to better opportunities for jobs

The Victorian Government is committed to improving Victoria's mental healthcare system by investing in better support, better environments and better facilities. By doing this now, and into the future, there will be better outcomes for many more Victorians.

In order to make this happen, the government needs to recruit many more people into the mental healthcare workforce, meaning there are better job opportunities across a range of disciplines, roles and levels.

A new approach to change

The Royal Commission made clear statements that the government's approach to reform needs to be different. Many flaws in the current system stem from how the system was designed – favouring expertise inside government or clinical settings or choosing organisational needs over people's experience.

To avoid repeating these mistakes, these reforms will apply a different approach, focused on collaboration and learning. Lived experiences will be central to the work and will be part of planning, design and delivery in the new system. There is a commitment to listen to expertise from diverse sources including the community, clinicians, providers, and other sectors who have been through change processes.

The workforce's role in system reforms

The mental health and wellbeing workforce will have a key role in these changes. Members of the workforce hold the knowledge and experience to guide service design; they are the trainers of new staff and continuous builders of skills; and they are the backbone of the system who will enable a holistic care environment for consumers.

In the Royal Commission's interim report, *Recommendation 7: Workforce readiness* sets out actions to strengthen and expand the workforce, and to build an evidence base to plan, project and respond to future needs and demand. The final report builds on these foundations. Implementation of *Recommendation 57: Workforce strategy, planning and structural reform* will see a workforce that is of the appropriate size, diversity and composition to deliver services to Victorians in the reformed system. *Recommendation 58: Workforce capabilities and professional development* will ensure members of the workforce have the right capabilities across professions, roles and settings, and *Recommendation 59: Workforce safety and wellbeing* will deliver sustainable working environments where staff feel safe, supported and valued.

Victoria's mental health and wellbeing workforce strategy 2021–2024 sets out priority activities to address existing challenges in the workforce pipeline, build attractive and rewarding workplaces, and pursue excellence in practice and outcomes. The Victorian Government has committed to refreshing the strategy every two years so it can reflect the changing needs of the system, the community, and of the mental health and wellbeing workforce.

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2. Overview of *Victoria's mental health and wellbeing workforce strategy 2021–2024*

Purpose of the strategy

Victoria's mental health and wellbeing workforce strategy 2021–2024 sets out a coordinated and strategic approach to deliver the diverse, skilled and multidisciplinary workforce required for Victoria's reformed mental health and wellbeing system. This strategy sets out the Government's vision for the mental health and wellbeing workforce, including the activities that are necessary in the short, medium and longer term to deliver on this vision and implement recommendation 57 of the Royal Commission's final report.

Approach to the strategy

This strategy sets out four key priorities for workforce reform, along with actions to build the mental health and wellbeing workforce that Victoria needs. It reflects immediate and inherited challenges to reform, and focuses on the urgent need to stabilise workforce supply. The strategy will provide a basis for structural reforms that assist in attracting, training and transitioning staff into new roles, services and models of care. These structural reforms will be revisited every two years to ensure the strategy reflects and responds to the evolving mental health and wellbeing system.

Final report recommendation 57: workforce strategy, planning and structural reform

The Royal Commission recommended that the Victorian Government:

1. ensure that the range of expanded mental health and wellbeing services is delivered by a diverse, multidisciplinary mental health and wellbeing workforce of the necessary size and composition across Victoria.
2. by the end of 2023, implement and support structural workforce reforms to:
   a. attract, train and transition staff to deliver the core functions of services across Local, Area and Statewide Mental Health and Wellbeing Services; and
   b. develop new and enhanced workforce roles as described by the Royal Commission in its final report.
3. develop, implement and maintain a Workforce Strategy and Implementation Plan and, by the end of 2021, enable the Department of Health to:
   a. conduct ongoing workforce data collection, analysis and planning;
   b. establish a dedicated workforce planning and strategy function; and
   c. encourage collaborative engagement and partnerships with relevant workforce stakeholders in implementing recommendations.

Stakeholder input

This strategy has been developed through the active support and leadership of the mental health sector. The Department of Health hosted a number of consultation activities, which were attended by more than 350 people and 100 organisations.

Lived experience engagement

Lived experience is central to the transformation of the mental health and wellbeing system. Engagement on this strategy included people who brought lived experience perspectives, including consumer and carer peak bodies (the Victorian Mental Illness Awareness Council (VMIAC) and Tandem) and their members as well as members of the lived experience workforces.

People with a lived experience will have a central role in implementing the strategy. To further embed lived experience perspectives and support engagement on strategy initiatives, the Department of Health has funded two workforce lead roles at VMIAC and Tandem.

Engagement activities

A summary of engagement activities is set out in Figure 2, with further detail provided in Appendix 1.

Figure 2: Engagement activities to support the development of the workforce strategy

Workforce forum

146 attendees

Workforce Technical Advisory Group

23 members

Targeted engagement workshops

219 people across 6 workshops

Public consultation process

41 submissions received

Workforce census and personnel survey

All 19 Victorian public mental health services completed the workforce census, with 1,932 personnel survey responses received

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Vision for the mental health and wellbeing workforce

Five principles will guide the design and delivery of workforce reforms, as set out in Figure 3.

Figure 3: Workforce reform principles

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Key priorities

The Victorian Government is committed to reforming the system and workforce and is already delivering **$269 million to supporting workforce reform**.

This includes **$41 million in new initiatives** for *Victoria's mental health and wellbeing workforce strategy 2021–2024* which will provide **358 full-time equivalent positions** across the mental health system. These new initiatives build on the **$228 million** previously invested through the 2020-21 and 2021-22 Victorian State Budgets, which provided approximately **580 new entry-to-mental health positions** for nurses, lived experience workers and allied health roles.

This **$269 million** investment includes:

Graduate mental health nurses

$70 million

to support up to **120 graduate mental health nurses** and supporting nurse educators each year

Lived experience workforces

$40.7 million

to support and grow the consumer and carer **lived experience workforces,** including support for 30 peer cadets each year

Allied health graduates

$39.4 million

in funding to support **60 allied health graduates** annually, with an additional **41 graduates** and eight educators funded to boost critical supply in 2022

Junior doctors

$37.4 million

to continue training up to **575** of Victoria's junior doctors in **foundational mental health skills**

Mental health and AOD workforces

$30 million

annually for workforce development for the mental health and AOD workforces

Allied health and nurse clinicians

$12.2 million

for a training program for experienced allied health and nurse clinicians to transition into mental health with up to **50 nurses**, **30 allied health** training positions and supporting educator roles funded

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Key priorities (cont.)

Rural and regional workforce

$10.5 million

for the rural and regional workforce incentive program

Students

$8 million

to provide students the opportunity to work and start building careers in mental health alongside their study

Enrolled nurses

$4.6 million

for a new enrolled nurse pipeline, with **40 enrolled nurses** and eight educators trained in mental health in 2022

Capacity building programs

$4.5 million

investment in capacity building programs for the psychiatry training pipeline, including **a new training group**, continued support of **mandatory training placements** and new **Directors of Training**, including for addiction psychiatry and rural and regional services in 2022

Mental health careers

$3.7 million

to attract people to mental health careers

Postgraduate scholarships

$1.3 million

for up to **70 postgraduate scholarships**, including 20 to AOD practitioners in 2022 to undertake postgraduate training such as a Graduate Certificate in Mental Health

Capability training program

$0.6 million

capability training program to implement the Victorian Mental Health and Wellbeing Workforce Capability Framework

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Strategy overview

Priority	Action areas
Priority 1: Building workforce supply	**1a:** Attracting people to mental health careers **1b:** Growing graduate, post-qualifying and transition training pathways **1c:** Building emergent and new workforces **1d:** Ensuring workforce meets regional needs
Priority 2: Building workforce skills, knowledge and capabilities	**2a:** Ensuring education and training meets the needs of the community **2b:** Embedding a system wide capability focus **2c:** Improving capability through ongoing training opportunities **2d:** Ensuring workforce reflects and responds to diverse communities
Priority 3: Supporting the safety, wellbeing and retention of the mental health and wellbeing workforce	**3a:** Establishing workforce wellbeing monitoring and supports
Priority 4: Building system enablers for excellence in workforce	**4a:** Improving system planning and sustainability **4b:** Shaping the workforce for the future

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SPOTLIGHT

3. Lived and living experience workforces

The Royal Commission outlines a vision for a system in which people with lived experience of mental illness or psychological distress and their families and carers shape the design and delivery of services, and where lived experience workforces are a core part of multidisciplinary teams and care models.

There are designated lived and living experience workforce positions across the mental health, Alcohol and Other Drug (AOD) treatment and harm reduction sectors.

To enable lived and living experience workforces to be effective, the roles need to be supported, valued and sustained. The 2021–22 Victorian State Budget invested $40 million over four years to build the required supports, structures and career pathways for the lived and living experience workforces to ensure a solid foundation for growth.

Initiatives to meet the following 10 actions will be designed and implemented with lived experience leadership and using the principles of co–production. Priorities for action are:

1. Strengthen discipline foundations

Commencing in early 2022, discipline frameworks to articulate each discipline's professional and ethical values, practice principles and scope of practice will be developed.

2. Improve understanding of lived and living experience workforces in mental health and AOD services and create conditions that support best practice lived experience work and models of care

Commencing in 2022, services will have access to training and development from lived experience educators to build their capability in this area.

3. Increase lived and living experience leadership roles

In addition to establishing new lived and living experience leadership roles within the Mental Health and Wellbeing Division and in the mental health and AOD sectors, a further $2 million has been invested in new leadership positions and professional development for lived experience workers in mental health services.

New and expanded services will result in lived experience leadership roles increasing across every part of the system. Growth will be measured through a workforce census and personnel surveys that will be conducted every 12–24 months.

4. Promote sustainability of lived experience roles and models of care that include lived and living experience workforces

Work will be undertaken to understand how to effectively embed establishing lived and living experience workforces into models of care and multidisciplinary teams; identify optimal workforce models and composition (role types, numbers and distribution) including models that support interconnections with Aboriginal social and emotional wellbeing workforces.

5. Create access to quality training and development and qualifications for lived and living experience workforces

A $360,000 grant program is in place to support lived experience workforce leadership, project management skills, and capability building in community mental health services. From 2022, an ongoing program of training and development will be commissioned and higher education needs will be identified.

6. Create equitable access to discipline specific supervision for lived and living experience workforces

A program of work is underway to build mental health lived experience workforces' capability and capacity to provide supervision through development and delivery of training, supervision supports and access to discipline-specific supervisors through the Centre for Mental Health Learning supervision database.

7. Support career pathways into lived and living experience work

A $1.3 million 12–month peer cadet program is underway across six community-managed mental health services to support lived

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experience workforces studying a Certificate IV in Mental Health Peer Work to gain valuable work experience and mentoring as they study. This program will be expanded into public specialist mental health services and opportunities identified across all lived and living experience workforces and for priority population groups.

8. Create accountability by establishing and monitoring measures for change

In addition to data published in the *Lived Experience Workforce Positions Report 2019–20*, projects are underway to collect current workforce data; understand the experiences of the lived and living experience workforces; understand organisational attitudes and establish ongoing measures to monitor change.

9. Strengthen networks and support communities of practice

Communities of practice are resourced and in place for AOD treatment and harm reduction peer workers and the Centre for Mental Health Learning supports a number of online communities of practice.

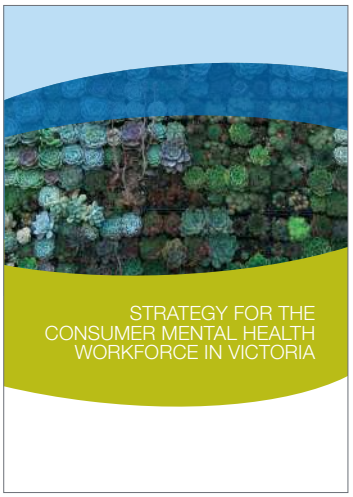
Communities of practice will be established for Consumer and Carer Consultants in 2022. Work will commence to identify ways to strengthen and support existing networks.

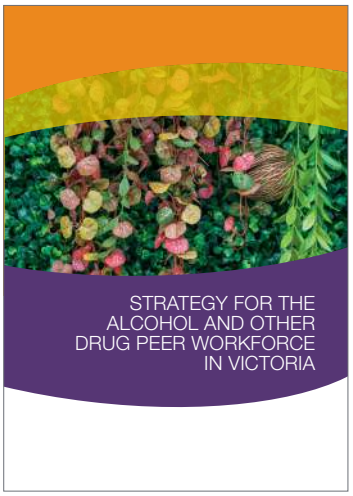
10. Attract people into lived and living experience work and promote careers

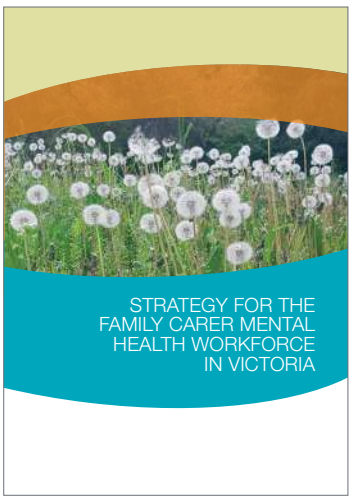
On completion of the discipline frameworks and establishment of key structures and supports, an approach to attraction and promotion of lived and living experience workforces will be developed.

Recognising that each of the lived and living experience workforce disciplines are at different stages of development, strategies for each discipline have been co-produced that outline further actions. These strategies will be monitored on an annual basis in partnership with the Department of Health's Lived Experience Workforce Advisory Group. Further information about lived experience workforce positions and access to the strategies can be found on the department's lived experience workforce initiatives website (www.health.vic.gov.au/workforce-and-training/lived-experience-workforce-initiatives).

A strategy for the harm reduction peer workforce is currently in development.







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4. Workforce profile

The mental health workforce comprises a range of different professionals and disciplines which contribute both to direct treatment, care and support and to the operational and leadership requirements of the system. This includes lived experience workers, nurses, a wide variety of allied health professionals, psychologists, psychiatrists and other medical practitioners, as well as health management and administration and support personnel. To fulfil recommendation 7 of the Royal Commission's interim report, work has been undertaken to create a current profile of the mental health workforce utilising Commonwealth Government datasets of Australia Health Practitioner Regulation Agency (Ahpra) registered professionals, as well as drawing on data from the Victorian Department of Health's August 2021 Workforce Census, which was completed by all 19 public mental health services.

Figure 4: Ahpra-regulated professionals (headcount) by sector

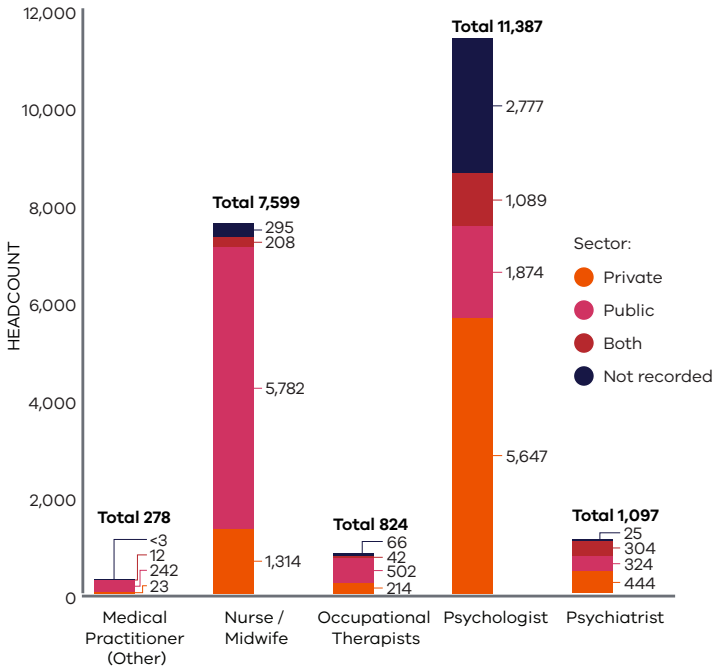
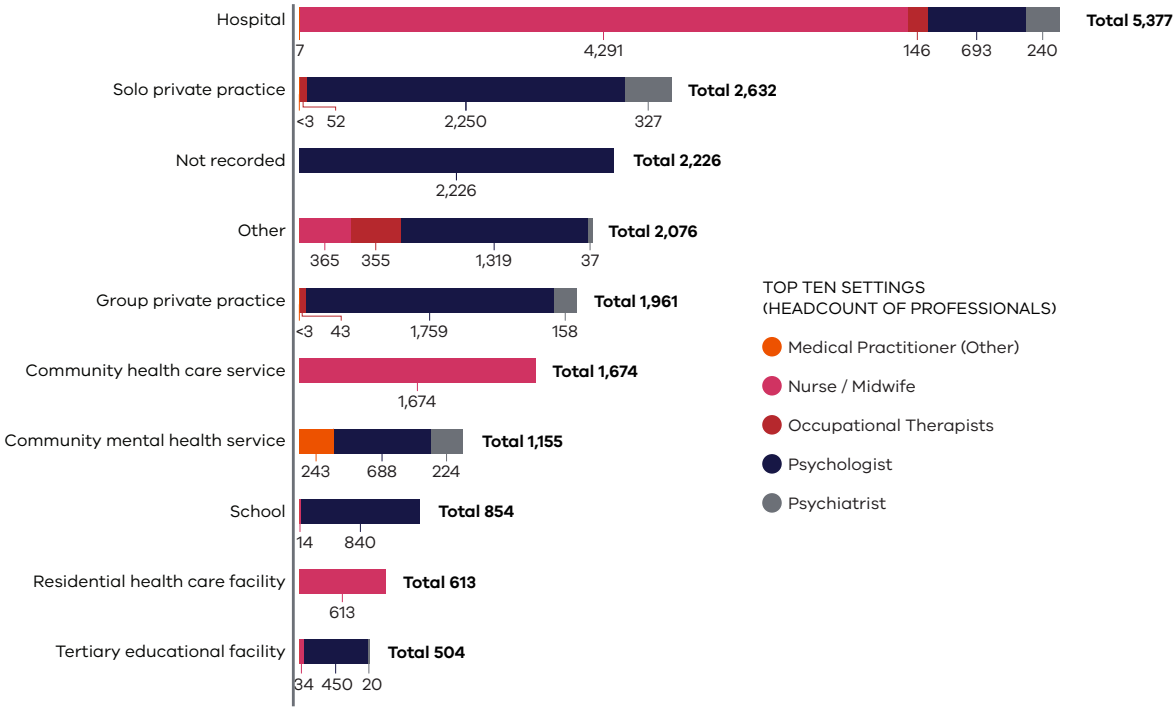
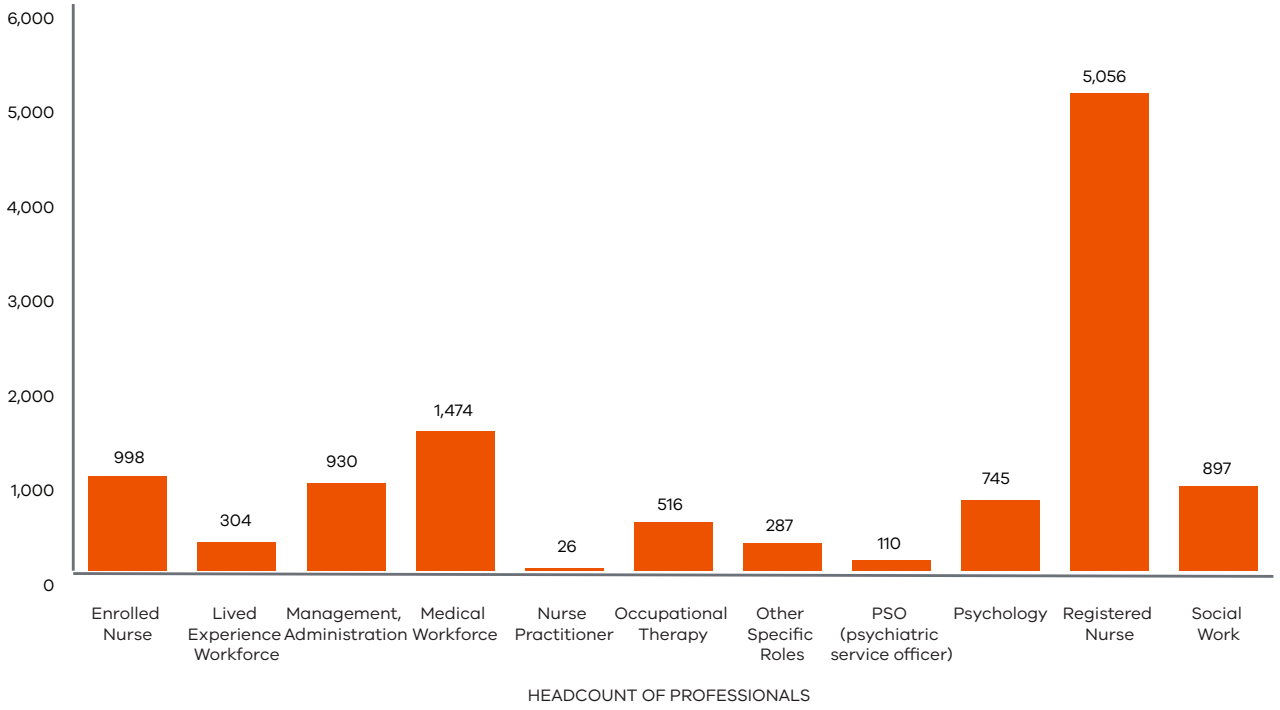


Figure 5: Top ten workplace settings for Ahpra-regulated professionals



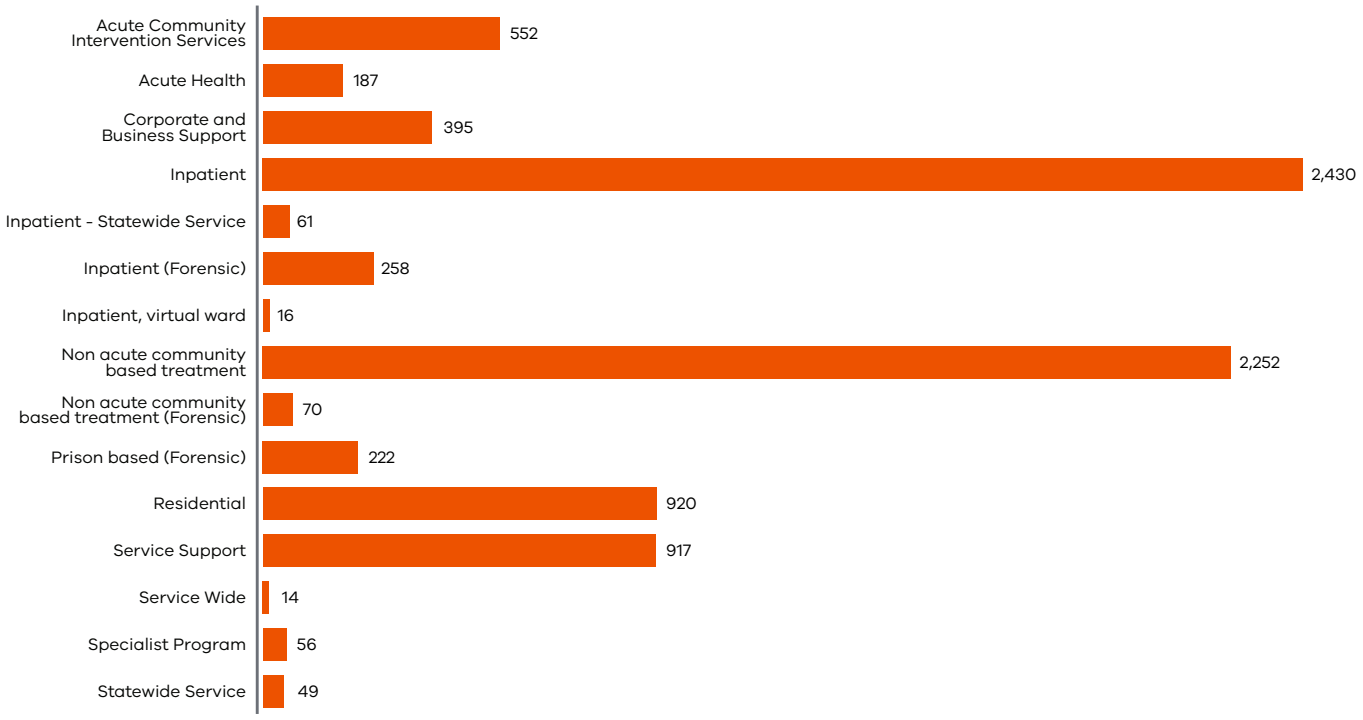
Source: Commonwealth Healthcare Workforce Dataset Tool data (2020)
Note: Data is presented in headcount. Medical practitioners include (1) Addiction medicine practitioners, and (2) Other medical practitioners that work in community and residential mental health settings (this relates to any medical practitioner that has 'job setting' filtered for 'community mental health' and 'residential mental health'. This may include general practitioners and physicians).

Figure 6: Headcount of public specialist mental health professionals



Source: Service Census Survey dataset (2021).

Figure 7: Public specialist mental health professionals (FTE) by job setting



Source: Service Census Survey dataset (2021)

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SPOTLIGHT

5. Supporting workforce capability to provide integrated care

The Royal Commission highlighted the lack of integration of treatment for co-occurring substance use and addiction and mental health concerns. The separation of mental health and AOD services has resulted in consumers having to navigate two distinct systems that often treat their interrelated needs separately.

Recommendations 35 and 36 of the Royal Commission's final report create the opportunity to improve outcomes for people with co-occurring concerns, by requiring mental health services to provide integrated care – including through the establishment of a statewide service for people living with mental illness and substance use or addiction – and by increasing the number of addiction specialists in Victoria. As well as providing dedicated research, primary and secondary consultation functions, the statewide service will have a role in supporting education and training initiatives for a broad range of mental health and AOD practitioners and clinicians.

Current initiatives to support integrated care capability include the cross-sector Victorian Dual Diagnosis Initiative, which aims to develop the capacity of mental health and AOD workers, agencies and sectors to recognise and respond effectively to people experiencing co-occurring mental health and substance use concerns and related issues.

Victoria's mental health and wellbeing workforce strategy 2021–2024 includes additional investment of $1.3 million to provide up to 70 postgraduate scholarships, including 20 to AOD practitioners in 2022 to undertake postgraduate training such as a Graduate Certificate in Mental Health.

An integrated care capability pilot is also underway, led by First Step in partnership with 11 services across greater Melbourne to test the implementation of the Comprehensive Continuous Integrated System of Care model at each service. This project will identify service and workforce development requirements to enable provision of integrated care.

The AOD workforce will make a significant contribution to the new mental health and wellbeing system over the coming years. There are existing and predicted workforce supply challenges for the AOD sector, which will be exacerbated by planned mental health and wellbeing service expansion. It is therefore important to consider AOD workforce needs as part of this strategy.

In addition to funding 100 new positions in the AOD sector in 2020–21 to support vulnerable people who became disconnected from AOD services during the pandemic, the Victorian Government supports a number of AOD-specific capability building initiatives, including:

- a program of workforce development to support new workers entering the AOD sector
- AOD training for nurses
- scholarships for the Graduate Certificate in Addictive Behaviours
- professional development webinars
- delivery of the AOD Skill Set (four VET units of competency)
- AOD peer workforce development
- resources to assist services to support student placements
- support for addiction medicine and addiction psychiatry advanced trainees.

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6. Priority 1: **Building workforce supply**

Victoria's mental health and wellbeing workforce needs to grow significantly to deliver the treatment, care and support that Victorians need. Supply challenges need to be addressed both in order to meet increasing demand for mental health services and to prepare for changes to frontline service delivery as reforms are implemented.

The new system will shift demand patterns for mental health and wellbeing services, with most consumers using Local Mental Health and Wellbeing Services, and more intensive needs being met through Area Mental Health and Wellbeing Services and statewide services. Changed approaches to treatment, care and support, service delivery settings, and the anticipated reach of service offerings will all require the workforce to grow in a planned way.

The long-term objective is for Victoria's expanded mental health and wellbeing services to be delivered by a diverse, multidisciplinary workforce of the necessary size and composition. To achieve this, critical existing shortages must be addressed, and a pipeline must be built to grow the workforce.

Demand for services

Demand for mental health services has steadily increased over time and is at an all-time high. The coronavirus (COVID–19) pandemic has compounded demand for services, with the impacts expected to persist for many years. The pandemic has simultaneously exposed the sector to great stress; shown the sector to be capable of great innovation and flexibility; and resulted in broad recognition of the importance of mental health in community wellbeing.

Throughout consultations, stakeholders communicated overwhelmingly that workforce shortages are affecting workforce wellbeing and the ability of the system to meet demand for services and to deliver the high-quality treatment, care and support the workforce aims to provide.

Workforce requirements

The size of Victoria's mental health workforce needs to increase to keep up with current community demand for mental health services. In addition, it needs to grow substantially – and in a planned way – to deliver on the Royal Commission's recommendations.

As well as an overall increase in size, the profile of the workforce will change. New workforce cohorts will need to be created to deliver the expanded range of services and initiatives, and there may be changes to team composition. The distribution of the workforce will also transform as new services are established and shift the centre of mental health service delivery from acute, tertiary care to community-based treatment, care and support. Figure 8 sets out the types of roles which will be required in the reformed service system.

Building workforce supply: Priority action areas

Action area 1a	Action area 1b	Action area 1c	Action area 1d
Attracting people to mental health careers	Growing graduate, post-qualifying and transition training pathways	Building emergent and new workforces	Ensuring workforce meets regional needs

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Figure 8: Indicative workforce supply considerations

Local

- Allied health and other therapeutic roles across local services
- Lived experience and peer support roles
- Wellbeing support workers across local services
- Young career support positions
- Psychiatry and clinical psychology roles across local services

Area

- Specialist trauma practitioners
- Adult and older adult and youth mobile assertive outreach teams
- Expert older adult multidisciplinary teams
- Forensic community outreach teams and forensic transition teams
- Crisis response telephone/ telehealth workers
- Mental health crisis outreach teams
- Peer support worker roles across bed-based services, emergency department crisis hubs, and crisis respite facilities
- Specialist infant, child, youth and family mental health practitioners
- Wellbeing support workers
- Psychiatry, clinical psychology, allied health and therapeutic roles across bed-based and other area services

Statewide

- Mental health and addition specialist practitioners for the new statewide substance use or addition services
- Trauma education and development specialists for the new Statewide Trauma Service
- Specialist youth forensic mental health practitioners for the new Statewide Specialist Youth Forensic Mental Health Service
- Specialist suicide bereavement clinicians and peer support workers for state postvention bereavement support
- Specialist suicide prevention and response mental health practitioner and LGBTIQ peer support worker roles for the new LGBTIQ model of aftercare service

System wide

- Lived experience roles, including consumer and carer roles across a range of service needs and settings
- Koori mental health liaison officers across service settings
- 'Liaison' or 'peer' roles to support LGBTIQ and culturally diverse communities

Supply challenges

The scale of Victoria's mental health workforce challenge is large. Modelling shows a need for approximately 2,500 additional workers in the public mental health system over the next three and a half years to stabilise the system and implement funded reforms.

This modelling includes projections for existing disciplines in the public mental health system, and is based on state and national datasets, including the department's August 2021 Workforce Census. In addition to these 2,500 workers for existing disciplines, the reformed system will also require new workforce disciplines and roles, with further design work needed before demand for these workforce requirements can be estimated. This estimate does not include demand in adjacent settings such as the private sector, justice or education.

> **'Focus recruitment to industries that have portable skills. Particularly target people from industries that have been impacted by COVID-19 including hospitality, tourism and travel. These people can be recruited and trained to deliver low intensity interventions, life coaching, service navigation and peer groups.'**
>
> *Submission to Department of Health, August 2021*

There are shortages of mental health workers across most occupations and professional groups, with service expansion and an ageing workforce expected to add further challenges.

Addressing the challenge

Through these reforms, the Victorian Government is committed to making the mental health system better for all.

This means more jobs for nurses and psychiatrists, allied health and lived experience workers, as well as new disciplines to deliver new programs and services across the state.

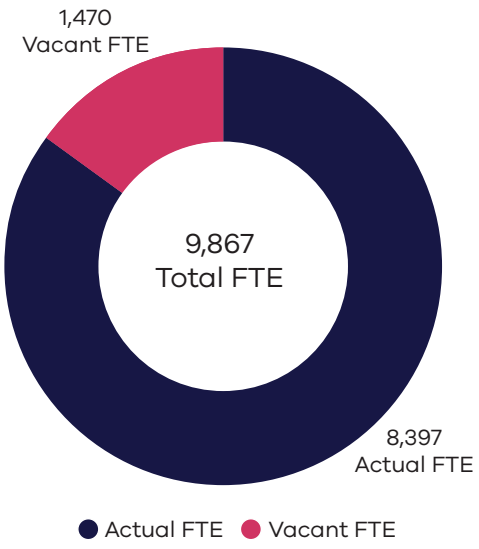
Ultimately, this is about enabling all Victorians with mental illness and psychological distress and their families, carers and supporters to receive the care they need.

Important levers in ensuring sustainable workforce supply include:

- attraction and entry – promotion and marketing, education and training pathways, student places, and curriculum
- accreditation and employment – accreditation, registration, recruitment, workplace conditions and industrial relations
- development and retention – ongoing professional development, career pathways, incentives and credentialling.

These levers feature in the actions outlined below. However, achieving workforce reform will require multiple layers of government, professional bodies, unions, service providers and training providers to work together.

Figure 9: Public specialist mental health service overall vacancy rate (FTE)



Source: Service Census Survey dataset (2021). Melbourne peri-urban areas surround Metropolitan Melbourne and interface with rural or bush areas – they are neither urban nor rural in the conventional sense. There are six peri-urban areas in Victoria (Bass Coast, Baw Baw, Mansfield, Mitchell, Moorabool and Murrindindi).

Figure 10: Public specialist mental health FTE positions by region (actual and vacant FTE positions)

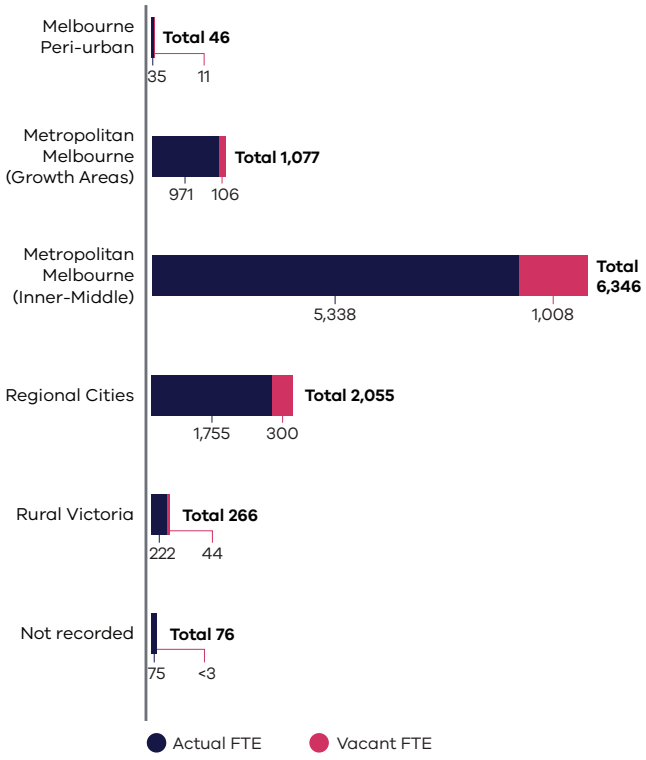
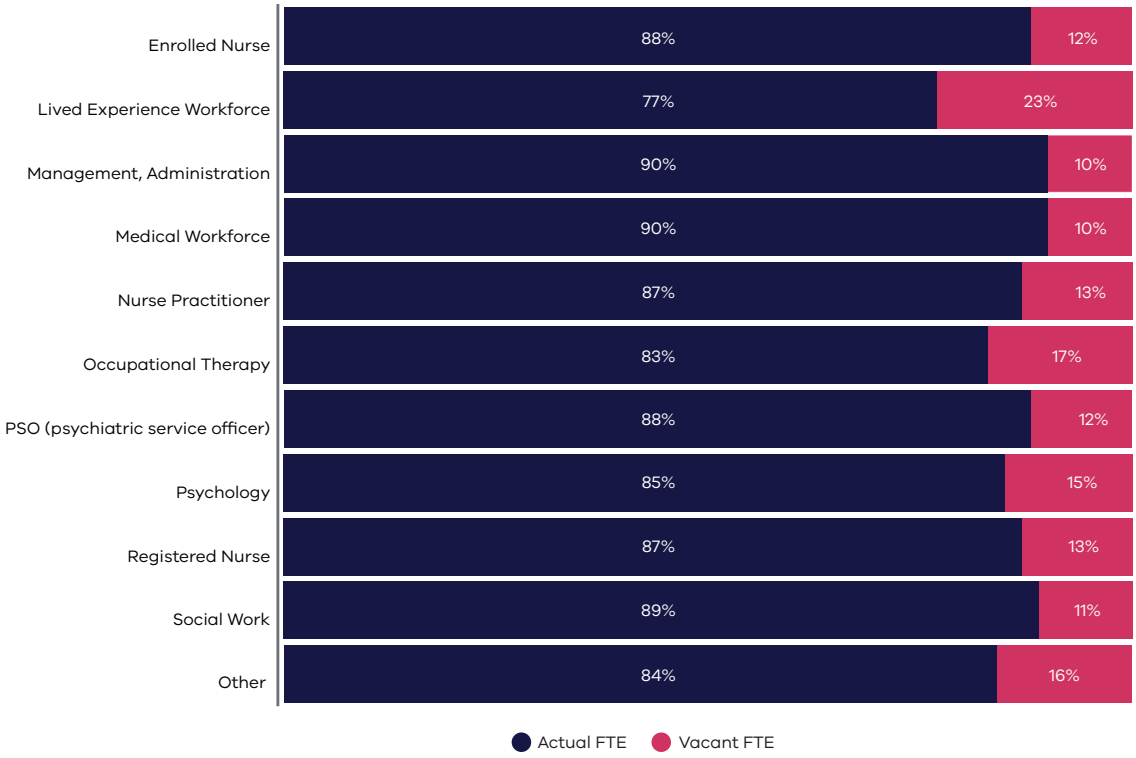


Figure 11: Public specialist mental service vacancy rate by professional discipline



Source: Service Census Survey dataset (2021). 'Other specific roles' refers to AOD workers / substance use and addiction support, child psychotherapists, welfare workers, youth workers, community development workers, community engagement workers, dieticians, eating disorder workers, music therapists and more. 'Generic clinical vacant roles' refers to generic vacancies.

Action area 1a: Attracting people to mental health careers

Positive and early exposure to the mental health system is one of the strongest indicators for pursuit of a mental health career, countering stigma and community perceptions of working in the mental health sector. Increasing awareness of mental health careers and the opportunities available in the sector is therefore a key focus.

In addition to attracting Victorians and interstate workers to the sector, Australia relies on overseas-trained mental health workers to meet its workforce needs. In Victoria, international recruitment is used to respond to shortages in both public and private settings and across metropolitan and rural health services. The coronavirus (COVID–19) pandemic has significantly interrupted this source of expertise, compounding workforce supply shortages in key professional groups.

> 'Develop strong linkages with universities and explore opportunities for innovative student placement models and pre-qualification initiatives...'
>
> *Submission to Department of Health, August 2021*

Actions outlined below seek to attract people from Victoria and interstate into mental health careers, pave the way to restore the international workforce pipeline, and provide additional exposure and understanding of the sector to potential workers.

Initiatives commenced and commencing

The local mental health workforce is the backbone of the reforming mental health and wellbeing system, but the demand for workers across the sector exceeds the current supply. To complement local and interstate attraction of new workers, the Victorian Government is working to restore the supply of international workers. International recruits and Australian healthcare workers currently located overseas are eligible for facilitated entry supports upon employment at a Victorian public health service. This includes up to 1,000 relocation subsidies of up to $2,000 in value. Additional relocation supports and funding for mental health workers moving to regional and rural locations are currently available.

A new domestic attraction campaign aims to encourage local and interstate clinicians to take up career opportunities in Victoria's reforming system. The campaign will be scaled up and expanded to target non-clinical and international workforces in the 2022–23 financial year.

Medium and longer-term actions

Over the long term, an attraction campaign will play a leading role in attracting new workers into the system. The campaign will be periodically refreshed to keep pace with reforms, with future iterations to include online recruitment support and department-led partnerships with recruitment agencies.

Resuming international recruitment at scale will also occur in the medium and longer term. To assist this, additional supports for international recruitment will be rolled out. This will include migration toolkits, community orientation, settlement supports and mentoring for migrants to promote their successful transition into the Victorian community and the public mental health and wellbeing system.

The Victorian Government will continue to advocate to the Commonwealth Government to address barriers to immigration for mental health professionals. Currently, age limits for permanent residency are an impediment to attracting much-needed specialists and leaders, and limits to working hours for international students can delay qualifications. Streamlined immigration pathways will also be sought to support the successful attraction of overseas professionals.

> 'Overseas and interstate workforce attraction will be key to us being able to enact the required growth in service provision.'
>
> *Submission to Department of Health, August 2021*

Action area 1b: Growing graduate, post-qualifying and transition training pathways

For most workforces in the mental health system, qualifying as a mental health worker takes time. To support training requirements and workforce growth, the system needs the right number of training positions and clinical supervision structures.

Mental health and wellbeing services need the capacity to support mandatory rotations in psychiatry training, and more senior psychologists are needed to fulfil the training requirements of probationary psychologists.

> 'Educational institutions and tertiary services need to work together to develop an appropriately trained workforce.'
>
> *Submission to Department of Health, August 2021*

In the psychiatry training pipeline there are particular challenges with the number of trainees exceeding the number of places in mandatory rotations in Child and Adolescent and Consultation Liaison Psychiatry, which results in delayed graduation for trainees.

In addition, Victoria has historically relied on international migration to augment local training shortages in key disciplines, and particularly in psychiatry. Victoria recruits Senior International Medical Graduates, however lower examination pass rates for this cohort means training places are filled but do not necessarily materialise into trained resources. As international recruitment again gains pace, additional training support needs to be provided to boost qualification rates for this cohort.

For allied health graduates – including psychology and social work students – high training hurdles impact on entry and completion, including the requirement for social work students to undertake 1,000 hours of unpaid placements, and significant supervision requirements for psychology. Removing these barriers, in collaboration with the Commonwealth Government, is a priority.

Experienced professionals from other areas of practice are well equipped to work in the mental health sector. To encourage recruitment of members from this cohort, clear transition pathways providing appropriate support are needed.

Attrition of experienced and senior allied health staff is also a key challenge. More senior career opportunities and supports will be needed to retain these professionals.

Initiatives commenced and commencing

The Victorian Government has invested $228 million over the 2020–21 and 2021–22 Victorian State Budgets to build a diverse and skilled mental health workforce. Across the five years from 2020–21 to 2024–25, the funding will support an increase to workforce supply by funding approximately 582 full-time equivalent entry positions. That has supported implementation for:

- **Postgraduate mental health nurse scholarships: $16.1 million** for up to 685 scholarships. This provides up to 140 scholarships annually, as recommended in the Royal Commission's interim report and assists in building a highly skilled and experienced specialist mental health nursing workforce. The scholarships offer those with an interest in mental health an opportunity to build on their foundational clinical skills and cover the full course fees of a Graduate Diploma in Mental Health Nursing for successful applicants from 2021.
- **Entry pathways for mental health nurses: $76.0 million** for up to 560 graduate mental health nurses (up to 120 graduates each year), and up to 40 nurses through the nurse transition program. This has allowed new mental health nurses to be trained from 2021 and continues to support capability and leadership development in the sector's largest clinical cohort and facilitates experienced general nurses interested in a career change to become mental health nurses.
- **Junior medical officer psychiatry rotations: $37.4 million** to provide a psychiatry rotation for 126 junior doctors in 2021, and up to 575 junior doctors in 2022 and 2023. Increasing junior doctors' exposure to psychiatry both improves their skills in mental health and promotes psychiatry as a vocational choice.

- **Prequalification initiative: $8 million** to provide jobs for allied health, nursing and medicine students to work part-time in mental health services while they study. The initiative supported 120 pre-qualification roles in 2021, and continue into 2022 to provide students with valuable experience working with consumers, families and carers and early exposure to the mental health sector, increasing the likelihood that they will choose a career in mental health.
- **Psychiatry leadership development: $2.3 million** to support leadership development for psychiatrists in the public mental health system. This program has supported psychiatrists to pursue professional development opportunities and in 2022 will build Victorian psychiatrists' leadership capability in priority reform areas, including co-leadership with consumers, carers and their families, change management, quality improvement and safety management.
- **Supporting psychiatry registrars to undertake mandatory rotations: $7.5 million** to support 43 psychiatry registrars undertake mandatory rotations in child and adolescent psychiatry in 2021 and 2022.

The Victorian Government has invested in a range of new initiatives to grow training pathways, given the time-critical need to build workforce supply. Initiatives include:

- **Graduate allied health positions: $34 million** for up to allied health graduates in psychology, social work and occupational therapy to work in mental health, with 132 graduates starting in 2022. This exceeds the interim report recommendation for 60 positions and will provide entry points into mental health and wellbeing services for allied health professionals who will have a key role in providing therapeutic and evidence-based treatments.
- **Expanded postgraduate scholarship program: $1.3 million** for up to 70 postgraduate scholarships for allied health clinicians, including 20 scholarships for clinicians providing AOD and integrated care, building on the postgraduate mental health nurse scholarship program. This investment will help provide integrated treatment, care and support to people living with mental illness and substance use or addiction, as per recommendation 35 of the Royal Commission's final report.
- **Psychiatry training support package: $4.5 million** to improve the capacity of the psychiatry training pipeline, through a new training group, continued support of mandatory training placements and new Directors of Training, including for addiction psychiatry and rural and regional services in 2022, as well as continue a training program to support specialist international medical graduates.
- **New graduate program for enrolled nurses: $4.6 million** for eight mental health nurse educators to train 40 enrolled nurses in key skills and capabilities. This will establish a clear pipeline for enrolled nurses to enter mental health, increase the nursing workforce and provide immediate relief in clinical services.
- **Transition program for experienced allied health and nursing clinicians: $12.2 million** to support mid-career practitioners to transition into mental health careers. The existing nurse transition program will be scaled up to support an additional 50 nurses, and a new program for allied health practitioners will see 30 clinicians commencing in 2022, with trainees supported by 16 educators.

Medium and longer-term actions

The workforce needs to grow significantly to deliver the Royal Commission's recommended reforms. Over the medium to longer term, promising and successful initiatives to address workforce supply will be adapted to respond to system needs.

In addition, Victoria will continue to advocate to the Commonwealth Government to reduce barriers to entry for the workforce through removing blockages in the training pipeline, including expansion of critical provision of training places, delivery of quality and fit-for-purpose course content, and support for placements in mental health settings. Further detail can be found under Spotlight: Collaborating with the Commonwealth and other partners.

Action area 1c: Building emergent and new workforces

Emergent and new workforces will be crucial in delivering holistic and person-centred treatment, care and support in the reformed service system.

Emergent workforces include the lived experience workforce, and workforces with capability in delivering integrated care for substance use and addiction. Workforce development pipelines for both of these workforces need to be scaled up and refined, and in some cases established.

New workforce cohorts are also needed to deliver consumer-centred care and new service models, such as expanded wellbeing supports in Local Mental Health and Wellbeing Services. Changing the workforce composition to include new professions, potentially including mental health-trained paramedics, counsellors and wellbeing roles delivered across tertiary and community settings, has the potential to mitigate current workforce pressures. It will be important to consider how other professions with transferable skills will be integrated with established disciplines, and how these new skillsets can best be used to meet consumer needs.

Initiatives commenced and commencing

The Victorian Government committed $40 million in the 2021–22 Victorian State Budget to support the consumer and carer lived experience workforces. Work has commenced on initiatives to address both supply and systemic supports, including:

- a new **lived experience peer cadet program** to promote career pathways for up to 100 lived experience peer cadet positions in mental health services. The program will promote career pathways for lived experience workforces in community mental health services, helping cadets studying a Certificate IV in Peer Work to gain valuable experience and mentoring in the sector, and will be expanded into clinical settings in future years.
- improved access to **supervision for lived experience workers** in clinical services and supporting architecture such as organisational benchmarking and readiness frameworks, micro-credentialling, scholarships, standardised training and development of a discipline framework. These systemic work programs will build system-wide and service structures for the lived experience workforces and lay the foundations for further expansion.
- funding two **lived experience workforce lead positions** at Victoria's consumer and carer peak bodies. Workforce leads at VMIAC and Tandem will strengthen consumer and carer perspectives on mental health workforce policy, ensuring that reforms are guided by the experience and expertise of lived experience workers. They will also liaise with members of the lived experience workforces to coordinate reform activities in partnership with the Department of Health.
- a **lived experience workforce – consumer and carer feedback** program is being piloted in 2021–22, and recognises the critical role of the lived experience workforce in engaging with consumers and carers at services. An initial investment of $1.3 million funded a 12–month pilot to improve the ways in which services use consumer and carer feedback. As part of the pilot, sites have recruited members of the lived experience workforce to collect, translate, share and utilise feedback as part of the services' performance improvement activities. Current pilot sites include 18 adult Hospital Outreach Post Suicide Attempt Engagement (HOPE) and two mental health hospital in the home (HITH) sites. Findings from the pilot will be used to help services understand how lived experience workers can improve and embed a responsive performance management approach.

Further information on work underway to support lived experience workforces can be found under Spotlight: Lived and living experience workforces.

Medium and longer-term actions

New services and models of care – including a Lived Experience Residential Centre, Statewide Trauma Centre and Local Child and Youth Hubs – will be established over the medium to long term. An understanding of the workforce supply needs of the reformed system will develop in parallel and will inform statewide service planning and future iterations of this strategy.

There will be a continued focus on opportunities for new workforces in the reformed mental health system, and on support for existing workforces to maximise their scopes of practice.

Once the foundations for emergent and new workforces are in place, the focus will move to the scale of the workforce pipeline.

Previous investment in capacity building initiatives, including the Lived Experience Organisational Readiness and Discipline Framework, will support retention and allow for future investment and growth to be sustained.

Action area 1d: Ensuring workforce meets regional needs

Supply challenges are exacerbated in rural and regional areas. This is not unique to Victoria, with rural and regional areas nationally struggling to fill vacancies and provide supportive workplaces for staff and adequate supervision to trainees.

A number of incentives and supports will encourage mental health professionals to train, live and work in regional and rural communities.

> 'We would like to challenge the narrative that careers in rural and regional areas offer less opportunities than those in urban regions… With fewer competitors and resources in rural and regional areas, workers can have a broad range of experiences and progress their career in ways that may not be possible in an urban setting.'
>
> *Submission to Department of Health, August 2021*

Initiatives commenced and commencing

A relocation grants pilot program, administered by the Rural Workforce Agency Victoria, is underway. The program supports mental health workers to move and settle in rural and regional Victoria, taking up roles in public specialist mental health services. The program offers financial incentives to cover relocation costs.

The following initiatives aim to attract mental health and AOD workers to rural and regional Victoria through:

- **Workforce incentive grants:** encourage and support mental health workers to relocate, settle and remain in rural and regional areas. Qualified workers recruited to priority, hard-to-fill positions within state-funded mental health services will be eligible for grants equal to $3.2 million over two years. The grants will refine the relocation grants pilot to offer a higher incentive and an expanded and more flexible range of items for reimbursement, including childcare, school fees and vehicle costs.
- **Integration support for workers and their families:** Ensuring candidates are adequately supported prior to employment, during relocation while they settle into local communities is key to long-term retention. A new $2.6 million program will provide pre-employment and integration support to help individuals and their families to settle into their new communities by connecting them to essential services, social and professional opportunities.
- **A pilot incentive program** to attract the AOD workforce into rural and regional services will be developed in collaboration with stakeholders, with access to incentives commencing in early 2022.
- **A pilot internship program** for students studying allied health courses or a Certificate IV in AOD. Rural and regional AOD services will teach job-ready skills and prioritise interns from culturally and linguistically diverse and LGBTIQ communities. This will be developed in collaboration with stakeholders and rolled out in 2022.

Medium and longer-term actions

Rural and regional workforce incentive program offerings will be further developed and refined based on a review of implementation in 2022 and 2023. From 2023, the incentive scheme will be refreshed to support successful components of the early program, and consider opportunities for new components, through a planned scale-up in line with the $10.5 million allocated in the 2021–22 Victorian State Budget.

The incentive scheme refresh will be undertaken alongside improved workforce planning, supported by the establishment of Regional Mental Health and Wellbeing Boards, which will focus on localised workforce needs and ensuring workforces are reflective of local communities.

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SPOTLIGHT

7. Capability Framework

The Victorian Mental Health and Wellbeing Workforce Capability Framework sets out the skills, knowledge and ways of working that the workforce will require in the new integrated and responsive mental health and wellbeing system.

The Capability Framework recognises the diverse, multidisciplinary and evolving nature of the mental health and wellbeing workforce, and articulates what is required to deliver high-quality, compassionate and person-centred care and support to consumers and their carers, families and supporters. It delivers on recommendation 58(2) of the Royal Commission's final report, and is designed to be a practical and living framework. The framework aims to provide a common language for all members of the health and wellbeing workforce – regardless of professional discipline, background, role and setting – and to generate a sense of collective identity and reciprocal responsibility for how treatment, care and support is delivered in Victoria.

A framework for now and for the future

The Capability Framework sets out seven practice principles and 15 priority capability domains to guide the professional practice of all those who work in, or interact with, the mental health and wellbeing system—regardless of setting, role, or level of specialisation. The practice principles represent the common values, approaches and attitudes required when working with individuals, their personal support networks and colleagues. The capability domains encompass the knowledge and skills required of every professional, in addition to the specific capabilities required of treatment, care and support professionals, specialist and technical professionals, and service managers and leaders.

The first iteration of the Capability Framework represents a point in time at the beginning of a ten-year reform journey. It will be reviewed and revised to keep pace with emerging and evolving needs of the Victorian mental health and wellbeing system and workforce.

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8. Priority 2: **Building workforce skills, knowledge and capabilities**

The mental health and wellbeing workforce needs the right capabilities, skills and knowledge to deliver the highest quality care to consumers. Throughout consultations, sector stakeholders strongly communicated the need to invest in capability and professional development as part of a suite of actions to support wellbeing and aid worker retention.

In rebuilding the mental health and wellbeing system, new and enhanced capabilities will need to be developed across professions, roles and settings. A comprehensive and networked approach to building capability across the whole workforce will support access to priority learning and professional development activities and educational resources in collaboration with training providers, statewide services and others.

The long-term objective of this priority area is for the workforce as a whole to have the capabilities, skills and knowledge to provide safe, effective and collaborative care to consumers.

Initial actions will focus on capabilities that are universal across the system and workforces, as well as building specific skills needed in disciplines and service settings.

Final report recommendation 58: workforce capabilities and professional development

The Royal Commission recommended that the Victorian Government:

1. through the Department of Health, by the end of 2021, define the knowledge, skills and attributes required of a diverse, multidisciplinary mental health and wellbeing workforce, starting with the priorities as described by the Royal Commission
2. develop a Victorian Mental Health and Wellbeing Workforce Capability Framework as a component of this
3. detail the approach to capability development across the mental health and wellbeing workforce as part of the workforce strategy and implementation plan
4. build on the interim report's recommendation 1 and enable the Collaborative Centre for Mental Health and Wellbeing, in collaboration with training providers, mental health and wellbeing services and people with lived experience, to coordinate learning and professional development activities across the whole mental health and wellbeing workforce.

Capability: Priority action areas

Action area 2a	Action area 2b	Action area 2c	Action area 2d
Ensuring education and training meets the needs of the community	Embedding a system wide capability focus	Improving capability through ongoing training opportunities	Ensuring workforce reflects and responds to diverse communities

Action area 2a: Ensuring education and training meets the needs of the community

There are significant education and training bottlenecks that require Commonwealth support to solve

The mental health workforce is highly skilled, and demands a contemporary education and training program that reflects this. The Victorian Government does not control all the strategic and operational levers needed to create and sustain a sufficient workforce pipeline – many of these levers rest with the Commonwealth Government and national bodies.

Currently, the specialist skills for clinical mental health work require professionals in most disciplines to undertake training in addition to their generalist qualifications. While this creates valued opportunities for immersive learning and development for clinicians, it places a significant burden on the State and health services to support job-readiness through graduate programs and does not reflect the significance and prevalence of mental illness as a health issue. For example, recent reports indicate that Victorian universities are graduating thousands of psychology students who never qualify to practice, with only a small percentage completing the necessary six years of university and on-the-job supervision and training.

Fewer than one per cent of students go on to complete masters programs despite the demand for services. Undergraduate psychology students compete for a handful of places in honours and masters programs, then face the challenge of finding a placement to complete their 1,500 hours of practical training, including one-on-one supervision.

Working together to jointly address challenges with Commonwealth and national bodies

Structural pressures on the mental health and wellbeing workforce need to be urgently resolved to ensure a sufficient workforce pipeline for Victoria.

Unlike the education sector, accreditation levers are not held by the State or Commonwealth Governments. Training programs are accredited by different bodies for each professional discipline. Several professions require registration with the Australian Health Practitioner Regulation Agency (Ahpra) to be able to practice.

To ensure the workforce is equipped with the right skills, knowledge and capabilities, and that investments in tertiary qualifications meet the needs of the mental health system, action needs to be taken to ensure:

- appropriate accreditation, registration and training requirements
- availability of high-quality education and training programs with appropriate curricula
- support for graduates in specific disciplines to complete the additional education and training required to transfer into clinical mental health roles
- support for health services to undertake their role in graduate training programs.

Progress in each of these domains will require extensive work with the accrediting bodies for each discipline, Aphra, training and education providers, and the Commonwealth Government.

Initiatives commenced and commencing

The Commonwealth Government is leading development of a ten-year National Medical Workforce Strategy and a National Mental Health Workforce Strategy, which will consider the quality, supply, distribution and structure of Australia's mental health workforce. The Victorian Government is working closely with the Commonwealth on both strategies and will continue to advocate to the Commonwealth for actionable implementation plans.

Establishment of the Mental Health Higher Education Reference Group

A Mental Health Higher Education Reference Group will be established to tackle immediate and medium-term priorities in the Victorian education and training sector in a partnership approach between the Victorian Government and the sector. This recognises that the Victorian Government does not hold all critical education and training levers. The group will be co-chaired by the Department of Health and the Department of Education and Training and comprise representatives from Victorian universities and training organisations that deliver mental health-related courses.

Areas of focus may include providing early, positive exposure to mental health content in undergraduate degrees to encourage graduates to take up roles in the sector, expansion of clinical research roles, recognition of prior learning for allied health and redesign of mental health content in educational pathways where required, particularly for generalist courses.

National efforts on priority education and training areas

The Victorian Government will advocate to the Commonwealth on priority education and other matters that require a national effort, including:

- expediting the National Mental Health Workforce and National Medical Workforce strategies with actionable implementation plans
- increasing Commonwealth Supported Places for core disciplines, including postgraduate training in psychology and expediting training pathways (for example, by running parallel university coursework/registrar pathways, and considering a consolidated two-year intensive postgraduate (qualifying) training model)
- leading reviews of undergraduate mental health course content that impacts graduate job-readiness in the key disciplines of nursing, social work, and occupational therapy
- incentivising and setting targets for student placements in mental health settings, and funding appropriate placement supports within training institutions
- developing postgraduate training in contemporary mental health therapies to reduce the burden on health services to fund foundational skill development
- providing additional supports for undergraduate placements, particularly in rural and regional settings, through prioritising course offerings and reducing Higher Education Contribution Scheme fees
- improving job-readiness and the acquisition of contemporary skills, knowledge and capability to practice in mental health by reviewing and re-designing mental health curricula, as well as setting standards for undergraduate training in core disciplines
- identifying and removing barriers to the completion of training for clinical psychologists and psychiatrists.

The Victorian Government will also work with Colleges and professional bodies on training requirements, including:

- mandatory training requirements for psychiatrists: advocating to the Royal Australian and New Zealand College of Psychiatrists to remove the requirement to undertake rotations in Child and Adolescent and Consultation Liaison Psychiatry, where there are more trainees than positions available and doctors are delayed in qualifying
- social worker placements: students are currently required to complete 1,000 hours of unpaid placements, which is a barrier to qualifying. The Victorian Government will advocate to the Australian Association of Social Workers to recognise paid work hours of practice for postgraduate qualifying students and introduce parallel coursework and placements to expedite the pathway.

Standardising regulation and registration schemes

The Victorian Government will ask regulators and key registration bodies to consider standardised registration schemes and registration of overseas-trained practitioners, including:

- registration of psychologists: currently, only Registered Psychologists trained in New Zealand can apply for registration. Psychologists from other countries with comparable training standards are required to undertake additional probation and high-cost supervision to qualify. This is a disincentive for overseas trained professionals to practice in Australia. The Victorian Government will advocate to the Australian Psychological Society to recognise registration for psychologists registered for practice in the United Kingdom, the United States, Ireland, and Canada, and to review of eligibility for other countries.
- statutory registration scheme for social workers: in contrast to comparable jurisdictions, Australia does not currently have a statutory registration scheme for social workers. Absence of title protection and safeguards compromises quality and safety, and limits how this discipline functions within the mental health sector. The Victorian Government will advocate to Ahpra for a statutory registration scheme for social workers.

Medium and longer-term actions

Changes to training and accreditation requirements need to happen at a national level. Over the medium to longer term, the Victorian Government will continue to work with the Commonwealth Government and the professional bodies and Colleges that accredit training programs, and advocate to Ahpra for the registration of counsellors and mental health nurses.

Action area 2b: Embedding a system wide capability focus

Specific new and enhanced capabilities will be needed to deliver consumer-focused, recovery-oriented care in the reformed system. Some will be core, whole-of-workforce skills, whereas others will be specific to disciplines and service settings.

A system wide approach will be taken to building capability. This will allow areas of need to be identified in a coordinated way, and support and training that addresses those areas to be provided.

> **'More creative and robust training and professional development structures and models are required.'**
>
> ***Submission to Department of Health, August 2021***

It will also promote consistency across disciplines and services, and better equip services to provide care for their communities by ensuring that core elements such as diversity and cultural safety are incorporated in training.

This whole-of-system approach to capability will support the workforce to develop the collective skills, knowledge and values needed to deliver cohesive multidisciplinary care.

Initiatives commenced and commencing

The Victorian Collaborative Centre for Mental Health and Wellbeing

The Victorian Collaborative Centre for Mental Health and Wellbeing is currently being established, with the *Victorian Collaborative Centre for Mental Health and Wellbeing Act* passed by the Victorian Parliament in November 2021. The legislation provides for representation of people with consumer and carer lived experiences on the skills-based board and an innovative co-director model of executive leadership. The Collaborative Centre's interim board will be in place by mid-2022.

Upon establishment, the Collaborative Centre will have capability uplift responsibilities, including:

- conducting interdisciplinary research alongside service delivery
- developing, translating and sharing best practice across the system
- educating the mental health workforce through coordinating and delivering practice improvement, training, and professional development programs, and
- driving exemplary practice for the full and effective participation and inclusion of people with lived experience across the mental health system.

The Collaborative Centre will play an important role in ensuring an adaptive, coordinated mental health system for all Victorians.

Regional Mental Health and Wellbeing Boards

Eight interim regional bodies are currently being established and will precede the establishment of legislated Regional Mental Health and Wellbeing Boards. The interim regional bodies will provide locally-informed advice to the Department of Health as it plans, develops and funds a range of mental health and wellbeing services in each region.

This advice will contribute to an understanding of capability needs and development across the state and assist in monitoring improvement.

Statewide service for people living with mental illness and substance use or addiction

A new statewide service for people living with co-occurring mental illness and substance use or addiction will be established by the end of 2022, delivering on recommendation 36 of the Royal Commission's final report. The service will build on the foundations of the Victorian Dual Diagnosis Initiative and will provide integrated care to people with co-occurring mental health and substance use or addiction challenges, as well as education and training to enhance workforce capability in this area across the sector. Further information can be found under Spotlight: Supporting workforce capability to provide integrated care.

Statewide Trauma Service

A new Statewide Trauma Service will be established by the end of 2022, as set out in recommendation 23 of the Royal Commission's final report. The new service will deliver the best possible mental health and wellbeing outcomes for people with lived experience of trauma. As part of its functions, the service will develop and deliver training that will enhance the capability of the mental health and wellbeing workforce to provide trauma-informed care.

Release and embed the Victorian Mental Health and Wellbeing Workforce Capability Framework

The Victorian Mental Health and Wellbeing Workforce Capability Framework defines the skills, knowledge and capability needed by a multidisciplinary workforce. This will support coordinated and consistent training across the system, particularly in relation to specific reform priorities including workforce culture, workforce diversity, workplace and professional practice, and to lifting capability in areas such as physical health in mental health services.

Stakeholder feedback highlighted the importance of implementation support to ensure the framework results in practice change and higher quality service delivery to consumers. Implementation of the framework will commence in the first quarter of 2022. This will provide practical and translatable support for the workforce to assess and grow the required capabilities at an individual, team and organisation level.

Tools and guidance will be developed to integrate the new framework into practice at individual, team and service levels, supported by $570,000 in funding.

To assist implementation, additional resources will be developed, including consideration of a training program, practice tools and guidance. An interactive web platform will also be scoped to support implementation.

Further detail about the framework can be found under Spotlight: Capability Framework.

Medium and longer-term actions

Statewide capability entity

A new capability entity will be established to lead a whole-of-mental-health workforce approach to capability development and training, as described by the Royal Commission in its final report. The entity will be auspiced by the Victorian Collaborative Centre for Mental Health and Wellbeing.

The capability entity will work collaboratively with the Department of Health and educational, academic and specialist service organisations, and build on the work of the Centre for Mental Health Learning to:

- help create learning, development and professional supports for senior clinical and specialist educator roles in the new service system
- develop resources and professional supports for priority workforce groups
- in partnership with service providers and education providers, increase rural and regional access to learning and development
- help the workforce make the most of high-quality professional learning opportunities to strengthen priority capabilities and support career and leadership pathways
- coordinate learning and development activities and access to specialist knowledge and expertise across services, professions and geographic areas
- integrate lived experience expertise in the design and delivery of professional learning opportunities
- increase the availability of learning and development.

Work will be undertaken in association with the Collaborative Centre to consider the most appropriate design for the capability entity.

Action area 2c: Improving capability through ongoing training opportunities

Once members of the workforce commence in the mental health and wellbeing system they need to be continually equipped with new and enhanced skills to deliver high-quality care. Needs will vary across professions, specialties, roles and settings, however there are common capabilities that are fundamental for all those working in the sector.

There is an immediate need to build new knowledge and skills and enhance existing capabilities in a number of areas, including mental health legislation and human rights, family- and carer-inclusive practice, reflective practice and professional practice supervision, trauma-responsive practice, and cultural responsiveness. Lifting capability in these areas will be key to achieving culture change and promoting best practice in service delivery in the reformed system.

Activities will focus on training, leadership within services and disciplines, and supports such as professional practice supervision.

As highlighted by stakeholders, there is a need for professional collaboration across service and geographic boundaries, and to support individuals in specialist roles to connect with others in their field. Specific initiatives therefore support skill sharing and innovation across services.

Initiatives commenced and commencing

The Victorian Government invests $30 million annually in workforce development for the mental health and AOD workforces. The funding ensures services have training and academic capacity and provides access to statewide training and development from specialist providers. This funding also enables the Centre for Mental Health Learning to support coordination of workforce development, facilitate statewide leadership networks and communities of practice, and to identify and deliver activity aligned with strategic priorities.

In addition, the Victorian Government has funded a range of activity, including:

- strengthening supervision
- supporting leadership and co-design capability
- increased support for psychiatry trainees
- development of mental health leaders.

Strengthening supervision

Two frameworks – *Consumer Perspective Supervision: a framework for supporting the consumer workforce* and the *Family Carer Perspective Supervision Framework* – have been co-produced for the lived experience workforce. Development and delivery of training related to these frameworks is underway, support for consumer perspective supervisors is in place, and the infrastructure to connect lived experience workers with discipline-specific supervisors has been created.

Implementation of Victoria's clinical supervision framework for mental health nurses is continuing. Activities for the next two years will be informed by implementation planning workshops and a community of practice, and will include support for Standards of Practice and training programs.

To support implementation of the Royal Commission's interim report recommendation to provide foundational mental health skills for junior doctors, psychiatry registrars are also being supported to upskill through clinical supervision training, with a program designed by the Royal Australian and New Zealand College of Psychiatrists.

Supporting leadership and co-design capability

Communities of practice are in place to support Specialist Family Violence Advisor positions in mental health and AOD services and Clinical Nurse Consultants.

The 2019–20 Victorian State Budget invested $1 million in psychiatry leadership development, providing Victoria's public sector psychiatrists with professional development opportunities. A psychiatry leadership development program is also being established, led by the Royal Australian and New Zealand College of Psychiatrists.

Co-design capability building workshops were commissioned by the Department of Health and delivered to mental health and AOD workforces over 2021–22. In addition, a co-design lead role has been established at the Centre for Mental Health Learning to support mental health services with co-design planning and capability.

Increased support for psychiatry trainees

Recent initiatives to better support psychiatry trainees include:

- The establishment of two key positions to support training, funded through the 2019–20

Victorian State Budget: a Director of Training for Specialist International Medical Graduates, based at Goulburn Valley Health, and Directors of Advanced Training for addiction psychiatry and medicine at Turning Point.

- An exam preparation support program for Specialist International Medical Graduates. This program was piloted in 2020, significantly increasing exam pass rates.
- 43 Child and Adolescent Psychiatry rotations funded in the 2020–21 Victorian State Budget to ensure trainees progress through training without delay.

Development of mental health leaders

Designated workforce lead positions have been established to cultivate leaders within the mental health system:

- A codesign lead (a designated lived experience role) has been established at the Centre for Mental Health Learning. This position will provide co-design and co-production support to members of the mental health workforce who are leading co-design projects.
- Across the state, 31 clinical nurse consultant positions provide leadership for staff and teams in inpatient units. The consultants act as mentors to other staff and have the clinical experience to address priority issues such as consumer and staff safety and support vulnerable consumers presenting with high level needs.

Training and development for Infant, Child and Youth Area Mental Health and Wellbeing Service workforce

The 2021–22 Victorian State Budget allocated $2.5 million over four years for training and development to support new and existing workers as part of the establishment of new Infant, Child and Youth Area Mental Health and Wellbeing services. Scoping is currently underway to identify training and development requirements, with training available to access from early 2022.

Statewide coordination of the Child and Adolescent Mental Health Service Autism Program

Since the release of the 2019 Autism State Plan the Department of Health has provided funding to Mindful as the statewide coordinator for the Child and Adolescent Mental Health Service Autism Program to build capacity and capability to assess and diagnose autism, with increased funding provided in 2021–22. Mindful delivers Autism Spectrum Disorder training in assessment, diagnosis and early intervention for mental health services to all clinicians in the public and private sector.

Medium and longer-term actions

Workforce capability needs – particularly in relation to multidisciplinary care – will evolve in tandem with system reforms. Priority training needs will therefore be regularly assessed at both a discipline-specific and whole-of-workforce level.

Over the medium to longer term, the Department of Health will continue to work with stakeholders, the Collaborative Centre and the statewide capability entity to ensure investment in training and professional practice supports continues to meet consumer and system needs.

Collaboration with professional colleges, education institutions and regulators will be critical for ensuring that training pathways are responsive to capability needs.

Over the medium to long term, work will continue to identify and build both the whole-of-workforce and discipline-specific targeted skills needed to deliver service and system reforms.

Action area 2d: Ensuring workforce reflects and responds to diverse communities

Victoria's diverse and marginalised communities can experience additional barriers to accessing mental health care, despite being some of Victoria's most vulnerable. To better meet the needs of communities, Victoria's mental health workforce needs to be more representative, and more responsive to those it serves.

Across all professional disciplines, roles and settings, people from diverse backgrounds – including Aboriginal, LGBTIQ, workers with disabilities and culturally diverse workers – need to be represented to enable care to be provided in culturally safe, inclusive, and appropriate ways. This needs to be complemented by other strategies to build broader workforce capability to respond to the specific needs of priority populations, and to build culturally safe and inclusive workplaces.

DOH.0003.0001.0410

> 'By requiring clinicians and other mental health service providers to reflect upon their own cultural identity and biases in relation to how they interact with other practitioners and consumers, culturally safe practices can help to safeguard all stakeholders engaging in mental health care from experiencing exclusion, discrimination or other effects of power imbalances.'
>
> *Submission to Department of Health, August 2021*

Initiatives commenced and commencing

Specialised care for vulnerable people who need intensive support

As part of a $5.7 million package to deliver more specialised care for vulnerable people who need intensive support, Victorian Transcultural Mental Health (VTMH) at St Vincent's Hospital received funding to expand its training programs. As culturally and linguistically diverse communities are less likely to engage with mainstream mental health services, this service improves the cultural sensitivity of mental health services across the sector.

The funding allows VTMH to deliver its training, which focuses on building capability more widely so services can reach more diverse Victorian communities whose members are living with mental illness.

Work is also underway with stakeholders in Aboriginal and Torres Strait Islander communities to expand the Aboriginal social and emotional wellbeing workforce across Aboriginal community-controlled organisations and to improve the cultural safety and responsiveness of mainstream mental health services. Further detail can be found under Spotlight: Aboriginal social and emotional wellbeing workforce.

The Diverse Communities' Mental Health and Wellbeing Framework and Blueprint for Action

The Diverse Communities' Mental Health and Wellbeing Framework and Blueprint for Action will be launched by the end of 2022 and will complement this strategy and the Victorian Mental Health and Wellbeing Workforce Capability Framework.

In developing the framework, consideration will be given to supporting workforce diversity planning both within organisations and across the system, to identifying different roles and care models which support culturally responsive practice and increased service accessibility of diverse communities, and to the need for targeted workforce pipeline programs for priority population groups.

Medium and longer-term actions

The Diverse Communities' Mental Health and Wellbeing Framework will set short- and long-term strategic priorities for delivering safe and inclusive mental health treatment, care and support in Victoria, including supporting the capability uplift of ethno- and cohort-specific services. Importantly, the framework will help drive ongoing organisational- and service-wide capacity building and culture around responsiveness to diversity, inclusion and equity.

DOH.0003.0001.0411

SPOTLIGHT

9. Aboriginal social and emotional wellbeing workforce

> **'Aboriginal self-determination is respected and upheld in the design and delivery of treatment, care and support, and where Aboriginal people can choose to receive care within Aboriginal community-controlled organisations, within mainstream services or a mix of both. Irrespective of where treatment, care and support is delivered for Aboriginal people, communities and families, it is fundamental that it is safe, inclusive, respectful and responsive.'**
>
> *Royal Commission into Victoria's Mental Health System, Final Report, volume 3, p. 143.*

Aboriginal Victorians experience disproportionate rates of mental illness, trauma and suicide compared to the non-Aboriginal population. Meeting current levels of need and the expected growth in service demand for Aboriginal people and communities requires a highly skilled and adequately resourced social and emotional wellbeing workforce.

The Royal Commission recommended expanding Aboriginal social and emotional wellbeing (SEWB) workforces across Aboriginal community-controlled organisations and improving the cultural safety and responsiveness of mainstream mental health services.

Key initiatives to address these recommendations cover areas of supply, capability, wellbeing and system enablers:

- a minimum of 30 scholarships awarded by 2024 for Aboriginal SEWB workforces to obtain clinical and/or therapeutic mental health qualifications
- establishing and expanding multidisciplinary SEWB teams in Aboriginal Community Controlled Health Organisations with statewide coverage within five years
- the Aboriginal Mental Health Traineeship Program which provides a pathway for Aboriginal Victorians to enter the clinical mental health workforce. Clinical placements are undertaken within mainstream mental health services while trainees complete a bachelor degree in mental health. Ongoing employment is offered with the service on completion of this specialised program
- clinical and therapeutic positions funded to expand the social and emotional wellbeing workforce in Aboriginal community-controlled organisations (ACCOs)
- establishment of an Aboriginal Social and Emotional Wellbeing Centre to support mental health and social and emotional wellbeing services with:
  a. clinical, cultural and organisational governance planning and development
  b. workforce development for Aboriginal and non-Aboriginal workers
  c. guidance, tools and practical supports for building clinical effectiveness in assessment, diagnosis and treatment for Aboriginal peoples
- establishment of two co-designed healing centres
- Koori Mental Health Liaison Officers funded to provide culturally safe and responsive advocacy and support for Aboriginal people during their time in hospital and during follow-up care.

DOH.0003.0001.0412

10. Priority 3: **Supporting the safety, wellbeing and retention of the mental health and wellbeing workforce**

Workforce safety and wellbeing is a key enabler of high quality and safe practice, ultimately ensuring better experiences and outcomes for consumers and their families, carers and supporters. It is also critical for workforce retention.

Many factors impact on worker wellbeing, with members across the workforce communicating their experiences of fatigue, workload and burnout, and how these have been compounded by the stress of the coronavirus (COVID–19) pandemic.

The long-term objective of this priority is for Victoria's mental health and wellbeing services to be safe for all, promote respect and collaboration, prioritise wellbeing, and support workers to apply their full range of professional skills.

New actions to address this priority will focus on better data collection, improved governance and accountability for workforce wellbeing, and expanded wellbeing supports. The Mental Health Workforce Wellbeing Committee, to be established in response to recommendation 59 of the Royal Commission's final report, will be the vehicle for identifying, monitoring and addressing health, safety and wellbeing needs.

Longer-term actions will aim to address fatigue, workload and burnout, and support positive wellbeing through better monitoring, oversight and support.

Wellbeing:
Priority action areas

Action area 3a

Establishing workforce wellbeing monitoring and supports

Final report recommendation 59: workforce safety and wellbeing

The Royal Commission recommended that the Victorian Government:

1. by the end of 2021, establish an ongoing Mental Health Workforce Wellbeing Committee to address occupational health and safety needs, co-chaired by the Department of Health and WorkSafe Victoria that will:

   a. identify, monitor and address existing physical safety and wellbeing risks as well as those that may emerge throughout the reform process; and

   b. develop tailored monitoring approaches for the psychological health and safety of staff in the mental health and wellbeing workforce.

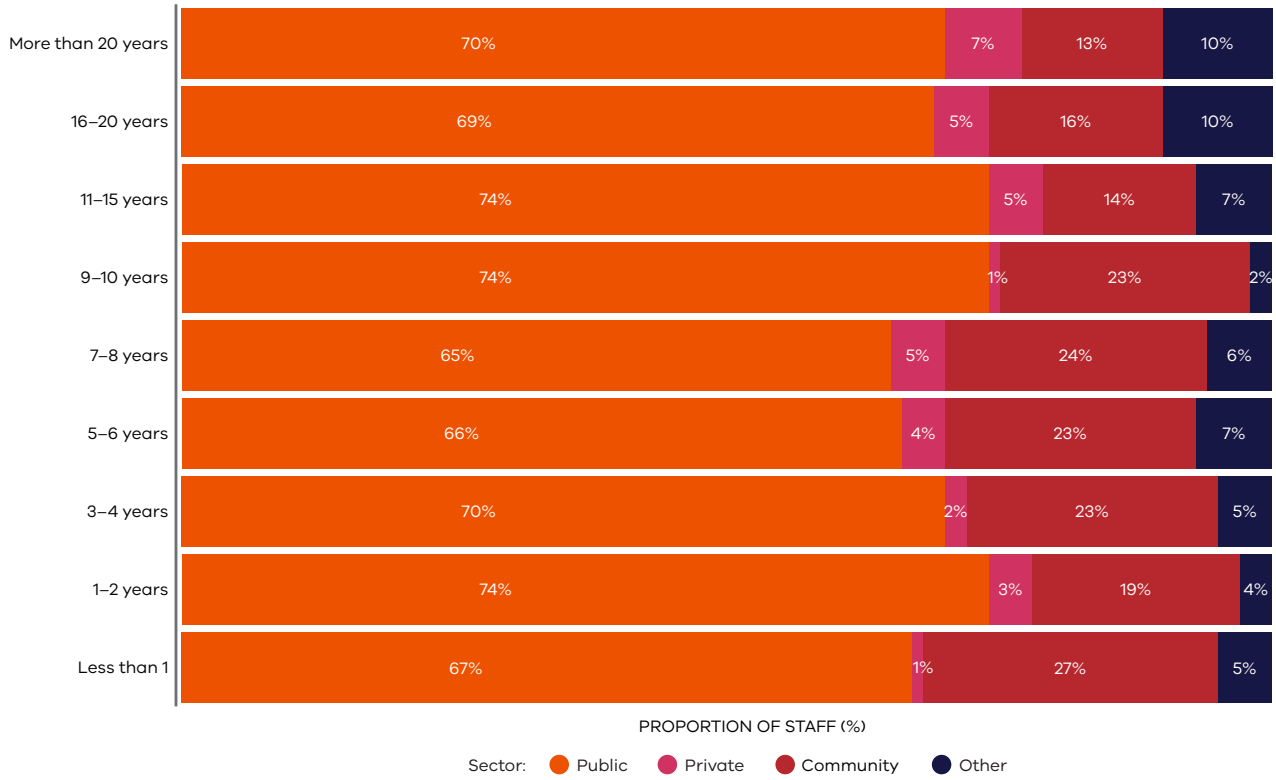
3. work with service providers, workers (including lived experience workers), unions, representative and professional bodies to set clear expectations and implement a range of measures to support the professional wellbeing of the mental health and wellbeing workforce, as described by the Royal Commission in its final report.

4. beginning in 2021, work with the Mental Health Workforce Wellbeing Committee to monitor workforce wellbeing outcomes at least once a year.

Current wellbeing of the mental health workforce

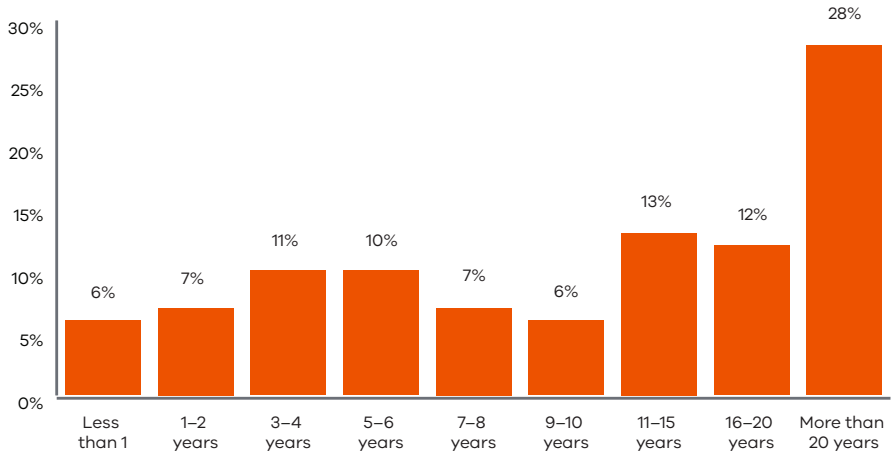
A mental health workforce personnel survey was carried out in October–November 2021, asking mental health workers in public, community and private settings to give feedback on their experiences of working in the sector. The findings set out below will inform workforce planning and provide insights into what is needed to attract, train, support and retain a stronger workforce for Victoria's reformed mental health system.

Figure 12: Surveyed mental health and wellbeing professionals (proportion) by years of experience and sector



Source: Department of Health (Victoria) Personnel Survey Dataset (2021)

Figure 13: Years of experience across surveyed mental health and wellbeing professionals (proportion)

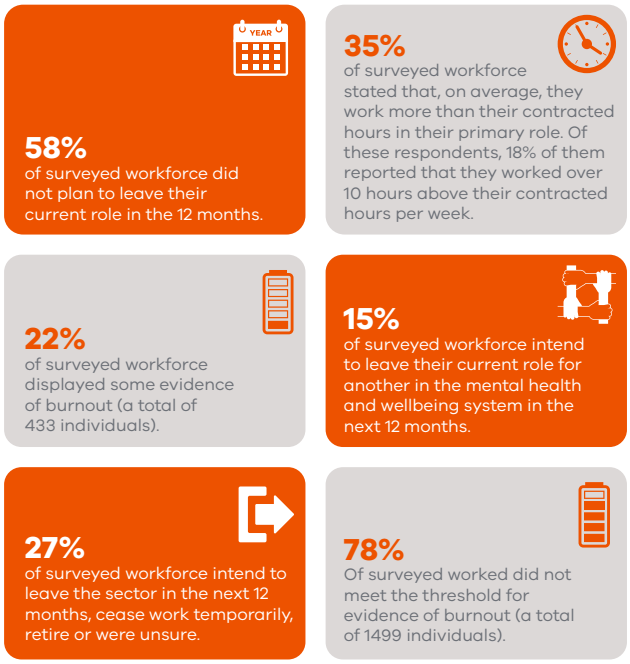


Source: Department of Health (Victoria) Personnel Survey Dataset (2021)

Figure 14: Motivations to work in the sector (survey respondents)

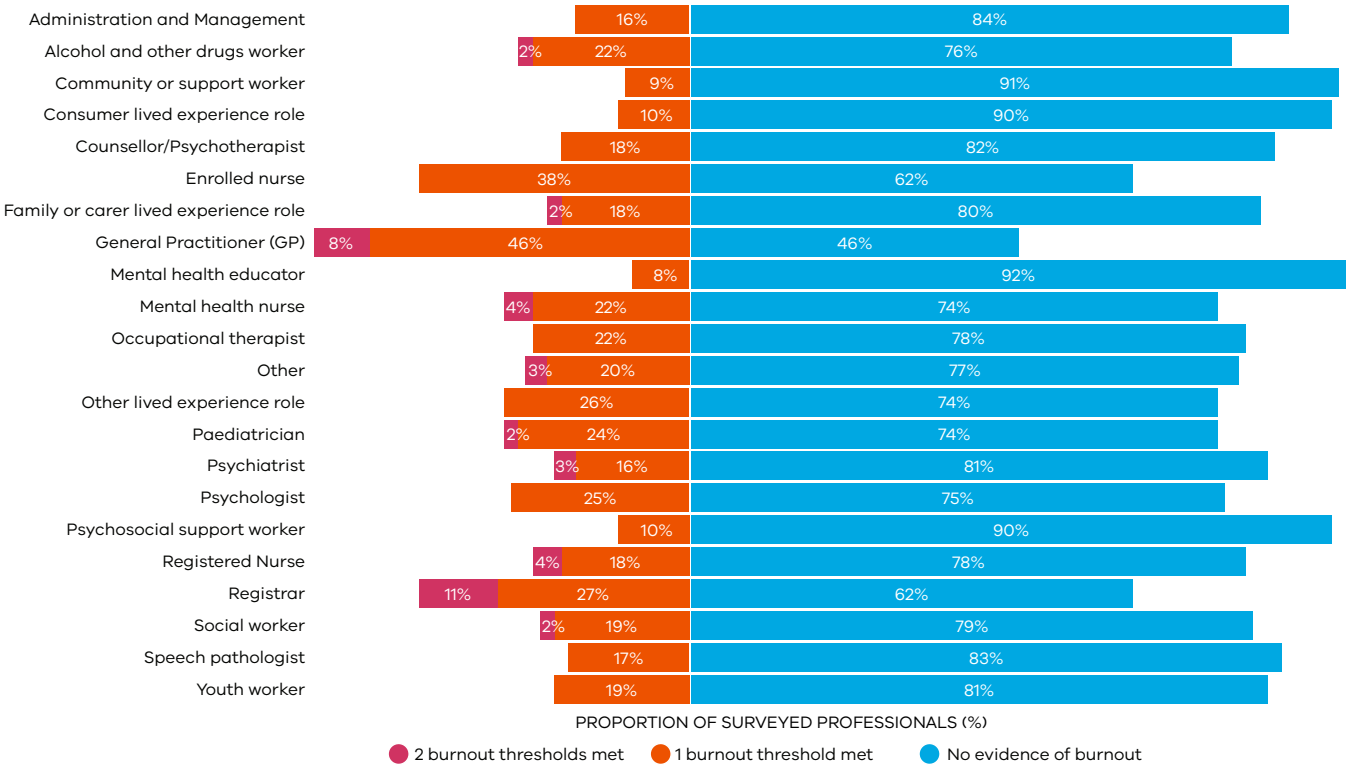
Source: Personnel Survey Dataset (2021). Note: Personnel Survey respondents were asked what their motivations were for working in the mental health and wellbeing system and were able to provide up to 3 responses. N = 1932.

Figure 15: Workforce wellbeing summary (survey respondents)



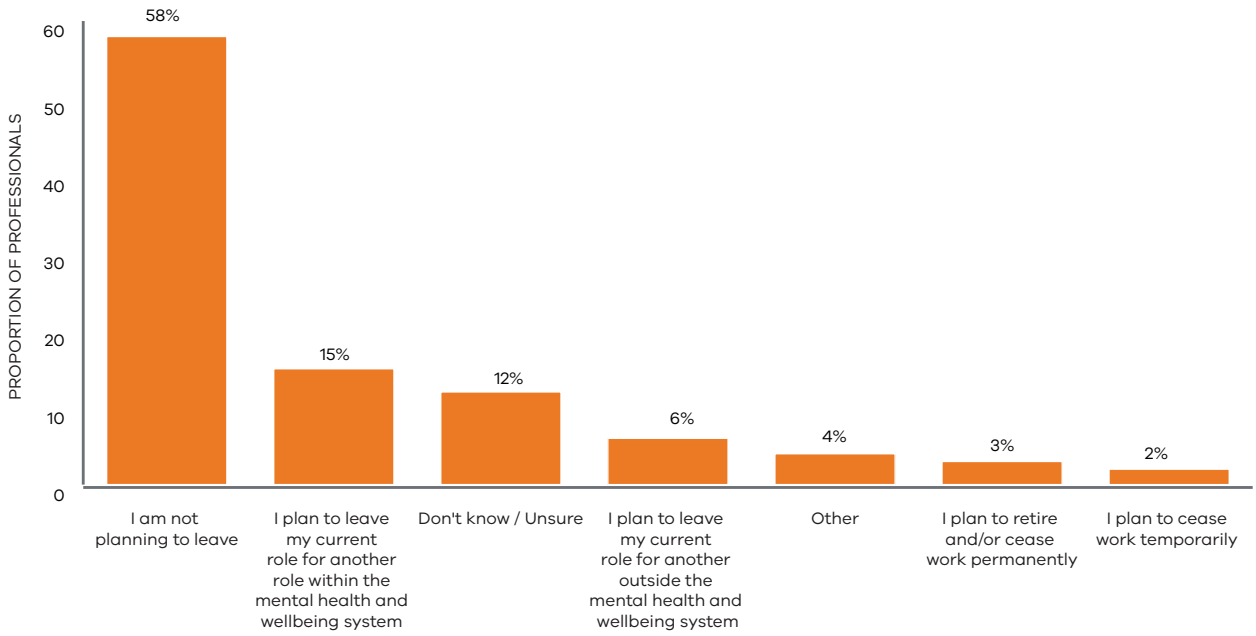
Source: Department of Health (Victoria) Personnel Survey Dataset (2021)

Figure 16: Evidence of burnout across survey respondents by professional discipline



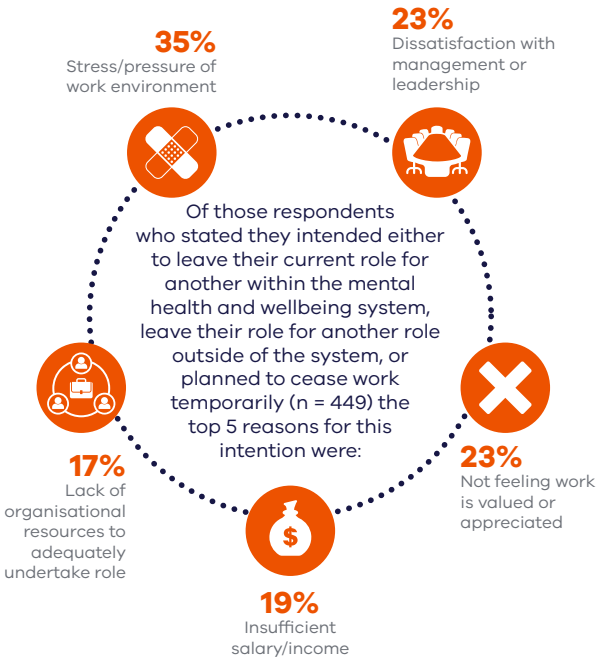
Source: Department of Health (Victoria) Personnel Survey Dataset (2021). Note: The above chart represents the evidence of burnout that may be present within the workforce. Calculated by collating the results from the three MBI sub-scale thresholds (emotional exhaustion, depersonalisation, and personal accomplishment).

Figure 17: Intentions to leave the sector across survey respondents



Source: Department of Health (Victoria) Personnel Survey Dataset (2021)

Figure 18: Motivations to leave the sector across survey respondents



Source: Department of Health (Victoria) Personnel Survey Dataset (2021)

Action area 3a: Establishing workforce wellbeing monitoring and supports

Actions to improve the wellbeing of the workforce focus on workplace safety, professional practice supports and professional development.

Everyone has the right to feel safe and supported at work. This action area therefore promotes workplace safety at a system wide and organisational level, which is essential for the physical and psychological wellbeing of workers, consumers, and families, carers and supporters.

> 'Establish preventative wellbeing programs to help workforce develop their own wellbeing knowledge and capabilities, build resilience, understand role of self-care and self-compassion.'
>
> *Submission to Department of Health, August 2021*

Professional practice supports also play a vital role in workforce wellbeing, as do access to professional development and career pathways. These opportunities are essential for ensuring staff are equipped to deliver effective treatment, care and support, and will be critical to sustaining the mental health and wellbeing system over time.

Initiatives commenced and commencing

Supporting better wellbeing outcomes requires a multifaceted approach, and work has already started on a range of initiatives to improve workforce safety and wellbeing.

Monitoring workforce safety and engagement

Formal monitoring of workforce wellbeing is integral to achieving a safe work environment and delivering safe, high-quality care. In 2020, the annual People Matter Survey for public sector health workforces was extended to measure mental health workforce engagement, job and work-life balance satisfaction, career development, stress and psychological safety. Preventing and managing occupational violence will be a future focus.

A prototype of the annual workforce wellbeing survey was rolled out during 2021 as a component of the mental health personnel survey. The workforce wellbeing survey will provide essential information to the Department of Health, and will assist the Mental Health Workforce Wellbeing Committee, described further below, to monitor wellbeing outcomes. The Mental Health Workforce Wellbeing Committee will continue to provide advice to the department on how the workforce wellbeing survey can best be tailored to capture the wellbeing of the workforce.

Healthcare worker wellbeing centre

In February 2021, the Chief Clinical Officers at Safer Care Victoria launched the Healthcare worker wellbeing centre as part of the Victorian Government's $9.8 million healthcare worker wellbeing package.

This virtual wellbeing centre, the first of its kind in Australia, is a place where all healthcare workers can find support, helplines and resources. Mental health people managers and leaders can access 'bite sized' wellbeing learning modules, as well as Health Care Wellbeing Resources developed in partnership with the Chief Mental Health Nurse.

Mental health and AOD Workforce Wellbeing Grants

Forty Workforce Wellbeing Grants totalling $338,000 were awarded to the state-funded mental health and Alcohol and Other Drug workforces as part of the Keeping Victorians Connected and Supported – Mental Health and Wellbeing Coronavirus Response Package in May 2021.

The grants funded initiatives that supported staff teams to come together, improved physical spaces, and provided additional supervision, reflective practice and training sessions. Staff attended self-care and resilience workshops and Hand-in-Hand Peer Support, emotional CPR and psychological safety and supervision training. Outdoor relaxation spaces, staff wellbeing zones, wellness kits, 'Little Bag of Calm' sensory aids and Big Feels at Work program podcasts all improved staff wellbeing. A further $700,000 in grants have been provided in 2021–22.

Safety and wellbeing in the coronavirus (COVID–19) pandemic

In 2020, the Victorian Government established the Healthcare Worker Infection Prevention and Wellbeing Taskforce to keep workers safe and well during the coronavirus (COVID–19) pandemic. Taskforce actions contributed to a reduction in the number of healthcare worker infections through the Respiratory Protection Program. The Department of Health provided specific guidance to mental health services to protect and provide surge support to the workforce to deliver essential services. Resources and training to establish a COVID–safe work environment, infection control, the selection, fit and use of personal protective equipment, zoned care and quarantine nursing models were a key focus.

A Hospital Surge Support Allowance was also established in October 2021 to better support nurses, paramedics and doctors working hard on the frontline to protect Victorians during the Covid-19 pandemic. The allowance is paid to patient-facing healthcare workers, providing direct care in public hospital services and Ambulance Victoria, to ensure highly skilled staff are well supported to deliver world class patient care

Safewards

The Safewards model and associated interventions have been highly effective in reducing conflict and containment and increasing a sense of safety and mutual support for staff and consumers. Led by the Chief Mental Health Nurse, the model was initially rolled out statewide across all units in 18 mental health services, and was followed by a trial in three emergency departments in 2019 and 2020. The model will be trialled in two general health services during 2021 and 2022.

Professional leadership through mental health nurse communities of practice

Senior Mental Health Nurses from across the state participate monthly in a community of practice with the Chief Mental Health Nurse and the mental health team in Safer Care Victoria, providing a forum to consult and advise the Chief Mental Health Nurse on current professional issues.

Chief Mental Health Nurse also hosts a community of practice for the Clinical Nurse Consultant group. Members of the group have a key role in promoting safety for in inpatient units and supporting the roll-out of Safewards, Reducing Restrictive Interventions and recovery-oriented practice.

Safety for all

Safer Care Victoria is the statewide agency for safety and quality improvement for Victoria's public healthcare system. 'Safety for all' is an initiative of the Mental Health Improvement Program within Safer Care Victoria which will respond to the Royal Commission's key quality improvement priorities.

Within Safer Care Victoria the Chief Mental Health Nurse and the mental health team will focus on safety initiatives including the reduction of seclusion and restraint practices, improving gender safety and the reduction of suicide in services.

Safer Care Victoria will partner with Victorian mental health and wellbeing services to ensure 'Safety for all' in mental health inpatient units. Expressions of interest are currently open to join the planning phase of this initiative, with improvement activities in chosen mental health inpatient units commencing from March 2022.

Sector-led network for occupational safety

Safer Care Victoria, through the Chief Mental Health Nurse and the mental health team, is supporting a number of sector leaders to come together in a forum to support and review training to increase occupational safety.

Mental Health Workforce Wellbeing Committee

The Mental Health Workforce Wellbeing Committee is being established in response to recommendation 59 of the Royal Commission's final report, with its first meeting to occur in 2022. The committee is responsible for monitoring, identifying and addressing safety and wellbeing issues, and will have responsibility for the annual workforce wellbeing survey.

The committee will be jointly led by the Department of Health and WorkSafe Victoria, and will comprise senior representatives from both bodies as well as Safer Care Victoria, the Mental Health and Wellbeing Commission and representatives from the sector including professional colleges, unions and mental health service employers.

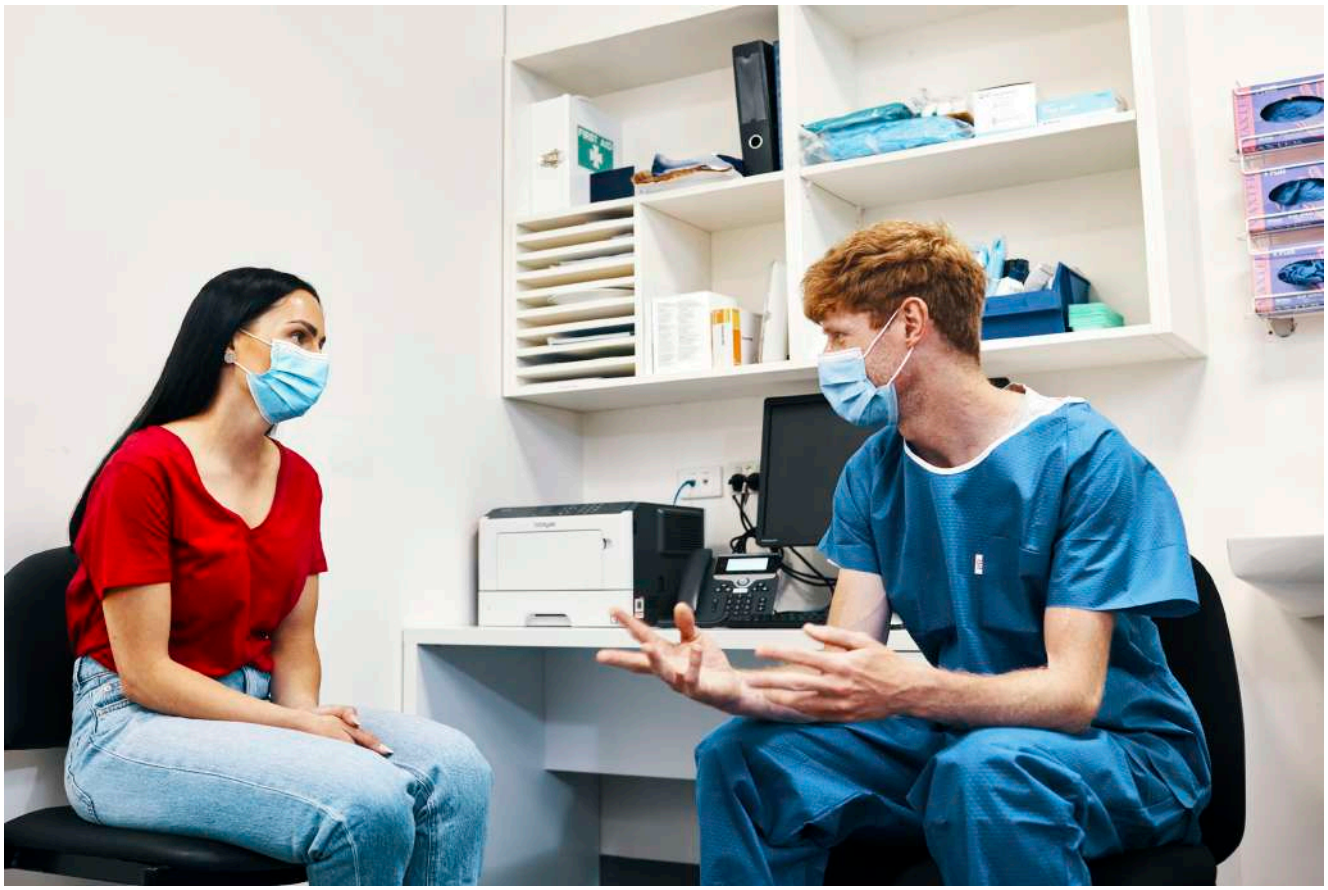
Pay and working conditions to attract, retain and support the mental health workforce

The Public Mental Health Services Enterprise Agreement 2020–24 aligns with recommendations of the Royal Commission with a focus on recruitment and retention, gender equity, and health and wellbeing. Changes to the Agreement will improve conditions for workers employed in Victoria's public specialist mental health services and support the priorities of this strategy. Changes include:

- pay increases (of three per cent for nurses; and two per cent plus an annual retention payment for all other employees) which will aid wellbeing and retention of the existing workforce
- an additional week of annual leave for all weekend workers, and 2.5 days of additional annual leave for health professionals to align with nurses
- improved access to long service leave, including pro rata access at seven years
- development of multi-level classification and salary structure lived experience workforces that will improve career pathways, attraction and retention
- inclusion of new roles including speech pathology and art therapy, Aboriginal traineeship arrangements, nursing indigenous health cadetship arrangements and mental health engagement worker arrangements
- increased parental leave and professional development leave, including study leave entitlements
- introduction of clinical educators for Parent and Infant Units to support workforce capability
- introduction of designated Mental Health Director of Nursing positions for each mental health service where they do not already exist
- enhanced administrative staffing for acute inpatient services.

Medium and longer-term actions

Into the future the Mental Health Workforce Wellbeing Committee will have carriage of developing, monitoring and implementing medium- and longer-term priorities to address mental health and wellbeing workforce wellbeing and safety needs, building on the range of activities already underway and regular workforce wellbeing survey data.



SPOTLIGHT

11. Rural and regional incentive

The Royal Commission highlighted the ongoing workforce challenges that rural and regional areas experience across primary, secondary, and tertiary mental health services. This has not been unique to the mental health sector, with broader health services across the state experiencing ongoing challenges. In recent years, the Victorian Government has directed investment to the workforce through key initiatives such as the Regional Health and Human Services Workforce Development Program.

Work is underway on an incentive scheme to alleviate mental health workforce shortages and attract and retain new workers into rural and regional areas. This will deliver on *Recommendation 40: Providing incentives for the mental health and wellbeing workforce in rural and regional areas* of the Royal Commission's final report.

The 2021–22 Victorian State Budget allocated $10.5 million over four years to the Rural and Regional Workforce Incentive Scheme. The budget also included $3.2 million to deliver time limited rural and regional workforce incentive grants while a more fulsome incentive scheme is developed.

Incentives have been designed to be concrete, multifaceted and complementary, and deliver a mental health and wellbeing workforce with the capability and expertise to meet the needs of communities in rural and regional areas:

1. Workforce relocation and incentive grants

These will encourage and support mental health workers to relocate, settle and remain in rural and regional areas. Suitably qualified workers recruited to priority, hard-to-fill positions within state-funded mental health services will be eligible for grants. The grants will be flexible to support costs such as accommodation, relocation, childcare, school fees and vehicle costs for recipients.

2. Integration support for workers and their families

Ensuring candidates are adequately supported prior to employment, during relocation and to settle and integrate into local communities is key to long-term retention.

Pre-employment and integration support will be provided to connect individuals and their families to essential services and to create social and professional connections needed to settle into their new community.

In addition to the broader health workforce initiatives for rural and regional attraction, the following initiatives are underway or planned for mental health and AOD services:

- a relocation grants pilot in 2020–21 to support workers to move and settle in rural and regional areas
- incentives for attracting the AOD workforce into rural and regional services
- internship program for allied health and AOD Certificate IV students in rural and regional AOD services
- additional support for psychiatry trainees in rural areas.

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12. Priority 4: **Building system enablers for excellence in workforce**

Workforce reform must be underpinned by sophisticated data systems, strategic planning capabilities, and support to enable the workforce to deliver treatment, care and support that meets consumers' needs.

To deliver the best outcomes, there needs to be a centralised and comprehensive approach to workforce data collection and analysis, and for a reliable evidence base to understand, plan and respond to workforce needs as the system undergoes reform. The move away from crisis-driven care will require mental health and wellbeing professionals to be supported to work across their scopes of practice and deliver effective multidisciplinary care.

A dedicated workforce planning and strategy function within the Department of Health, along with ongoing workforce data collection, analysis and planning, will provide the policy, planning and technical capability needed to improve system planning and sustainability, as required by recommendation 57 of the Royal Commission's final report.

Initial actions will focus on improving workforce data and planning models; developing more sustainable workforce pipelines; and building workforce capacity to provide holistic and multidisciplinary care. Actions will also recognise and consolidate recent improvements to working conditions, raised by stakeholders throughout the consultation process as having an important impact on workforce attraction, retention and wellbeing.

Over the longer term, these foundations will enable government to better identify and respond to need in different parts of the system, and to drive future workforce reforms. The focus will shift to supporting the workforce to deliver high-quality, holistic and evidence-based care, which will both benefit consumers and assist workforce wellbeing and retention.

In addition, there will be a focus on ensuring the system is better able to sustain itself. Historically, workforce demand has largely been met through programs that 'top up' the system, and the system itself has limited capacity to regenerate. Reform brings an opportunity to change this, by strategically embedding the roles of training professionals into new model of care design.

System enablers: Priority action areas

Action area 4a	Action area 4b
Improving system planning and sustainability	Shaping the workforce for the future

Action area 4a: Improving system planning and sustainability

Data has a fundamental role in workforce planning. As noted in the Royal Commission's interim report, a reliable evidence base is crucial to planning and shaping the workforce needed to deliver system wide change.

> 'Data collection [needs to be a priority] to ensure a deeper understanding of the workforce, skill levels and location.'
>
> *Submission to Department of Health, August 2021*

Improved data is required to understand workforce supply, composition and distribution demands and gaps, and to respond to these needs and risks into the future. At present, access to data about the diversity of the mental health workforce is limited, especially for those occupations not regulated by Ahpra. Consistent data about workforce size, composition, and educational attainment is also lacking for the community and private sectors.

For effective system-level planning, it is critical to understand workforce drivers and needs at the local, area and statewide level, as well as population growth and demographic changes, global workforce trends and discipline-specific challenges.

Modern data systems are needed to support up-to-date data capture, sophisticated analysis and system-level planning. These will be integral to understanding the funding, resourcing and workforce requirements of the mental health and wellbeing system, reducing inequalities in service access and experiences, and improving mental health outcomes.

Initiatives commenced and commencing

Improving data capture and analysis

The Royal Commission's interim and final reports highlighted the need for a robust and ongoing mechanism to capture and monitor mental health workforce data. Reliable data is essential to making informed decisions about workforce planning and new initiatives, and so changes are needed to the way in which workforce data is collected, analysed and used.

In 2021, the Victorian Government launched two key projects to implement part of recommendation seven of the Royal Commission's interim report, namely:

- A mental health workforce personnel survey – a new workforce personnel survey, carried out in October–November 2021, asked mental health workers in public, community and private settings to give feedback on their experiences of working in the sector. Survey results will inform workforce planning and provide insights into what is needed to attract, train, support and retain a stronger workforce for Victoria's reformed mental health system.
- A mental health workforce census for all specialist public mental health services – the census was carried out in August-September 2021, with services asked to provide total numbers of full-time equivalent staff (actual and vacancy) and headcount numbers for staff employed across all locations, disciplines, settings and sub-specialties, as well as those employed in education, administration and management positions.

Data from the two projects form the basis for the workforce profile above, and will contribute to immediate and longer-term workforce planning.

Medium and longer-term actions

Using data to inform workforce planning

Work over the medium to long term will build on these projects, to produce longer-term data sets and analytics which can be used to identify supply, composition and distribution demands and gaps. In future years, these point-in-time data sets will be expanded to include community mental health services, in line with reform priorities.

This data will also be shared with Regional Mental Health and Wellbeing Boards to enable them to take a data-informed approach to local workforce planning and development.

Lived experience workforce data and accountability

The Royal Commission's interim report recommended a program of work to expand the lived experience workforces and enhance workplace supports for their practice. As part of this, data will be used to measure organisational attitudes and the experience of lived experience workers.

Understanding and measuring the experience of the lived experience workforces is a new challenge for the sector. It is important to understand the different types of roles with the consumer and family-carer workforces, which include peer workers, consultants, advisors, and education and research roles.

It will also be important to capture data that represents all members of the workforces, and to use this data in quality improvement activities and to track changes over time as the Royal Commission recommendations are implemented and the lived experience workforces expand.

Over the medium to long term, this data can be used to support organisations' operations and could be linked to funding agreements, accreditation and accountability frameworks.

Funding model reform

The Royal Commission identified funding reform as a critical mechanism for encouraging the provision of mental health and wellbeing services that consumers, families and supporters value and the equitable allocation of resources. The new ways of funding recommended by the Royal Commission for trial and implementation include activity-based funding – linking provider funding directly to the volume and type of services delivered, which in turn is linked to the profile of consumer needs which the services are designed to meet. The Royal Commission also recommended trialling bundled funding models (funding for a care pathway, not just an episode within that pathway) as well as capitation models (individualised care packages which enable more complex needs to be more flexibly addressed through a range of health and non-health care and supports). The Royal Commission envisaged that the major steps towards implementation of activity-based funding would commence in 2022, while work to develop and trial other funding models would occur in the medium term (to 2026).

Through linking service funding more explicitly to demand, these new funding models will contribute to workforce planning. In particular, activity-based funding models can directly translate the estimates of service demand into budget planning and allocation processes.

Action area 4b: Shaping the workforce for the future

The Royal Commission highlighted the need to increase support for mental health and wellbeing workers to be able to use their diverse skillsets, by optimising scopes of practice across a broad range of professions. Enabling specialist professionals to work across teams and services to provide genuinely multidisciplinary care will have a positive impact on workforce wellbeing and retention, as well as the quality, breadth and continuity of care available to consumers, families, carers and supporters.

While there is an immediate priority to grow the total workforce, which will provide the much-needed capacity to shift from crisis-driven to holistic and therapeutic service provision, there is an additional need to engage in a broader conversation about the scopes of practice that will be most effective to support innovative models of care for a transformed mental health and wellbeing system in Victoria.

Definition:
'Full and optimal scopes of practice'

This strategy uses the term 'full scope of practice' to mean the full range of skills that a mental health professional has been trained in and is competent to perform.

The strategy uses 'optimal scope of practice' to talk about the most effective configuration of professional roles and responsibilities within a team or service. This is determined by considering other team members' relative competencies and the skills they are trained and competent to perform.

Source: Royal Commission into Victoria's Mental Health System, Final Report, volume 4, p. 483

Reform of system architecture and service design is an opportunity for Victoria to innovate and reform roles to increase discipline representation to utilise the skills of a broader range of workers, and to re-design jobs and create new roles that free up capacity from skilled professionals to perform their specialised function.

New and emerging workforces – including paramedics, consumer wellbeing support officers and counsellors, who have the skills that will support new models of care – need to be built to help stabilise the workforce.

Over the medium to longer term, actions will focus on optimising professional roles and scopes of practice across teams and services, enabling mental health and wellbeing workforces to use their diverse skillsets effectively and in a way that meets consumer needs.

Initiatives commenced and commencing

Community mental health engagement workers

In 2018–19, additional resources were introduced into public clinical community mental health services for a new role to be implemented to complement the existing services provided by clinicians and peer workers. These new roles, known as community mental health engagement workers, take on some of the logistical aspects of engaging and supporting consumers and their families/carers. Newly graduated health practitioners who are nurses (registered and enrolled), social workers and occupational therapists are eligible to be employed in these roles.

These time limited roles create an additional pathway for health professionals to enter the mental health workforce, and are a valuable asset in enabling community clinicians to prioritise their focus on therapeutic engagement with consumers and their families/carers.

Pre-qualification positions

The introduction of pre-qualification employment programs in mid–2021 across ten of Victoria's specialist mental health services for students of nursing (registered and enrolled nurses), allied health (social work, occupational therapy and psychology) and medicine has been another key vehicle to support optimized practice. While promoting mental health as a career, the program also frees valuable clinical resources through the support provided by the pre-qualification employees across a range of tasks.

The program is being implemented throughout 2021–22 in mental health services out across metropolitan and regional Victoria, with over 100 participating students.

Establishment of a new Workforce Reform Taskforce

An immediate priority to support and optimise workforce practice is the establishment of a new Workforce Reform Taskforce. The taskforce will have responsibility for directing workforce reform activities, and considering how models of care, the introduction of new roles and workforces, and system planning can improve opportunities for Victoria's mental health and wellbeing workforce to work across the full breadth and depth of their trained scopes of practice to improve consumer outcomes.

To be established in 2022, the taskforce will also consider the administrative demands of mental health practice, guide the introduction of new workforces described in Priority 1: Building Workforce Supply, and consider how career progression opportunities outlined in this strategy can further optimise workplace practices. Future versions of the strategy will rely on this advice to understand the alignment of workforces across settings and service types, as well as the integration and alignment of practice areas between existing and new disciplines.

The taskforce will comprise the department's Chief Psychiatrist and Chief Mental Health Nurse as well as unions and professional bodies. The taskforce will work collaboratively with the workforce, professional bodies, stakeholders, and advisory groups, including the new Mental Health and Wellbeing Workforce Education Reference Group.

Medium and longer-term actions

Future iterations of this strategy will respond to the taskforce's advice on how various practice areas complement and support consumer, carer and system outcomes; the distribution of workforces across settings and service types; and the skills and workforces that should be prioritised in the next stage of reform.

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SPOTLIGHT

13. Collaborating with the Commonwealth and other partners

Collaborating with strategic partners to achieve change

There are many factors that influence the supply, distribution, retention, and experience of the mental health and wellbeing workforce. Levers are held by multiple parties and achieving a mental health workforce of the right skills, size, composition, and distribution will require decisive action from the Commonwealth and other national bodies to ensure the potential of Victoria's investments are maximised and all Victorians receive the care they need and deserve.

As described in Figure 19, this will include multiple layers of government, professional regulatory and worker representative bodies, education and training providers, services and peak bodies. The Victorian Government will actively work across these layers and with all partners to achieve the priorities and action areas described in this strategy.

Working with the Commonwealth Government and professional bodies

Collaboration between the Commonwealth and Victoria to align the Victorian Mental Health and Wellbeing Workforce Strategy and the National Medical Workforce Strategy, National Mental Health Workforce Strategy, and proposed National Mental Health Workforce Data plan is essential. This includes coordinated action using the levers within each jurisdiction's control to support and strengthen the workforce with a priority focus on increasing workforce supply. Recognising that responsibility for workforce is shared, the Commonwealth must:

- incentivise delivery of mental health training programs by increasing Higher Education Commonwealth Supported Places in core disciplines, including the availability of psychology honours and masters positions
- improve job-readiness and the acquisition of contemporary skills, knowledge and capability to practice in mental health by reviewing and re-designing mental health curricula, as well as setting standards for undergraduate training in core disciplines
- fund the development of contemporary postgraduate mental health therapies training to reduce the burden on health services to fund foundational skill development
- incentivise and set targets for student placements in mental health settings and fund appropriate placement supports within training institutions
- expand allied health graduate programs in Commonwealth funded services and support the development of allied health graduate programs and standards in community non-government organisations
- expand university debt reduction schemes for health practitioners in rural and regional areas to include allied health practitioners working in public mental health settings
- review the standards being used by the counsellor and psychotherapist peak bodies and provide recommendations for regulation and scope of practice to apply nationally
- increase permitted paid working hours for students
- increase age-limits for eligibility for permanent residency
- expedite permanent residency and graduate visa applications
- fund support programs for Senior International Medical Graduates

Ensuring a secure pipeline for a contemporary mental health and wellbeing workforce will also require improved transparency and action on training and regulation processes, including:

- the Royal Australian and New Zealand College of Psychiatrists to take immediate action on poor examination processes and pass rates, supports to International Medical Graduates, and removal of

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SPOTLIGHT

pipeline-blocking mandatory rotations in Child and Adolescent Psychiatry and Consultation Liaison Psychiatry

- the Australian Association of Social Workers to review 1,000-hour unpaid student placement requirements, and consider the introduction of paid registrar programs or recognition of paid work toward placement hours
- the Australian Psychological Society to recognise registration of psychologists registered for practice in the United Kingdom, the United States, Ireland, and Canada, and undertake a review of eligibility for other countries
- Ahpra to align registration of social workers with other comparable jurisdictions to ensure title protection and safeguards to maximise the value of social work in the delivery of therapies across all settings.

SPOTLIGHT

Figure 19: Workforce reform roles and responsibilities

Who	Responsibility
Commonwealth Government	• setting national strategic direction • primary care access through Primary Health Networks and general practitioners, and Medicare rebates for psychologists • funding and regulation of the tertiary sector • responsibility for immigration levers which support recruitment and retention
Victorian Government	• funding public and non-government mental health services • system design and policy development • responsibility for service quality and safety mechanisms
Regional Mental Health and Wellbeing Boards	• supporting regional workforce planning, including relating to supply, capability and wellbeing activities • selecting providers of mental health and wellbeing services, including new providers and partnerships • holding mental health and wellbeing service providers to account and improving performance over time
Australian Health Practitioner Regulation Agency and National Registration Boards	• setting standards and policies that registered health practitioners must meet • conducting registration and compliance processes • investigating complaints against registered practitioners
Professional peak bodies and colleges	• defining training and education standards and continuing professional development requirements • administering self-regulated practitioner schemes • representing members
Education providers	• developing, designing and delivering education and training programs
Unions and industrial stakeholders	• protecting the integrity of the trade or group they represent • negotiate pay and working conditions • ensuring the health and safety of workers is protected
Health and community services providers	• delivering treatment, care and support services • employing, supervising, and supporting staff • create safe and supportive work conditions and environments to attract and retain mental health and wellbeing workforces

14. Implementation

The Royal Commission has set a long-term vision for the future of the mental health and wellbeing workforce, however essential elements of the system – including models of care – are yet to be designed and established. The mental health system will undergo rapid change as these critical elements come online, so at this point in time it is difficult to predict long-term workforce needs with accuracy.

The strategy leverages the experience of the sector to build on proven initiatives and prototypes, but also creates opportunities for innovation that will require further collaboration, testing and evaluation – and input from both the mental health and wellbeing workforce and lived experience voices.

The Victorian Government has committed to refreshing the strategy every two years to ensure that it reflects the changing needs of the system, the community, and of the mental health and wellbeing workforce.

An approach based on learning, innovation and collaboration

Implementation of workforce reforms will be underpinned by human centred design approaches with the diverse voices of the community, clinical, community, and lived and living experience workforces, and the voices of consumers, families, carers and supporters.

Measuring progress against outcomes

This strategy sets out the Victorian Government's commitment to outcomes-driven workforce reform. It underpins the approach to delivering on the Royal Commission's vision, outlined in *Mental Health and Wellbeing in Victoria: Our priorities and progress in system reform and delivery*, released in October 2021.

Work is underway to develop a Mental Health and Wellbeing Outcomes and Performance Framework as recommended by the Royal Commission in its final report. It will be essential to measure the impact of initiatives to build workforce supply, capability and wellbeing and of system enablers, and this work will allow progress against key outcomes to be tracked.

Aligning the strategy to improved outcomes will be supported through implementation of recommendation 65 which seeks to embed evaluation and the building of an evidence base for reform activities as an underlying feature of reform. In line with this, initiatives proposed in the strategy will be accompanied by data collection, improved data and reporting standards and the production of evaluation reports to understand the impact of these programs.

Communicating progress

Regular updates will be provided as these vital workforce reforms are delivered. Significant milestones, announcements, events and opportunities will be shared with all Victorians through media releases, news articles and the mental health reform website, as well as through direct emails to key partners and stakeholders.

Regular and ongoing feedback will be sought from the sector about the preferred content, frequency and platforms for communications and updates.

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Overview of key priorities and actions

1. Building workforce supply

Action area	Initiatives commenced and commencing	Medium to longer-term actions
a Attracting people to mental health careers	• A new attraction campaign for local and interstate clinicians	• Expanded international recruitment campaign • Rollout of additional supports for international recruitment
b Growing graduate, post-qualifying and transition training pathways	• Postgraduate mental health nurse scholarships • New entry positions for mental health nurses • Junior medical officer psychiatry rotations • Prequalification initiative to employ allied health, nursing and medicine undergraduates • Psychiatry leadership development • Supporting psychiatry registrars to undertake mandatory rotations • Expanded allied health graduate program • Psychiatry training support package • New graduate program for enrolled nurses • Transition program for experienced allied health and nursing clinicians	• Adapt and implement at scale successful and promising initiatives
c Building emergent and new workforces	• a lived experience peer cadet program • improved access to supervision for lived experience workers in clinical services • funding two lived experience workforce lead positions at Victoria's consumer and carer peak bodies • a lived experience workforce – consumer and carer feedback program	• Once the foundations for emergent and new workforces are in place, the focus will move to the scale of the workforce pipeline
d Ensuring workforce meets regional needs	• Relocation grants program • Workforce incentive grants • Integration support for workers and their families • A pilot incentive program for the AOD workforce • A pilot internship program for allied health and Certificate IV AOD students in AOD services, prioritising interns from diverse communities	• Refreshed workforce incentive program

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2. Building workforce skills, knowledge and capabilities

Action area	Initiatives commenced and commencing	Medium to longer-term actions
a Ensuring education and training meets the needs of the community	• Supporting the Commonwealth Government's development of a ten-year National Medical Workforce Strategy and a National Mental Health Workforce Strategy • Establish a Mental Health Higher Education Reference Group • Advocate to the Commonwealth on priority education and training areas • Seek standardised registration schemes and registration of overseas-trained practitioners	• Work with the Commonwealth, professional bodies and Colleges on necessary changes to training, accreditation and registration
b Embedding a system wide capability focus	• Work to establish the Victorian Collaborative Centre for Mental Health and Wellbeing • Establishment of Regional Mental Health and Wellbeing Boards • Statewide service for people living with mental illness and substance use or addiction • Establishment of Statewide Trauma Service • Release and embed the Victorian Mental Health and Wellbeing Workforce Capability Framework	• Establish the new statewide capability entity, under the auspices of the Collaborative Centre for Mental Health and Wellbeing
c Improving capability through ongoing training opportunities	• Strengthening supervision for lived experience workforce, mental health nurses and psychiatry registrars • Supporting leadership and co-design capability in family violence, psychiatry leadership and organisational level • Increased support for psychiatry trainees • Development of mental health leaders • Training and development for Infant, Child and Youth Area Mental Health and Wellbeing Service workforce • Statewide coordination of the Child and Adolescent Mental Health Service Autism Program	• Identify and build on skills needed at both a discipline-specific and whole-of-workforce level
d Ensuring workforce reflects and responds to diverse communities	• Specialised care for vulnerable people who need intensive support • Development of the Diverse Communities' Mental Health and Wellbeing Framework and Blueprint for Action	• Continue to consider workforce capability needs to better respond to diverse communities as reforms are implemented

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3: Supporting the safety, wellbeing and retention of the mental health and wellbeing workforce

Action area	Initiatives commenced and commencing	Medium to longer-term actions
a Establishing workforce wellbeing monitoring and supports	• People Matter Survey and mental health workforce personnel survey to monitor workforce wellbeing • Launch of the Healthcare worker wellbeing centre • Mental health and AOD Workforce Wellbeing Grants • Ensuring safety and wellbeing in the coronavirus (COVID–19) pandemic • Continued roll-out of the Safewards model • Professional leadership through mental health nurse communities of practice • Implementation of the 'Safety for all' initiative • Sector-led network for occupational safety • Establish the Mental Health Workforce Wellbeing Committee • A new Public Mental Health Services Enterprise Agreement 2020–24	• Ongoing monitoring of workforce safety and engagement

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4: Building system enablers for excellence in workforce

Action area	Initiatives commenced and commencing	Medium to longer-term actions
a Improving system planning and sustainability	• Improving data capture and analysis through the mental health workforce census and personnel survey	• Produce data sets and analytics to identify supply, composition and distribution demands • Establish lived experience workforce data benchmarks • Commence implementation of activity-based funding and develop and trial other funding models
b Shaping the workforce for the future	• Community mental health engagement workers • Pre-qualification employment program for students of nursing, allied health and medicine • Establish a Workforce Reform Taskforce	• Taskforce to advice on priorities for the next stage of reform

15. Appendices

Stakeholder engagement

Workforce forum The forum was held in July 2021 and brought together a broad range of stakeholders including community and clinical services, peak bodies, professional bodies, academic institutions and more to identify challenges and priorities for the workforce strategy.	**146 attendees**
Workforce Technical Advisory Group An external advisory body established to provide expert input into the development of the strategy and the progression of the workforce reform agenda, particularly around implementation barriers and risks.	**23 members**
Targeted engagement workshops Six targeted engagement groups were established across the workstreams of workforce supply, capability, wellbeing and rural and regional workforces. Membership brought together consumers, carers, clinicians, regulators, and subject matter experts who participated in a series of workshops to test ideas, validate assumptions and generate innovative solutions to the problems identified by the Royal Commission.	**219 people across six workshops**
Public consultation process Members of the public and sector stakeholders were invited to provide additional submissions through the Engage Victoria portal.	**41 submissions received**
Workforce census and personnel survey A separate workforce census survey was undertaken throughout August–September 2021 with participation from specialist mental health services to gather data about the workforce. In October 2021, workers across the mental health sector were invited to participate in a survey that provides insights into demographic mental health workforce data, as well as gathering information on worker wellbeing and feedback on the Capability Framework.	**All 19 Victorian specialist mental health services completed the workforce census, with 1,932 personnel survey responses received**

Members of the Workforce Technical Advisory Group

The Mental Health and Wellbeing Workforce Technical Advisory Group provided specialised and expert advice on implementation of the Royal Commission's recommendations relating to workforce, which informed the development of *Victoria's mental health and wellbeing workforce strategy 2021–2024*.

Standing membership of the group includes:

Member	Organisation	Expertise
Lyn Morgain (Chair)	Oxfam Australia	Mental health, non-government sector
Craig Wallace	Victorian Mental Illness Awareness Council	Consumer perspective
Marie Piu	Tandem	Carer perspective
Gaby Bruning	Victorian Aboriginal Community-Controlled Health Organisation	Indigenous communities and workforces
Adriana Mendoza	Victorian Transcultural Mental Health	CALD communities and structural inequality
Simon Ruth	Thorne Harbour Health	LGBTIQ
Madeleine Harradence	Australian Nursing and Midwifery Federation	Nursing union
Leon Wiegard	Australian Services Union	Social and community services sector, NDIS
Paul Healey	Health and Community Services Union	Union for specialist mental health, disability and drug and alcohol workforces
Associate Professor Genevieve Pepin, PhD	Occupational Therapy Australia	Occupational therapy workforce
Rachel Reilly	Australian Association of Social Workers	Social Workers
Rosemary Kelly	Victorian Psychologist Association	Psychology workforce
Angus Clelland	Mental Health Victoria	Statewide peak body
Astha Tomar	Royal Australian and New Zealand College of Psychiatrists	National psychiatric workforce
Dr Roderick McRae	Australian Medical Association	Medical workforce
Morton Rawlin	Mental Health Professionals Network, Royal Australian College of General Practitioners	General practitioners
Chris Hynan	Victorian Dual Diagnosis Initiative	Dual Diagnosis
Sam Biondo	Victorian Alcohol and Drug Association	AOD and dual diagnosis sector
Ruth Vine	Personal Capacity	Psychiatrist and Commonwealth Department of Health
Dr. Zena Burgess	Chief Executive Officer, Australian Psychological Society	Psychology workforce
Andrew Tomlinson	Director, System Reform, Tandem	Carer lived experience
Rick Corney	Senior Peer Support Worker at Ballarat Community Health	Consumer lived experience
Dan Stubbs	Victorian Disability Worker Commissioner	Disability Workforce

Glossary

Language and words are powerful and have different meanings for each person.

There is no single set of definitions used to describe people's experience of their mental health, psychological distress or mental illness. This diversity is reflected in the many words used by people to express their experiences.

There is also diversity in the ways mental health and wellbeing workforces describe themselves, their knowledge, skills and ways of working with consumers, carers, families, and supporters.

Words can have a lasting impact on a person's life, both positive and negative.

Words are also deeply questioned and nuanced, with many perspectives on terminology. The language used through this document aims to be inclusive and respectful.

Carer	Means a person, including a person under the age of 18 years, who provides care to another person with whom they are in a relationship of care.
Consumer	People who identify as having a living or lived experience of mental illness or psychological distress, irrespective of whether they have a formal diagnosis, who have used mental health services and/or received treatment.
Family	May refer to family of origin and/or family of choice.
Good mental health	A state of wellbeing in which a person realises their own abilities, can cope with the normal stresses of life, can work productively and is able to contribute to their community.
Lived experience	People with lived experience identify either as someone who is living with (or has lived with) mental illness or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or psychological distress. People with lived experience are sometimes referred to as 'consumers' or 'carers'. It is acknowledged that the experiences of consumers and carers are different.
Mental health and wellbeing system	The addition of the concept of 'wellbeing' represents a fundamental shift in the role and structure of the future system. In the future mental health and wellbeing system for Victoria, mental health and wellbeing refers to the absence of mental illness or psychological distress and to creating the conditions in which people are supported to achieve their potential. The focus on the strengths and needs that contribute to people's wellbeing is purposeful. To achieve balance between hospital-based services and care in the community, the types of treatment, care and support the future system offers will need to evolve and be organised differently to provide each person with dependable access to mental health and wellbeing services, and links to other supports they may seek.
Mental illness	A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory. It acknowledges that mental illness can be described using terms such as 'neurodiversity', 'emotional distress', 'trauma' and 'mental health challenges'.

Psychological distress	One measure of poor mental health, which can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness. This is consistent with the definition accepted by the National Mental Health Commission.
Scopes of practice	This strategy uses the term 'full scope of practice' to mean the full range of skills that a mental health professional has been trained in and is competent to perform. The strategy uses 'optimal scope of practice' to talk about the most effective configuration of professional roles and responsibilities within a team or service. This is determined by considering other team members' relative competencies and the skills they are trained and competent to perform.
Social and emotional wellbeing	Being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life. This is consistent with Balit Murrup, Victoria's Aboriginal social and emotional wellbeing framework.
Treatment, care and support	This phrase is used to present treatment, care and support as fully integrated, equal parts of the way people will be supported in the future mental health and wellbeing system. In particular, wellbeing supports (previously known as 'psychosocial supports') that focus on rehabilitation, wellbeing and community participation will sit within the core functions of the future system.

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Royal Commission into
Victoria's Mental Health System

Final Report

Volume 3

Promoting inclusion and addressing inequities

Royal Commission into
Victoria's Mental Health System

Volume 3
Promoting inclusion and addressing inequities

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Except where otherwise indicated, the images in this publication show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. This publication may contain images of deceased Aboriginal and Torres Strait Islander peoples.

In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

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Acknowledgement of Aboriginal land and peoples

The heritage of Aboriginal communities throughout Victoria is vibrant, rich and diverse. We value these characteristics and consider them a source of strength and opportunity. We recognise that the leadership of Aboriginal communities and Elders in Victoria is crucial to improving outcomes for Aboriginal people. Also to be acknowledged, however, are the devastating impacts and the accumulation of trauma resulting from colonisation, genocide, the dispossession of land and children, discrimination and racism.

The Royal Commission into Victoria's Mental Health System proudly acknowledges Aboriginal people as the First Peoples and Traditional Owners and custodians of the land and water on which we rely. We acknowledge that Aboriginal communities are steeped in traditions and customs, and we respect this. We acknowledge the continuing leadership role of the Aboriginal community in striving to redress inequality and disadvantage, and the catastrophic and enduring effects of colonisation.

We recognise the diversity of Aboriginal people living throughout Victoria. Although the terms 'Koorie' and 'Koori' are commonly used to describe Aboriginal people of south-east Australia, we use the term 'Aboriginal' in this report to include all people of Aboriginal and Torres Strait Islander descent who are living in Victoria. This approach is consistent with the language conventions of key Victorian frameworks such as the *Aboriginal Affairs Framework 2018–2023*.

The Royal Commission is conscious that its work is taking place concurrently with renewed efforts to achieve constitutional recognition of Aboriginal peoples and treaty processes that are underway in Victoria. We commit to building on this momentum and to ensuring our work is shaped by the voice of Aboriginal people.

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DOH.0003.0001.0443

Contents

Acknowledgement of Aboriginal land and peoples iii

A note on content x

Terminology and language xi

Personal stories and case studies xiv

Introduction 1

Chapter 18: The leadership of people with lived experience of mental illness or psychological distress 9

18.1 Establishing the foundations for the leadership of people with lived experience of mental illness or psychological distress 13

18.2 Shifting power 18

18.3 Limited opportunities to genuinely lead and drive change 22

18.4 Constraints on systemic advocacy efforts 26

18.5 Cross-cutting reforms to strengthen the leadership of people with lived experience of mental illness or psychological distress 28

18.6 Lived experience of mental illness or psychological distress within the Mental Health and Wellbeing Commission 30

18.7 A new agency led by people with lived experience of mental illness or psychological distress 46

Chapter 19: Valuing and supporting families, carers and supporters **65**

19.1 The Royal Commission's vision for families, carers and supporters 70

19.2 People live in a social context 72

19.3 The different experiences and perspectives of consumers, families, carers and supporters 74

19.4 Families, carers and supporters are essential to the future mental health and wellbeing system 76

19.5 Concerns raised by families, carers and supporters about the mental health system 79

19.6 Families, carers and supporters need support in their own right 81

19.7 Rebalancing the system's relationship with families, carers and supporters 92

19.8 Family and carer leadership in the future mental health and wellbeing system 94

19.9 Working with families, carers and supporters is core business 96

19.10 Expanding models of care that involve families, carers and supporters 104

19.11 Establishing a statewide program of supports for families, carers and supporters 107

19.12 Supporting young carers and children and young people who have a family member experiencing mental illness or psychological distress 117

19.13 Families, carers and supporters across the Commission's recommendations 130

Chapter 20: Supporting Aboriginal social and emotional wellbeing **139**

20.1 Aboriginal social and emotional wellbeing 142

20.2 Aboriginal social and emotional wellbeing in the interim report 145

20.3 The impact of intergenerational trauma, colonisation and systemic racism 149

20.4 Lack of cultural safety and cultural responsiveness in mainstream services 154

20.5 Self-determination as the foundation of reform 156

20.6 The need for healing approaches 162

20.7 Supporting Aboriginal children and young people 176

20.8 The Aboriginal health workforce 191

20.9 Culturally safe and responsive mainstream services 193

DOH.0003.0001.0445

Chapter 21: Responding to the mental health and wellbeing needs of a diverse population **205**

21.1 A safe, inclusive and responsive mental health and wellbeing system for people from diverse communities 208

21.2 Mental health of diverse communities 211

21.3 Experiences of diverse communities in the mental health system 224

21.4 Language and communications services 236

21.5 Transforming mental health and wellbeing treatment, care and support for diverse populations 243

21.6 A new approach to supporting the mental health and wellbeing of Victoria's diverse communities 257

Chapter 22: Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction **281**

22.1 An integrated approach to improve consumer outcomes 285

22.2 The Commission's approach to mental illness and substance use or addiction 288

22.3 Mental illness and substance use or addiction 292

22.4 Current services for mental illness and substance use or addiction in Victoria 306

22.5 Challenges for people living with mental illness and substance use or addiction, and for Victoria's alcohol and other drug services 310

22.6 The case for integrated treatment, care and support for mental illness and substance use or addiction 321

22.7 The future system: providing integrated treatment, care and support for mental illness and substance use or addiction 328

22.8 Supporting the system to provide integrated treatment, care and support for mental illness and substance use or addiction 333

Chapter 23: Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems **345**

23.1 Improving mental health outcomes across the criminal justice system 349

23.2 Improving mental health outcomes across the adult forensic mental health system 375

23.3 Improving mental health outcomes across the youth justice system 400

DOH.0003.0001.0446

Chapter 24: Supporting the mental health and wellbeing of people in rural and regional Victoria **431**

24.1 Responsive and accessible services in rural and regional Victoria 435

24.2 Diverse and growing rural and regional communities 436

24.3 Mental health and wellbeing needs in rural and regional communities 440

24.4 Access to mental health and wellbeing services in rural and regional areas 453

24.5 Funding to reflect the cost of service delivery 475

24.6 Workforce shortages 477

24.7 The future system: building on the strengths and resilience of rural and regional communities 486

Chapter 25: Addressing stigma and discrimination **515**

25.1 Our shared responsibility to end stigma and discrimination 518

25.2 Defining stigma and discrimination 520

25.3 People with lived experience are stigmatised 524

25.4 People with lived experience face widespread discrimination 527

25.5 Stigma and discrimination have profound impacts on people's lives 531

25.6 Confronting stigma and discrimination sets the foundations for mental health and wellbeing 544

25.7 Strategies to reduce stigma have not materially shifted attitudes 547

25.8 The success of international programs in reducing mental health-related stigma 556

25.9 Confronting stigma will require a coordinated, multilevel response 559

25.10 Confronting discrimination and ensuring equality 562

Glossary 576

DOH.0003.0001.0447

A note on content

The Royal Commission recognises the strength of people living with mental illness or psychological distress, families, carers and supporters, and members of the workforce who have contributed their personal stories and perspectives to this inquiry.

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

Aboriginal readers are advised that this report may contain photos, quotations and/or names of people who are deceased.

If you are upset by any content in this report, or if you or a loved one need support, the following services are available to support you:

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

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Terminology and language

Language is powerful and words have various meanings for different people.

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

As stated in the Commission's interim report, words and language can have a lasting impact on a person's life. They can empower and embolden. They can be used to convey hope and empathy. But they can also be divisive when used to dispossess and divide, and to stigmatise and label.

The Commission has considered the many perspectives on terminology, and acknowledges that language can be deeply contested and nuanced. Although it has at all times tried to use inclusive and respectful language, the Commission is aware that not everyone will agree with the terminology used.

Another consideration for the Commission has been this report's broad audience, including people with lived experience of mental illness or psychological distress, families, carers and supporters, workers in the mental health system, government and the wider Victorian community. This diverse audience needs to be able to read the report and understand its intent at this point in time in the development of the mental health system.

Below is a list of important terms in the report and how the Commission understands them. This list largely reflects the requirement to align with definitions outlined in the Commission's letters patent. It is also consistent with the Commission's interim report for the purposes of clarity.

Carer	Means a person, including a person under the age of 18 years, who provides care to another person with whom they are in a relationship of care.
Consumer	People who identify as having a living or lived experience of mental illness or psychological distress, irrespective of whether they have a formal diagnosis, who have used mental health services and/or received treatment.
Family	May refer to family of origin and/or family of choice.
Good mental health	A state of wellbeing in which a person realises their own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to their community.

Lived experience	People with lived experience identify either as someone who is living with (or has lived with) mental illness or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or psychological distress. People with lived experience are sometimes referred to as 'consumers' or 'carers'. The Commission acknowledges that the experiences of consumers and carers are different.
Mental health and wellbeing system	The Commission outlines in this report its vision for a future mental health and wellbeing system for Victoria. Mental health and wellbeing does not refer simply to the absence of mental illness or psychological distress but to creating the conditions in which people are supported to achieve their potential. As part of this approach, the Commission has also purposefully chosen to focus on the strengths and needs that contribute to people's wellbeing. To better reflect international evidence about the need to strike a balance between hospital-based services and care in the community, the types of treatment, care and support the future system offers will need to evolve and be organised differently to provide each person with dependable access to mental health and wellbeing services and links to other supports they may seek. The addition of the concept of 'wellbeing' represents a fundamental shift in the role and structure of the system.
Mental illness	A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory. The Commission uses the above definition of mental illness in line with the *Mental Health Act 2014* (Vic). However, the Commission recognises the Victorian Mental Illness Awareness Council Declaration released on 1 November 2019. The declaration notes that people with lived experience can have varying ways of understanding the experiences that are often called 'mental illness'. It acknowledges that mental illness can be described using terms such as 'neurodiversity', 'emotional distress', 'trauma' and 'mental health challenges'.
Psychological distress	One measure of poor mental health, which can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness. This is consistent with the definition accepted by the National Mental Health Commission.
Social and emotional wellbeing	Being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life. This is consistent with *Balit Murrup*, Victoria's Aboriginal social and emotional wellbeing framework.

Treatment, care and support	The Commission uses this phrase consistently with its letters patent. This phrase has also been a deliberate choice throughout this report to present treatment, care and support as fully integrated, equal parts of the way people will be supported in the future mental health and wellbeing system. In particular, wellbeing supports (previously known as 'psychosocial supports') that focus on rehabilitation, wellbeing and community participation will sit within the core functions of the future system.

The Commission only departs from these terms when referring to specific data sources, describing research works, or quoting an individual or organisation. The original language is retained wherever possible to accurately reflect the views and evidence presented to the Commission. For example, the Commission quotes individuals and organisations that sometimes refer to 'mental disorder', rather than the Commission's preferred terms of 'mental illness or psychological distress'. Terms such as 'disorder' can be pathologising and stigmatising, so the Commission only retains them if others use them to convey a specific meaning.

Personal stories and case studies

Throughout all phases of its work, the Commission has heard from people with lived experience of mental illness or psychological distress, families, carers and supporters, members of the workforce, organisations, experts and members of the broader Victorian community through consultations, submissions, correspondence, public hearings and witness statements.

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

The Commission has also included a selection of case studies that are primarily about services or approaches that illustrate reform opportunities or innovation.

The Commission wanted to consider a broad range of ideas for improving the mental health system. Therefore, some of these personal stories and case studies include perspectives from outside of Victoria.

With the permission of the individuals involved, these have been modified for privacy and confidentiality where appropriate. In some instances, the Commission has also made non-publication orders to protect privacy and confidentiality.

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Introduction

As required by the Commission's letters patent, the Commission was a policy-based inquiry. This report presents the findings from this process and sets out recommendations to inform the design of a new mental health and wellbeing system.

The Victorian community made more than 12,500 contributions to inform the Commission's work. The Commission has listened to this diversity of voices and analysed a wide variety of data and research. These inputs have illustrated the factors that shape people's experiences of mental health and wellbeing and have formed the basis for the design of the future system and services.

Volume 1 of this report outlines a new approach to providing Victorians with the right mental health treatment, care and support at the right time, and in the right places across the state. Volume 2 describes the collaboration needed to support good mental health and wellbeing. Volume 4 explains the features that will ensure the system provides high-quality and safe services. Volume 5 sets out the enablers of system transformation, including the technology, information and expertise needed to make the system work effectively, and how it will drive continuous improvement.

This volume outlines how the system will promote inclusion and address inequities in the mental health and wellbeing system. It describes the central role of people with lived experience of mental illness or psychological distress, families, carers and supporters in the future system. It explains how the new system will support Aboriginal social and emotional wellbeing, and how it will respond to the needs of diverse communities. It details integrated approaches to treatment, care and support for people with co-occurring mental illness and substance use or addiction. It also details the future system design for people living with mental illness who are in contact with the criminal justice system, including the youth justice system. It addresses how the new mental health and wellbeing system will provide an improved response to people who live in rural and regional Victoria. Finally, it describes what will be done to address stigma and discrimination.

Placing lived experience at the centre

The current system does not adequately value or respond to the knowledge and expertise of people with lived experience of mental illness or psychological distress, or families, carers and supporters of someone living with mental illness or psychological distress. These failures must be addressed.

The Commission is recommending a central role for people with lived experience of mental illness or psychological distress and families, carers and supporters in the ongoing design and development of the system, and in the delivery of services.

The Commission acknowledges the knowledge and expertise of mental health and wellbeing that people with lived experience of mental illness or psychological distress, families, carers and supporters have, based in their individual and shared experiences.

At times, people with lived experience of mental illness or psychological distress and families, carers and supporters may have shared interests based in common experiences, but this is not always the case. At times, their views may differ. In creating opportunities for the leadership of people with lived experience of mental illness or psychological distress and families, carers and supporters, the future system will respond to the differing knowledge and expertise that each group draws on (and indeed the differing knowledge and expertise of each individual).

The future system will provide dedicated, separate spaces for people with lived experience of mental illness or psychological distress and family, carer and supporter leadership, as well as opportunities for these groups to come together.

A future mental health and wellbeing system will see people with lived experience of mental illness or psychological distress in multiple and substantive leadership positions, working collaboratively with others to lead and influence change and balance power.

A new agency led by people with lived experience of mental illness or psychological distress will help establish organisations, including services led by people with lived experience of mental illness or psychological distress. These organisations will be supported to develop over time through accredited training and resources.

In the new mental health and wellbeing system, understanding consumers' social contexts will be a key part of service delivery. This means that involving families, carers and supporters in care and recovery will become standard practice for all services. Family, carer and supporter inclusion will also be a routine aspect of the commissioning of mental health and wellbeing services, and of workforce development and training.

The system will respond to the significant role that relationships of care and support play in promoting mental health and wellbeing for people living with mental illness or psychological distress. Families, carers and supporters will have access to dedicated supports from eight family- and carer-led centres. Tailored and intensive supports will also be provided to young carers.

Refer to Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress* and Chapter 19: *Valuing and supporting families, carers and supporters* for detailed descriptions of these reforms.

Improving responses to the community's diverse needs

Victoria's population is diverse, growing and changing, and the mental health and wellbeing system needs to extend its responses to better meet the specific needs of different communities.

The interim report acknowledged the urgent need to support the mental health of Aboriginal people. As an immediate response, the Commission outlined how the Victorian Government will expand Aboriginal social and emotional wellbeing services and establish a new Aboriginal Social and Emotional Wellbeing Centre to support these services.

The next stage of reform will establish new healing centres that will draw on Aboriginal knowledge and expertise on healing from trauma, distress and mental illness. These centres will be co-designed, developed and delivered through partnerships between the Aboriginal Social and Emotional Wellbeing Centre and Aboriginal community-controlled health organisations and Aboriginal communities.

A detailed description of the reforms to address Aboriginal mental health and wellbeing are described in Chapter 20: *Supporting Aboriginal social and emotional wellbeing*.

The new system will also have increased oversight and accountability for supporting the mental health and wellbeing of Victoria's diverse communities.

People who identify as LGBTIQ+; refugees; asylum seekers; people living with disabilities; and people from culturally diverse backgrounds are exposed to a range of factors, including stigma and discrimination that increase the likelihood they will have poor mental health outcomes.

Consumers will experience safe and responsive care, including access to appropriate and accessible information and language services. Community-led organisations will be recognised as important partners in supporting and delivering services to their communities. Service providers will be required to report on how well they are meeting the needs of Victoria's diverse communities.

Multiple social and environmental factors influence mental health outcomes, and people are best served when services are both universally accommodating and tailored to different population groups and communities. The new system will strengthen current services that target specific communities and support community-led organisations by increasing their capacity to address diversity and geographic challenges.

For a detailed description of the ways in which the new system will respond to the diversity of Victoria's population, refer to Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population*.

Integrating care for those often marginalised and excluded

Removing the gaps and silos between sectors is vital for everyone but especially for groups that comprise some of the most marginalised and excluded Victorians. The future system will ensure services are integrated for people living with mental illness or psychological distress who also need help with substance use or addiction, and for those who are involved with, or at risk of involvement with, the criminal or youth justice systems, or those in the forensic mental health system.

The Commission recognises that many people who experience mental illness or psychological distress are also affected by substance use or addiction. In the new system, consumers will be able to get integrated treatment, care and support for mental illness and substance use or addiction across the care continuum. A new statewide service will be established to support existing services to deliver these joined-up responses, and to provide a specialist mental health and substance use or addiction response for those consumers who need it. Refer to Chapter 22: *Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction* for details of these reforms.

People living with mental illness are over-represented throughout the criminal and youth justice systems, including in prisons and youth justice centres. They are also more likely to be victims of crime.

The Commission's suite of reforms across crisis and emergency responses and the new community mental health and wellbeing system will go some way to address this. The new system will also deliver specific measures in response by improving coordination between justice and community mental health services and delivering a range of strategies including expanded access to 'problem-solving' courts (in particular the Assessment and Referral Court). Problem-solving courts seek to understand and address the underlying issue behind a person's offending behaviour and to develop, with the individual and a multidisciplinary team, a management plan that considers legal aspects and wider issues.

The Victorian Government will expand community-based mental health and wellbeing services to offer more forensic mental health services to people who need them. The system will also provide improved transitions out of the criminal justice system to ensure people who need ongoing intensive treatment, care and support receive it when they leave prison. They will be supported to begin or continue their involvement with the appropriate Area Mental Health and Wellbeing Service.

Thomas Embling Hospital provides treatment, care and support to consumers who are transferred from prison or ordered by courts to be detained for psychiatric assessment and treatment. The hospital will receive funding for a full refurbishment and to increase its capacity to meet demand through building new beds for both those it currently provides services to and for those consumers who cannot receive safe and appropriate treatment, care and support in extended rehabilitation settings or other inpatient services. The Victorian Government will also establish a statewide youth forensic mental health service.

Refer to Chapter 23: *Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems* for details of these reforms.

Addressing inequities for rural and regional Victorians

In its interim report the Commission stated that, wherever possible, people living in rural and regional Victoria should be able to obtain mental health services close to home, and close to their families and loved ones. The new system is designed to respond to the changing composition, needs and choices of rural and regional Victorians through a networked service approach across rural and regional areas.

Regional Mental Health and Wellbeing Boards will commission Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, ensuring these services respond to the needs of local communities and recognise the unique strengths and challenges of each region. Area Mental Health and Wellbeing Services based in regional centres will have more responsibility for providing inreach services (services to people in their own communities) to more geographically isolated or smaller rural communities.

Services will be supported to attract, develop and retain a more sustainable mental health and wellbeing workforce through a multifaceted Mental Health Workforce Rural Incentive Scheme that will support meaningful career pathways. Digital service delivery will also be accelerated to provide more flexible and accessible options for treatment, care and support.

For a detailed description, refer to Chapter 24: *Supporting the mental health and wellbeing of people in rural and regional Victoria*.

Tackling stigma and discrimination

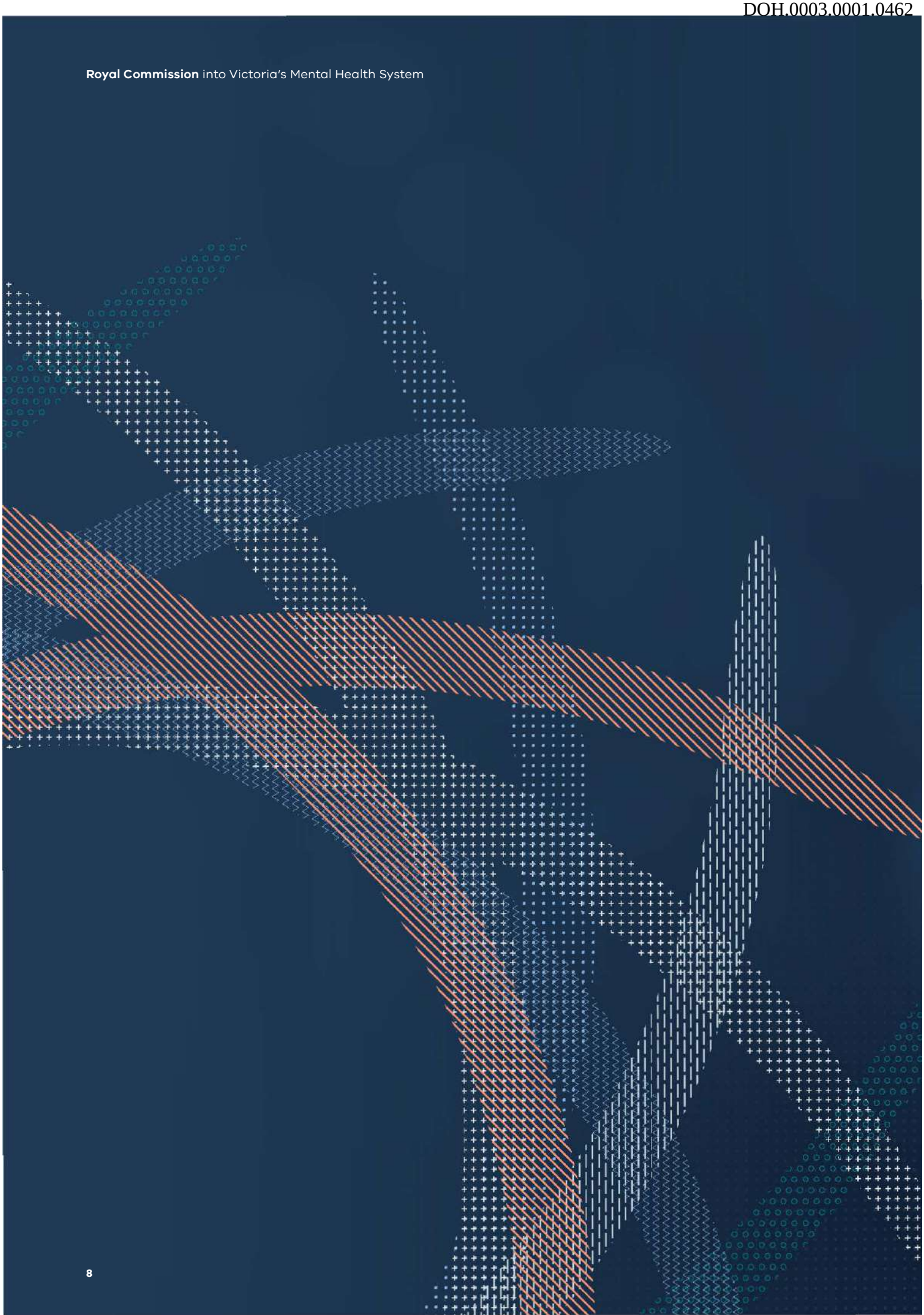
Finally, this volume outlines how stigma and discrimination are significant contributors to poor mental health and how people with lived experience of mental illness or psychological distress are significantly affected. The new system will tackle stigma and discrimination through targeted programs in the settings where Victorians live, work and learn, and by empowering consumers to challenge discrimination when they experience it.

The Victorian Government will establish a Mental Health and Wellbeing Commission (see Volume 4), which will lead a long-term, funded program in partnership with healthcare providers, schools and employers to confront stigma and discrimination in those settings and more broadly. Community-led organisations and community members will be able to apply for grants to undertake initiatives that respond to stigma and discrimination in their communities. This program of activity will be comprehensively evaluated and findings fed back into the system as it develops.

The Victorian Government will establish mechanisms to address systemic mental health discrimination and will support people with lived experience to access legal advice.

Refer to Chapter 25: *Addressing stigma and discrimination* for details of these reforms.

Together, the recommended reforms described in this volume will create a more inclusive and equitable mental health and wellbeing system so that all Victorians can get treatment, care and support that meet their needs.



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Chapter 18

The leadership of people with lived experience of mental illness or psychological distress

Recommendation 28:

Developing system-wide roles for the full and effective participation of people with lived experience of mental illness or psychological distress

The Royal Commission recommends that the Victorian Government:

1. in addition to the nominated roles specified in other recommendations, develop key roles across the mental health and wellbeing system for people with lived experience of mental illness or psychological distress.
2. enable the Mental Health and Wellbeing Commission (refer to recommendation 44) to:

   a. elevate the leadership and support the full and effective participation of people with lived experience of mental illness or psychological distress in decision-making about policies and programs, including those directly affecting them;

   b. develop and support the leadership capabilities of people with lived experience of mental illness or psychological distress through learning and development opportunities;

   c. design and deliver initiatives to prevent and address stigma towards people living with mental illness or psychological distress; and

   d. design and deliver initiatives to develop awareness and understanding of the experiences and perspectives of people with lived experience of mental illness or psychological distress.

Recommendation 29:

A new agency led by people with lived experience of mental illness or psychological distress

The Royal Commission recommends that the Victorian Government:

1. build on the interim report's recommendation 5 and establish a new non-government agency, overseen by a skills-based board chaired by and consisting of a majority of people with lived experience of mental illness or psychological distress, to:

   a. deliver accredited training and resources to aid the development of organisations led by people with lived experience of mental illness or psychological distress;

   b. develop and deliver mental health and wellbeing services led by people with lived experience of mental illness or psychological distress; and

   c. facilitate co-location, shared resourcing, learning opportunities and the creation of new partnerships and networks between people with lived experience of mental illness or psychological distress and the organisations they lead.

18.1 Establishing the foundations for the leadership of people with lived experience of mental illness or psychological distress

The leadership of people with lived experience of mental illness or psychological distress is a fundamental tenet of an inclusive, compassionate and humane mental health and wellbeing system. Many people have shared their aspirations with the Commission for a future system where people with lived experience of mental illness or psychological distress lead and make decisions about the matters that affect their lives, and where their contributions are recognised and acted on.

Ms Honor Eastly, a witness before the Commission, shared her ambitions:

> Now is an opportunity for Victoria to join with the global progress in mental health and be a leader in the world in this arena, and to truly value and elevate the wisdom of lived experience.[1]

The Consumer Foundations Working Group[2] shared their hopes for a future mental health and wellbeing system that is led by consumers, '[a] new system will require new and innovative ideas. At the heart, and leading this, should be consumers.'[3]

Others have reflected on the value and benefits of people with lived experience of mental illness or psychological distress participating in policy development, practice and research. As Dr Sarah Pollock, Executive Director of Research and Advocacy at Mind Australia, said:

> It is a means to shore up people's humanity, dignity and right to decide for themselves about how they live their lives. It is a means of achieving systems that are anti-oppressive and just in the ways in which they achieve outcomes and benefits for all—consumers, families, workers, the general public.[4]

The Commission shares the aspirations of those who have contributed to its inquiry. It, too wants a reformed mental health and wellbeing system in which people with lived experience of mental illness or psychological distress are valued as leaders and change-makers, in the community and as part of reforms to the system.

The leadership and participation of people with lived experience of mental illness or psychological distress is not only a response to a moral matter. It is, in fact, recognised in international human rights frameworks, the most important of these being the United Nations *Convention on the Rights of Persons with Disabilities*, ratified by Australia in 2008.[5] It states, among other things, that 'persons with disabilities should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them'[6] and promotes their 'full and effective participation and inclusion in society'.[7]

Reflecting the intent of the *Convention on the Rights of Persons with Disabilities*, the Commission's guiding principles describe a future mental health and wellbeing system in which the inherent dignity of people with lived experience of mental illness or psychological distress is respected and support is provided to ensure their full and effective participation in society.[8]

The Commission's interim report made a number of priority recommendations to elevate the expertise and perspectives of people with lived experience of mental illness or psychological distress and work with them as equal partners and contributors throughout the mental health and wellbeing system. These recommendations included reforms to: better support, expand and establish lived experience workforces[9] as a recognised profession; create Victoria's first residential service designed and delivered by people with lived experience of mental illness as a true alternative to acute hospital-based care; and establish the Victorian Collaborative Centre for Mental Health and Wellbeing to drive a more inclusive and interdisciplinary research agenda, with joint executive leadership by a clinical academic and a person with lived experience of mental illness.[10]

Alongside these interim report recommendations, the Commission also committed to redesign a system in which people with lived experience of mental illness or psychological distress, families, carers and supporters will be at the forefront, listened to and valued as active contributors and leaders.[11]

Delivering on this commitment requires that people with lived experience of mental illness or psychological distress are at the centre of reform. Ms Mary O'Hagan MNZM, former New Zealand Mental Health Commissioner and current Manager of Mental Wellbeing at Te Hiringa Hauora in New Zealand, giving evidence in a personal capacity, emphasised the deep change that is required of the system:

> In my view, the reforms we need are not about 'giving greater voice' to people with lived experience. Rather, we need to transform the system from within, so that those voices are central to the discourses and are deeply heard.[12]

To this end, there are a number of recommendations detailed in this report that will further strengthen and pave the way for the leadership of people with lived experience of mental illness or psychological distress across the reformed mental health and wellbeing system.

These recommendations call for:

- employing people with lived experience of mental illness or psychological distress in multiple and substantive positions, including leadership positions, in the Mental Health and Wellbeing Division in the Department of Health, as outlined in Chapter 27: *Effective leadership and accountability of the mental health and wellbeing system—new system-level governance*
- ensuring representation of people with lived experience of mental illness or psychological distress on Regional Mental Health and Wellbeing Boards with responsibilities including planning, funding and monitoring mental health and wellbeing services, as described in Chapter 5: *A responsive and integrated system*
- establishing new services led by people with lived experience of mental illness or psychological distress as part of a diverse community-based service offering, delivering innovative treatment, care and support, referred to in Chapter 5: *A responsive and integrated system* and Chapter 28: *Commissioning for responsive services*
- expanding and creating new lived experience workforce roles, supported by a new approach to building workforce capabilities, with access to professional learning and development opportunities, as stated in Chapter 33: *A sustainable workforce for the future*
- strengthening the role of people with lived experience of mental illness or psychological distress in research and innovation, including establishing collaborative networks that include people with lived experience as key partners in efforts to expand innovative practice across the mental health and wellbeing system, as outlined in Chapter 36: *Research innovation and system learning*.

In addition to these nominated roles specified in other recommendations in this report, it is imperative that proactive efforts to develop key roles across the mental health and wellbeing system for people with lived experience of mental illness or psychological distress continue. This chapter makes specific recommendations to support this ambition by expanding lived experience leadership and shifting power to people with lived experience of mental illness or psychological distress so that they can lead and influence decisions on an equal basis as others. These reforms include establishing at least one Commissioner with lived experience of mental illness or psychological distress within the new Mental Health and Wellbeing Commission to elevate the leadership of people with lived experience of mental illness or psychological distress in decision-making processes about policies and programs, including those directly concerning them.

As with all individuals in leadership roles, in the reformed mental health and wellbeing system deliberate efforts must be made to build and strengthen the existing capabilities and skills of people with lived experience of mental illness or psychological distress so that they can thrive as leaders and decision-makers.

Together, these reforms will help build a critical mass of diverse people with lived experience of mental illness or psychological distress in leadership positions, working collaboratively, to lead and influence change and innovation.[13] As Ms Robyn Kruk AO, Interim Chair of Mental Health Australia, giving evidence in a personal capacity, stated: '[h]aving the lived experience voice embedded in health systems needs to become business as usual, rather than something that exists on the side of the system.'[14]

This chapter also recommends an approach to support the establishment of new and emerging organisations including services led by people with lived experience of mental illness or psychological distress that will mature through accredited training and resources.

While these reforms will help change community attitudes and responses, shifting leadership to people with lived experience of mental illness or psychological distress means action will be needed at all levels. It is not the role of people with lived experience of mental illness or psychological distress to bring about changes in community attitudes and responses alone; a system has to be designed that respects and works alongside them, providing them opportunities to lead and make decisions. As the Victorian Mental Illness Awareness Council said:

> It is not appropriate to have consumers responsible for bringing about a major cultural change ... The management of cultural change needs to rest with the management and leadership of the system both at the systems level and within each hospital and service.[15]

The reforms detailed in this chapter will set the foundations for a future system in which people with lived experience of mental illness or psychological distress are leading and influencing across all aspects of the mental health and wellbeing system.

18.1.1 Different experiences and perspectives

Throughout the course of its inquiry, the Commission has considered how the different sets of experiences, knowledge and expertise held by people with lived experience of mental illness or psychological distress and families, carers and supporters inform their perspectives in relation to themselves and to the wider system.

The Commission reflected on the different experiences of people with lived experience of mental illness or psychological distress and families, carers and supporters as well as the need for nuanced and tailored responses to respond to the different perspectives and experiences of these two distinct groups.

For example, the Consumer Foundations Working Group submitted:

> Mental health and the systems that surround it affect us all. But as consumers, we experience these impacts in a direct way, but often with limited avenues or space to advocate for change.
>
> Where spaces are created aside from clinical perspectives, it is common that consumers must share this space with carer perspectives. While there are significant shared interests between consumers and carers, there are also often significant differences in our positions and experiences.[16]

The Commission acknowledges that people with lived experience of mental illness or psychological distress are experts in their own life, just as families, carers and supporters are experts in theirs. While at times these groups may have shared interests, they speak from their own perspectives and experiences and at times may have different views.[17]

This potential for difference is not always undesirable, noting that people within the field of mental health and across other related disciplines often hold different views and perspectives. In many respects, creating safe spaces that actively seek to address power dynamics and allow for this healthy contestability of ideas may lead to more innovative practices that are respectful of people's different needs and experiences. A future mental health and wellbeing system will recognise the differing knowledge, expertise and perspectives of these two groups and create opportunities for dedicated spaces, such as services led by people with lived experience of mental illness or psychological distress, as well as avenues for these groups to come together, including in practice approaches that can involve a consumer's family, carers or other supporters.

Acknowledging these dynamics, the Commission has considered how the system can first meet the individual needs and preferences of people with lived experience of mental illness or psychological distress and, second, meet the individual needs and preferences of families, carers and supporters. While the reforms detailed in this chapter focus on creating an enduring foundation for the leadership of people with lived experience of mental illness or psychosocial distress, opportunities to better promote the leadership, contributions and involvement of families, carers and supporters are an important consideration, detailed in the next chapter of this report.

18.2 Shifting power

Complex power imbalances rooted in professional, historical, social and statutory hierarchies continue to influence the opportunities available for people with lived experience of mental illness or psychological distress to lead, shape and participate in Victoria's mental health system.

Power can be understood as the ability to influence or control, and it can be held and distributed among individuals, groups and organisations. There are different forms and types of power operating across different structures and environments.[18]

Many aspects of Victoria's mental health system are characterised by 'old power', a currency held by a privileged few to the exclusion of others, with a focus on consumption, ownership and control.[19]

This form of power is evident in some of the professional and institutional hierarchies that operate in Victoria's mental health system. It is also often evident in the lack of structural support for people with lived experience of mental illness or psychological distress to lead and make decisions about the matters that affect their lives.

Experiences of stigma and discrimination related to mental illness or psychological distress demonstrate the power imbalances that permeate the current system. Some of the impacts of inadvertent experiences of stigma and discrimination on developing the peer workforce are described in *Peer Work in Australia: A New Future Mental Health System*:

> Inadvertent stigma and discrimination take many forms and can prevent the development of peer work [for example] ... Managers that do not support peer workers to apply for opportunities to advance their careers out of misguided concern that the advance would place extra pressure on the individual. This may be done out of concern that the peer worker is not capable of achieving in the new position not because there is any evidence of this but rather because of the knowledge that the person has lived experience.[20]

The language used to describe people's experiences of mental illness or psychological distress also exemplify the power structures present across Victoria's mental health system. Ms Janet Meagher AM, an advocate for people with lived experience of mental illness, described the importance of language in shifting culture and attitudes:

> I am quite against people being seen as a "patient" (i.e. as a passive recipient of service), because patienthood is only ever a small proportion of anyone's life. I want a person who uses mental health supports to be seen as someone with potential, who has something to offer the world, who just needs assistance at this point in time to enable them to move forward to achieve those hopes and dreams.[21]

These power imbalances can mean that the experiences, perspectives and expertise of people with lived experience of mental illness or psychological distress are not valued, understood or recognised. This poses a fundamental challenge to the realisation of the leadership and equal participation of people with lived experience of mental illness or psychological distress and can conflict with established human rights conventions.

One member of the Consumer Foundations Working Group described the negative impacts of power on consumers and peer workers:

> the basic issue is power and the power imbalance is so strong, that consumers and peer workers who've been employed, talk to us about how, they are not respected, they are not listened to, they have no capacity—because they are not given the mandate to take it on.[22]

Acknowledging, understanding and actively seeking to confront power imbalances is crucial to a future in which people with lived experience of mental illness or psychological distress are recognised as leaders and equal partners in system transformation. But the Commission has heard that some people do not recognise the power that operates within the mental health system. Ms Rachel Bateman, a witness before the Commission, reflected on the power held by the mental health workforce, '[o]ften people do not recognise the power that they hold, and it is hard to encourage them to proactively choose to view things differently.'[23] The first step, then, is to be able to openly explore power, before tackling its manifestations.

Shifting power is not about removal or loss. It is more about designing a system that acknowledges, challenges and actively seeks to redistribute power more evenly—providing space for those who have traditionally held less power with opportunities to lead and influence decision making on an equal basis to others. As Ms Cath Roper, Consumer Academic of the Centre for Psychiatric Nursing at the University of Melbourne, suggests:

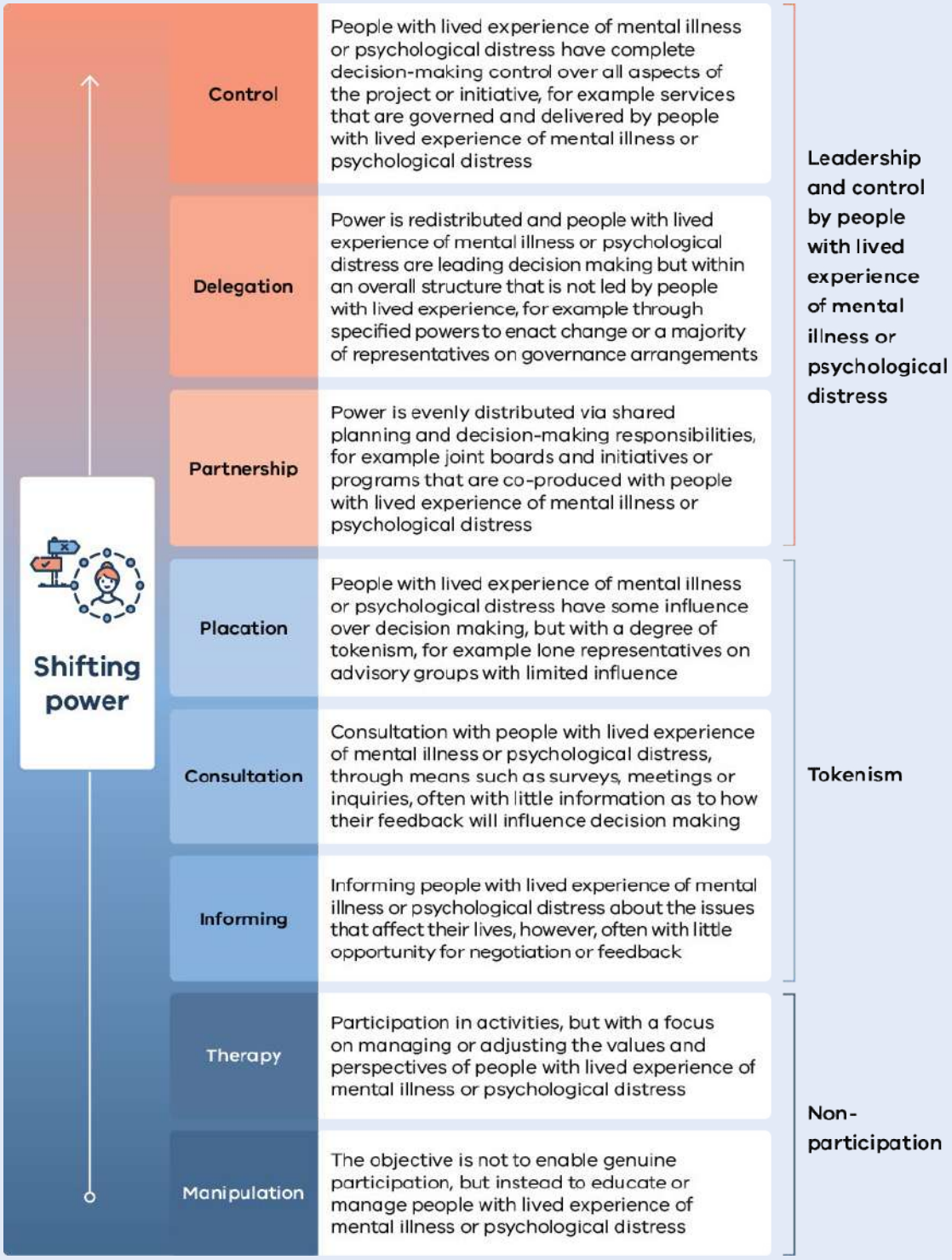
> We need approaches in which we deliberately and proactively try to understand issues around power. We need to think consciously about whose voice might be the thinnest or the hardest to hear (and that approach will usually help the consumer).[24]

It is important to consider the leadership and participation of people with lived experience of mental illness or psychological distress in light of power imbalances.

The sharing of power can take many forms and could include, for example, projects and initiatives that are co-produced,[25] founded on equal partnerships with people with lived experience of mental illness or psychological distress. It can also include leadership roles for people with lived experience of mental illness or psychological distress and founding organisations that are led by people with lived experience of mental illness or psychological distress.

A commonly cited way of conceptualising types of participation is by drawing on Arnstein's Ladder of Citizen Participation. As depicted in Figure 18.1, Arnstein describes eight levels of participation across a spectrum of shifting power, from non-participation to tokenism, and through to complete control.[26] Arnstein's approach suggests that there remains a risk of tokenism, where power is not shared or evenly distributed.

Figure 18.1: Types of participation, drawing on Arnstein's Ladder of Citizen Participation



Source: Adapted from Sherry R Arnstein, 'A Ladder Of Citizen Participation', *Journal of the American Planning Association*, 35.4 (1969), 216–224 (p. 217) and Cath Roper, Flick Grey, and Emma Cadogan, *Co-Production: Putting Principles into Practice in Mental Health Contexts*, 2018, p.4.

Others have described the importance of changing from the rhetoric of 'participation' to that of 'leadership'—to challenge the attitudes held by some about the role that people with lived experience of mental illness or psychological distress can and should play, and further develop these leadership roles in practice. For example a 2005 edition of *Australasian Psychiatry* states, '[i]t is contended that the paradigm shift from consumer 'participation' to consumer 'leadership' may be more fruitful in realizing the considerable benefits that result from effective consumer involvement in mental health services.'[27]

Current approaches to partnering with people with lived experience of mental illness or psychological distress often sit at the lower rungs of Arnstein's Ladder and can be hampered by tokenism. Processes can also lack transparency about parameters and intent and may be inauthentic.[28] This needs to change, to ensure that a future mental health and wellbeing system is founded on the needs and perspectives of people with lived experience of mental illness or psychological distress and to drive broader cultural and behavioural change.

Proactively redistributing and balancing power across the redesigned mental health and wellbeing system will ensure that people with lived experience of mental illness or psychological distress have the same opportunities to lead and be influential, as afforded to others.

The Commission's reforms detailed in this chapter, complemented by other proposed reforms throughout this report, actively shift power by cultivating the leadership of people with lived experience of mental illness or psychological distress and encouraging approaches to participation that sit at the top rungs of Arnstein's Ladder of Citizen Participation.

18.3 Limited opportunities to genuinely lead and drive change

Over past decades, there has been a gradual shift to more active and measurable participation of people with lived experience of mental illness or psychological distress across some aspects of service delivery, policy and planning. This shift has been demonstrated by the development of numerous guidelines, policies and international human rights frameworks with varying degrees of emphasis on protecting the rights of people and their participation.[29]

Over time, Victoria has witnessed the expansion of lived experience workforces. Some limited leadership positions have been created and advisory groups both established and dissolved, with varying degrees of power and influence, to advise government and take on specific projects.[30] These developments have also been accompanied by the emergence of some limited mental health and wellbeing services delivered by people with lived experience of mental illness or psychological distress, typically operating within the governance structure of an organisation that is not led by people with lived experience.

While the shift to increase the participation of people with lived experience of mental illness or psychological distress has been visible across Victoria's mental health system, there are several structural barriers that continue to prevent people with lived experience of mental illness or psychological distress from genuinely leading and driving change. The most pervasive of these barriers is the effect of power imbalances, as discussed earlier.

The Commission was told that the current system can encompass unconsidered and tokenistic approaches to partnering with people with lived experience of mental illness or psychological distress. These approaches include consultation after major decisions have already been made, lone lived experience workers who are expected to represent the views of all people with lived experience of mental illness or psychological distress, inadequate remuneration and limited career pathways.[31]

Giving evidence in a personal capacity, Ms Indigo Daya, Consumer Academic of the Centre for Psychiatric Nursing at the University of Melbourne, conveyed some of these challenges:

> Most work in the sector still excludes consumers/survivors, and the next biggest group of work tends to use tokenistic consultation: where a big group can offer small feedback on something that is already mostly planned. We have no say in whether or not our advice is taken and often we never find out what happened with our advice. Often these opportunities are unpaid or at very low levels of remuneration.[32]

Also giving evidence in a personal capacity, Ms Julie Anderson, Senior Consumer Advisor in the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist, described similar experiences:

> There have also been instances when government has funded a service system and made a model of care without consulting consumers. At the time they consulted consumers on the model of care, they had already decided on what the model of care was going to be so the consultation was tokenistic and was not meaningful participation.[33]

Where people with lived experience of mental illness or psychological distress do participate, they often describe feeling disempowered, with their views and advice given insufficient consideration or being discounted altogether. Ms Bateman shared reflections from participating on various committees:

> I sit on more than 15 different committees at work, which is a lot, but I am the only consumer in my area. If I have an agenda item, I am usually given 5 to 10 minutes to discuss that item. In that kind of setting, there is no way I can get my views across, genuinely be heard, and have the opportunity to engage in discussion and explore multiple worldviews.[34]

The Commission has also been made aware of instances in which the needs and perspectives of some people with lived experience of mental illness or psychological distress are privileged over others.[35] For example, Ms Meagher described experiences of 'preferred consumers' being 'hand-picked' for particular positions:

> some of us are picked because we are "tame" and will "go along" with whatever is said and done ... others of us are picked to "represent" because we are known and it's easier to pick us because we are a "known" element.[36]

In a 2020 article published in the *International Journal of Mental Health Nursing,* staff from the Centre for Psychiatric Nursing at the University of Melbourne argue that authentic and respectful participation must actively seek out diverse views and perspectives that include different experiences of treatment, care and support and that are relevant to the specific context and purpose.[37]

Elevating the perspectives and expertise of some people (while excluding others) means that opportunities are missed to genuinely engage with different experiences and to foster appreciation of diversity. This approach poses fundamental challenges to developing policies, programs and services that are nuanced and reflect the diversity of people's experiences and perspectives.

While there have been some notable exceptions, leadership opportunities for people with lived experience of mental illness or psychological distress within Victoria's mental health system remain a rarity. The few roles that do exist tend to be advisory, without the power to enact systemic change.[38] Mr Graham Panther, a witness before the Commission, suggests that shifting power to people with lived experience of mental illness or psychological distress beyond advisory positions requires that they have decision-making authority, with influence over policy and resourcing decisions.[39]

People with lived experience of mental illness or psychological distress holding positions as directors, heads of departments or funded agencies are not overt nor visible across the current system. As the Consumer Foundations Working Group reflected:

> As consumers, we do not see ourselves in any leadership positions in the current mental health system ... there are no designated consumers in leadership roles in services, in the department, in regulators ...[40]

The Commission was told, however, that there may be people with lived experience of mental illness or psychological distress who are working in leadership positions across Victoria's mental health system but have made the decision to not disclose their experiences.[41] Ms Elizabeth Porter, a witness before the Commission, reflected, '[i]n one organisation, I knew that a member of a leadership team had significant lived experience, and she didn't feel safe to disclose that to the lived experience team.'[42] This reluctance to disclose is likely a response to a system that continues to stigmatise and discriminate against people living with mental illness or psychological distress.[43] While it is possible that people may draw on their lived experience to inform the ways in which they lead, if this is not actively encouraged and supported, it may not always occur.[44]

The Commission was told that leadership roles for people with lived experience of mental illness or psychological distress are often not enduring. This may be explained in part by a lack of designated roles that are allocated to people with lived experience of mental illness or psychological distress.[45] Ms Erandathie Jayakody, a witness before the Commission explained:

> in Victoria in both the public and community sector, there have been lived experience positions at senior levels, which have been short lived. These positions get lost in restructures or when the person occupying the position leaves the role changes so that it is no longer designated as a lived experience role.[46]

Others have made similar observations. The Victorian Council of Social Service described how consumer leadership can sometimes be an afterthought:

> consumer leadership is sometimes "tacked on" instead of being embedded at all levels of an organisation. Services may employ a single peer worker, or establish a consumer advisory service, but they are unable to impact and influence the broader organisations practice or policy.[47]

Victoria Legal Aid reflected on the work required to further transform consumer leadership to realise its potential:

> Although there have been consumer positions in the mental health system for a long time, much more must be done to embed consumer leadership, at all levels, in order for it to be truly influential and to realise its potential in improving services.[48]

This variability in commitment and susceptibility to tokenism may be partly explained by discriminatory and stigmatising assumptions about the capabilities of people with lived experience of mental illness or psychological distress to lead and participate. There may be a perception that other types of experiences are more valued without adequate consideration of the unique expertise that people with lived experience of mental illness or psychological distress have to offer. Ms O'Hagan explained:

> There is still a lot of stigma, discrimination and negative assumptions about people with lived experience in the mental health system. I think some people still hold a view that people with lived experience don't possess the capabilities required to perform certain roles. There needs to be greater recognition of the expertise, supports and services that people with lived experience have to offer.[49]

The Commission considers that negative assumptions and experiences of stigma and discrimination may be partly fuelled by the use of language and words that do not reflect the perspectives and worldviews of people with lived experience of mental illness or psychological distress. For example, it has been suggested that using diagnostic terms can serve to label people,[50] posing a fundamental challenge to the participation and leadership of people with lived experience of mental illness or psychological distress.

A lack of access to professional development and training to support people with lived experience of mental illness or psychological distress to thrive in leadership roles has also been raised as a deficiency of the current system, which may inhibit people's potential.[51]

Resourcing and time constraints may also hamper opportunities to partner with people with lived experience of mental illness or psychological distress. As Professor Bruce Bonyhady AM, Executive Chair of the Melbourne Disability Institute at the University of Melbourne, giving evidence in a personal capacity stated:

> When people are under pressure to get things done quickly, they tend to take shortcuts—co-design will often be neglected in those circumstances. This is not to downplay the difficulties involved with co-design; it generally always leads to better outcomes.[52]

These challenges may also be coupled with a lack of commitment, understanding and structural supports to embed lived experience leadership and effective approaches to partnering with people with lived experience of mental illness or psychological distress.[53] In the current system, the leadership of people with lived experience of mental illness or psychological distress is often not considered an essential part of core business, meaning that it is susceptible to being marginalised by other priorities.

People with lived experience of mental illness or psychological distress must be integral to all aspects of a reformed mental health and wellbeing system. Challenging and transforming the rudimentary and somewhat stifled approaches to the leadership of people with lived experience within the current system will require foundations to be reset and power to be balanced.

This statement from Ms Roper resonated with the Commission:

> There are some examples of consumers in leadership roles, but those examples have not come about as a result of systemic change. We need to embed in the existing system structural expectations about consumers taking leadership roles. Unless we do that, nothing much will change, and those few existing leadership roles will remain vulnerable.[54]

The recommendations in this chapter are not simply about adding more roles throughout the system—they seek to deal with power imbalances, promote human rights and shift community attitudes and responses to a future where people with lived experience of mental illness or psychological distress are recognised as leaders and active partners in reforming the mental health and wellbeing system.

18.4 Constraints on systemic advocacy efforts

Systemic advocacy can be understood as promoting community and system-wide change to deal with structural inequalities and inadequacies. It is critical to ensuring individuals and groups of people are actively involved in decision-making processes about the things that affect them, galvanising community support for reform and promoting enduring change.

Systemic advocacy also plays a role in designing and developing new initiatives and ideas that reflect the needs, aspirations and desires of communities.[55] Some have also suggested it is vital to ensure the continued prioritisation of mental health and wellbeing.[56] The Consumer Foundations Working Group pointed out the important link between research that is led by and co-produced with people with lived experience of mental illness or psychological distress in informing systemic advocacy efforts.[57]

It is important to acknowledge that individual and systemic advocacy are not always mutually exclusive, with many advocacy organisations drawing on individual experiences to inform systemic advocacy and related reform ideas.[58]

The Commission's interim report noted that while there are examples of systemic advocacy in comparable systems that have resulted in considerable change in recent years, strong and sustained levels of systemic advocacy are not as apparent in the mental health sector.[59] For example, Every Australian Counts was a grassroots advocacy campaign made up of thousands of people living with disability, families, carers and workers that came together to advocate for the introduction of the National Disability Insurance Scheme.[60] It is arguably one of the driving forces behind the implementation of the scheme,[61] demonstrating the value of lived experience leadership in leading and driving change. As Professor David Copolov AO, Professor of Psychiatry and Pro Vice Chancellor Major Campuses and Student Engagement at Monash University suggested:

> In particular, the early history of the [National Disability Insurance Scheme] teaches us that we need ... people with lived experience of the mental health system playing a key public role as advocates from the outset.[62]

The same ambitions are yet to be realised across Victoria's mental health system. One member of the Consumer Foundations Working Group described how advocacy in mental health was often thought of as an 'add on' rather than a foundational aspect of the system, '[s]o often advocacy is thought of systemically as a nice thing to add on, but not an essential embedded part of core business.'[63]

Advocacy organisations and countless individuals play important roles in gaining recognition of the perspectives and experiences of people with lived experience of mental illness or psychological distress. Yet inadequate resourcing and diverse priorities among advocacy organisations can limit their impact.

A lack of resources may have culminated in a tendency for advocacy entities to focus their efforts on the most pressing problems.[64] While understandable, this may have detracted from broader systemic advocacy projects and ambitious reform agendas. Dr Tricia Szirom, the CEO of the Victorian Mental Illness Awareness Council at the time of giving evidence, said:

> Advocacy should be a blueprint for supporting mental health services as they develop. However, advocacy currently attempts to 'fill the gaps' missing in mental health service. In the future advocacy will identify and direct mental health services to address their own service gaps in a more timely and effective manner.[65]

An article published in the 2015 edition of *The Australian Journal on Psychosocial Rehabilitation*, reflected on the historical lack of funding for advocacy entities, '[h]istorically, there have been competing demands for funding dollars between individual advocacy and other forms of existing or potential systemic advocacy, particularly for consumer organisations.'[66]

In its submission to the Productivity Commission, Mental Health Australia made similar observations, reflecting on the impacts of inconsistent and inadequate funding for peak bodies providing systemic advocacy:

> Peak bodies, which carry out systemic advocacy, are subject to funding uncertainty created by unpredictable and short term contracts that do not provide enough funding to ensure organisational sustainability. This has resulted in inadequate support for robust systemic advocacy in a period of significant change and upheaval, precisely when such activities are needed most. It appears that both individual and systemic advocacy are largely missing from the ecosystem imagined by governments.[67]

As well as a lack of resources and competing advocacy priorities, real or perceived conflicts of interest, where advocacy entities must raise concerns with the very bodies that fund them, may also influence and affect advocacy efforts.[68] At the systemic level, the Commission considers that these challenges are obstructing people with lived experience of mental illness or psychological distress from leading and influencing change.

Systemic advocacy will be integral to a future mental health and wellbeing system where people with lived experience of mental illness or psychological distress are respected as equal partners and leaders, and their participation in public life is promoted.

18.5 Cross-cutting reforms to strengthen the leadership of people with lived experience of mental illness or psychological distress

The experiences, preferences and expertise of people with lived experience of mental illness or psychological distress must be integral to the implementation of all recommendations in this report.

Victoria Legal Aid expressed a similar belief:

> **People whose lives are directly affected by the mental health system should shape and have influence over the re-imagined mental health system that emerges from the Royal Commission. In examining and reforming Victoria's mental health system, consumers must be central, not just as users of the services, but in co-producing, delivering and evaluating them.**[69]

As described earlier, and building on the recommendations in the interim report, the Commission recommends a number of complementary reforms that will embed leaders with lived experience of mental illness or psychological distress throughout the reimagined mental health and wellbeing system, detailed throughout this report.

As described in Chapter 27: *Effective leadership and accountability of the mental health and wellbeing system—new system-level governance*, the Department of Health must lead by example in paving the way for the expanded leadership of people with lived experience of mental illness or psychological distress. This includes employing people with lived experience of mental illness or psychological distress in multiple and substantive positions, including leadership positions in the Mental Health and Wellbeing Division in the Department of Health. These positions will ensure people with lived experience have an enduring and influential role in government decision making, with particular regard to implementing the Commission's recommendations and developing policy decisions related to mental health and wellbeing.

Further, as established in Chapter 5: *A responsive and integrated system*, people with lived experience of mental illness or psychological distress will also be represented on the Commission's recommended Regional Boards. Here they will play a role in decision-making with respect to service and capital planning, commissioning mental health and wellbeing services, alongside other related services, workforce planning, as well as research and evaluation initiatives. These arrangements will ensure the views, experiences and perspectives of people with lived experience of mental illness or psychological distress are a part of planning and resourcing decisions, driving progress towards a system that recognises and responds to the differing needs of consumers.

A reimagined mental health and wellbeing system will also see new service providers led by people with lived experience of mental illness or psychological distress emerge. This includes, for example, investment in consumer-led innovative 'safe spaces' and crisis respite facilities as stated in Chapter 9: *Crisis and emergency responses*. As established in Chapter 5: *A responsive and integrated system*, the Department of Health and Regional Boards will support providers, including services led by people with lived experience of mental illness or psychological distress, to thrive and develop over time as part of a diverse service offering. This endeavour will also be supported by a new set of service standards, with tools, resources and supports to develop the capabilities of providers, including providers led by people with lived experience of mental illness or psychological distress, described in Chapter 28: *Commissioning for responsive services*.

A number of future community mental health and wellbeing services will be delivered in part by lived experience workforces. Acknowledging the priority reforms put forward in the Commission's interim report to support, expand and establish lived experience workforces as a recognised profession, Chapter 33: *A sustainable workforce for the future,* details a number of additional priorities to support the growth of a more diverse lived experience workforce, with a range of new and expanded roles. This ambition will be supported by a new whole-of-workforce approach to develop the collective values, knowledge, skills and attributes the workforce needs to provide consumer-focused, recovery-oriented treatment, care and support.

As described in the Commission's interim report, the Collaborative Centre for Mental Health and Wellbeing, with joint executive leadership from a person with lived experience of mental illness and a clinical academic, will lead exemplary practice for the leadership of people with lived experience of mental illness or psychological distress in the design, development and co-production of research.[70] The Commission recommends a number of additional reforms in Chapter 36: *Research, innovation and system learning,* to strengthen the role of people with lived experience of mental illness or psychological distress in research and innovation. This includes calling on the Collaborative Centre to have a priority focus on research that is co-produced and led by people with lived experience of mental illness or psychological distress, with a focus on experiential knowledge,[71] as well as the creation of innovation networks supported by flexible funding to expand and diversify innovative practice across the mental health and wellbeing system. The recommended innovation collaborative networks will include a flexible and evolving group of partners, including people with lived experience of mental illness or psychological distress, ensuring they have influence over the design and development of promising innovation.

In addition to roles specified in other recommendations, it is imperative that the Victorian Government continues efforts to develop key roles across the mental health and wellbeing system for people with lived experience of mental illness or psychological distress. This chapter makes specific recommendations to support this endeavour, as detailed in the following sections.

Collectively, the Commission's reform approach will fundamentally alter the way in which people with lived experience of mental illness or psychological distress lead and shape decisions. No longer will the expertise of people with lived experience of mental illness or psychological distress be seen as the 'icing on the cake';[72] rather, they will have an equal seat at the table, working in partnership with others to lead and drive change.

18.6 Lived experience of mental illness or psychological distress within the Mental Health and Wellbeing Commission

Progressing towards a future that values people with lived experience of mental illness or psychological distress as active leaders and equal partners takes determination, leadership and the redistribution of power. The implementation of the Commission's recommendations is a rare opportunity to transform the leadership of people with lived experience of mental illness or psychological distress.

As established in Chapter 27: *Effective leadership and accountability of the mental health and wellbeing system—new system-level governance*, a new independent statutory authority— the Mental Health and Wellbeing Commission— will provide strong system leadership and keep government and the system accountable to the Victorian community. The Mental Health and Wellbeing Commission will exemplify and enable the leadership of people with lived experience of mental illness or psychological distress across the redesigned mental health and wellbeing system.

To set the foundations for lived experience leadership, the Commission recommends that at least one Commissioner within the Mental Health and Wellbeing Commission has lived experience of mental illness or psychological distress. All appointments to the Mental Health and Wellbeing Commission will be merit-based, with lived experience of mental illness or psychological distress made explicit as a condition of at least one appointment, which will be established in legislation and made by the Governor-in-Council. The new Mental Health and Wellbeing Commission will also include designated roles across its structures that only people with lived experience of mental illness or psychological distress can apply for.

The new Mental Health and Wellbeing Commission will, as part of its broader functions, promote the leadership and the full and effective participation of people with lived experience of mental illness or psychological distress in decision-making processes about policies and programs, including those directly concerning them. The Mental Health and Wellbeing Commission will act as a statewide voice, representing the diversity of people with lived experience of mental illness or psychological distress across age ranges, locations, experiences and backgrounds (refer to Figure 18.2).

Having designated leadership positions within the new Mental Health and Wellbeing Commission held by people with lived experience of mental illness or psychological distress will be critical to ensuring these arrangements are meaningful rather than tokenistic.

Victoria is falling behind other jurisdictions with respect to leadership roles for people with lived experience of mental illness or psychological distress, and the absence of these voices is a detriment to individuals, to the operation of the system itself and to the quality of mental health policy and reform processes.

Figure 18.2: Responsibilities of the new Mental Health and Wellbeing Commission to elevate the leadership of people with lived experience of mental illness or psychological distress

The Mental Health and Wellbeing Commission

A statutory authority, established in legislation with responsibility for elevating the status of mental health and wellbeing; holding government to account; and exemplifying and enabling lived experience leadership.

A Chair Commissioner

Established in legislation and appointed by the Governor-in-Council.

Commissioners

Including at least one designated commissioner with lived experience of mental illness or psychological distress and a commissioner with lived experience as a family member or carer of a person with lived experience of mental illness or psychological distress, established in legislation and appointed by the Governor-in-Council.

Elevating the leadership of people with lived experience of mental illness or psychological distress:

- elevate the leadership and support the full and effective participation of people with lived experience of mental illness or psychological distress in decision making about policies and programs, including those directly affecting them
- develop and support the leadership capabilities of people with lived experience of mental illness or psychological distress through learning and development opportunities
- design and deliver initiatives to prevent and address stigma towards people living with mental illness or psychological distress
- design and deliver initiatives to develop awareness and understanding of the experiences and perspectives of people with lived experience of mental illness or psychological distress.

System monitoring and improvement, as detailed in Chapter 3: *A system focused on outcomes* and Chapter 30: *Overseeing the safety and quality of services*

Promoting the role, value and inclusion of families, carers and supporters, as detailed in Chapter 19: *Valuing and supporting families, carers and supporters*

Personal story:

Mary O'Hagan MNZM

As a young woman, Mary used New Zealand's mental health services for eight years. She said these experiences had a profound impact on her.

> Ever since then, I have worked to make a difference to the way society and services respond to people with major mental distress.

Mary has now been involved in mental health support for more than 30 years. She was an initiator of the mental health service user movement in New Zealand in the late 1980s, and since then she has occupied several roles, including mental health adviser to the United Nations and the World Health Organization and is a former New Zealand Mental Health Commissioner.

Reflecting on her time as a Mental Health Commissioner, Mary spoke about the need for more lived experience leadership.

> As a collective, we need to take up leadership roles. I was a Commissioner in the New Zealand Mental Health Commission ... I was amazed at the power of position, which is quite ridiculous. I'd been an advocate, and nobody took any notice of me, and as soon as I became a Commissioner everyone [listened to] what I said. I was saying exactly the same thing!
>
> I think we need 'position power' in the mental health system. Very few of us have it.

Mary believes that roles for people with lived experience must go well beyond peer support.

> Importantly, roles for people with lived experience should not be limited to roles that require lived experience, like a peer support role. Rather, we need to develop the capacity for people with lived experience to take on generic roles—to be the managers, receptionists, chief executives, analysts, social workers, doctors or nurses. This would be one solution to the problem of low labour market participation of people with mental distress.

Following her role as a New Zealand Mental Health Commissioner, Mary established a peer-led social enterprise called PeerZone, delivering peer-led workshops for people with lived experience and providing group and one-to-one peer support.

> As a small business, one of the big difficulties we faced at PeerZone was that there were not many organisations in the mental health marketplace who wanted what we were offering—because the system is skewed towards 'pills and pillows' responses and traditional community service responses.

Mary advocates for growth in peer-led organisations and said more sustainable funding mechanisms are required.

> We need to nurture peer-led organisations and grow the peer workforce. The way the system currently operates, peer-led organisations tend to be poorly funded and they can't grow.
>
> To support peer-led organisations to flourish, we need to address the way the system as a whole is organised and the biases in the system which influence how we think about and value different ways of responding to people in distress.

In Mary's view, 'a transformation of the mental health system from within' is required to put the views and perspectives of consumers at the centre.

> We need to change the whole way we think about people with distress and about the system, so that we make decisions and distribute resources in a way that creates the space for the lived experience voice to be strong. Otherwise, the values and preferences of people with lived experience are no more than an afterthought, tacked on to a system that doesn't truly notice or value them.

Source: *Witness Statement of Mary O'Hagan MNZM,* 16 June 2020; Mary O'Hagan, First Person: The Role of Lived Experience in Shaping Mental Health Services (presented at the Communities in Control Conference, Melbourne, 2010).

Other jurisdictions have championed the leadership of people with lived experience of mental illness or psychological distress at the highest levels. For example, more than a decade ago Ms O'Hagan, who used New Zealand mental health services for eight years as a young woman, held the position as fulltime New Zealand Mental Health Commissioner (refer to personal story for further information).[73] Similarly, the New South Wales Mental Health Commission is currently led by part-time deputy Commissioners with lived experience of mental illness, with a requirement made clear in legislation that either the Commissioner or at least one Deputy Commissioner 'must be a person who has or has had a mental illness'.[74] More recently, one fulltime Mental Health Commissioner and two deputy part-time Commissioners were appointed in South Australia in 2020, with a requirement for 'lived experience of mental health as either a consumer of services or carer'[75] made explicit as conditions of their appointments.

To ensure the leadership of the new Mental Health and Wellbeing Commission is streamlined and able to make effective decisions across the breadth of its functions, the appointment of at least one Commissioner with lived experience of mental illness or psychological distress is preferred.

The Commission acknowledges that some people have provided a rationale for creating at least two or more positions when establishing new roles for people with lived experience of mental illness or psychological distress, to reduce the risk of isolation and tokenism.[76] The Commission has sought to achieve this through its aspiration for a future in which people with lived experience of mental illness or psychological distress are represented in multiple leadership positions across entities involved in the future mental health and wellbeing system. As described earlier, to begin this work the Commission has recommended creating substantive leadership roles for people with lived experience of mental illness or psychological distress with significant power and influence. These leadership positions will usher in collective learning opportunities in ways that have never existed before, providing opportunities for designated leadership positions and other roles performed by people with lived experience of mental illness or psychological distress to work together and learn from one another and others.

While the Chair of the new Mental Health and Wellbeing Commission is not designated as a position that must be held by a person with lived experience of mental illness or psychological distress, the Commission considers that a person with lived experience of mental illness or psychological distress who has the relevant skills and expertise can lead the Commission.

There should be an assumption that all Commissioner roles are fulltime-equivalent, with relevant supports and reasonable adjustments made. Flexible working arrangements, such as hours of work, days of work or location, should be made available to all Commissioner roles, to accommodate personal circumstances and individual preferences. The intent of fulltime-equivalent positions reflects the breadth of work required by the new Commission and a desire to mitigate against these appointments being tokenistic. A persistent voice and presence is pivotal to transforming lived-experience leadership and to countering the sometimes-held belief that people with lived experience of mental illness or psychological distress cannot handle fulltime work.[77]

Like with all individuals in leadership roles, proactive efforts must be made to support and build the strengths and capabilities of people with lived experience of mental illness or psychological distress who may hold a role as a Commissioner. Providing professional development and mentorship with a focus on leadership, policy making and government processes will be essential. This professional development should include supervision that is specific to the consumer perspective discipline[78] and/or co-reflection[79] as well as broader training and shadowing opportunities to support leaders to be influential in their roles.

This approach to the leadership of the new Mental Health and Wellbeing Commission, supported by designated positions for people with lived experience of mental illness or psychological distress across the Mental Health and Wellbeing Commission's structures and working alongside other leadership roles across the mental health and wellbeing system, will begin the work of shifting power and pave the way for greater lived experience leadership.

18.6.1 Responsibilities to elevate the leadership of people with lived experience of mental illness or psychological distress

All Commissioners in the Mental Health and Wellbeing Commission will work collectively to fulfil its broader objectives including to elevate mental health and wellbeing, to hold government to account and to exemplify and enable lived experience leadership.

Strengthening government accountability and delivering independent, statewide oversight of the whole system will require continuous collaboration between the Chair and Commissioners, noting that each will bring their own unique set of skills and expertise to their roles. The success of the new Mental Health and Wellbeing Commission will be measured on the ability of the Chair and Commissioners to harness each other's strengths, learn from one another and work together. These arrangements represent a new model of collaborative leadership within the reimagined mental health and wellbeing system, requiring new leadership skills and capabilities to shift power and reset culture and values.

The other responsibilities of the Mental Health and Wellbeing Commission, including system monitoring and improvement and promoting the role, value and inclusion of families, carers and supporters, are detailed in separate chapters in this report. The Commission's responsibilities to promote the leadership of people with lived experience of mental illness or psychological distress in decision making about the things that affect their lives are detailed in this chapter (refer to Figure 18.2). The Royal Commission considers that the initiatives described in the following sections should be prioritised by the new Mental Health and Wellbeing Commission as part of its lived experience leadership functions, following the establishment and recruitment phase.

These initiatives include practical ways to support the development of key leadership roles for people with lived experience of mental illness or psychological distress across the reimagined mental health and wellbeing system, as well as initiatives that focus on resetting culture and values and tackling stigmatising beliefs so that lived experience leadership can flourish.

18.6.2 Develop and support leadership capabilities

People with lived experience of mental illness or psychological distress have significant skills, experience and expertise to bring to the design and delivery of innovative services and to the creation of policy, systems reform and social change. They have expertise and wisdom that no one else has. Alongside this distinct knowledge and discipline of the consumer perspective,[80] people with lived experience of mental illness or psychological distress can offer a range of skills and strengths that are integral to a redesigned mental health and wellbeing system.

As Dr Pollock reflected:

> When we involve people with lived experience of mental distress and recovery in service design, development and delivery, and treat their knowledge and input as equal to other ways of knowing, then we understand things about what we are trying to do that we cannot find out any other way.[81]

Fostering and embedding this wisdom and expertise is vital to a mental health and wellbeing system that is compassionate. An article published in a 2018 edition of the *Psychiatric Rehabilitation Journal* suggested that true system transformation can only occur with the leadership of people with lived experience of mental illness or psychological distress:

> For true system transformation to occur, we argue it is essential for more attention and resources to be allocated to cultivating leadership skills among persons with lived experience of recovery and for opportunities to be created for such individuals to take on senior-level leadership positions within their respective countries and communities.[82]

Like all people in leadership roles, people with lived experience of mental illness or psychological distress must have opportunities to build and further strengthen their existing capabilities and skills so they can flourish as leaders and decision-makers. Opportunities for people to strengthen their leadership, governance and management skills will be important for leaders at all levels across the new system. This includes individuals who are stepping into executive leadership roles across the new system, for example the Mental Health and Wellbeing Division of the Department of Health and the Collaborative Centre for Mental Health and Wellbeing.

Currently, there are few opportunities for people with lived experience of mental illness or psychological distress to access relevant training, education and professional development opportunities focused on strategic leadership, governance and policy development, compromising their ability to be effective and influential in these roles. As Ms Jayakody stated:

> If we are to create career progression and introduce lived experience positions in senior management the workers need to have the appropriate training such as financial literacy, governance, management and leadership training. Such opportunities are rare for lived experience workers.[83]

The Consumer Foundations Working Group told the Commission that consumers are often required to perform leadership roles without the same structural supports and resources that can be provided to others, submitting that 'consumers are currently asked to enter spaces without the same resources, cultural legitimacy and professional supports to contest ideas with other stakeholders in the sector'.[84]

Evidence before the Commission suggests that additional training and professional development across a range of diverse areas is required to develop and build on the skills and capabilities of people with lived experience of mental illness or psychological distress.[85] In its report, *Sit Beside Me, Not Above Me*, the National Mental Health Commission made the following observations about the need to build capacity across a range of areas:

> Of itself, having a lived experience does not make an individual an expert in systems, strategy, governance, policy or service delivery. In the same way that training as a clinician ... does not of itself equip a person with the expertise to sit on boards and national advisory structures ... Building capacity in a broad range of areas – such as leadership, clinical and corporate governance, financial management, strategy, policy development, advocacy, conflict management, co-design, co-production, monitoring and reporting – is required to fill the increasing number of roles needed for a contemporary and future-focused system.[86]

An initial priority of the new Mental Health and Wellbeing Commission will be to co-produce leadership and learning and development initiatives with people with lived experience of mental illness or psychological distress. Initiatives should include training, professional development, mentoring and supervision, with a focus on leadership, policy making and government processes. Opportunities to connect with leaders with a range of expertise and skills, both within and outside of the consumer community should also be made available.

The Commission envisages that these opportunities will be made available to all executive teams with leadership roles for people with lived experience of mental illness or psychological distress and emerging leaders within the reimagined mental health and wellbeing system. Leadership and learning and development initiatives will further develop the expertise and talent of individuals and embed a new culture that is founded on collaboration and equal partnerships.

Leadership and continuing learning and development initiatives would encompass both 'depth training', focusing on the foundations of the consumer movement, and 'breadth training', to develop a broader set of skills and capabilities, for people with lived experience of mental illness or psychological distress to lead across a diverse range of areas. Ms Daya explained:

> In terms of depth, there would be significant value in developing more training that addresses a deeper knowledge of the consumer movement and our history of debates and conclusions on many different issues in mental health ... Breadth training could add significant value in areas such as critical thinking, influence and negotiation, coproduction, practice supervision, leadership, research, governance, policy and management skills, depending on career interest. Potential learning streams in these and other breadth topics could be targeted towards different career pathways.[87]

Leadership and continuing learning and development initiatives will respond to the individual ambitions of people with lived experience of mental illness or psychological distress and reflect broader system-wide need. Based on comparative leadership initiatives and skills frameworks[88] and leadership opportunities identified in the evidence before the Commission,[89] this may include a focus on the following skills:

- fostering individual leadership styles and competencies, including career development planning
- leading transformational change, with a focus on executive leadership skills and driving collaboration for change
- broadening structures and systems that support people to lead, including mentoring, supervision and co-reflection
- identifying, influencing and driving strategic outcomes, including understanding government processes, policy design and development, and leadership on boards and advisory groups
- enhancing problem-solving skills, with a focus on critical thinking and designing and developing effective solutions
- developing stakeholder management skills, including co-production and partnering with others, with a focus on how to influence decision making and interpersonal skills
- managing people and teams, with a focus on fostering talent, building capabilities and leading and managing change.

The Commission's interim report called for deliberate and systemic efforts to promote and embed lived experience workforces in area mental health services and identified non-government organisations. To achieve this, it recommended, among other things, learning and development pathways, education and training opportunities and a statewide approach to organisational readiness training[90] to ensure all agencies receiving government funding for mental health and wellbeing services are equipped to support lived experience workforces.[91] Promoting the understanding and value of lived experience expertise and perspectives at all levels of an organisation is integral to the 'introduction, ongoing support and sustainability of lived experience work'.[92]

In addition, the Commission recommends a whole-of-workforce approach to capability development and training to be led by the Collaborative Centre for Mental Health and Wellbeing. As described in Chapter 33: *A sustainable workforce for the future*, these reforms focus on building the expertise of individual frontline workers to deliver treatment, care and support in the future mental health and wellbeing system. Leadership initiatives led by the Mental Health and Wellbeing Commission will have a broader focus, supporting executive teams with leadership roles for people with lived experience of mental illness or psychological distress and emerging leaders to lead and make decisions about the policies and programs that affect their lives, including engaging in the design, delivery and implementation of policy reform.

The new Mental Health and Wellbeing Commission may partner with other entities to design and deliver leadership training and education, including the new agency led by people with lived experience of mental illness of psychological distress recommended in this chapter and the Collaborative Centre for Mental Health and Wellbeing.

18.6.3 Prevent and tackle stigma

The new Mental Health and Wellbeing Commission will be responsible for preventing and tackling experiences of stigma related to mental illness or psychological distress. A Commissioner with lived experience of mental illness or psychological distress will play an important role, working alongside other Commissioners to deliver the Royal Commission's recommended lived experience-led initiatives to reduce stigma.

The new Mental Health and Wellbeing Commission will work in partnership with people with lived experience of mental illness or psychological distress to design and deliver long-term, evidence-informed stigma-reduction programs, focusing on organisational settings. It will also establish an anti-stigma community grants program aimed at communities and social groups at risk of stigma—for example, Aboriginal people, rural and regional communities and older Victorians—as recommended in Chapter 25: *Addressing stigma and discrimination*.

Dismantling stigmatising and discriminatory beliefs about people with lived experience of mental illness or psychological distress is central to a future in which the experiences, skills and expertise of people with lived experience of mental illness or psychological distress are valued as assets in leadership roles.

Despite some progress, stigma and discrimination remain pervasive influences on the lives of people with lived experience of mental illness or psychological distress, and these prejudiced beliefs are inhibiting people from leading and contributing on an equal basis. The Commission considers that this minimal progress may be explained, in part, by the fact that stigma reduction efforts do not always meaningfully partner with the people who are most affected by stigma and discrimination.

The need for the perspectives and experiences of people with lived experience of mental illness or psychological distress to be at the forefront of stigma-reduction efforts and innovations has been impressed upon the Commission.[93] As Ms Georgie Harman, CEO of Beyond Blue, reflected:

> Another opportunity to address stigma in Victoria is through lived experience leadership. People with an experience of mental health conditions are drivers of social change and should be supported and empowered to challenge stigma at all levels.[94]

Mr Panther said that current stigma-reduction efforts are sometimes designed and delivered without adequate input from people with lived experience of mental illness or psychological distress, thereby compromising their effectiveness:

> There are many, well-funded programs and campaigns that aim to 'raise awareness' or 'reduce the stigma' of psychological distress. But so often, these campaigns and programs are not run by people like us, and it shows. They often use the language of the system—a language of deficits and disorder that, to many of us, feels like a laundry list of our worst traits, rather than a description of our rich internal experience.[95]

The new Mental Health and Wellbeing Commission will be well placed to lead and build the evidence base for stigma-reduction efforts, with a view to progress towards an equal Victoria, where the human rights of people with lived experience of mental illness or psychological distress are promoted, as is their leadership and participation in public life.

As a public and statewide voice promoting the experiences and perspectives of all people with lived experience of mental illness or psychological distress, the new Mental Health and Wellbeing Commission will play a critical role in dismantling the discriminatory and stigmatising practices that persist and impact negatively on people living with mental illness or psychological distress, including preventing them from leading.

Across all stigma-reduction efforts led by the new Mental Health and Wellbeing Commission there will be an expectation that people with lived experience of mental illness or psychological distress are leaders, not only participants. Future stigma-reduction initiatives should see approaches to participation that sit at the top rungs of Arnstein's Ladder of Citizen Participation (refer to Figure 18.1), including some initiatives that are entirely led by and co-produced with people with lived experience of mental illness or psychological distress.

Confronting prejudice and stigmatising beliefs will not be the responsibility of people with lived experience of mental illness or psychological distress alone; rather, it will require continuous collaboration, connection and dialogue across the Victorian community.

This sentiment from Ms Julie Dempsey, a witness before the Commission, spoke to the importance of a shared response to tackling stigma:

> We are all someone else's someone else. Mental illness does not discriminate and neither should we. We need to share the struggle together, not push consumers to the fringe of common social existence.[96]

As a community, we must work together to build a compassionate and humane society that better understands and respects the profound experiences and perspectives of people with lived experience of mental illness or psychological distress.

18.6.4 A new language guide

The new Mental Health and Wellbeing Commission will develop and implement strategies that help reset the culture and values across the reformed mental health and wellbeing system so that the leadership of people with lived experience of mental illness or psychological distress can thrive.

Calls have been made to the Commission for support and resources to improve the way in which government and service providers support lived experience leadership. As Victoria Legal Aid submitted, '[g]uidance should be developed to support mental health services to embed consumer leadership and advocacy (e.g. how to establish, consult with, and implement recommendations from Community Advisory Committees).'[97]

The use of language is central to progressing the leadership of people with lived experience of mental illness or psychological distress. Language is powerful and plays an influential role in shaping people's beliefs and attitudes. Thus, an important part of addressing stigma and discrimination and progressing towards a society that values people with lived experience of mental illness or psychological distress as leaders and change-makers is using language that accurately reflects the diversity of people's experiences. As the Victorian Mental Illness Awareness Council stated, '[a] key part of cultural change is the adoption of more appropriate language which describes the world as we want it to be.'[98]

As an initial priority, the Commission suggests that the Mental Health and Wellbeing Commission lead a project, in co-production with people with lived experience of mental illness or psychological distress, to develop a language guide that acknowledges and respects the diversity of experiences, language use and worldviews of people with lived experience of mental illness or psychological distress.

Rather than providing singular language suggestions, the language guide will make space for difference and foster appreciation of diversity. This approach reflects the fact that, as observed in the Commission's interim report and elsewhere in this report, 'there is no single set of definitions used to describe how people experience their mental health'.[99] The Victorian Mental Illness Awareness Council Declaration, for example, notes that there are varying ways of understanding the experiences that are frequently called 'mental illness'. It acknowledges that these experiences are informed by different worldviews and can be described using terms such as 'emotional distress', 'trauma', 'mental health challenges' and 'neurodiversity'.[100]

The guide will explain, in practical terms, how to enquire into people's worldviews and appreciate and use their preferred language and concepts. This guide will be used to inform development of subsequent policies, programs and services across government, funded organisations and service providers and will also be made publicly available.

The new Mental Health and Wellbeing Commission, with leadership from a Commissioner with lived experience of mental illness or psychological distress, will lead efforts to promote the language guide. This includes delivering training and education programs and working with government and service providers to support implementation.

The Commission's interim report and this report acknowledges the power of language and that words have different meanings for different people:

> Words and language can have a lasting impact on a person's life. They can empower and embolden. They can be used to convey hope and empathy. But they can also be divisive when used to dispossess and divide, and to stigmatise and label.[101]

Mr David Pearl, Innovator, Author and Public Speaker of The Studios, London, spoke in a personal capacity about the importance of words:

> the choice of words is important. The story is different if the words used are "mental wellness" and when the words used are "mental illness". Vocabulary shapes meaning, clearly. New words stimulate new ways to think about things.[102]

The origins of words and language are often not well understood. In her memoir, Merinda Epstein, a self-proclaimed 'old-campaigner', described how the frequently used term 'consumer' originated within a broader health context in the 1970s, reflecting the desire of health system users to make informed decisions about their treatment, care and support.[103] In the decades following, it is understood that a group of activists in the United States agreed to replace the word 'patient' with 'consumer,' a term that was subsequently adopted in Victoria in the 1990s, in the hope that it would improve the rights of people to make their own decisions and have their choices respected and promoted.[104]

Language preferences have continued to evolve to reflect the changing needs, preferences and experiences of people with lived experience of mental illness or psychological distress. As Ms O'Hagan described in her submission to the New Zealand Government Inquiry into Mental Health and Addiction, the *Wellbeing Manifesto*:

> From time to time we need to change our terminology. In the early 1900s people stopped using the term 'lunatic' and after World War Two they stopped referring to 'mental hygiene'. We think 'mental health' and 'mental illness' have now reached their use-by date.[105]

People's experiences of mental health services can influence how they identify with and use different words to describe themselves and their experiences. For example, a study by the Centre for Psychiatric Nursing at the University of Melbourne explored the relationship between people's experiences of treatment, care and support and the views they hold.[106] The study suggested that where a person has a positive experience of treatment, care and support, they may be more likely to embrace clinical and diagnostic terms such as 'patient'. In contrast, a person with negative experiences may prefer language that deliberately contrasts with this terminology, such as 'survivor'.[107]

While the Commission is bound by language used in its letters patent, evidence before it identifies future opportunities to refine language for a redesigned mental health and wellbeing system.[108] Language that reflects the dignity and diversity of people's experiences and perspectives is central to advancing cultural change towards a more equal and compassionate Victoria, where people with lived experience of mental illness or psychological distress are leaders, actively participating in public life.

18.6.5 Develop awareness and understanding of people's experiences

Opportunities for people to share their individual stories, and to have their experiences heard and acknowledged, is integral to a respectful and compassionate mental health and wellbeing system. Alongside individual benefits, the sharing of individual stories and experiences plays an important role in creating a system that responds to people's changing needs and expectations.

The new Mental Health and Wellbeing Commission will be adept at developing partnerships across the breadth of the Victorian public, including community leaders and the media. It will provide opportunities for people to share their stories so the mental health and wellbeing system can continue to improve and learn from these experiences.

Efforts must proactively contact and partner with people with lived experience of mental illness or psychological distress from all walks of life. Like any cross-section of the population, people with lived experience of mental illness or psychological distress are not a homogenous group—they have different experiences and hold different perspectives and views. Countering tokenistic approaches to engagement will require inclusive approaches and active efforts to partner with diverse groups and communities, including those who may have previously been silenced or had insufficient opportunities to participate.[109] This includes deliberate efforts to partner with Aboriginal people, culturally diverse people, people living with disability and LGBTIQ+ people.

Geographical location will not be a barrier because the new Mental Health and Wellbeing Commission will make concerted efforts to reach into metropolitan, rural and regional Victoria. This may be supported by an online and digital presence, as well as local and tailored approaches to engagement.

The new Mental Health and Wellbeing Commission, with leadership from people with lived experience of mental illness or psychological distress, will act as a public voice, promoting the experiences and perspectives of people with lived experience of mental illness or psychological distress across Victoria. This work will include engaging with the media to promote continuous improvement in reporting of mental health and wellbeing and to counter unfounded assumptions that perpetuate stigma and discrimination associated with mental illness or psychological distress.

The Commission's interim report noted that perspectives on community safety may be partly influenced by media coverage that does not accurately portray the experiences of people with lived experience of mental illness or psychological distress.[110]

Associate Professor Nicola Reavley, Head of the Population Mental Health Unit and Deputy Director of the Centre for Mental Health at the University of Melbourne, described the role of the media in influencing people's perception of mental illness:

> People are more likely to have stereotypical beliefs where they don't know anyone personally with a mental illness and are instead informed by representations of the mental illness in the media. These have a considerable impact, particularly in cases of extreme acts of violence, which often receive significant media coverage in Australia.[111]

In an individual contribution to the Commission, Greg Calder made similar observations:

> Media and social media platforms can often contribute to or heighten a perception that mentally ill people are incapable or violent, whereas in fact people who are mentally ill are overwhelmingly the victims rather than perpetrators of violence.[112]

The Commission recognises the significant efforts made to improve media reporting of mental illness and the notable example of SANE Australia's StigmaWatch program. Dr Michelle Blanchard, Deputy CEO of SANE Australia and Founding Director of the Anne Deveson Research Centre, explained how the program monitors and responds to stigmatising media reporting, providing advice to media professionals to promote responsible reporting.[113] Yet, despite the best efforts of many and some signs of progress, the Commission was told that much reporting still contains stigmatising content about mental illness, with media content described as 'inaccurate, irresponsible or offensive'.[114]

Inaccurate reporting may be partly influenced by the absence of the voices and perspectives of people with lived experience of mental illness or psychological distress, including reporting of mental illness that does not include interviews from those with first-hand lived experience.[115]

The Commission considers that proactive partnerships between the new Mental Health and Wellbeing Commission and media organisations are essential to changing the narrative and encouraging media content that is respectful and reflects the needs and perspectives of people with lived experience of mental illness or psychological distress.

The Mental Health and Wellbeing Commission will partner with and contact the media in a number of ways to promote the experiences and perspectives of people with lived experience of mental illness or psychological distress, ensuring they are represented in public reporting on the matters that affect their lives. For example, it could provide training, guidance and advice on how to develop media content about mental illness or psychological distress that is accurate and sensitive. The Mental Health and Wellbeing Commission could also promote the voices of people with lived experience of mental illness or psychological distress in media content and reporting.

The Royal Commission was told that co-producing media content with people with lived experience of mental illness or psychological distress is crucial to ensuring their representation in stories about the matters that affect their lives. For example, Ms Eastly said that on completion of the *No Feeling is Final* series (a podcast that was co-produced with the ABC and documented Ms Eastly's experiences of suicidality), the executive producer at the ABC reflected that working on the series had assisted him to develop a deeper understanding of the perspectives of people with lived experience of mental illness or psychological distress and the intricacies associated with reporting on these experiences.[116] To this end, Ms Eastly advocated for opportunities to build the capabilities of mainstream journalists and consumers with an interest in writing and media, including professional development and networking opportunities:

> I see these as being akin to leadership programs rolled out to educate, and empower consumer leaders, or leaders in other sectors. We need to develop allies in the media space to build on and make space for consumer voice and concerns.[117]

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In addition, Ms Dempsey called for more investment in monitoring of stigmatising media reports, as well as reporting that actively sources contributions from consumers, families, carers and supporters to 'increase the understanding and appreciation of struggles faced by consumers, carers and their friends and families, fighting the ongoing and devastating nature of mental illness'.[118]

Accurate and sensitive media reporting that reflects a diversity of experiences and perspectives—and, most importantly, includes the voices of people with lived experience of mental illness or psychological distress—is essential to promoting a diversity of leadership and reducing stigma.

18.7 A new agency led by people with lived experience of mental illness or psychological distress

The Commission's interim report acknowledged that despite the positive impacts of services led by people with lived experience of mental illness or psychological distress, including improved outcomes and experiences for people and return on investment, the current suite of services in Victoria's mental health system is very narrow.[119]

The Commission subsequently recommended establishing Victoria's first residential mental health service designed and delivered by people with lived experience of mental illness or psychological distress. It also acknowledged that, at the time of preparing its interim report, Victoria lacked an organisation led by people with lived experience of mental illness or psychological distress able to offer an alternative to acute hospital-based care as a result of structural failings with the mental health system.[120]

To deal with this shortcoming, the Commission committed to help the emergence of organisations, including services led by people with lived experience of mental illness or psychological distress.[121] Evidence before the Commission indicates the benefits and value of these organisations, with many people and organisations advocating for their expansion across the system:

> I'd like to see the establishment of peer-led organisations, peer respites and peer support groups prioritised. We need alternative support options to become available in addition to the current mental health services in place.[122]
>
> it is now time for consumer-led services to be brought into the community, for and by people with lived experience around the impacts of mental health issues, consequences, strategies for coping and recovery, and ways people can re-position themselves into the world, perhaps finding strength in doing things more in their own terms.[123]
>
> It would be good if we had a collective of consumer thinkers, leaders and people with expertise around alternative forms of care. The government should bite the bullet and fund services that are governed and delivered by consumers.[124]

The Commission has reached the view that cultivating the emergence of organisations led by people with lived experience of mental illness or psychological distress requires accredited training and resources, including organisational supports to help these new initiatives to develop and flourish over time.

To this end, the Commission recommends establishing an agency led by people with lived experience of mental illness or psychological distress (the agency) to aid the development of other organisations, including services led by people with lived experience of mental illness or psychological distress. It will also deliver its own mental health and wellbeing services and create opportunities for networking and new partnerships across the community (refer to Figure 18.3).

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Figure 18.3: Functions and governance arrangements of an agency led by people with lived experience of mental illness or psychological distress

The agency will be established by the Department of Health as a new non-government organisation that is governed and delivered by people with lived experience of mental illness or psychological distress. The Commission recommends that the agency has a set of functions that will enable it to aid the establishment of new organisations led by people with lived experience of mental illness or psychological distress, create opportunities for networking and help it interact with the breadth of the Victorian community (refer to Figure 18.3).

Independence in the form of a new non-government organisation is preferred to ensure the agency is truly led by people with lived experience of mental illness or psychological distress. The Commission did consider whether there was an existing organisation that could perform this role, noting that there are established organisations within Victoria's mental health system that play an exceptional role in advancing the leadership of people with lived experience of mental illness or psychological distress, including the consumer-led peak body the Victorian Mental Illness Awareness Council. For the past 40 years the Victorian Mental Illness Awareness Council has played a vital role promoting the rights and choices of people with lived experience of mental illness or psychological distress (refer to Box 18.1 for further information). It also played an important role throughout the Commission's inquiry, including supporting people who participated in the Commission's consultations, as described in Chapter 39: *The work of the Commission*.

As described earlier, advocacy plays a critical role in ensuring people with lived experience of mental illness or psychological distress are actively involved in decision making and in promoting community support for system reform.

The role of the Victorian Mental Illness Awareness Council is therefore essential, both to advancing the leadership of people with lived experience of mental illness or psychological distress and to progressing the Commission's reform agenda. Dr Szirom shared her hopes for the future of advocacy:

> **Advocacy should be independent in funding and governance and hold services accountable. It will continue to be a voice for consumers and help identify what is and isn't working, and beyond the mental health system itself to social determinants. Advocacy will actively engage with and respond to minority groups.**[125]

The Commission has reached the view that rather than recommending that the Victorian Mental Illness Awareness Council performs additional functions, a new non-government organisation will be established to be the agency and partner and work alongside it.

Recognising the significant contribution of the Victorian Mental Illness Awareness Council in advancing the rights, will and preferences of people with lived experience of mental illness or psychological distress, the Commission considers that service agreements between the Department of Health and the Victorian Mental Illness Awareness Council should be extended for at least five years.

Box 18.1: The Victorian Mental Illness Awareness Council

The Victorian Mental Illness Awareness Council has a long and proud history in progressing the rights, will and preferences of people with lived experience of mental illness or psychological distress across Victoria's mental health system. Established in 1981, it was originally created by two social workers who wanted to bring the experiences of people with lived experience of mental illness or psychological distress to the fore of the 'International Year of the Disabled'.[126] In the decades that followed it has continued to advocate with, by and for people with lived experience of mental illness or psychological distress.[127] The late 1990s saw the Victorian Mental Illness Awareness Council gain a reputation for its formidable approach to advocacy, and in the 2000s it played a pivotal role in supporting the growth of the consumer workforce.[128] Today, the Victorian Mental Illness Awareness Council is the peak Victorian non-government organisation for people with 'direct lived experience of mental health issues or emotional distress'.[129] It is entirely consumer-led and governed,[130] and strives to work towards a future 'where all mental health consumers stand proud, live a life with choices honoured, rights upheld, and these principles are embedded in all aspects of society'.[131]

Consumer-led advocacy is at the heart of the Victorian Mental Illness Awareness Council's approach. It performs its advocacy role at the individual, group and systemic levels with a focus on ensuring the rights and choices of people with lived experience of mental illness or psychological distress are respected and promoted. Alongside its advocacy role, it has a range of other functions, including delivering consumer perspective education and training, undertaking research, developing resources on a range of topics and working closely with other entities and across the sector more broadly on the development and implementation of projects and policies.[132]

As described earlier, while not discounting the significant efforts of many, funding constraints and diverse priorities among advocacy organisations limit their impact.[133] These responsibilities are only likely to intensify as Victoria's mental health and wellbeing system prepares for significant change and individuals and entities look to advocacy organisations for leadership and support. Funding certainty is critical to ensuring consistent and sustained levels of advocacy across Victoria's mental health and wellbeing system.[134] A funding agreement extension of at least five years will recognise the pivotal role the Victorian Mental Illness Awareness Council will play in working with the agency led by people with lived experience of mental illness or psychological distress. It will also provide it with continuity and certainty in delivering on its plan to continue elevating the experiences, perspectives and expertise of people with lived experience of mental illness or psychological distress across the future mental health and wellbeing system. Strengthening systemic advocacy via funding cycles of at least five years was also a key conclusion of the Productivity Commission's *Mental Health Inquiry Report*.[135]

As detailed in Chapter 27: *Effective leadership and accountability of the mental health and wellbeing system—new system-level governance and Chapter 37: Implementation*, the Victorian Government must also undertake proactive efforts to support and resource the Victorian Mental Illness Awareness Council, alongside other advocacy organisations and peak bodies, so it can lead and influence the significant changes associated with implementing the Commission's recommendations. These supports may include, for example, providing mentorship, executive coaching, training and professional development to ensure it can effectively engage and partner with implementers of the Commission's recommendations.

18.7.1 Accredited training, resources and service delivery

The Commission recommends that the agency aids the development of organisations led by people with lived experience of mental illness or psychological distress by providing accredited training and resources, including organisational supports. The agency will also be able to develop and deliver its own mental health and wellbeing services. This will be particularly important in the short-term, while services led by people with lived experience of mental illness or psychological distress are supported to develop and mature over time.

To perform its functions, the agency will establish itself as a registered training organisation. This will enable it to deliver accredited training focused on developing the capabilities of people with lived experience of mental illness or psychological distress to lead and manage their own organisations. This could include, for example, governance and corporate training. It may partner with an existing registered training organisation in the short-term.

Evidence before the Commission identifies the need for resources, including organisational supports and training to provide people with lived experience of mental illness or psychological distress with the support and resourcing they need to establish their own projects and initiatives. As Ms Eastly reflected:

> What is needed to establish and develop consumer-led services is significant long-term investment in the foundations that would make this genuine alternative a reality: … a long-term (10 years+) investment in skilling up of consumer-led organisations, including professional development to become sustainable, healthy businesses that provide competitive services to the public … support for strategic partnerships between lived experience-led organisations who are more matured, if sometimes from adjacent areas.[136]

Ms Daya made similar observations, advocating for a model built on maturation—that is, supporting services led by people with lived experience of mental illness or psychological distress to develop over time by providing professional supports:

> The following mechanisms could be implemented to enable the emergence of service provider organisations that are governed and delivered by consumers/survivors: … fund a staged approach that can grow over time. For example, fund small peer-run initiatives that allow skill development through experience. This could include funding small groups of consumers to run smaller scale peer support projects, like regular group programs at a neighbourhood house, or short-stay recovery camps, or even social enterprises. Funding could include access to lived experience mentoring, and/or other relevant mentoring or skills training …[137]

Similarly, reflecting on establishing an informal peer respite service, Ms Porter described the need for resourcing, training and supports to build the skills and capabilities of people with lived experience of mental illness or psychological distress to establish their own services:

> Setting people up to be able to resource their existing community connections and organising things like this would be great. We should help people to set up their own networks, to set it up for themselves. This takes a lot of skill and experience ... But there are many people who don't have that level of resourcing or capability.[138]

Auspicing arrangements and partnership approaches—where an established organisation supports a new project to happen, for example, through sharing skills and resources and providing management and governance—have also been identified as essential to supporting and scaling up small organisations.[139] Mr Panther reflected on the importance of these arrangements in promoting the establishment of organisations run by people with lived experience of mental illness or psychological distress in a personal story. Further, Ms Lin Hatfield Dodds, Associate Dean for the Australian and New Zealand School of Government of the Crawford School, Australian National University, who gave evidence in a personal capacity, explained the effectiveness of these approaches:

> Resourcing a larger organisation in a community to act as a big sibling to a group of smaller ones can be quite effective. Or funding the creation of networks of smaller organisations to come together regularly to share information and experiences ... Small organisations don't have the capacity to develop these kinds of support and development opportunities on their own.[140]

The agency will use various strategies to provide small-scale organisations, including services led by people with lived experience of mental illness or psychological distress, with the supports they need to develop over time. This includes auspicing arrangements, partnership approaches and accredited training described earlier.

Being able to learn from similar models, from organisations and from peers has also been identified as key to success.[141] The agency should partner with other entities to design and deliver accredited training and resources, including the recommended Mental Health and Wellbeing Commission and the Collaborative Centre for Mental Health and Wellbeing, as well as international peers to learn from their experiences. As described in Chapter 33: *A sustainable workforce for the future*, these reforms will occur in parallel with the Commission's recommended whole-of-workforce approach to capability development and training. Led by the Collaborative Centre for Mental Health and Wellbeing, these reforms will build the expertise of the frontline workforce, including the lived experience workforces, to deliver consumer-focused, recovery-oriented treatment, care and support.

The Commission is aware that it will take time and resources to cultivate the emergence of new organisations led by people with lived experience of mental illness or psychological distress. Achieving the Commission's ambition for a future in which mental health and wellbeing services led by people with lived experience of mental illness or psychological distress are operating as part of a diverse service offering will be supported by a staged and deliberate approach that is built on maturation, supporting organisations to develop their capabilities over time. As established in Chapter 5: *A responsive and integrated system*, the Department of Health and Regional Boards will support providers, including services led by people with lived experience of mental illness or psychological distress, to thrive and develop over time as part of a diverse service offering.

Personal story:

Graham Panther

Graham has been a mental health advocate for many years. He is the co-founder of the Big Feels Club, an online mental health initiative, and Redpanther, a consultancy that combines consumer expertise and evidence-based service improvement.

Prior to moving to Australia, Graham worked in New Zealand with Mind and Body Consultants, a peer-led organisation that advocates for leading change in mental health services using lived experience of mental illness and recovery.

> There is no Victorian equivalent of Mind and Body we can point to in mental health—a large, thriving peer-led organisation operating a range of service contracts that were, until Mind and Body, delivered by mainstream agencies. There is no equivalent of Mary O'Hagan, a Mental Health Commissioner who openly talks about her experience of being in psychiatric hospitals and how those experiences have shaped her views.

Graham noted that while Victoria has seen a small growth in consumer leadership roles over the past decade, these opportunities have often been informal, with limited influence. Graham believes that real change is only possible when you give consumers the power to make policy and budget decisions.

> As a leader in this space, the Victorian Government can expedite the growth of lived experience leadership in two main ways. Firstly, they can do what New Zealand did: take a calculated punt on hiring people with first-hand lived experience into prominent positions of real influence.
>
> The second immediate way forward I see is for government to invest in developing more and better-resourced peer-led organisations in Victoria ... If lived experience expertise is to truly have a voice in shaping the future service system, we need peer-led organisations that advocate for and further develop that expertise, alongside mainstream bodies and agencies.

Drawing on his experience, Graham advocates for flexible approaches, and organisational supports and structures, to promote the establishment of services and organisations that are led by consumers.

> I would argue that having more peer-led organisations—services run 'by' us—can help support the development of services run 'as' us, over time, by which I mean, truly grassroots, peer-run offerings that fill the gaps that mainstream services can't easily fill.

> The Big Feels Club is a practical example. Our 6,000-odd community members tell us we're not like any mental health initiative they've ever come across, but one of the reasons we can take that fresh approach is because we're auspiced by Self Help Addiction Resource Centre (SHARC), an alcohol and other drug organisation with significant peer leadership at the top ranks. SHARC provides us with the support on governance and funding we would struggle to find elsewhere, while also understanding that what we're doing is not business as usual, and it's not meant to be.
>
> To be truly trusted by mainstream organisations, peer-led organisations also need to be supported from the outset to develop their leadership capacity.

Graham described how greater investment in consumer-led organisations can support the consumer workforce and consumer-led organisations to flourish.

> Mind and Body Consultants became a feeder organisation of sorts, the starting point for many talented people who would otherwise never have worked in mental health, and have since gone on to lead organisations of their own.
>
> If there are more peer-led organisations in the sector, or organisations like SHARC that clearly embrace the 'it's okay to not be okay' end of the service continuum, we will have more 'natural allies' in the sector—more places we could go for funding or other forms of support, without having to worry about losing the magic of what we do.

Source: *Witness Statement of Graham Panther*, 6 July 2020; Graham Panther, *Correspondence to the RCVMHS*, 2020.

In light of this long-term endeavour, the agency will also be able to deliver its own mental health and wellbeing services. To inform its approach to service delivery, it should engage with people with lived experience of mental illness or psychological distress, across age ranges, locations and backgrounds, to understand their needs and experiences and tailor its service delivery approach. Existing services led and delivered by people with lived experience of mental illness or psychological distress vary in scope and functions and include, for example, drop-in-style centres, residential homes and post-discharge support programs.[142] The agency should not be limited by the scope of existing services, but may look to learn from these approaches.

The service offering of the agency must also align with the recommended core functions for future community mental health and wellbeing services, as described in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*, and other service features recommended by the Commission. These features should also include consideration of the role and needs of families, carers and supporters. The agency may also look to partner and work with other providers. For example, as described in Chapter 9: *Crisis and emergency responses,* the Commission recommends the agency works with the Victorian Government and non-government organisations to establish innovative 'safe spaces' and crisis respite facilities that are consumer-led.

The agency will also be able to consult with and provide expert training and supports to mainstream organisations and service providers, with the intention of supporting them to embed lived experience leadership and better reflect the needs and experiences of people with lived experience of mental illness or psychological distress. This is noting that in the immediate to medium term, its focus should be on supporting the establishment of organisations led by people with lived experience of mental illness or psychological distress and delivering its own mental health and wellbeing services.

Specialist training, consultation and support will be determined by the agency, tailored to and reflecting the different outcomes and objectives of mainstream organisations and service providers. These opportunities could include, for example, practical guidance and support to increase understanding of the principles of co-production and effective approaches to partnering with people with lived experience of mental illness or psychological distress.[143]

Contributions to the Commission have raised the importance of supports, resources and training for mainstream organisations and service providers to genuinely engage and partner with people with lived experience of mental illness or psychological distress.[144] For example, Perinatal Anxiety & Depression Australia (PANDA) said:

> **Meaningful consumer engagement is a skilled and iterative process. It requires that people and organisations have access to quality training and ongoing support to facilitate consumer engagement, and resources to ensure consumers are supported and paid for their time.[145]**

Consultation and providing expert advice and supports to mainstream organisations and service providers will ensure the leadership of people with lived experience of mental illness or psychological distress is ingrained in organisational structures and cultures that prepare the system for a future in which people with lived experience are leading across all aspects of Victoria's mental health and wellbeing system.

18.7.2 Co-location of organisations led by people with lived experience of mental illness or psychological distress

The agency led by people with lived experience of mental illness or psychological distress will act as a hub for innovation and new initiatives. As an initial priority, it will facilitate the co-location of new and existing organisations, including services led by people with lived experience of mental illness or psychological distress. This should be facilitated via an agreement between the agency and organisation, such as memoranda of understanding or commercial leases.

A centralised location for organisations that are led by people with lived experience of mental illness or psychological distress will be pivotal to the creation and exchange of ideas, fostering new partnerships and alliances and promoting collaboration between people with lived experience of mental illness or psychological distress and the organisations they lead.

Co-location will also ensure small-scale organisations led by people with lived experience of mental illness or psychological distress are financially viable and sustainable. For example, it would allow for shared resourcing, accommodation and operational expenses, including the use of flexible and multiuse spaces. The need for resourcing and sustainable funding is a crucial factor to support development of these organisations.[146] Early investment in providing these supports will set these organisations up for success over the long term, with the capacity to develop and mature over time.

Hosting organisations also has the added benefit of providing people with lived experience of mental illness or psychological distress with a centralised location to engage with peers and use services and supports from a home base. Alongside co-location, opportunities for other forms of collaboration are explored further below.

18.7.3 New partnerships and networks

The importance of building a community of leaders with lived experience of mental illness or psychological distress has been impressed upon the Commission.

Communities of place, identity and interest play a vital role in fostering appreciation of diversity, building connections and leading social change. Mr Rick Corney, a witness before the Commission, reflected on the importance of community, '[i]n my view, if you strengthen the individual, you strengthen the community; the community is the resource.'[147]

Some have reflected on the central role that communities play in fostering a shared sense of belonging and identity. Mr Andrew Jackomos PSM, Executive Director of Aboriginal Economic Development at the Department of Jobs, Precincts and Regions, and a Yorta Yorta man, said of culture and community for Aboriginal people:

> I know from what I have witnessed over my life time and particularly in the last twenty years, that connectedness to culture, country and community is the foundation stone for building stronger individual and collective identities.[148]

Others have noted the importance of communities and networks in supporting good mental health and wellbeing because they promote a sense of social connection and inclusion.[149] For example, witness Mr Al Gabb, a farmer who grew up in Skipton, described the strength and support of his local community:

> I've experienced a great sense of community and support. People in town know what I have been through and I walk through town with my head held high. I have received some inconsiderate comments, but I have also been told I am brave.[150]

Every community has its own unique identity and culture and the consumer community is no different. While it may be brought together by shared ideas, the individual experiences, perspectives and worldviews of the individuals within it are diverse, ever-changing and sometimes conflicting.

The need for greater investment in communities and places to network has been raised with the Commission. The Victorian Mental Illness Awareness Council, for example, advocated for investment in communities and places for people with lived experience of mental illness or psychological distress to collaborate, including community meeting places and networks, '[u]sing coproduction methods, community members can both contribute to community support spaces, and seek support from those spaces.'[151]

Similarly, Ms Sandy Jeffs OAM, a witness before the Commission, reflected on the importance of community for people to gather and have their experiences heard and acknowledged:

> The best thing about providing such a community is for people to have their mad comrades around them to offer support to each other and tell their war stories ... The problem is that there's nowhere for people to gather to tell their war stories - there are no drop-in centres, no art studios or places for people with mental illness to actually congregate and talk to each other, or support each other.[152]

The agency will create safe, welcoming and inclusive places for people to network and better understand the diverse, rich and powerful experiences of people with lived experience of mental illness or psychological distress. This will include opportunities for informal gathering places, discussion groups and forums. It will also sponsor and host a diverse range of programs and events that focus on celebrating the diversity of people with lived experience of mental illness or psychological distress and connecting community leaders.

Ro Allen, the Victorian Commissioner for Gender and Sexuality (now known as the Commissioner for LGBTIQ+ Communities), reflected on the importance of community support and community-led events in fostering a sense of pride, celebrating the diversity of difference and 'provid[ing] LGBTIQ people with the opportunity to connect and celebrate being themselves'.[153]

The agency must belong to everyone, with opportunities for all Victorians to be involved and feel they are valued, safe, included and respected. This includes deliberate efforts to partner with diverse communities and groups, including Aboriginal people, culturally diverse Victorians, people living with disability, LGBTIQ+ people and older Victorians. Networking opportunities, programs and events will be made available across the breadth of the state in a variety of accessible formats, including digitally, to ensure that geographical location is not a barrier, particularly for people living in rural and regional Victoria.

The agency will bring people with lived experience of mental illness or psychological distress together, creating opportunities for collaboration and shared learning while also acknowledging and respecting the individual identities of those within it. It will celebrate the diversity of difference and create opportunities for the Victorian community to understand the experiences and perspectives of people with lived experience of mental illness or psychological distress, and their powerful contributions.

18.7.4 Governance and initial establishment phase

As a first step, the Commission recommends that the Department of Health establishes the governance of a non-government organisation to be the agency, which will be overseen by a skills-based board chaired by and consisting of a majority of people with lived experience of mental illness or psychological distress.

Members must have a range of skills and experiences to represent the diversity of people with lived experience of mental illness or psychological distress, including across age ranges, types of mental health services accessed, backgrounds and locations. This includes people from diverse communities such as Aboriginal people, culturally diverse people, people living with disability, and LGBTIQ+ people.

Independent of demographics, identity and culture, people with lived experience of mental illness or psychological distress all hold different experiences and perspectives. Genuinely engaging with and fostering the diversity of these experiences needs an open-door approach that involves a variety of people, including those who may challenge the status quo and those who may not have been previously heard.[154]

Proactive efforts must also be made to support and build the capabilities of potential board members and staff, including providing professional development, training, mentorship, supervision and other tailored supports where required.

As is commonplace where government identifies a need or gap that could best be dealt with by an independent organisation, the Department of Health will support the initial establishment phase. This will involve running an open and transparent process to establish the board and giving the new non-government organisation legal status.

People with lived experience of mental illness or psychological distress must be involved in the process to establish the initial board. This could involve, for example, co-producing a set of criteria or skills matrix that defines desired expertise and experiences to guide the initial appointment of board members.

Following the appointment of an initial board and an establishment phase, the constitution of the agency would enable new directors to be removed and replaced from the board, without government involvement. This will ensure it is independent, led and governed by people with lived experience of mental illness or psychological distress.

Upon its appointment, the board will lead the design and development of the agency, co-producing it with people with lived experience of mental illness or psychological distress. This process would start with obtaining a building that is accessible, welcoming and inclusive, with enough space to support the co-location of new and existing organisations that are led by people with lived experience of mental illness or psychological distress.

The agency will also establish a strong digital presence, offering online resources, information, supports and services across the state in various accessible formats. Its virtual platform will ensure all people with lived experience of mental illness or psychological distress, including those living in rural and regional Victoria, can get vital resources and supports in one place.

The board will also lead the recruitment of the CEO to run the day-to-day operations and to implement the functions of the agency, with most positions throughout the organisation's structures designated to people with lived experience of mental illness or psychological distress.

The Department of Health will manage the funding contract with the agency and provide it with sustainable funding. Over the long term, it may be funded through more diverse means, including generating its own revenue to support its independence. For example, it is envisaged that the agency, in time, may seek funding via the Commission's recommended community collectives or may attract philanthropic investment. It may also consider a membership approach, corporate partnerships and funding opportunities associated with providing specialist training.

The Commission envisages that the agency led by people with lived experience of mental illness or psychological distress will lay the groundwork for a reimagined mental health and wellbeing system where these organisations are prosperous. Combined, the reforms detailed throughout this chapter and more broadly across this report will see people with lived experience of mental illness or psychological distress acting as leaders and agents of change across a reformed mental health and wellbeing system.

1 *Witness Statement of Honor Eastly*, 14 September 2020, para. 66.

2 In July 2020, the Consumer Foundations Working Group was established to provide advice to the Commission, particularly about reforms related to the leadership of people with lived experience of mental illness or psychological distress. While the Commission advocates for the leadership of people with lived experience of mental illness or psychological distress throughout implementation, the Commission's engagement process was conducted within the bounds of the *Inquiries Act 2014* (Vic), with final decision making on all matters in this report resting with the Commission. Refer to Chapter 39: *The work of the Commission*, for further information.

3 Consumer Foundations Working Group, *Correspondence to the RCVMHS: Consumer Leadership and Mobilisation*, 2020, p. 15.

4 *Witness Statement of Dr Sarah Pollock*, 14 May 2020, para. 71.

5 United Nations, *Convention on the Rights of Persons with Disabilities*, 6 December 2006, Article 1 states that Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. United Nations Treaty Collection, Chapter IV, Human Rights: 15. Convention on the Rights of Persons with Disabilities, Entry into Force: 3 May 2008, in Accordance with Article 45(1). New York, 13 December 2006, <treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4>, [accessed 18 December 2020] states that Australia issued a declaration to the Convention, stating that substituted decision making is permitted when it is necessary, when used as a last resort, and when subject to safeguards.

6 United Nations, Preamble (o).

7 United Nations, Article 3(c).

8 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 13.

9 The Commission uses 'lived experience workforces' as a broad term to represent two distinct disciplines—people with personal lived experience of mental illness ('consumers') and families and carers with lived experience of supporting a family member or friend who has experienced or is experiencing mental illness.

10 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 391, 405, 491, 507 and 509.

11 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 2.

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

13 Parallels can be drawn to women entering into historically male dominated workforces, refer to: Mariateresa Torchia, Andrea Calabrò, and Morten Huse, 'Women Directors on Corporate Boards: From Tokenism to Critical Mass', *Journal of Business Ethics*, 102.2 (2011), 299–317 (p. 311), which suggests that women board directors' contribution to innovation becomes evident when there is a critical mass of at least three women directors.

14 *Witness Statement of Robyn Kruk AO*, 4 May 2020, para. 32.

15 Victorian Mental Illness Awareness Council, *Consumer Led Transformational Change: Consumer Workshop and Survey Results*, 2020, p. 56.

16 Consumer Foundations Working Group, p. 10.

17 *Witness Statement of Indigo Daya*, 12 May 2020, para. 86.

18 Cath Roper, Flick Grey and Emma Cadogan, *Co-Production: Putting Principles into Practice in Mental Health Contexts*, 2018, p. 7.

19 Jeremy Heimans and Henry Timms, Understanding "New Power", *Harvard Business Review*, December 2014, p. 2.

20 Janet Meagher and others, *Peer Work in Australia: A New Future for Mental Health*, 2018, p. 57.

21 *Witness Statement of Janet Meagher AM*, 1 July 2019, para. 21.

22 RCVMHS, *Consumer Foundations Working Group, 16 July 2020: Record of Proceedings*, 2020.

23 *Witness Statement of 'Rachel Bateman' (pseudonym)*, 16 June 2020, para. 61.

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

25 Co-production involves people with lived experience of mental illness or psychological distress leading or partnering across all aspects of an initiative or program from the outset—that is, co-planning, co-designing, co-delivering and co-evaluating, refer to: Roper, Grey and Cadogan, p. 2.

26 Roper, Grey and Cadogan, p. 4; Sherry R. Arnstein, 'A Ladder Of Citizen Participation', *Journal of the American Planning Association*, 35.4 (1969), 216–224 (p. 217).

27 Sarah Gordon, 'The Role of the Consumer in the Leadership and Management of Mental Health Services', *Australasian Psychiatry*, 13.4 (2005), 362–365 (p. 365).

28 *Witness Statement of Erandathie Jayakody*, 4 June 2020, para. 68; *Witness Statement of Cath Roper*, para. 17.

29 Commonwealth Government, *National Mental Health Policy 1992*, 1992, pp. 7–8; Department of Health and Community Services, *Victoria's Mental Health Service: The Framework for Service Delivery*, 1994, p. 8.

30 Centre for Mental Health Learning Victoria, *History of Lived Experience Work in Victoria*, 2019, p. 1; Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 510–511; *Witness Statement of Kym Peake*, 24 July 2019, paras. 91–92.

31 *Witness Statement of Vrinda Edan*, 10 July 2019, para. 19; Ingrid Ozols, *Submission to the RCVMHS: SUB.0002.0019.0021*, 2019, p. 3; *Witness Statement of 'Rachel Bateman' (pseudonym)*, paras. 91 and 168; *Witness Statement of Erandathie Jayakody*, paras. 52 and 56.

32 *Witness Statement of Indigo Daya*, para. 113.

33 *Witness Statement of Julie Anderson*, 28 May 2020, para. 50.

34 *Witness Statement of 'Rachel Bateman' (pseudonym)*, para. 65.

35 RCVMHS, *Consumer Foundations Working Group, 14 August 2020: Record of Proceedings*, 2020.

36 Janet Meagher, 'Changing Perspectives on Consumer Involvement in Mental Health', *Health Voices*, 8, 2011, 27–28 (pp. 27–28).

37 Indigo Daya, Bridget Hamilton, and Cath Roper, 'Authentic Engagement: A Conceptual Model for Welcoming Diverse and Challenging Consumer and Survivor Views in Mental Health Research, Policy, and Practice', *International Journal of Mental Health Nursing*, 29.2 (2020), 299–311 (pp. 300–309).

38 *Witness Statement of Cath Roper*, para. 17.

39 *Witness Statement of Graham Panther*, 6 July 2020, para. 137.

40 Consumer Foundations Working Group, p. 18.

41 *Witness Statement of Erandathie Jayakody*, para. 44; *Witness Statement of Graham Panther*, paras. 128–129 and 132.

42 *Witness Statement of 'Elizabeth Porter' (pseudonym)*, 27 April 2020, para. 94.

43 *Witness Statement of Rita Brown*, 24 June 2020, para. 27; *Joint Witness Statement of Lisa Annese and David Morrison AO*, 14 July 2020, para. 24.

44 *Witness Statement of Graham Panther*, para. 129.

45 Louise Byrne, Anthony Stratford and Larry Davidson, 'The Global Need for Lived Experience Leadership', *Psychiatric Rehabilitation Journal*, 41.1 (2018), 76–79 (p. 76).

46 *Witness Statement of Erandathie Jayakody*, para. 50.

47 Victorian Council of Social Service, *Submission to the RCVMHS: SUB.0002.0029.0282*, 2019, p. 21.

48 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, 2019, p. 24.

49 *Witness Statement of Mary O'Hagan*, para. 103.

50 L. Johnstone and M. Boyle, *The Power Threat Meaning Framework: Towards the Identification of Patterns in Emotional Distress, Unusual Experiences and Troubled or Troubling Behaviour, as an Alternative to Functional Psychiatric Diagnosis* (Leicester: The British Psychology Society, 2018), p. 221.

51 *Witness Statement of Erandathie Jayakody*, para. 55; Consumer Foundations Working Group, p. 14.

52 *Witness Statement of Professor Bruce Bonyhady AM*, 16 June 2020, para. 55.

53 *Witness Statement of Erandathie Jayakody*, paras. 46–47 and 52; Perinatal Anxiety and Depression Australia, *Submission to the RCVMHS: SUB.0002.0030.0055*, 2019, pp. 4 and 28.

54 *Witness Statement of Cath Roper*, para. 43.

55 Productivity Commission, *Draft Report on Mental Health, Volume 2*, 2019, pp. 909–910.

56 *Witness Statement of The Hon. Andrew Robb AO*, 26 June 2019, para. 37.

57 Consumer Foundations Working Group, pp. 22–23.

58 *Witness Statement of Dr Tricia Szirom*, 12 May 2020, para. 24.

59 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 123.

60 Every Australian Counts, What Is Every Australian Counts?, <everyaustraliancounts.com.au/about/>, [accessed 11 May 2020]; Every Australian Counts, Journey So Far, <everyaustraliancounts.com.au/about/journey-so-far/>, [accessed 1 July 2020].

61 National Disability Insurance Agency, *Correspondence to the RCVMHS: CSP.0001.0001.0001*, 2020, p. 4; *Witness Statement of Professor Bruce Bonyhady AM*, para. 32.

62 *Witness Statement of Professor David Copolov AO*, 7 July 2020, para. 296(a).

63 RCVMHS, *Consumer Foundations Working Group, 14 August 2020: Record of Proceedings*.

64 Allan Pinches, 'Better Mental Health Advocacy: A "Virtual Panel" of Consumer Thinkers Explore Some Possibilities', *Australian Journal on Psychosocial Rehabilitation*, 2015, 24–30 (p. 25).

65 *Witness Statement of Dr Tricia Szirom*, para. 25.

66 Pinches, Better Mental Health Advocacy: A "Virtual Panel" of Consumer Thinkers Explore Some Possibilities, p. 24.

67 Mental Health Australia, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, p. 36.

68 Jenny Pearson and Associates Pty Ltd, *Research of the Models of Advocacy Funded Under the National Disability Advocacy Program Final Report*, 2009, p. 33.

69 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 24.

70 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 405 and 410.

71 Experiential knowledge can be understood as the knowledge gained from having a personal lived experience of mental illness or psychological distress, refer to: Alison Faulkner, 'Survivor Research and Mad Studies: The Role and Value of Experiential Knowledge in Mental Health Research', *Disability and Society*, 32.4 (2017), 1–21 (pp. 10–11).

72 *Witness Statement of Erandathie Jayakody*, para. 50.

73 *Witness Statement of Mary O'Hagan*, paras. 7–8.

74 *Mental Health Commission Act 2012* (NSW), sec. 8; New South Wales Mental Health Commission, Deputy Commissioners, <nswmentalhealthcommission.com.au/our-people/deputy-commissioners>, [accessed 20 October 2020]; Mental Health Commission of New South Wales, *Annual Report 2018–19*, 2019, p. 7.

75 South Australia Health, Review of Mental Health Governance in South Australia, <www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/reviews+and+consultation/review+of+mental+health+governance+in+south+australia/review+of+mental+health+governance+in+south+australia>, [accessed 21 August 2020].

76 *Witness Statement of Graham Panther*, para. 120; *Witness Statement of Erandathie Jayakody*, para. 55.

77 Meagher and others, p. 168.

78 Consumer perspective discipline-specific supervision allows consumers to deepen their knowledge and skills and address related challenges, refer to: Meagher and others, p. 165.

79 Co-reflection with other consumer workers can assist in development, refer to: *Witness Statement of Indigo Daya*, para. 94.

80 Consumer perspective is more than a direct personal experiences of recovery or accessing services, it is a unique discipline in the field of mental health that involves new ways of knowing and thinking about people's experiences, refer to: Roper, Grey and Cadogan, p. 4.

81 *Witness Statement of Dr Sarah Pollock*, para. 72.

82 Byrne, Stratford and Davidson, pp. 77–78.

83 *Witness Statement of Erandathie Jayakody*, para. 59.

84 Consumer Foundations Working Group, p. 14.

85 Victorian Mental Illness Awareness Council, *Consumer Led Transformational Change: Consumer Workshop and Survey Results*, p. 55; *Witness Statement of Julie Anderson*, para. 61; Consumers Health Forum of Australia, *Submission to the RCVMHS: SUB.0002.0026.0069*, 2019, p. 14.

86 National Mental Health Commission, *Sit Beside Me, Not Above Me*, 2019, p. 16.

87 *Witness Statement of Indigo Daya*, paras. 92–93.

88 Leadership Victoria, Program Methodology, <www.leadershipvictoria.org/program-methodology/>, [accessed 13 November 2020]; Victorian Public Sector Commission, *Victorian Public Service Capability Framework*, 2020, p. 1; Victorian Public Sector Commission, Into the Future: VLA Deputy Secretary Leadership Program, 2019.

89 *Witness Statement of Dr Tricia Szirom*, para. 23(c); *Witness Statement of Indigo Daya*, para. 112; *Witness Statement of Julie Anderson*, para. 61; Victorian Mental Illness Awareness Council, *Consumer Led Transformational Change: Consumer Workshop and Survey Results*, p. 55; National Mental Health Commission, p. 16.

90 For example, building on and/or adopting SHARC's organisational readiness training available at Self Help Addiction Resource Centre, SHARC Peer Worker Model, <www.sharc.org.au/peer-support/peer/>, [accessed 12 November 2019]; Mental Health Coalition, Lived Experience Workforce Toolkit for Organisations, <www.mhcsa.org.au/toolkit/>, [accessed 12 November 2019].

91 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 507, 516–517 and 520.

92 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 520.

93 *Witness Statement of Rita Brown*, paras. 62–63; L. Sweeney and others, *National Stigma Report Card: Recommendations for Action from the Our Turn to Speak Survey*, 2020, p. 8; *Joint Witness Statement of Lisa Annese and David Morrison AO*, para. 73.

94 *Witness Statement of Georgie Harman*, 2 July 2020, para. 115.

95 *Witness Statement of Graham Panther*, para. 43.

96 *Witness Statement of Julie Dempsey*, 23 July 2019, para. 57.

97 Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, May 2020, p. 6.

98 Victorian Mental Illness Awareness Council, *Consumer Led Transformational Change: Consumer Workshop and Survey Results*, p. 57.

99 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 5.

100 Victorian Mental Illness Awareness Council, The VMIAC Declaration, <www.vmiac.org.au/declaration/>, [accessed 6 November 2019].

101 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 5.

102 *Witness Statement of David Pearl*, 11 May 2020, para. 20.

103 Merinda Epstein, *The Consumer Movement in Australia. A Memoir of an Old Campaigner*, 2013, p. 4.

104 Victorian Mental Illness Awareness Council, About Mental Health Consumers, <www.vmiac.org.au/info/about-consumers/>, [accessed 21 October 2020].

105 Mary O'Hagan, *Wellbeing Manifesto for Aotearoa New Zealand: A Submission to the Government Inquiry into Mental Health and Addiction*, 2018, p. 12.

106 Daya, Hamilton and Roper, p. 301.

107 Daya, Hamilton and Roper, p. 305.

108 *Witness Statement of Cath Roper*, para. 18; *Witness Statement of Dr Tricia Szirom*, para. 10(a).

109 Daya, Hamilton and Roper, p. 309.

110 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 51.

111 *Witness Statement of Associate Professor Nicola Reavley*, 3 July 2019, para. 31.

112 Greg Calder, *Submission to the RCVMHS: SUB.0002.0028.0166*, 2019, p. 6.

113 *Witness Statement of Dr Michelle Blanchard*, 27 June 2019, paras. 14–15.

114 *Witness Statement of Dr Michelle Blanchard*, para. 16.

115 People with Lived Experience, Consumers and Survivors of the Mental Health System, An Open Letter to the ABC, <pleasedont.com.au/>, [accessed 18 September 2020]; *Witness Statement of Honor Eastly*, paras. 86–87.

116 *Witness Statement of Honor Eastly*, paras. 11 and 130–131.

117 *Witness Statement of Honor Eastly*, para. 138.

118 *Witness Statement of Julie Dempsey*, para. 56.

119 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 494.

120 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 500.

121 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 500.

122 Anonymous 61, *Submission to the RCVMHS: SUB.0002.0030.0222*, 2019, p. 7.

123 Allan Pinches, *Submission to the RCVMHS: SUB.0002.0032.0164*, 2019, p. 5.

124 *Witness Statement of Cath Roper*, para. 52.

125 *Witness Statement of Dr Tricia Szirom*, para. 26.

126 Epstein, pp. 7–8.

127 Victorian Mental Illness Awareness Council, Our Story, <www.vmiac.org.au/about/our-story/>, [accessed 24 November 2020].

128 Epstein, p. 12; *Witness Statement of Douglas Holmes*, 4 May 2020, para. 96.

129 Victorian Mental Illness Awareness Council, *Annual Report 2018–19*, 2019, p. 1.

130 Victorian Mental Illness Awareness Council, Our Story.

131 Victorian Mental Illness Awareness Council, *Annual Report 2018–19*, p. 1.

132 Victorian Mental Illness Awareness Council, *Annual Report 2018–19*, p. 1; *Witness Statement of Dr Tricia Szirom*, para. 8; Victorian Mental Illness Awareness Council, Our Story.

133 *Witness Statement of Dr Tricia Szirom*, para. 25; Pinches, Better Mental Health Advocacy: A "Virtual Panel" of Consumer Thinkers Explore Some Possibilities, p. 25.

134 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, 2020, p. 1107.

135 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1107.

136 *Witness Statement of Honor Eastly*, para. 63.

137 *Witness Statement of Indigo Daya*, para. 116.

138 *Witness Statement of 'Elizabeth Porter' (pseudonym)*, para. 101.

139 *Witness Statement of Graham Panther*, paras. 155–156; RCVMHS, *Consumer Foundations Working Group, 14 August 2020: Record of Proceedings*, pp. 22–23; *Witness Statement of Erandathie Jayakody*, para. 45.

140 *Witness Statement of Lin Hatfield Dodds*, 15 June 2020, para. 43.

141 *Witness Statement of 'Rachel Bateman' (pseudonym)*, para. 177; *Witness Statement of Douglas Holmes*, para. 122.

142 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 494.

143 *Witness Statement of 'Rachel Bateman' (pseudonym)*, para. 59; *Witness Statement of Indigo Daya*, para. 113(a).

144 *Witness Statement of 'Rachel Bateman' (pseudonym)*, para. 59; Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, p. 5; *Joint Witness Statement of Lisa Annese and David Morrison AO*, paras. 35 and 38.

145 Perinatal Anxiety and Depression Australia, p. 28.

146 *Witness Statement of Richard (Rick) Corney*, 3 May 2020, para. 35; *Witness Statement of Graham Panther*, para. 152.

147 *Witness Statement of Richard (Rick) Corney*, para. 28.

148 *Witness Statement of Andrew Jackomos PSM*, 11 July 2019, para. 26.

149 *Witness Statement of Professor Rob Moodie*, 9 June 2020, para. 9; *Witness Statement of Rod Jackson*, 22 July 2019, para. 31; Thorne Harbour Health, Rainbow Health Victoria and Switchboard, *Submission to the RCVMHS: SUB.0002.0028.0150*, 2019, p. 14; Neighbourhood Houses Victoria, *Submission to the RCVMHS: SUB.0002.0028.0171*, 2019, p. 2.

150 *Witness Statement of Al Gabb*, 11 July 2019, para. 16.

151 Victorian Mental Illness Awareness Council, *Submission to the RCVMHS: SUB.0002.0028.0645*, 2019, p. 15.

152 *Witness Statement of Sandy Jeffs OAM*, 5 April 2020, para. 14.

153 *Witness Statement of Commissioner Ro Allen*, 2 July 2019, para. 66.

154 Daya, Hamilton and Roper, p. 309.

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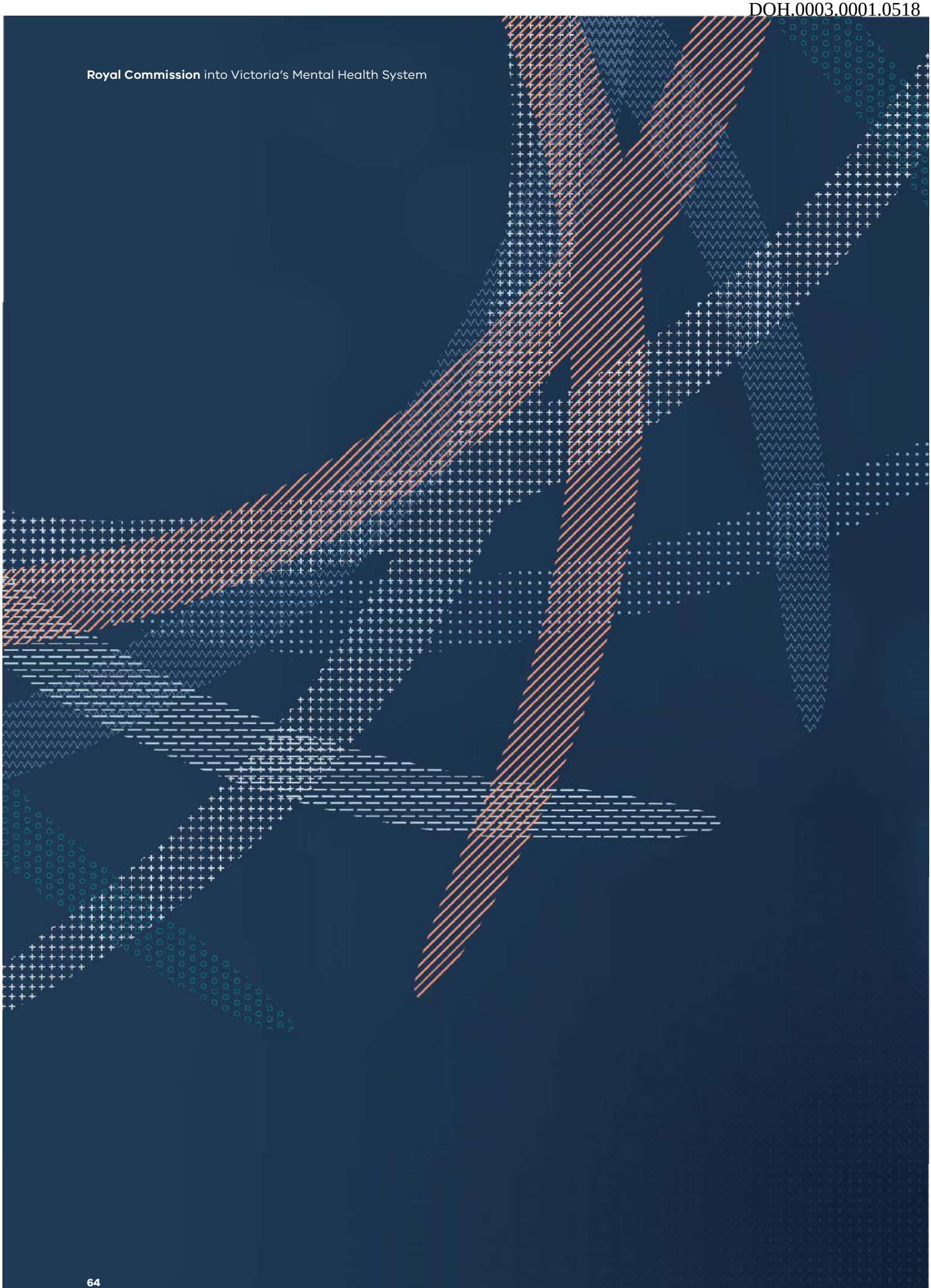

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Chapter 19

Valuing and supporting families, carers and supporters

Recommendation 30:

Developing system-wide involvement of family members and carers

The Royal Commission recommends that the Victorian Government:

1. in addition to the nominated roles specified in other recommendations, develop key roles across the mental health and wellbeing system for people with lived experience as family members and carers.
2. enable the Mental Health and Wellbeing Commission (refer to recommendation 44) to:
   - **a.** elevate the leadership and promote the valued role of family members and carers of people living with mental illness or psychological distress throughout the mental health and wellbeing system; and
   - **b.** develop and support the leadership and governance capabilities of families and carers of people living with mental illness or psychological distress through learning and development opportunities.
3. ensure that:
   - **a.** in commissioning mental health and wellbeing services, expectations are set for working with families, carers and supporters;
   - **b.** families, carers and supporters are included in a range of therapeutic interventions in each Area Mental Health and Wellbeing Service; and
   - **c.** working with families, carers and supporters is part of system-wide workforce training.
4. in addition to reforms to improve information sharing outlined in other recommendations, develop standards for services and practitioners to guide the sharing of appropriate information with families, carers and supporters.

Recommendation 31:

Supporting families, carers and supporters

The Royal Commission recommends that the Victorian Government:

1. by the end of 2022, commission non-government organisations to use consistent branding and deliver one family and carer-led centre in each of the eight regions (refer to recommendation 3(3)) to:

   a. provide tailored information and supports for families, carers and supporters in the region;

   b. work with families, carers and supporters to help identify their needs and connect them to the supports that will best respond to those needs;

   c. provide access to increased funds for immediate practical needs including short-term respite (brokerage); and

   d. deliver support for family and carer peer support groups in the region.

2. establish a statewide peer call-back service for families, carers and supporters caring for people experiencing suicidal behaviour.
3. ensure there is tailored information for families, carers and supporters, such as on the new statewide mental health website (refer to recommendation 6(4)).

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Recommendation 32:

Supporting young carers

The Royal Commission recommends that the Victorian Government:

1. by the end of 2022, fund a non-government organisation such as the Satellite Foundation to co-design and expand the range of supports across Victoria for young carers and children and young people who have a family member living with mental illness or psychological distress.
2. by the end of 2022, broaden the scope and reach of the Families where a Parent has a Mental Illness program, including by:
   - **a.** enabling each Area Mental Health and Wellbeing Service to employ new workers to support young carers in their local environment; and
   - **b.** increasing the funding available to young carers to help with practical needs (brokerage).
3. strengthen identification and referral pathways for young carers through the mental health and education systems.

19.1 The Royal Commission's vision for families, carers and supporters

Many families, carers and supporters have shared their stories with the Commission. These are stories of dedication to the people they care for and support, and stories of a system that is failing to meet people's needs. They are also stories about hope for a better future.

Families, carers and supporters have much to contribute to a future mental health and wellbeing system, with lived experience knowledge gained from years (sometimes decades) of navigating a complex system—and for many, a passion and personal commitment to making the system better for others in the future.

The future mental health and wellbeing system will acknowledge that most consumers have relationships of care and support, and that these relationships play an important role in wellbeing and recovery.

This chapter focuses on the challenges that families, carers and supporters can experience, and makes recommendations to rebalance the relationship between the system and families, carers and supporters.

The future system will be accountable to families, carers and supporters. To support accountability, new family and carer governance and leadership roles will be created to ensure the needs, experiences and outcomes of families, carers and supporters are considered and shape the system.

The system will also be explicitly responsible for supporting families, carers and supporters. Working with the people in consumers' social contexts will be embedded in service delivery. This means that involving families, carers and supporters in care and recovery will become standard practice for all services, and an expectation from the government when commissioning providers.

Families, carers and supporters across the state will also have access to dedicated supports, including from eight family- and carer-led centres, and young carers will have access to tailored and intensive supports.

Together, these recommendations deliver on the vision the Commission expressed in its interim report for 'a system in which families and carers are supported by the mental health system in return'.[1]

Over time, the load that is currently carried by families, carers and supporters, and the trauma they themselves have experienced because of the mental health system, will ease. Families, carers and supporters will have confidence that the people they care for will receive treatment, care and support in a redesigned system that is more compassionate and more responsive.

The future system will also better support families, carers and supporters—both in their own right, and to help them to carry out their caring role.

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Box 19.1: A note on terminology

The 'Terminology and language' section at the beginning of this volume defines the terms 'family', 'carer' and 'lived experience' in accordance with the Commission's letters patent.[2] Note in particular that 'family' is defined as including family of origin and/or family of choice.

The Commission acknowledges that the terms 'family' and 'carer' do not reflect the full range of relationships, social connections and supports that many people have in their lives, and the important role these relationships play as part of a support network. For example, in its interim report, the Commission noted that LGBTIQ+ communities, in particular, may draw on support from relationships beyond biological family.[3]

The terms 'family' and 'carer' are not interchangeable, and people may not identify with a particular term. Not all carers are family members, and family members do not always take on a caring role. Family members may, however, be valued supporters of a person experiencing mental illness or psychological distress, along with other people in that person's broader social and support network.

As Ms Rebecca Thomas told the Commission, 'I have never felt like the word carer was appropriate to my role, what I was, was part of my mums and my brothers support network, along with many other people'.[4]

'People with lived experience' is also defined in the Commission's letters patent to include 'people living with mental illness, their family members and carers'.[5] For clarity in this chapter, when the Commission refers to family and carer lived experience only, this is explicitly stated.

In this chapter, the Commission uses the term 'young carers' to describe young people who may be in a formal caregiving relationship (and eligible for supports such as funding). The term 'children and young people who have a family member experiencing mental illness or psychological distress' is used to describe children and young people who may or may not have a formal caregiving role, but may be affected nonetheless by mental illness or psychological distress in their family, whether that is experienced by a parent, sibling or other family member.

19.2 People live in a social context

Evidence suggests that Victoria's adult mental health system primarily takes an individualistic approach to treatment, care and support without consistently considering the social contexts within which most people live in the community.[6] This individualised approach means that the valuable role families, carers and support networks can play in a consumer's recovery is often overlooked by services, as is the notion that families, carers and supporters have needs in their own right.

In reality, people live within a relational, or a social, context. They interact with one another, form relationships and interdependencies, and influence one another.[7]

Data suggest that most people in Australia have relationships of support outside their household.[8] These social connections and relationships can be important for mental health, wellbeing and recovery.[9] Witnesses have also told the Commission that people may experience isolation despite having people around them, and that isolation and loneliness can significantly impact a person's wellbeing.[10] The Commission has therefore considered the importance of a mental health and wellbeing system that actively seeks to engage with support networks and harness the benefits they may bring.

Results of the Australian Bureau of Statistics' fourth General Social Survey, conducted in 2014, also suggested that people experiencing a mental health condition had similar levels of family and social connectedness as those not experiencing a mental health condition.[11] The General Social Survey conducted in 2019 indicated that people with a mental health condition continued to have similar levels of face-to-face contact with family and friends outside their household as people who did not have a mental health condition.[12] Results also indicated that fewer people experiencing a mental health condition were able to get support from outside their household during a time of crisis in 2019 (88 per cent) compared with 2014 (93 per cent).[13] However, these results did not examine the availability of support from within a person's household during a time of crisis.

The Commission takes as its starting point that most people live within relationships of care and support, and considers that this should also be the starting point for the design of the future mental health and wellbeing system. Dr Paul Denborough, Clinical Director of Alfred Child and Youth Mental Health Service and headspace, Alfred Health, giving evidence in a personal capacity, told the Commission that, 'in order to be effective, the mental health system must involve the patient's family and social network, and not just approach people as individuals'.[14]

In this context, we can learn from collectivist cultures that recognise the importance of family and community in wellbeing. For example, Aboriginal communities have a broad view of health, which 'does not mean the physical wellbeing of an individual, but refers to the social, emotional, and cultural wellbeing of the whole community'.[15] In New Zealand, the 'Whānau Ora approach focuses on the family, not the individual ... Whānau Ora workers provide a lot of navigational support — they help to coordinate the various services or resources that a family needs to be a healthy family'.[16] In some southern African communities, *ubuntu* is a philosophy that embraces caring for each other's wellbeing and fostering mutual support;[17] it 'means that people are people through other people'.[18]

By necessity, due to the age of the consumers, Victoria's current child and youth mental health services take a less individualistic approach. Dr Denborough told the Commission, '[t]he adult system usually regards the individual as the client, whereas the child and youth system views the family unit as the client.'[19] Dr Denborough also told the Commission that young people aged 18–25 years would benefit from a system that supports family involvement in their care.[20] Professor Patrick McGorry AO, Executive Director of Orygen and Professor of Youth Mental Health at the University of Melbourne, giving evidence in a personal capacity, told the Commission that family is usually a 'vital scaffolding for the successful completion of the transition to mature adulthood and independent living'.[21]

The Commission acknowledges that any change to the individualistic culture in the Victorian mental health system as a whole will take some time, as this culture is deeply ingrained. However, the Commission's ambition is for a future where consumers, families, carers and supporters are more connected, more engaged and more supported. Support will be easier to find and to use. Services will routinely work with consumers in a way that has regard to their social context, and families, carers and supporters will receive information and education to help them with their role.

19.3 The different experiences and perspectives of consumers, families, carers and supporters

As it conducted its work, the Commission considered how the distinct experiences and knowledge of consumers, families, carers and supporters inform their views, particularly in relation to the wider system.

The Commission acknowledges that families, carers and supporters hold expertise in relation to their own lives. This is distinct from the expertise held by consumers. While at times these groups may have shared interests, they speak from their own perspectives and experiences, and at times they may have conflicting views.[22]

The Commission also notes that relationships of care and support are complex and bidirectional. As described in the Victorian Government's *Recognising and Supporting Care Relationships: A Department of Human Services Policy Framework*, there is a need to recognise 'the high degree of reciprocity and mutuality in care relationships'.[23]

The perspectives of consumers, families, carers and supporters must be considered, given the impact that decisions made in the mental health system have on both groups. To create nuanced responses for these diverse perspectives, the Commission has separated the different matters its inquiry must consider: first, how the system can most effectively support people to recover from mental illness,[24] and second, how to best support the needs of families and carers.[25]

Without separating these considerations, there is a risk of masking the differences in the lived experiences of consumers and the lived experiences of families, carers and supporters.

A human rights analysis can help to understand these broader perspectives, including what it means for the future mental health and wellbeing system to work with a focus on the whole person, rather than just a diagnosis or label—a person who exists in a social context.

19.3.1 A human rights approach

All publicly funded Victorian mental health services have a legal obligation under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) to act in ways that are compatible with human rights.[26] All people have the right to protection from unlawful and arbitrary interference with their privacy. This includes the right to protection from unlawful or arbitrary interference with a person's autonomy and their inherent dignity.[27] These rights are about people being able to make decisions in relation to their own lives, including decisions about their bodies, what is meaningful and important to them, and the choice to take risks. Such rights are particularly important for consumers in the mental health system, because mental health services hold a lot of personal information and decisions about treatment, care and support can impact on individual autonomy.

All people also have human rights to family and social connection.[28] In the preamble to the *Convention on the Rights of Persons with Disabilities*, States Parties (of which Australia is one) recognise 'that persons with disabilities and their family members should receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities'.[29]

Within this context, the Commission seeks to:

- acknowledge the social context that consumers live in
- acknowledge the substantial contribution families, carers and supporters make within the mental health system
- confront the barriers that currently exist for those who would like greater inclusion of their families, carers and supporters in their care
- provide support to families, carers and supporters to better meet their own needs.

Nothing proposed here in relation to families, carers and supporters is intended to detract from human rights, which are held by all people.

19.4 Families, carers and supporters are essential to the future mental health and wellbeing system

Families, carers and supporters make a substantial contribution to the wellbeing of the people they care for and support.

Ms Marie Piu, CEO of Tandem (Victoria's peak body representing family and friends supporting people living with mental health issues[30]—refer to Box 19.2) told the Commission, '[u]npaid mental health carers in Australia play an essential role in our society',[31] suggesting that:

> Most people with mental health issues live in the community with family and friends supporting them. Mental health carers report that they provide care for the following reasons: *first,* because they believe they can provide better quality of care than they could otherwise afford, *secondly*, because of the bonds of family or friendship or *thirdly*, because no comparable or otherwise helpful service is available.[32]

The contributions of families, carers and supporters benefit the mental health system as well as individuals and families. The Commission acknowledged this in its interim report, stating that '[t]he work of families and carers is crucial, not only for the people they look after but also for the functioning and sustainability of the mental health system as a whole'.[33]

The Commonwealth Department of Health and Ageing (now the Department of Health), in setting out *A National Framework for Recovery-Oriented Mental Health Services*, acknowledged the role and importance of many factors beyond the mental health system that contribute to a consumer's recovery, including not only families, but broader social connections:[34]

> Most of a person's recovery occurs at home, so their family, friends, neighbours, local community, church, clubs, school and workplace have an important part to play.[35]

As part of a support network, families, carers and supporters may take on multiple roles. For example, Dr Margaret Leggatt AM, Founding Director of Wellways Australia, Founder and patron of SANE Australia and board member of Tandem, outlined four main roles that families and carers assume in caring for someone living with a diagnosis of schizophrenia:

- seeking and sourcing of help for the person being cared for
- being the primary carer for the person
- being a support network for the person
- being the landlord or household supervisor for the person.[36]

The range of these caring roles will vary according to individual and family needs and circumstances, and the independence of the consumer.

Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services* formally recognises the role of families, carers and supporters in providing support in a redesigned mental health and wellbeing system (along with informal supports, virtual communities and communities of place, identity and location).

As well as making contributions on an individual level, families, carers and supporters have collectively made an important contribution to the mental health system over many decades. For example, in the Victorian context, Wellways, a not-for-profit mental health and disability support organisation,[37] was founded in 1978 (as the Schizophrenia Fellowship of Victoria) by 'families and community members to promote the welfare of people with schizophrenia and their families'.[38]

Dr Leggatt says of its establishment, '[w]e wanted to find the best ways for families and friends to help and support someone they loved to recover and lead a meaningful life.'[39] Dr Leggatt describes the foundation of the fellowship as the beginning of:

> a process to have families recognised as an important component of treatment and care—a long haul because of the existing clinical paradigm that believed in and practiced the exclusivity of the doctor–patient relationship.[40]

To give a current overview, in its interim report, the Commission estimated that there were more than 58,000 carers of people living with mental illness in Victoria in 2018–19, and that about 5,600 of these carers were aged under 25.[41] More recently, as outlined in *Victoria's Mental Health Services Annual Report 2019–20*, the then Department of Health and Human Services estimated there are 60,000 Victorians caring for an adult living with mental illness, with about 9,000 of these being young carers.[42] The Commission estimated that this group provided '$3.7 billion worth of unpaid care … annually in Victoria … ($3.1 billion after accounting for [deducting] welfare payments [from this figure])'.[43]

Box 19.2: Tandem

Tandem is Victoria's peak body representing family and friends supporting people living with mental health issues.[44] In its role as a peak body, Tandem:

- advocates for carer involvement in planning and care, participation in system change and support for families and carers
- promotes and supports mental health carer workforce development and leadership
- promotes and collaborates on the delivery of training on family inclusive practices for mental health professionals
- provides information, education and training to mental health families, friends and supporters
- collaborates on research and policy matters related to mental health carers
- administers the Carer Support Fund, which provides financial assistance to families, friends and supporters of people who are receiving services from a Victorian public mental health service or program.[45]

Tandem also runs a support and referral line with advisers and service navigators who provide carers with non-legal advocacy, peer support, assistance with the National Disability Insurance Scheme and connection to carer support groups.[46]

In its submission, Tandem told the Commission:

> Victoria can potentially have a world class mental health system. This system must be safe, inclusive, fair and well-funded. It must challenge the stigma that those with mental health issues and their carers face. It must have the resources to address all people's issues and to ensure that families and friends are seen as a critical part of the team that treat and manage mental health issues.[47]

As the peak body, and in light of the Commission's recommendations to increase family and carer involvement, the Commission envisages a substantial role for Tandem in a future mental health and wellbeing system that is more responsive to and inclusive of families, carers and supporters. Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance* outlines the Commission's expectation that the Department of Health will continue to fund Tandem to fulfil functions such as advocacy and participation in engagement activities run by government agencies.

Tandem also played an important role throughout the Commission's inquiry, including supporting families and carers who took part in the Commission's focus groups and facilitating meetings between its members and Commissioners. Tandem's role in helping to facilitate these engagement activities is outlined in more detail in Chapter 39: *The work of the Commission*.

Funding certainty is critical to ensure consistent and sustained levels of advocacy across Victoria's mental health and wellbeing system.[48] To support Tandem's critical role as the peak body, the Commission considers that service agreements between the Department of Health and Tandem should be extended to at least five years. This is consistent with the Commission's recommendation in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress* for service agreements of at least five years with the Victorian Mental Illness Awareness Council as the consumer peak body. The Commission notes that the Productivity Commission reached similar conclusions in its *Mental Health Inquiry Report*, recommending that systemic advocacy is strengthened through funding cycles of at least five years.[49]

DOH.0003.0001.0533

19.5 Concerns raised by families, carers and supporters about the mental health system

Despite their essential contribution to the mental health system, families and carers have consistently told the Commission that they do not feel adequately supported.

The challenges that families, carers and supporters face were outlined in detail in Chapter 9 of the Commission's interim report. A high-level overview of the concerns raised is provided in Figure 19.1. These concerns are explored in further detail throughout this chapter, as the Commission outlines its recommendations in relation to families, carers and supporters.

DOH.0003.0001.0534

Figure 19.1: Concerns raised by families, carers and supporters

Concerns raised by families, carers and supporters

Lack of access to information about treatment, care and support

'Trying to get any sort of information or feedback was just about impossible'[1]

Lack of options in a crisis

'I'm always fearful [my son] may be injured by the police ... the real dilemma for me now is, I don't think I could call the CAT [crisis assessment and treatment] team'[3]

Lack of housing options

'And what keeps me awake at night is the idea of my son—what's going to happen to him in the future? Where is he going to go? Where is he going to live?'[15]

Feeling excluded by the system

'I wasn't treated respectfully. And so talking about communication, there was no good communication, so I didn't know what was going on'[7]

Limited opportunities for respite

'Carers need to be supported and provided opportunities that allow for a break. I am absolutely exhausted. I am doing 24-hour shifts, 7 days a week'[9]

Difficulties finding information about available supports

'my mum had a lot of trouble finding the right services for her. She spent nights just googling various questions such as: support for a partner to someone who has an addiction. She really struggled to find that information'[2]

Gaps in care options

'As soon as our young people need extra support, that next tier above the counsellor, that's where we struggle with getting them support'[4]

Safety risks in services

'My daughter was 18 and had lots of drugs to sedate her. She was vulnerable. We ended up taking shifts and staying with her in the hospital to keep her safe'[6]

Failing to use family and carer knowledge

'Why couldn't the authorities have taken a team approach and consulted people who actually knew this young woman? They could have talked to Dr D, who had spent hundreds of hours with Anna. They could have consulted John and Katie and me, who had loved and cared for her for 26 years'[8]

Stigma and discrimination

'My mother was ill. She had Schizophrenia. No worse than having diabetes or cancer yet people treated her like a second-class citizen when I was growing up. I never felt okay with telling my friends what was wrong with her. There was so much stigma and no insight or understanding'[10]

Source: 1. RCVMHS. *Box Hill Community Consultation – May 2019;* 2. *Witness Statement of Denna Healy*, 26 May 2020, para. 21; 3. RCVMHS, *Carers Human Centred Design Focus Group – Melbourne, Session 12*: Record of Proceedings, 2019; 4. RCVMHS, *Shepparton Community Consultation* – May 2019; 5. RCVMHS, *Carers of Children Under 12 Focus Group: Record of Proceedings,* 2020; 6. RCVMHS, *Warragul Community Consultation* – May 2019; 7. RCVMHS, *Carer Human Centred Design Focus Group – Information Sharing: Record of Proceedings*, 2020; 8. *Witness Statement of Mary Pershall*, 9 July 2019, para. 47; 9. *Witness Statement of 'Anna Wilson' (pseudonym)*, 3 August 2020, para. 76; 10. RCVMHS, *Preston Community Consultation* – May 2019.

19.6 Families, carers and supporters need support in their own right

Being a carer can be a rewarding role.[50] However, it can also take a toll on a carer's own health and wellbeing, and it can have financial implications due to both expenses incurred and effects on employment.[51]

While many of the issues families and carers raised with the Commission focus on their concerns for the person they care for, carers have needs in their own right.[52] As Ms Erin, Davies, witness, told the Commission:

> there were so many opportunities along the way for our family to be connected with services and supported. I feel that these opportunities were missed and turned into disasters. If we had been supported earlier on, it would have been better for both Matthew and our family.[53]

Professor Bruce Bonyhady AM, Executive Chair of the Melbourne Disability Institute at the University of Melbourne and giving evidence in a personal capacity, told the Commission that families and carers need to be supported, or else 'many of the informal supports that are provided by families and carers are at risk of being worn away or exhausted'.[54] Professor Bonyhady also stated that '[n]urturing and sustaining families and carers is a critical part of designing disability or mental health support systems. It is also essential for system sustainability.'[55]

Caring for someone living with mental illness is distinct from other types of caring roles. Reasons for this include: the need to provide higher degrees of emotional support; managing crises; maintaining vigilance to prevent self-harm or suicide attempts; having strained relationships; dealing with the unpredictable and episodic nature of care giving; and stigma and isolation.[56] According to Mental Health Carers Australia, '[p]roviding these supports, and a range of other day-to-day supports, long-term can have a significant impact on their economic security, health and wellbeing and education.'[57]

Families and carers often described their own experiences of caring and their interactions with the mental health system in terms of trauma. The following observations from two people highlight this:

> our daughter ... was too unwell to go into the private system and too well to go into the public system ... And that was absolutely traumati[s]ing. We just had to watch her get sicker and sicker and sicker. And we're completely powerless to do anything about it. And that was a situation I hope no-one else ever gets into.[58]
>
> When my son goes off his medication and medicates himself with alcohol, life becomes very difficult and stressful ... at times it has been so bad that I have had to sleep in my car. There have been hundreds of nights with no sleep, and not being able to work because I was so exhausted and I had to care for my son.[59]

Personal story:

Aaron and Kristy Robinson

Aaron and Kristy* care for their 22-year-old daughter, Thea*, who has multiple diagnoses including borderline personality disorder, obsessive compulsive disorder and generalised anxiety disorder. Thea has been hospitalised several times due to numerous suicide attempts and a serious eating disorder.

Caring for Thea has a significant impact on Aaron and Kristy's lives, causing them carer fatigue and ongoing financial and relationship stress.

> We have had no carer respite whatsoever throughout the time we have been Thea's carers. The stress we have been under for the past 10 years has been horrific.

Aaron and Kristy note that being a long-term carer for someone 'places a soul destroying burden on families, and affects the ability of these families to keep working'. They would like better financial support for carers of people living with complex and long-term mental illness.

Kristy has stopped work to care for Thea, and Aaron now works part-time nearby so he can be called on when there is a crisis at home. The financial pressures caused by Aaron and Kristy's caring responsibilities adds to what is an already stressful situation.

According to Aaron and Kristy, Thea requires constant supervision to remain safe. At times Aaron and Kristy have felt that Thea has not received sufficient care in a hospital environment, so they now remain with her even when she is in hospital.

Aaron and Kristy said they are not able to go out together, as one of them must be with Thea at all times.

> As carers we are unable to go out as a couple to dinner, the movies or to see friends, because at least one of us always has to be with Thea. Even if two support workers are at home, a parent always has to be there as well.

Aaron and Kristy would like carers to be supported by trained staff providing better treatment for complex, suicidal patients, as well as regular respite for carers.

> This respite could either be from other highly trained compassionate support workers coming into the family home ... or from Thea going somewhere outside of the home where she is looked after, in a caring safe way.

Source: *Joint Witness Statement of 'Aaron Robinson' and 'Kristy Robinson' (pseudonyms)*, 12 June 2020.

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

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Families, carers and supporters also need to feel safe as well as supported. There can be tensions between consumers and their families, carers and supporters, particularly during times of crisis. In a focus group the Commission held with carers about crisis responses, one parent described their experience of trying to help during a crisis, when their child was not able to be at their best, and feeling as though they were seen as an enemy.[60]

Another participant described her experience of caring for her son, who became aggressive and violent towards her, and her concerns for her own physical safety as well as that of her daughter. She told the Commission that police and hospital staff have at times been dismissive of her attempts to seek help for her son, including one occasion where she says police refused to attend her home.[61]

Caring for someone with a mental illness can be a lifelong commitment. Families, carers and supporters may need different supports at different times in their life as their own circumstances evolve, and their caring roles and responsibilities change.

Responding to these changing needs requires a whole-of-life approach. Mind Australia, a community-managed specialist mental health service, endorses the *Carer Life Course Framework*.[62] The framework outlines six phases that carers can go through, and provides information about each phase. The phases are:

- awareness that something is wrong
- confirmation of mental illness
- adjustment
- management
- purposeful coping
- end of active caring role.[63]

The phases are not linear and carers will go through different phases throughout the course of their caring role. Carers will also need different supports, such as education and respite, during different phases.

Families, carers and supporters also have different experiences and face different challenges based on the nature of the caring relationship they are in as well as their own stage of life. The Commission heard from people who had been caring before they were 10 years old, and others who were caring into their 90s. This is explored in Figure 19.2 and the following sections.

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Figure 19.2: Different relationships of care and support

Older people (parents, grandparents, partners)

'I am 65 years old; widowed. I wonder what will become of my son when i am dead. I wonder about supported accommodation later in his life, or if he can live at home, having a case worker who visits frequently'[7]

Adult children

'My dad was asking me to get involved and the mental health service wouldn't involve me'[1]

Siblings

'I was once told that I wasn't a young carer, I was just being a good daughter or a good sister. ... I was really angry because they don't see the things that I go through'[2]

Different relationships of care and support

Partners

'Speaking to the spouse is important, because I had been there for everything, and knew [him] and could describe how he was to them'[6]

Parents

'Your role as a parent is to nurture your child. But sometimes a parent needs some help, to really help those around them'[3]

Other relationships

'Because of confidentiality, carers are not often equipped with the right information to help their friends and family. Sometimes people don't realise their best support is their family and friends – their carers'[5]

Young carers

'I know mum's mental health, and sometimes I know what's going on more than the doctors do, but I am not asked my opinion or involved when she is in hospital'[4]

Source: 1. RCVMHS, *Werribee Community Consultation – May 2019*; 2. RCVMHS, *Young Carers Human Centred Design Focus Group – Melbourne*, 2019; 3. RCVMHS, *Pakenham Community Consultation – April 2019*; 4. *Witness Statement of 'Emily John' (pseudonym)*, 15 July 2020, para. 17; 5. RCVMHS, *Mildura Community Consultation – May 2019*; 6. *Witness Statement of Katerina Kouselas*, 15 July 2019, para. 7; 7. David Dunne, *Submission to the RCVMHS: SUB.0002.0002.0116*, 2019, p. 4.

19.6.1 Young carers

In its interim report, the Commission acknowledged some of the challenges that young carers face. These include adverse impacts on education and employment opportunities, normalisation of the caring role, difficulties being fully engaged in their childhood and education because of their caring role, and feeling excluded from services during a parent's hospital admission or discharge.[64]

Ms Piu told the Commission that long-term caring can have a range of adverse effects on young carers, including 'poor educational attainment, low self-esteem, difficult transitions into adulthood as well as developing their own experiences of mental health issues'.[65] Young carers can also face practical challenges, such as difficulties getting to school and support services if they are not old enough to drive or cannot afford public transport, the financial impacts on their family when a parent has a mental illness, and difficulties managing social activities.[66] Young carers might also feel extremely isolated, and may assume that no one will understand their experience:[67]

> Children and young people in caring roles can be viewed with pity, and easily feel patronised. In reality many of them are extremely capable, resourceful and skilled at navigating the health care systems, at the same time as feeling overwhelmed and burdened at times.[68]

The *Victorian Carer Strategy 2018–2022*, which sets the direction for government to support carers, also outlines some of the challenges faced by young carers, including that a '[l]ack of support during a person's formative years can have lifelong effects on cognitive and social development, learning and education, work opportunities, finances, emotional and mental health and physical health.'[69]

Young carers have shared their experiences with the Commission. In his witness statement, Mr Nathan Turner said he has had to be an adult since he was 16 years old.[70] Mr Turner described having to take on additional responsibilities in his early teenage years:

> My mum began to get sick and so I started to take on more responsibility for things around the house. ... I started to have responsibility for doing the shopping and helping around the house. I just took it all on because I felt like I had to and I didn't want to ask any questions. It was a lot to take on at such a young age.[71]

Mr Jesse Morgan, witness, told the Commission he was unaware of the financial supports that were available to him[72] and described the continuing challenges he experiences into adulthood as a result of being a carer throughout his teenage years:

> My caring role for mum was always my first priority growing up, to the detriment of my own life and development. I dropped out of year 12 as the caring responsibilities and my own mental health issues all got too much to be able to manage the workload. I feel like it has set me back in life.[73]

Miss Denna Healy, witness, told the Commission that she became a young carer at 16, after her father attempted to take his life. She took on household responsibilities and was an emotional support for her family. Miss Healy said, '[t]here was a period of time where I forgot about myself for a while.'[74]

Personal story:

Justin Heazlewood

Justin Heazlewood grew up in Tasmania in the 1980s and 1990s, an only child who never met his father. Justin became aware that 'something wasn't right' at a young age.

> At seven I remember lying in bed while Mum wailed in the bedroom next to mine ... I wanted the crying to stop. This is my first memory of monitoring Mum's illness, something I would spend a lifetime doing. I didn't know it then but I was a child carer.

Justin's mother lives with a diagnosis of schizophrenia. By age nine, Justin could see patterns forming in her behaviour. He recalls that she was well half the time and unwell half the time.

Justin describes his Nan and Pop as his main source of support. He would call them often in his early teenage years, as his mother cried uncontrollably, and ask his Nan to come and get him. She was reluctant to interfere, but told Justin he could call whenever he liked.

When he was 14, Justin secretly made an appointment with his mother's regular GP.

> I told her in detail how bad Mum was. The crying, the swearing, the violent episodes. The GP said something about doctor–patient confidentiality and that was that.

Justin says it is inconceivable to him now that a doctor listened to his story and didn't take any action. He describes this as an appalling result and says it discouraged him from seeking help again for a decade.

> When I look back on my experience I am struck by the complete lack of support I received. At school there was not a single lesson spent on educating us about mental illness or self-care. At no point was the role of the school counsellor adequately explained to us. I was never prompted to tell anyone about any of my problems at home. Meanwhile Nan was delivering the message that I had to remain strong and carry on. There was definitely a stigma around mental illness and our family kept a tight lid on the silence around Mum's story.

Having fretted over his mum for years, Justin has also experienced challenges to his own mental health, both in his teenage years and as an adult. He experienced what he describes as a nervous breakdown at age 33.

After years living interstate and a period in which he distanced himself from his family, Justin returned to Tasmania in July 2019. His mum was accepted into the National Disability Insurance Scheme in December 2019. Justin says he and his mum are now closer than they've ever been.

> I have accepted that I must carry the burden of being an only child who cares for his Mum. At least now I am able to do so with the support I've always needed.
>
> As Justin Heazlewood, son of Maureen Heazlewood, my whole life has been forged by schizophrenia. It has shaped and misshaped the person I am. The secret life of being a child carer has taken a personal toll on me. I now experience mild depression and generalised anxiety disorder as a result of my complex developmental trauma ... I continue to accept my limitations while believing that recovery is possible.

Justin is now an Ambassador for Satellite Foundation, a Melbourne-based not-for-profit that supports young carers with a range of peer support programs, workshops and respite through activities such as overnight camps.

Source: *Witness Statement of Justin Heazlewood*, 22 April 2020.

19.6.2 Older carers

Older carers may be caring for someone who is a spouse, an elderly parent, an adult child, a grandchild, a sibling or another relationship. This may include taking on multiple roles at once, such as caring for an adult child and a partner, as the carer experiences ageing and manages their own physical and mental health and wellbeing.

The Commissioner for Senior Victorians told the Commission '[t]here is a high risk of carer burnout, particularly for those who are older and [have] been a carer or support person for many years.'[75]

Evidence before the Commission suggests that many older carers are concerned about who will care for the person for whom they care and provide support when they can no longer do so,[76] and where the person they care for will live.[77]

Ms Piu told the Commission:

> I have observed that a huge fear of carers who are ageing grandparents, parents and siblings, is to who or what will fill the void when they are gone.[78]
>
> I have spoken to older carers who have explained this fear to me. One carer who is now 74 years of age, who began caring for her brother as a teenager said that she wanted to know that there were proper supports and plans in place for her brother after she is no longer around as a carer. Specifically, she wanted to know that someone would be available to check in on him and make sure he is okay.[79]

DOH.0003.0001.0543

Personal story:

Jean

Jean* is 73 years old, and is the full-time carer for her 43-year-old son, James,* who lives with her. Jean saw a decline in James' mental health after some distressing experiences in his late teens. He has been diagnosed with schizophrenia and a number of other medical conditions. James has a long history of experiences with the mental health system, including spending time in psychiatric wards and on compulsory treatment orders.

Caring is a full-time role for Jean. As James' carer, Jean says one of her key roles as carer is coordinating her son's healthcare.

> Advocating for his medical and specialist services, dealing with the [National Disability Insurance Scheme], managing his diabetes supplies and records, podiatry, pathology, dental care all contribute to a full load.

Jean spent almost two years trying to put in place longer-term living arrangements for her son. Despite successfully applying for a permanent place in supported independent living, her son wanted to remain living with his mother.

> My son, in all seriousness, expects me to care for him until I'm in my nineties.
>
> [M]y son declined the offer and said he would kill himself if I made him live there.

Jean is concerned about who will care for James if she is no longer in a position to support him.

> What are the options for my son should I die or become unwell given there is no one in the family who could take over my carer role? ... Recovery seems out of reach without significant input and support.

Jean highlights the importance of continuity of care and treating physical and mental health together and recommends providing comprehensive support for carers and families and including them as part of care and discharge plans.

Jean said she would like to see carer consultants work directly with carers, without session or time restrictions, as they try to seek help or navigate the complex mental health services.

Source: 'Jean' (pseudonym), *Correspondence to the RCVMHS*, 2019.
Note: *Names have been changed to protect privacy.

19.6.3 Aboriginal carers

The importance of family and community in Aboriginal communities in Australia is well established. In its interim report the Commission acknowledged 'the centrality of Aboriginal family and kinship connections to a person's mental health'.[80] The *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027* also explains this:

> The concept of Aboriginal health and wellbeing is different to the universal concept as it is regarded and recognised as a more holistic and whole-of-life view. It encompasses the social, emotional and cultural wellbeing of not only the individual, but the wider community thereby bringing about the total wellbeing of community.[81]

In a focus group the Commission held with Aboriginal carers, one participant said that as a carer and an Elder, he needed to show strength within the whole family unit, but there was no help for him. Participants also described a responsibility in Aboriginal communities to all families, not just immediate family members. This can mean helping families five or six nights a week.[82]

Another focus group participant talked about the importance of keeping family updated in Aboriginal communities and wanting services to do this, 'within our community, it's about sharing the lot. And it's about knowing what's best for our people'.[83]

Hands-on-Health Australia told that Commission that '[w]hile care giving can be beneficial for family members and care givers; there is also the potential for burn out, depression and other mental and physical issues',[84] and that this is prevalent within the Aboriginal community, where 'culture, language, emotions, family community, spirituality, ancestors need to be [part] of the carer profile'.[85]

19.6.4 Culturally diverse carers

Families, carers and supporters from culturally diverse communities can experience additional challenges when trying to navigate the mental health system and access support.

In her evidence to the Commission, Ms Kali Paxinos, who is in her 90s, told the Commission she was born in Australia to parents who had migrated from Greece. Ms Paxinos, who has cared for her now adult son, spoke of her experience supporting migrant communities and the difficulties people from culturally diverse backgrounds can face when 'coming to this country without the language, without people, without knowing anybody, without partnerships'.[86]

Ms Paxinos spoke about the difficulty of language barriers, and the need for professionals to use language and terms that can be understood by people for whom English is not their first language:

> So, I said, as professionals you've got to be very careful to understand that it's not a disgrace to use a simpler word when you're explaining something to people who don't speak English very well.[87]

The African Australian Communities Leadership Forum told the Commission that '[d]ue to fear of stigma and lack of knowledge of symptoms of mental illness, families keep people at home until crisis point'.[88]

The Multicultural Centre for Women's Health told the Commission that immigrant carers can have smaller family and support networks compared with people born in Australia, and this can place strain on families.[89]

The Ethnic Communities' Council of Victoria told the Commission:

> Responses to mental illness vary across communities, but in general in [culturally and linguistically diverse] communities family members and carers play a particularly important role in care provision. There are various reasons for this, including the underutilisation of mental health services by people from [culturally and linguistically diverse] backgrounds, their relative isolation from mainstream society, and the collectivist nature of many cultural groups, in which intra-group care is the norm.[90]

In his statement to the Commission, Mr Paris Aristotle AO, CEO of the Victorian Foundation for Survivors of Torture (Foundation House), outlined a need for processes that include the whole family of people who are newly settling in Victoria, and people with limited English and low incomes.[91] Mr Aristotle said, '[s]imply addressing the mental health problems of the person initially referred without understanding how they intersect within the home context, including what support others at home might need, makes it difficult to achieve positive long-term outcomes.'[92]

19.6.5 The impacts of COVID-19 on families and carers

The COVID-19 pandemic has been particularly challenging for many families and carers.

Caring Fairly, a national campaigning coalition led by unpaid carers and coordinated by Mind Australia, conducted a survey on the experiences of carers during the COVID-19 pandemic. The survey was open to carers from 21 April to 5 May 2020, and there were 471 responses.[93]

While the survey findings offer some insight into the impacts of the pandemic, Victoria continued to be under various restrictions for many months after the survey closed, and the effects of these extended restrictions are likely to be greater than those reported in April and May.

Results of the survey include:

- 60 per cent of respondents reported that the person they care for had reduced access to support services and 47 per cent reported having reduced access to support services for themselves[94]
- the proportion of carers who reported spending more than 45 hours per week on caring increased from 27 per cent before the pandemic, to 50 per cent[95]
- 81 per cent of respondents reported a deterioration in their mental health, and 88 per cent reported increased stress in their role as a carer[96]
- 71 per cent of respondents reported spending more on living costs, and 58 per cent reported spending more to support the person they care for[97]
- 38 per cent of respondents reported an increase in concern about their personal safety.[98]

19.7 Rebalancing the system's relationship with families, carers and supporters

In developing recommendations that respond to the needs of families, carers and supporters, the Commission aims to rebalance the relationship between the mental health system and families, carers and supporters. The future mental health and wellbeing system must be accountable to families, carers and supporters, as well as being accountable for including their needs and views as core considerations at both a system and service delivery level.

The Productivity Commission's *Mental Health Inquiry Report* also determined that this was an area requiring greater focus, stating, '[a]ll mental health services should be required to consider family and carer needs, and their role in contributing to the recovery of individuals with mental illness.'[99]

There is no single, simple strategy that will achieve this shift in the position of families, carers and supporters. A systemic approach is needed, including: establishing accountability for families, carers and supporters; embedding the expectation that mental health and wellbeing services will work with consumers' families, carers and supporters, including through government commissioning decisions; and providing dedicated supports for families, carers and supporters in their own right.

19.7.1 Establishing accountability for the involvement of families, carers and supporters

In the past decade, there has been increasing recognition of, and government policy mandate for, family and carer involvement in supporting mental health consumers. In several instances, this policy mandate has been enshrined in legislation, such as section 11(1) of the *Mental Health Act 2014* (Vic), which includes principles about involving carers (including children) of people receiving mental health services in decisions about assessment, treatment and recovery whenever possible, as well as recognising, respecting and supporting the role of carers.[100]

The policy position has been set out in relation to carers generally, as well as more specifically in the mental health context. Examples include:

- the *Carers Recognition Act 2012* (Vic), which includes a set of principles about the significance of care relationships, and specifies obligations for public care agencies and funded care agencies[101]
- the *Victorian Charter Supporting People in Care Relationships*, which reflects and supports the Carers Recognition Act. The charter encourages organisations and services to better respect the important role carers have in the community[102]
- the Mental Health Act, which provides for the disclosure of health information in general terms to a friend, family member or carer of the person to whom the information relates in certain circumstances[103] (discussed further at section 19.9.3)

- the *Victorian Carer Strategy 2018–2022*, which is the first Victorian whole-of-government strategy to support carers in their own right. The strategy sets the direction for government to support carers. Priority 5 in the strategy is that carers are recognised, acknowledged and respected[104]
- the *National Standards for Mental Health Services*, which aim to aid development and implementation of appropriate practices across a broad range of mental health services and includes standards in relation to working with carers[105]
- *Working together with families and carers: Chief Psychiatrist's guideline*, which provides advice to Victoria's publicly funded clinical mental health services in relation to involving families and carers in treatment, care and support.[106]

Despite these developments, the evidence examined above demonstrates a failure on the part of the mental health system to work effectively with families, carers and supporters. This failure is evident in the structural barriers and power imbalances that exist for families, carers and supporters.

The Commission's starting point is to establish clear accountability for involving families, carers and supporters across the system. Measures recommended or suggested elsewhere in this report to achieve this include:

- recognising the value of families, carers and supporters in the objectives or principles of the proposed Mental Health and Wellbeing Act, described in Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*
- establishing a new Mental Health and Wellbeing Commission, which will be responsible for promoting the role, value and inclusion of families, carers and supporters across the mental health system, described in Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*
- developing a new *Mental Health and Wellbeing Outcomes Framework* in consultation with families, carers and supporters to ensure the outcomes and measures reflect what is important to families and carers, described in Chapter 3: *A system focused on outcomes*
- establishing a new performance monitoring and accountability framework to improve the outcomes and experiences of families, carers and supporters, as well as a new approach to measure the effectiveness of mental health and wellbeing services from the perspective of families, carers and supporters, described in Chapter 28: *Commissioning for responsive services*
- including family, carer and community inclusive values and approaches in the future *Victorian Mental Health and Wellbeing Workforce Capability Framework*, described in Chapter 33: *A sustainable workforce for the future*.

Families and carers must also have opportunities to participate at senior levels within the system and its governance structures. This is the topic of the next section.

19.8 Family and carer leadership in the future mental health and wellbeing system

Families, carers and supporters have experienced some of the power imbalances in the mental health system. While families, carers and supporters are not subject to the mental health system in the same way as people with lived experience of mental illness or psychological distress many have their own experiences of being disregarded or made to feel invisible, while decisions are made that affect them.

In its interim report, the Commission committed to a redesigned system that puts people with lived experience of mental illness or psychological distress, their families, carers and supporters at the forefront, and listens to and values them as active contributors and leaders.[107] This is central to an inclusive, compassionate and humane mental health and wellbeing system. The Commission's vision is for a reformed mental health and wellbeing system where families, carers and supporters are valued partners who help drive reform and contribute to better outcomes.

To date, consultation with families, carers and supporters has largely taken place outside the current system's formal decision-making structures. For example, many different advisory groups with family and carer participation have been established over time to provide advice to the then Department of Health and Human Services and to individual services. These groups include the current Lived Experience Advisory Group, co-chaired by the department and the CEOs of the Victorian Mental Illness Awareness Council and Tandem, which is tasked with providing advice to the department and is also a key partner in implementing the Commission's recommendations.[108]

While this type of consultation dynamic can be effective and influential on particular projects, it means that families, carers and supporters have little say in budget allocation and service priority, performance and accountability decisions.

To rectify this, the Commission makes a number of recommendations to elevate the experiences, expertise and perspectives of families, carers and supporters, as it has with consumers, so that together, they are at the centre of the mental health and wellbeing system's governance and leadership structures.

In Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*, the Commission recommends the establishment of a new statutory authority—a Mental Health and Wellbeing Commission—to provide strong system oversight. Membership on the executive leadership of this new Commission will include one Commissioner with lived experience as a family member or carer.

The new Commission will be responsible for monitoring the performance of the mental health and wellbeing system and the Victorian Government's implementation of the Royal Commission's recommendations.

The Commissioner with family or carer lived experience will contribute to the functions of the Commission as a whole, particularly as they relate to the needs, experiences and outcomes of families, carers and supporters. The Commissioner with lived experience as a family member or carer could also be delegated responsibility for promoting the role, value and inclusion of families, carers and supporters in the mental health and wellbeing system.

Likewise, the Mental Health and Wellbeing Division within the Department of Health must employ people with family/carer lived experience in multiple and substantive leadership positions and throughout its internal structures. These positions will ensure leaders with family or carer lived experience have an enduring and influential role in government decision making that affects family and carer experience and outcomes, with particular regard to implementing the Commission's recommendations, for at least the initial four years, and related policy decisions.

Further, as established in Chapter 5: *A responsive and integrated system*, people with family or carer lived experience will also be represented across the recommended Regional Mental Health and Wellbeing Boards, where they will play a prominent role in decision making with respect to service and capital planning, commissioning mental health and other related services, workforce planning, and research and evaluation initiatives. These arrangements will ensure the views, experiences and perspectives of people with family and carer lived experience are at the heart of planning and resourcing decisions, driving progress towards a system that recognises and responds to the differing needs of families, carers and supporters.

Like all people in leadership and governance roles, families, carers and supporters must have opportunities to build and further strengthen their existing capabilities and skills so they can succeed in these roles.

At the individual service level, the Commission's recommendations in Chapter 28: *Commissioning for responsive services* include introducing new service standards that can be used to assess which providers to fund. The new service standards will improve service delivery, including through establishing accountability for family, carer and supporter involvement in treatment, care and support and in service planning, design, delivery and evaluation.

The National Mental Health Commission's *Sit Beside Me, Not Above Me* report highlights the importance of supporting people with lived experience to contribute effectively across all levels of the system. To complement this view, the National Mental Health Commission encourages a skills-based approach, noting that lived experience alone does not equate to expertise in policy and governance matters, and that capacity must be built in a broader range of areas to support greater participation.[109]

To put these principles into practice, the Commission recommends that the Victorian Government supports the Mental Health and Wellbeing Commission to develop and support leadership and governance capabilities of families and carers of people living with mental illness or psychological distress. This will be done through learning and development opportunities so they can participate in decision-making processes about policies and programs, in particular where these directly affect them.

These measures will ensure families, carers and supporters have an enduring role in decision making in the mental health and wellbeing system, and that there is an evolving group of family/carer leaders.

19.9 Working with families, carers and supporters is core business

Realising the Commission's vision for greater involvement of families, carers and supporters in the mental health and wellbeing system requires a comprehensive response. There are longstanding barriers, outlined in section 19.9.1, that must be overcome. This will only be possible through a consistent and coordinated response across the state that clearly establishes that government expects that mental health and wellbeing services will work with families, carers and supporters.

The Commission's recommended approach includes three key strategies to achieve this:

- ensuring that working with families, carers and supporters is an essential part of the commissioning of mental health and wellbeing services
- improving information sharing with families, carers and supporters, including developing standards for services and practitioners
- introducing system-wide training for the mental health and wellbeing workforce to facilitate working with families, carers and supporters.

This approach will be further strengthened by delivering a range of therapeutic interventions that involve families, carers and supporters, which is the topic of section 19.10.

19.9.1 Barriers and opportunities when working with families, carers and supporters

Despite the existing policy intent outlined in section 19.7.1, there are barriers at both the system and service levels to practices and models of care that support working with a consumer's family, carers or other supporters. These barriers include:

- **time and capacity**—limited resources mean the workforce is under pressure in challenging circumstances and an approach that includes a consumer's family, carers or supporters will not be given priority[110]
- **workforce training and capability**—some practitioners feel that working with a consumer's family, carers or other supporters is a speciality role they are not trained to do[111]
- **implementation**—implementing and sustaining change requires long-term commitment, including to workforce development and training; this can be difficult when there are many competing needs that practitioners face[112]
- **concerns about privacy**—concerns about risk and privacy leave many clinicians feeling uncomfortable working with family members and support networks,[113] and some may view client confidentiality as a barrier that prevents engaging with families, carers and supporters[114]
- **professional culture**—the current service culture is individualistic and has developed over a number of years, partly due to pressure on services[115] and partly because many professionals are trained to work one on one in their relationship with patients or clients[116]
- **accountability**—current standards for service providers about family-inclusive practice are voluntary, meaning organisations may not implement them.[117]

To respond to the barriers and embed a commitment to work with families, carers and supporters, the Commission draws on a range of levers across the system, including commissioning and funding, service standards, training, workforce culture and development, and the facilitation of information sharing. Improved accountability at the service and system levels will also be critical, as discussed in section 19.7.1.

This combination of approaches forms a system-wide strategy that was not previously available as a package of reforms to support the inclusion of families, carers and supporters. Family, carer and supporter-inclusive approaches will no longer rely on the priorities of individual services and practitioners.

19.9.2 Working with families, carers and supporters is an expectation of services

The Commission is satisfied of the need to provide 'a very clear message that family involvement is not an add-on, but is core business',[118] noting that this includes families of choice and broader support networks.

The Commission has recommended that the Victorian Government ensures that in commissioning mental health and wellbeing services, expectations are set for working with families, carers and supporters. Reporting on delivering these expectations will become part of the accountability measures in service agreements between service providers and the Department of Health.

This approach does not mean that all families, carers and supporters will have an automatic right to be involved in a consumer's treatment, care and support. But the system should presume that most people live with some form of relationship of care and support—relational approaches must be a central part of the approach to treatment, care and support and, when involved, families, carers and supporters must be supported in their caring role.

Dr Denborough told the Commission:

> The traditional approach in psychiatry is to focus ... on finding out what is 'wrong' with a person. However, to improve effectiveness the focus needs to be listening more carefully to the perspectives and issues being experienced by the individual and their family. This allows assistance and help to be provided more efficiently and allows the person and their family to have greater involvement in treatment options which will lead to more positive outcomes.[119]

A consumer's relationships with family, carers or supporters may break down or be fraught for a range of reasons. Sometimes these breakdowns are irreparable, but they may also fluctuate and improve over time.[120] Clinicians and services need to keep this in mind, taking a holistic view of the consumer and their family, carers and supporters. As one participant at a community consultation session said:

> Staff taking the time to understand family and friends and carers is critical—they are more than a person with behavioural issues ... staff can construct a 3D picture of that person.[121]

The Commission acknowledges that in some instances, such as where abuse has occurred or is occurring, involving the people in a consumer's social context, including their family of origin, in treatment, care or support is not appropriate and can be counterproductive.

Ms Indigo Daya, Consumer Academic from the Centre for Psychiatric Nursing at the University of Melbourne, gave evidence in a personal capacity, emphasising that families are not always supportive and can be a source of trauma for consumers.[122] But she also acknowledged that 'family can be the most helpful and supportive part of [a consumer's] recovery'.[123] Ms Daya also said that '[f]amilies/carers can be great advocates for our rights, will and preferences, and assist in supported decision making. Families/carers can also offer many very practical supportive resources.'[124]

In the event of a relationship breakdown, a consumer may still have other people in their support network who they want involved in their care, such as a different family member or a friend who could play a valuable support role. Dr Brendan O'Hanlon, Mental Health Program Manager of the Bouverie Centre at La Trobe University, told the Commission that friends can be excluded from involvement in care when, in some circumstances, they may be the most important relationship for a consumer.[125]

Dr O'Hanlon also told the Commission that in cases of relationship breakdown, services may not explore other potential relationships that could be involved in a consumer's care.[126] The question of relationships of care and support that consumers find helpful is one that should be revisited at different points during treatment because relationships evolve and vary over time.

When a consumer's views on involving their family, carers or other supporters do not align with those of the people in their support network, it can be challenging for both practitioners and families.[127] Dr O'Hanlon told the Commission that the way in which services and practitioners operate can have a considerable bearing on a consumer's openness to the involvement of their social context:

> **If practitioners are talking about the possibility of family involvement with consumers from the outset, and seeing it as a natural and normal part of the work that they do, it is likely that more families will be included. Some of the understandable and legitimate issues a consumer might have about having their family being involved can also be worked through with a clinician who is open to family involvement.[128]**

Part of the Commission's vision is a mental health and wellbeing system better equipped to deal with these complexities and where early connections with families, carers and supporters may help to limit the extent and frequency of relationship breakdowns.

19.9.3 Information sharing

Effective information sharing is important for working with families, carers and supporters.

Information exchange was one of the key concerns raised by families and carers throughout the Commission's work. Ensuring that families, carers and supporters have the information they need to carry out their caring role is a central aspect of a system that values and supports families, carers and supporters.

Families and carers have consistently told the Commission that they struggled with a lack of access to information about the treatment, care and support of the person they care for. The Commission considers that this matter must be dealt with while also acknowledging adult consumers' right to privacy and choice about who, if anyone, their information is shared with (unless disclosure is otherwise permitted by law).

The broader role of information management in the redesigned mental health and wellbeing system is explored in more detail in Chapter 35: *New approaches to information management*, including new approaches to support consumers to access their own information, effective and safe information sharing between services, and consent approaches in the future system.

Tandem told the Commission, '[f]amilies and friends almost universally report being denied basic information, which would aid them to care, build stronger relationships, or just understand what's going on.'[129] In her witness statement, Ms Piu said, '[c]arers continue to meet resistance when trying to access information vital to the carer relationship, and involvement in care planning and discharge. This must change.'[130] One carer told the Commission:

> The discharge summary should come to you as the consumer and the carer where that's appropriate. And where the person doesn't have capacity or lacks cognition, the carers role [is] very much about keeping that person alive and without adequate information. That makes it very difficult.[131]

In her witness statement, Ms Christine Thomas told the Commission about the difficulties she faced while caring for her husband, who was suicidal. Ms Thomas said 'I was constantly asking to speak with doctors but nobody was ever available, they tried to shut me out of meetings and in general I was given the run around.'[132]

The importance of two-way information sharing has also been raised with the Commission. Practitioners and services should seek and value information that families, carers and supporters can provide. One carer told the Commission:

> How can the counsellor help a person without knowing the wider context of what is going on, and only know the information presented by the patient? Why is it that a child requires a responsible adult but once a person turns 18yo their family is locked out of the treatment process due to privacy regardless of the vulnerability of that person's clinical presentation? Including the family in the treatment can be important to a positive outcome.[133]

Evidence indicates that this is not a problem limited to a particular age group of consumer. While the child and youth mental health system typically takes a more inclusive approach to family involvement, as examined earlier, Orygen reported that:

> A young person's privacy and confidentiality is often cited as a barrier to family inclusion and a key factor in family dissatisfaction with services. Legislation can also determine the amount or type of information a clinician can share with a family. Families report feeling particularly distressed when confidentiality is cited as the reason for not sharing information.[134]

The complexity of information-sharing arrangements makes it challenging for professionals in many instances. Research suggests that mental health professionals often 'do not have sufficient guidance as to how to balance the protection of confidentiality and the disclosure of information'.[135] There is also acknowledgement in the literature of the difficulty practitioners may have navigating this matter, including that 'the complexity of Australian laws relating to confidentiality makes it difficult for lawyers to identify and understand them, let alone health practitioners'.[136]

This is not a challenge limited to Victoria, nor indeed the mental health sector. The 2005 *Paving the Way: Review of mental health legislation in South Australia* report states, '[c]onfidentiality should not be interpreted as a barrier to proper sharing of information in the best interests of consumers'.[137] The review recommended both legislative change and professional development of mental health staff to overcome this barrier.[138]

The Royal Commission into Family Violence also examined the complexities of information sharing, finding that both legislative change and an information-sharing culture were required to respond to barriers in the system.[139]

The evidence before this Royal Commission suggests that the ambition of the Mental Health Act to provide clarity in this area has not been realised. This matter is also examined in Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*, including the underlying intentions of the current Mental Health Act and the distress that families, carers and supporters can experience in the absence of effective communication. For example, the provisions in the Act about disclosing health information allow service providers to reveal health information about a consumer if it is disclosed in general terms to a friend, family member or carer of the consumer and the disclosure is not contrary to the consumer's views and preferences.[140] That is, providers can share information of a general nature with families, carers and supporters that will help them to carry out their caring role—for example, what medication someone has been prescribed—provided that the information is not shared against the consumer's wishes. However, families, carers and supporters have consistently told the Commission that they do not receive this type of general information.

These provisions also allow the disclosure of a patient's health information to a carer if the information is reasonably required to provide care to a patient, and only if the patient's views and preferences are taken into account.[141] Such disclosure does not require consent. There is a distinction that these provisions apply only to a 'patient', a term defined in the Act to only include people subject to compulsory treatment (including orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic)),[142] so this provision does not apply to all consumers.

The Act also introduced nominated person provisions, which allow a patient to nominate someone from their support network to provide support, receive information, be consulted with, and represent their interests.[143] *Victoria's Mental Health Services Annual Report 2019–20* notes that only 2.55 per cent of adult consumers had a nominated person recorded (compared with 2.60 per cent in 2018–19 and 2.44 per cent in 2017–18).[144]

Evidence before the Commission about the difficulties families, carers and supporters have with accessing information suggests that these provisions have not been effective and may be poorly understood by the workforce, consumers, families, carers and supporters.

In Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*, the Commission outlines its recommendations for rebalancing mental health laws, including enacting a new Mental Health and Wellbeing Act. The objectives or principles of the new Act should include the recognition and promotion of the value of the role of families, carers and supporters. The Commission has further identified that simplifying provisions about information sharing with families, carers and supporters is an essential change required to the legislation.

The Commission considers that the biggest improvement in information-sharing practices with families, carers and supporters will be achieved through both legislative change and the practice and culture changes outlined throughout sections 19.9 and 19.10. To support new cultures of information sharing, the Victorian Government should articulate expectations in law about how information should be shared with families, carers and supporters.

Following legislative change, the Victorian Government should develop clear and consolidated standards to guide the sharing of appropriate information with families, carers and supporters.

The standards should reflect the new Mental Health and Wellbeing Act as recommended in Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*, once it is enacted (by the end of 2021 and no later than mid-2022). They should also be informed by the new consent approach to information sharing recommended in Chapter 35: *New approaches to information management*.

The Commission acknowledges there are existing guidelines for professionals in this area. An example is *Working together with families and carers: Chief Psychiatrist's guideline*, which includes a section about open communication with consumers, families and carers about privacy, confidentiality and information sharing.[145]

Despite the existence of such guidelines, the evidence before the Commission suggests that little appears to have been achieved in practice. Ms Piu told the Commission that despite recent acknowledgement of mental health carers, families and friends, including in the Chief Psychiatrist's guideline, 'these are only guidelines and [have] only limited scope to change practices in relation to identifying, including and supporting the consumer and their family and friends or support network services on the ground'.[146]

In making this recommendation for new standards, the Commission acknowledges that a range of measures are required to achieve a change in practice cultures. But as part of an overarching suite of reforms aimed at acknowledging the vital role of families, carers and supporters in care and recovery, major cultural change can be achieved.

Once developed, these standards will form part of the professional development training in working with families, carers and supporters that is detailed in section 19.9.4. This training will be critical to ensure understanding of the standards, as well as consistent and effective application.

The Commission supports the proposition that successful implementation and sustainability of work that involves a person's family, carers and supporters must include staff being trained 'in best practice in privacy, confidentiality and information-sharing'.[147] This includes asking families, carers and supporters for information about the person they care for or support, as appropriate, as well as sharing information that enables people to be effective in their caring role.

The Commission believes that conversations with consumers about who they may want to receive information about their treatment should start early in the therapeutic relationship and be ongoing. As noted by Dr Leggatt, when a person becomes acutely unwell, a failure to ask their family for information may lead to inadequate treatment, deterioration or escalated measures such as police involvement or involuntary hospitalisation.[148]

19.9.4 Training for the mental health and wellbeing workforce to facilitate work with consumers' families, carers and supporters

Mr Angus Clelland, CEO of Mental Health Victoria, told the Commission that many service providers do not feel adequately trained to work in a way that involves a consumer's social context.[149]

Dr O'Hanlon told the Commission, '[i]f clinicians in their undergraduate training have not had exposure to working with families (which is very often the case as the focus is on one-on-one interventions) the idea of having more than one person in the room is often quite daunting.'[150]

Dr O'Hanlon also considered that while the emphasis on family involvement in training varies from profession to profession, it transcends disciplines.[151]

The Commission recommends that the Victorian Government includes training in working with consumers' families, carers and supporters as part of continuing professional development requirements across the mental health workforce. This training will include coverage of the information-sharing standards outlined in section 19.9.3. The Victorian Government should also strongly advocate for including training in working with consumers' families, carers and supporters in both undergraduate and postgraduate tertiary-level mental health workforce qualifications.

In addition to this dedicated training, being family-, carer- and community-inclusive will be built in as a core value and approach of the mental health workforce, and working with families, carers and supporters will be a priority capability for the future system, as outlined in Chapter 33: *A sustainable workforce for the future*. These priorities will guide the broader system approach to workforce development.

Dr O'Hanlon told the Commission that 'there is a tendency to 'bolt on' new specialist programs in response to apparent need rather than to integrate them within existing services … There has been a lack of action in ensuring translation of admirable policies into actual practice.'[152] The Commission's recommendation for workforce training should be viewed as a supporting element of its broader recommendation that work with families, carers and supporters will be a built-in expectation of Victorian Government–funded mental health and wellbeing services.

Given the considerable practice and culture change required in the adult and older adult mental health and wellbeing system, practitioners from services within this system should also be given the opportunity to draw on secondary consultation and advice from the Bouverie Centre as a specialist family service.

The Bouverie Centre is a service that 'combines clinical family therapy, academic teaching … research, workforce development and community education in one integrated service'.[153] Its mission is 'to improve the lives of individuals and families through relationship focused services'.[154] It currently offers services including discrete one-off 'case-based' discussions, facilitation of reflective practice sessions, professional advice about building 'working with families' capacity within a team, program or organisation, and other professional support.

The capacity of the Bouverie Centre will be expanded to undertake this role in the future system.

19.10 Expanding models of care that involve families, carers and supporters

New accountabilities and expectations for mental health and wellbeing services to work with families, carers and supporters must be supported by a new approach to ensure more widespread availability of inclusive therapy models. This will be achieved through increased capacity and capability for service providers alongside a strengthened family and carer peer workforce.

As outlined in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*, Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will provide comprehensive, integrated treatment, care and support that is proportionate to the person's needs, including through family therapies and other approaches that consider a person's relational context. This will ensure these supports are available more equitably across rural, regional and metropolitan Victoria.

Family inclusion in the infant, child and youth mental health and wellbeing system is discussed in more detail in Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing* and in Chapter 13: *Supporting the mental health and wellbeing of young people*.

Across the mental health and wellbeing system there will be strong models of care across all age group services that will involve families, carers and supporters.

19.10.1 Ensuring the availability of inclusive therapy models

In addition to building in work with a consumer's social context as part of standard practice, there are a range of existing therapy models that specifically include families, carers and supporters. These models have varying intensities and require different levels of training in order to practise. Some of these models are currently used in the Victorian system, albeit with inconsistent availability.

The Commission's intent is that the capacity and capability of services across the state will be boosted to deliver these models more consistently, with additional support and/or secondary consultation (a consultation between clinicians without the consumer or family member(s), carer(s) or supporters present) available as required to provide more specialised support.

Several models are briefly explored below. This is not an exhaustive list, and the Commission notes that there are a range of well-researched models of family-inclusive practice. It is not the Commission's intent to be prescriptive about the particular models that service providers adopt; rather, the expectation is that they will be used and must provide capacity for meaningful inclusion of families, carers and supporters.

Single-session family consultation involves a consumer's social context and is a model that could have more widespread use across both the adult and older adult, and infant, child and youth mental health and wellbeing systems. Single-session family consultation was developed by the Bouverie Centre and combines family consultation with single-session therapy to maximise outcomes.[155]

In *From Individual to Families: a Client-Centred Framework for Involving Families*, the Bouverie Centre describes single-session family consultation as 'a time limited and structured process for meeting with a client and the family and is focused on achieving realistic and negotiated goals'.[156] The Bouverie Centre defines family as including 'family, significant others and social networks'.[157] According to the Bouverie Centre, single-session family consultation can create greater understanding of problems and their impacts on individuals and families, help families understand how they can best support the consumer, and provide clarity about how the consumer's network may be involved in their treatment.[158] Training in single-session family consultation can be completed in two days, making it cost-effective if training large groups of staff.[159] Alfred Health told the Commission that it provides single-session therapy based on the Bouverie Centre's model, and that young people and their families both value these sessions.[160]

Open Dialogue is another approach. Originating in Finland, the model helps people and their families feel 'heard, respected and validated'.[161] Its principles include providing immediate help (within 24 hours of first contact), social network inclusion, a flexible approach including often meeting in the consumer's home, the care team being responsible for treatment, care and support for as long as is necessary, and building an environment where all parties feel safe.[162]

Research indicates that as an alternative to treatment within a hospital, Open Dialogue can be associated with reduced likelihood of involuntary treatment, and small-scale studies suggest it may produce better outcomes than conventional treatment.[163]

Open Dialogue's 'largely non-institutional and non-medicalizing approach'[164] aligns with a human rights-based approach to treatment, care and support:[165]

> Its fundamental network perspective facilitates a contextual and relational understanding of mental well-being, as it is postulated by contemporary human rights approaches.[166]

Alfred Health currently uses the Open Dialogue methodology in its Youth Early Psychosis Program.[167] In its submission to the Commission, Alfred Health said that Open Dialogue:

> provides a set of values and techniques that seek multiple perspectives and client strengths ... Staff across the program received extensive training in the dialogic approach. After the technique was implemented, further training and supervision were provided ... The technique has now evolved, in response to differences experienced ... The approach to care continues to emphasise a collaborative adaptive network approach, which is shaped by family engagement and support.[168]

'Multiple family groups' is an example of a more intensive family-inclusive engagement model. It is a family psychoeducational intervention that brings multiple families together, including consumers, to support each other. These groups generally meet fortnightly for six to 12 months.[169] Multiple family groups provides an effective and efficient intervention because it only requires a small number of staff to support a broad group of families.[170] There are two such programs currently operating in Victoria—at the Inner West Area Mental Health Service and at Jigsaw Youth Mental Health Drugs and Alcohol Services at Barwon Health.[171]

Multiple family groups provides information to families while also creating a social network and a form of mutual support for families where they may otherwise feel isolated.[172] Research suggests that multiple family groups has specific benefits for consumers, including reduced relapse and readmission, and improved participation in rehabilitation and employment.[173] There is also evidence indicating that multiple family groups improves family functioning.[174]

19.10.2 The role of family and carer peer workers

The family and carer peer workforce helps services work effectively with families, carers and supporters.

As the Commission recognised in its interim report:

> **Lived experience work will be a central pillar of the future mental health system: new lived experience roles will be established and supported, spanning service design and delivery, service and system leadership, research and evaluation, and system accountability and oversight.**[175]

The current system includes only a limited number of family and carer peer workers. In 2017 there were 341 occupied lived experience positions in Victoria's public mental health services (amounting to 187 fulltime-equivalent positions).[176] Of the total number of positions, 102 worked from a family–carer perspective.[177] Chapter 33: *A sustainable workforce for the future* examines the lived experience workforce in more detail.

In its interim report, the Commission recommended that the Victorian Government expands the consumer and family and carer lived experience workforces and enhance workplace supports for their practice. To achieve this it recommended, among other things, learning and development pathways, education and training opportunities and a statewide approach to organisational readiness training[178] to ensure all agencies receiving government funding for mental health services are equipped to support lived experience workforces.[179] Promoting and understanding the value of lived experience expertise and perspectives at all levels of an organisation is integral to the 'introduction, ongoing support and sustainability of lived experience work'.[180]

The Commission sees existing family and carer peer workers as critical to the future mental health and wellbeing system. Many of the current family and carer peer roles help services to work with and support families, carers and supporters. These roles must continue and be expanded to deliver on the Commission's vision. The Commission makes specific recommendations for an increase in family peer workers elsewhere in this report. For example, in Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing*, the Commission recommends that the service stream of Infant, Child and Family Area Mental Health and Wellbeing Services significantly increase the number of family peer workers they employ. Chapter 13: *Supporting the mental health and wellbeing of young people* similarly recommends that family peer workers are employed across the service stream of Youth Area Mental Health and Wellbeing Services.

19.11 Establishing a statewide program of supports for families, carers and supporters

Families, carers and supporters make an enormous contribution to the system as well as the people they care for, often at the expense of their own wellbeing. They are a critical part of sustaining the system. Therefore, in designing the future mental health and wellbeing system, the Commission has considered two fundamental aspects of supporting the needs of families, carers and supporters—better support to help them carry out their role, and support in their own right as individuals with their own needs who are taking on a challenging role.

In recognition of this, the Commission recommends establishing a statewide program of supports for families, carers and supporters that consists of four central elements:

- eight family- and carer-led centres, one in each region across the state
- access to increased financial support to help with immediate practical needs (brokerage)
- a statewide peer call-back service for families, carers and supporters caring for people experiencing suicidal behaviour
- tailored online information for families, carers and supporters.

19.11.1 Family- and carer-led centres

The Carers Recognition Act sets out that '[a] carer should be respected and recognised as an individual with his or her own needs'.[181] As demonstrated throughout this chapter, the mental health system does not adequately recognise or respond to family and carer needs.

Tandem told the Commission that a 'system that recognises that family and friends are a critical part of the recovery journey [must] consequently [acknowledge they] are entitled to respect, kindness, information and support'.[182] The Commission agrees with this proposition.

The Commission therefore recommends that eight regional family- and carer-led centres be established by the end of 2022. Each centre will have a physical location (opportunities for co-location with existing community service settings should be explored) and an online presence, which could be provided via a central hub for all centres that also includes access to region-specific information. The centres will all have consistent branding to help families, carers and supporters find support more easily. The centres will:

- provide families, carers and supporters with tailored information about supports and services available in the region (online, face-to-face and telephone contact options)
- offer after-hours access
- work with families, carers and supporters to identify their needs and connect them to the supports that will best respond to those needs, including providing one-on-one support

- take a personalised strengths-based approach to needs identification and planning including coverage of health and wellbeing, practical, financial, employment/education and the social needs of the families, carers and supporters
- provide access to brokerage funding to help with immediate practical needs, which may include opportunities for rest or temporary alternative care options (short-term planned respite)
- support carers with additional needs and cultural diversity, including Aboriginal people, people from culturally diverse backgrounds, people with disabilities, people with coexisting mental and physical health conditions, young people (up to and including 25 years), older Victorians (people aged 65 years or older) and LGBTIQ+ people
- support older carers with transition planning
- provide clear referral pathways to help families and carers seek support and services, including to the primary health system, counselling and peer support groups
- deliver support and mentoring for volunteer-based family and carer peer support groups in the region.

The Commission's recommendation is that the Victorian Government commissions either a single non-government organisation or multiple organisations to deliver a network of centres. Each centre will work closely with mental health and wellbeing services in their region, which will have a role in raising awareness of the centres and helping people to connect to them. Tandem, through its existing Support and Referral Service, can also play a valuable role in connecting people to the centres. Families, carers and supporters will be able to use the centres without a formal referral.

A minimum of eight fulltime-equivalent support worker positions should be funded in each family- and carer-led centre to directly support families and carers.

It is expected that, over time, most workers in the family- and carer-led centres will be family and carer peer workers. Workers in the centres should be supported by a statewide coordinator who is a family and carer lived experience worker. This coordination role will work in a similar way to the Families where a Parent has a Mental Illness (FaPMI) program, where coordinators are supported by a statewide coordinator located within the Bouverie Centre,[183] and the Risk Assessment and Management Panel, where family violence coordinators are supported by a development officer who undertakes a statewide coordination role within Domestic Violence Victoria (the peak body).[184] As such they will facilitate collaboration across the regional centres and provide additional supervisory support.

In establishing the centres, lessons can be drawn from the New South Wales Family and Carer Mental Health Program described in Box 19.3.

19.11.2 Financial support

Carers can experience significant financial hardships associated with their caring roles. The Productivity Commission's *Mental Health Inquiry Report* stated that '[i]n 2018, 41% of primary carers of people with mental illness reported difficulty meeting everyday living costs as a result of caring (compared with 30% for other primary carers)'.[185] These hardships can arise from both reduced income and costs associated with caring.

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Box 19.3: New South Wales Family and Carer Mental Health Program

The New South Wales Family and Carer Mental Health Program is a statewide program funded by the New South Wales Government. The program is delivered in a partnership that includes local health districts and five specialist community organisations, and is delivered across 35 sites.[186]

The program aims to 'improve the wellbeing of families and carers of people with mental health conditions, and the people they support'.[187] Services offered include education and training packages for families and carers, information, resources and one-on-one support, health promotion activities and clinical services.[188] Supporting carers from diverse backgrounds and carers with additional needs is another important service offered. This includes Aboriginal people, people from culturally diverse communities, LGBTIQ+ people, people with a disability, young people and older people.[189]

Mental Health Carers NSW describes the program as 'one of the sole reliable sources of individual carer advocacy and one on one support in NSW and MHCN [Mental Health Carers NSW] routinely refers carers to the program for support. Although the program has not been comprehensively evaluated, the feedback which we have received from carers is that the support provided by the program is highly valued'.[190]

The weekly median income of carers is reported to be 42 per cent lower than that of non-carers.[191] The Productivity Commission reported that 32 per cent of employed carers worked reduced hours due to their caring role, and 44 per cent of carers who were not working would like to work.[192] Lower labour force participation has flow-on consequences for levels of income and, later in life, superannuation.

Ms Anna Wilson illustrated the individual impact of reduced income in her witness statement:

> Since Harold's illness, my whole career has gone out of the window. My annual income is down from around $50,000 to about $5,000. I have been too busy, stressed and exhausted from fighting and caring for my son to be able to work.[193]
>
> For Centrelink, there are all these rules and regulations around what you can and cannot claim. For example, you cannot claim travelling expenses, but travelling is a lot of what I do as a carer, whether it is to visit Harold in hospital or drive him to appointments.[194]

The practical costs associated with caring can also be broad ranging. For example, in their witness statement Aaron and Kristy Robinson said their daughter:

> struggles to access treatment and regularly runs away (at least once per week on average and more often recently) from home and treatment centres and attempts suicide.
>
> This generally involves breaking windows and climbing the fence when escaping from home ... Between replacing broken windows and having to put in fence extensions, we have spent about $4,000 in the last month. We don't have endless pockets of money and the National Disability Insurance Scheme ... seems reluctant to reimburse us for these costs.[195]

Some carers can access limited financial support from the Commonwealth Government. The Commonwealth Carer Payment is a fortnightly income support payment for carers of a person with a severe disability or medical condition or who is frail due to old age. As at 20 September 2020, the maximum rate was $944.30 for a single person per fortnight or $1,423.60 for a couple.[196] The Carer Allowance is an income supplement in recognition of the costs of caring and was $131.90 per fortnight as of 16 December 2020.[197] The Carer Supplement is an annual lump sum payment of $600 to assist with the costs of caring.[198]

In its interim report, the Royal Commission acknowledged concerns raised by families, carers and supporters about the Commonwealth's Carer Allowance and Carer Payment.[199] When considering similar concerns, the Productivity Commission's *Mental Health Inquiry Report* found there was 'some evidence to support claims that mental health carers are less likely to receive these payments than carers of people with a physical condition'.[200] The Royal Commission supports recommendation 18 from the Productivity Commission's *Mental Health Inquiry Report*, which suggests that the Commonwealth Government 'should amend the eligibility criteria for the Carer Payment and Carer Allowance to reduce barriers to access for mental health carers'.[201] In particular, the Productivity Commission recommended amending the eligibility criteria to reflect:

> the nature of care provided for someone with mental illness is not necessarily as 'constant' as that for a physical illness, can vary substantially from day to day, and is less likely to relate to the care recipient's 'bodily functions'. To provide more flexibility for the carer in undertaking their own economic and social activity, the restriction on hours that the carer can work should be evaluated over a month rather than each week, and the restrictions on study and volunteer activity should be removed.[202]

At the state level, the Royal Commission recommends changes to existing brokerage funding arrangements to provide families and carers with access to funds that support immediate practical needs.

Currently, families and carers can get modest brokerage funding through the Victorian Government–funded Mental Health Carer Support Fund, which has been administered by Tandem since 2009. To be eligible for funding the family member or carer applying for assistance must be supporting a person who is receiving services from an area mental health service.[203] The funding can be used for expenses such as transport, carer education programs, respite, educational and vocational opportunities, counselling, wellbeing activities and activities for groups of carers.[204]

In the 2018–19 financial year 3,427 applications to the Carer Support Fund were processed.[205] Based on the Commission's estimate that there were more than 58,000 carers of people living with mental illness in Victoria in 2018–19,[206] this means that, at most, just under 6 per cent of carers received support from the fund. Each application has a recommended cap of $850 per application with a maximum of $1,100 including GST per financial year.[207] In her statement to the Commission, Dr Melissa Petrakis, Chair of Tandem, said '[t]he reality is that in the 2019-20 financial year so far, the average amount per application has been $474.70'.[208]

Submissions made to the Commission indicate that the Mental Health Carer Support Fund is a well-used resource, and some submissions have advocated for an increase in its funding.[209] Dr Petrakis described the fund as 'effective at providing practical assistance for carers connected with [area mental health services] who are most likely to be experiencing the most acute economic, social and emotional distress'.[210] Dr Petrakis also told the Commission that Tandem has recommended that the Victorian Government reviews the level of support provided by the Carer Support Fund and increases the funding from $1.6 million to $2.6 million.[211] The Commission supports an increase to the Carer Support Fund but considers that a more substantial increase is required to meet its vision for greater supports for families and carers, as well as improved access pathways to the funding.

The Commission recommends that the Carer Support Fund be available through family- and carer-led centres as well as through Infant, Child and Youth Area Mental Health and Wellbeing Services and Adult and Older Adult Area Mental Health Services because these will become critical support points for families and carers in the future. Eligibility criteria should also be amended so that eligibility does not depend on supporting a person who is receiving treatment, care or support from a mental health and wellbeing service. Whether or not the person they care for is using services does not reflect the needs of families and carers.

The Commission considers that the Victorian Government should increase the fund to $4.2 million per annum by the end of 2022. This represents the $2.6 million sought by Tandem plus the equivalent of $200,000 per family- and carer-led centre.

While this total funding pool will be available via different pathways (through services and through the family- and carer-led centres), Tandem should retain its overall administrative role to provide a degree of oversight and consistency, as well as ensuring a streamlined application process for families and carers. The Victorian Government should also consider the resourcing implications for Tandem in administering a larger fund with a broader scope.

In practical terms, the substantial increase in brokerage funding available to carers across the state will allow families, carers and supporters greater access to respite and inreach supports. Respite for families and carers can take many forms including in-home support and a range of activities that allow families and carers to take a break, connect with others and look after their own wellbeing. Chapter 10: *Adult bed-based services and alternatives* provides details of the Commission's recommendations for investing in a range of time-limited, flexible and non-clinical respite services for consumers that are designed, delivered and evaluated by people with lived experience.

The Commission also recommends that brokerage funding available to young carers be substantially increased and made available to assist with the specific circumstances and needs of young carers (for example, general household supports such as cleaning, transport costs or tutoring).

The former Department of Health and Human Services estimated that in 2020 there were 9,000 young carers in Victoria.[212]

Coordinators under the FaPMI program currently provide access to a limited brokerage pool that is available to young people. According to departmental guidelines brokerage is incorporated into the program funding, with each area mental health service receiving $16,000 each year.[213] This level of funding would equate to an average of $195 per annum to 20 per cent of young carers.

The *Families where a Parent has a Mental Illness (FaPMI) Program Guidelines* stipulate that this brokerage funding can be used for 'goods and services to address a need and/or for the prevention of an emerging situation for which no alternative response is available'.[214] There are exceptions where support is not readily available and needs are assessed as urgent, such as food, clothing and transport.[215]

This funding should be increased to a minimum of $2.2 million per annum statewide and be made available through the new young carer support workers outlined in section 19.12.2. This would provide for average funding of $1,222 for 20 per cent of young carers per annum.

The Commission has concluded that young carers can experience particular disadvantage and that strong support when carers are young could substantially improve wellbeing, including mental health, and longer term engagement in education and employment.

Brokerage funding administered by Tandem and via young carer support workers should be reviewed every five years.

19.11.3 A statewide peer call-back service for families, carers and supporters caring for people experiencing suicidal behaviour

Many families, carers and supporters of someone experiencing suicidal behaviour shared their experiences with the Commission. Their caring experience often involved long-term psychological distress, hypervigilance, lack of sleep, practical strategies to keep the person they are caring for safe, and desperation in their efforts to get help for the person they cared for:

> I had to lock everything up at home, sleep on the floor of her room for 4 months and give her 24/7 attention. She was so suicidal she tried to jump out of cars.[216]
>
> We were not even told how to support someone who had attempted suicide, and they were just discharged.[217]

Ms Susan Trotter, witness, described caring for her son who first attempted suicide when he was 19 years old and who attempted suicide another 25 times before he died at age 33.[218] Ms Trotter said that 'for me it was a roller coaster and hospitals after hospitals'[219] over many years.

Families, carers and supporters play an important role supporting people who are experiencing suicidal behaviour, or following a suicide attempt. There are both system- and individual-level benefits to better supporting families, carers and supporters to perform this valuable role.[220]

Even with improved access to mental health and wellbeing services, families, carers and supporters will still carry most of the responsibility of the day-to-day caring and emotional support for people who are experiencing suicidal behaviour. Recognising how personally taxing this can be and the potential impacts on the families, carers and supporters, it is important that they themselves are supported.

Families, carers and supporters told the Commission of a need for better supports for people who are caring for someone who has suicidal thoughts.[221] The National Suicide Prevention Taskforce's *Interim Advice Report* to the Commonwealth Government also acknowledges the need for '[b]etter supports for family and caregivers – including those supporting someone through a suicidal crisis'.[222]

There is limited research on family and carer experiences of caring for someone who is experiencing suicidal behaviour. However, Australian research undertaken in 2019 that involved 758 people providing care to a family member or friend after a suicide attempt indicates that 65 per cent of respondents did not receive any information from the treating health professional about how to care for their loved one, and only 18 per cent felt supported to provide care.[223] Many sought information online, from support groups or relied on their own psychological supports.[224]

The Commission acknowledges the particular effects of long-term stress and hypervigilance on families, carers and supporters, and the need to provide tailored supports and information to help people in these circumstances with their caring role as well as their own wellbeing.[225]

In its interim report, the Commission recommended the full rollout of the HOPE (Hospital Outreach Post-suicidal Engagement) initiative's support and assertive outreach services to all area mental health services across the state.[226] The HOPE program is designed to support people after they are discharged from hospital following a suicide attempt or people who express suicidal ideation or repeatedly intentionally self-harm but who do not meet the threshold for entry to specialist clinical mental health services.[227]

While HOPE does provide support to a person's family, carers and supporters, its primary focus is on the person who has attempted suicide. The support that families, carers and supporters might receive from the HOPE program is limited and is provided in the context of how they might support the person they are caring for.[228]

In Chapter 9: *Crisis and emergency responses* the Commission outlines its vision for a reformed approach to crisis response. Acknowledging that families, carers and supporters are themselves often deeply affected when someone they care for is experiencing a mental health crisis, services will consider the specific needs of families, carers and supporters in crisis responses. Wherever possible, dedicated peer worker roles should be established for families and others involved in the crisis.

In addition to these measures, and acknowledging the considerable strain on families, carers and supporters experiencing long-term stress and hypervigilance, the Commission also recommends that the Victorian Government establishes a statewide peer call-back service for families, carers and supporters caring for people experiencing suicidal behaviour.

At a prearranged time that suits the family member, carer or supporter, a peer worker will provide emotional support delivered by telephone or online, as well as supporting the person's capability to look after the person they are caring for. This might include practical strategies drawn from evidence and the peer worker's own experience. The peer worker will also support the family member, carer or supporter in their own self-care and mental health and wellbeing.

Peer workers will be available at times that best suit families, carers and supporters, including after hours, and will consider the diverse needs of the community, including people from culturally diverse backgrounds and LGBTIQ+ people.

According to the Black Dog Institute, '[p]eer warm line models, where those with lived experience answer calls, reflects community demand for telephone based support'.[229] This new service will not be a crisis line. Instead, the warm line model is 'designed to support people who are in distress and need support before reaching an immediate crisis need'.[230] The service will differ significantly from existing services such as Lifeline (which provides 24-hour crisis support) and the Commonwealth Government–funded Suicide Call Back Service (which provides 24-hour access to a professional counsellor for people with suicidal ideation) in that it will connect families, carers and supporters with peer support that is specific to suicidal behaviour and to their role in caring for someone with suicidal behaviours. It will be delivered by families, carers and supporters with a lived experience of caring for someone experiencing suicidal behaviour rather than by peers with lived experience of mental illness more broadly. This is important because caring for someone with suicidal behaviour can be substantially different from caring for someone with other mental health and wellbeing challenges.

The service will also differ from the HOPE initiative, which is currently only available once a person has attempted suicide. The call-back service will be open to families, carers and supporters of people experiencing any form of suicidal behaviour. It will reach a much wider range of families, carers and supporters and offer more intensive and personalised support than the HOPE program does. Families, carers and supporters involved in the HOPE program can opt to be connected with the call-back service so they can receive dedicated support in their own right from people who have been in similar situations to them.

The peer call-back service draws on evidence about the effectiveness of peer support. The Commonwealth Government's guidance on the role of the peer workforce in mental health and suicide prevention highlights the important role peer workers can play:

> Peer workers draw on their lived experience to play unique roles in encouraging and supporting the recovery of people experiencing mental health issues by:
>
> - Offering hope and supporting … carers to develop a recovery-oriented perspective
> - Supporting … carers to develop important life skills
> - Supporting … carers to move beyond being a … carer to develop a personal sense of empowerment
> - Empathising with … carers from a position of experience.[231]

The service will provide a call-back following appropriate peer matching. Peer matching means that callers will be matched with someone with a similar experience—someone who has walked in their shoes and has had to make similar decisions or lived through similar periods of stress. For example, a parent caring for a teenager who has suicidal thoughts will be able to speak with another parent who has been in that position. This approach will ensure practical advice and supports tailored to the circumstances of the family can be provided.

The call-back element of the service recognises that caring for someone who is experiencing suicidal behaviour can be time consuming and requires flexibility as to when the person in the caring role can access help. The family member, carer or supporter can choose a time that best suits them—for example, it may be at night when the person they are caring for is sleeping. The remote delivery of the service means the person in the caring role does not have to physically leave the person they are caring for alone and can stay in the comfort of their home.

The Commission's recommended approach of a peer-led call-back service draws on a pilot program from Roses in the Ocean, an organisation 'committed to developing a national lived experience workforce to inform, enhance and lead initiatives and services within suicide prevention'.[232] Roses in the Ocean is currently trialling a suicide prevention 'Peer CARE Connect warm line service' for people affected by suicide.[233] The service will provide callers with the option of a response within 48 hours via either phone call, email or text message.[234]

This pilot program from Roses in the Ocean builds on its existing peer program (by providing the pilot call-back service), which provides 'a 'light touch' scaffolding of support to people impacted by suicide experiencing heightened emotions in times of adversity [delivered by] peers [who] are trained specifically to address this very specific and significant need within our communities'.[235]

Another example is Queensland's Peach Tree peer-led perinatal mental health call-back service established in 2020. Peach Tree supports perinatal resilience and recovery with individuals and families, and its peer call-back service offers emotional support to people parenting children aged 0–5 years. The service is designed to support parents who feel they are not coping with life and parenting, have low mood, heightened anxiety or are unsure about how to get help and support. Peach Tree has been offering face-to-face peer support for the past nine years, and the introduction of the peer call-back service was in response to the COVID-19 pandemic.[236]

Victoria should build on these emerging models.

The Commission has also made a separate set of recommendations on suicide prevention and response, which are explained in Chapter 17: *Collaboration for suicide prevention and response*. The recommendations in Chapter 17 will better support families, carers and supporters, including through a statewide postvention bereavement support program. The grief following a loved one's suicide can be profound and the emotions experienced, particularly when people experience stigma and isolation because of the way a loved one died, can differ considerably from the grief felt following other types of deaths. All Victorians bereaved by suicide should have access to evidence-informed services to reduce their risk of suicidality and poor mental health and, in the future, all people bereaved by suicide will be automatically referred to postvention bereavement support.

19.11.4 Tailored online information for families, carers and supporters

Families, carers and supporters, including young carers, have told the Commission that they often struggle to find information about supports available to them.[237]

A 'one-stop shop' with information for families and carers is difficult to achieve in practice, partly because the Commonwealth and Victorian governments are responsible for different services and supports.

Currently, information is spread across government, peak body and service provider websites. This situation could be vastly improved with better coordination and central delivery and management of online information (including the necessary resourcing to achieve and maintain this). A central website with statewide information will be established with links to other sources where relevant—for example, Commonwealth programs.

The Commission recommends that the Victorian Government be responsible for ensuring there is information for families, carers and supporters, such as on the new statewide mental health website outlined in Chapter 8: *Finding and accessing treatment, care and support*. These recommendations should be implemented alongside each other to ensure efficiencies in digital infrastructure and resourcing.

The online information should be co-designed with people with family and carer lived experience and will include:

- information and details for the eight family- and carer-led centres
- information for families, carers and supporters who are caring for someone who may be experiencing suicidal thoughts
- tailored information about supports available (including financial assistance and eligibility criteria) for young carers and other children and young people who have a family member experiencing mental illness or psychological distress.

Information should also be available in accessible formats.

The Commission also encourages the Commonwealth Government to improve its online information for mental health carers (as well as ease of navigation), including the Carer Gateway and guidance about federal financial supports available to young carers (such as eligibility criteria and application processes). The Commission notes that this aligns with findings from the Productivity Commission's *Mental Health Inquiry Report*, which made recommendations for the Commonwealth Government to evaluate and publicly report on how well the Carer Gateway:

- meets the needs of mental health carers relative to other types of carers
- meets the needs of young carers, Aboriginal carers and culturally diverse carers.[238]

19.12 Supporting young carers and children and young people who have a family member experiencing mental illness or psychological distress

As examined earlier in this chapter, young carers who take on formal caregiving responsibilities face particular disadvantage. However, all children in families where a parent, other family member or carer experiences mental illness or psychological distress can be affected by the experience. This includes being likely to obtain poorer education outcomes than their peers, experience social isolation and take on caring and household responsibilities beyond expectation for their age.[239]

Research suggests that approximately 25 per cent of children live with a parent who has a mental illness[240] and that:

> These children have an increased [likelihood] to experience additional adversities due to their family circumstances, which for some, may lead to negative long-term difficulties, in addition to substantial lifelong impacts for individuals, governments and the wider community.[241]

One limited study of the experiences of siblings concluded that '[a]ll participants had been greatly affected by the onset of the psychosis in their brother or sister. Most siblings did not identify themselves as carers, although most played a significant part in their brother's or sister's life.'[242]

Research from Orygen, the National Centre of Excellence in Youth Mental Health, suggests growing recognition of the need to support siblings of young people experiencing mental illness, alongside support for parents and caregivers. Orygen stated that '[t]he experience of siblings includes mixed emotions of resentment and guilt stemming from reduced parental focus, the need to be more self-reliant, overcompensating for their own behaviour and unmet needs for parental support. Alongside this experience they can also feel as if they have "lost" their sibling.'[243]

The Commission acknowledges the need to provide dedicated support to young carers and children and young people who have a family member experiencing mental illness or psychological distress to mitigate what can be lifelong impacts.

The level of support needed will vary, depending on the circumstances of the young person and their family, and the nature of any caregiving role. A flexible approach is therefore recommended, with a range of supports available not only to young carers but also other children and young people who have a family member experiencing mental illness or psychological distress. Intensive supports, tailored to the needs of young carers, will be available to young people with caring responsibilities. This flexible approach is outlined in Figure 19.3.

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Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing* and Chapter 13: *Supporting the mental health and wellbeing of young people* outline the Commission's recommended approach to mental health and wellbeing for people up to and including 25 years of age. The recommendations in these chapters will also benefit young carers and children and young people who have a family member experiencing mental illness or psychological distress, and who experience challenges with their own mental health. It is also noted that some young parents experiencing mental illness or psychological distress will be accessing support through the youth mental health and wellbeing service stream and that their children will have access to the supports outlined here.

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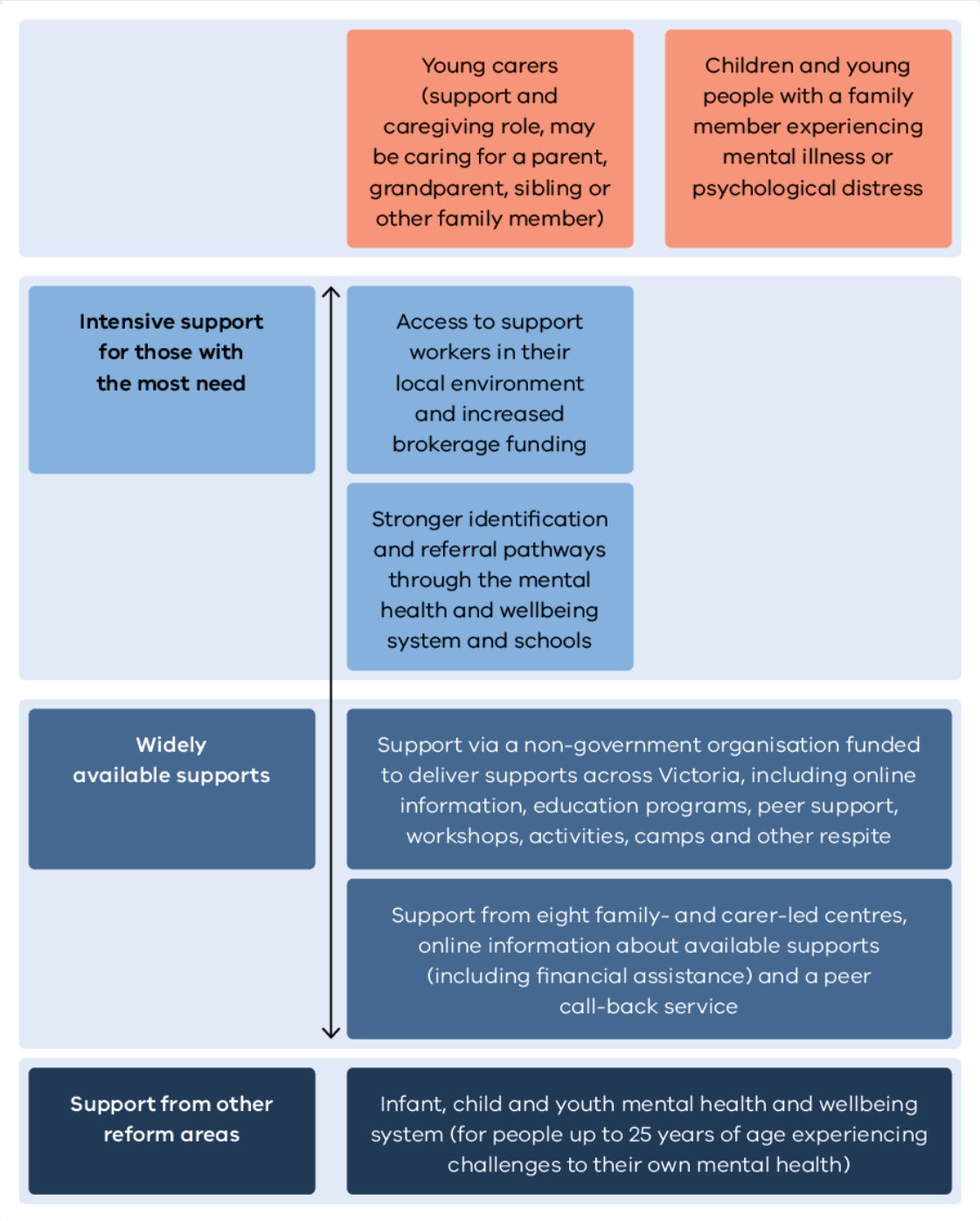
Figure 19.3: A graduated program of supports



19.12.1 A range of supports for children and young people

Young carers have told the Commission of the importance of being able to connect with other young people with similar experiences. This was highlighted during the Commission's focus groups with young carers:

> This focus group has made me feel very validated and shown me that I need to go and try and find more young carers because my experience with carers has ... been with older carers so I just didn't reali[s]e the extent of what it would do for me and how great of an opportunity it is for me ...[244]
>
> knowing that there are ... other people who experience what I experienced. And it's been so wonderful to hear what everyone's talked about ... I really, really need to try and ... meet other young carers or join some sort of support, because this has been really good for my mental health.[245]

The Commission recommends that the Victorian Government funds a non-government organisation such as Satellite Foundation to creatively co-design and deliver, by the end of 2022, an expanded range of supports that will be available across the state to both young carers and other children and young people who have a family member experiencing mental illness or psychological distress.

While there are several networks to support young carers—the Carer's Australia Young Carers Network and Little Dreamers being two notable examples—these networks offer a range of programs, activities and support to young carers broadly, not just mental health carers. The Commission believes, however, that there is a need for supports dedicated to the needs of young mental health carers and children and young people who have a family member experiencing mental illness or psychological distress. This is due to the particular challenges they may experience (and the distinct nature of the mental health caring role) including the impact of stigma, the level of emotional support provided and intergenerational effects on mental health and wellbeing.

Supports and programs will cater for a range of age groups up to and including 25 years. The supports offered will be co-designed with children and young people with lived experience as a young carer or having a family member experiencing mental illness or psychological distress and will include:

- online information, education programs, resources and supports, including peer support
- face-to-face peer support, workshops, activities, camps and other respite
- creative responses through a positive and supportive environment
- creative educational programs and materials that can be delivered in and shared with schools
- programs that support children and young people in rural and regional areas (including face-to-face programs)
- programs that respond to diverse needs, including those of Aboriginal communities, culturally diverse communities and LGBTIQ+ people.

The funded non-government organisation should also:

- actively engage with schools and mental health service providers to build referral pathways
- build partnerships to expand collaborative research opportunities.

According to Ms Rose Cuff, State-wide Coordinator of FaPMI and Executive Director and co-founder of Satellite Foundation, young carers can feel extremely isolated and may assume that no one will understand their experience.[246] Supporting children and young people who have a family member experiencing mental illness or psychological distress to come together in a welcoming and positive environment will be an important way to help combat these feelings of isolation.

Satellite Foundation (refer to case study) is an organisation that operates on a small budget with the support of volunteers. Young carers have told the Commission about their positive experiences with Satellite Foundation, including people who are now adult ambassadors.[247]

In her statement to the Commission, Ms Cuff described Satellite Foundation as an organisation that 'develops programs that enable children and young people to focus on their hopes and dreams for their future whilst connecting them with others who may have similar experiences'.[248]

The remit of the funded non-government organisation will include co-designing creative programs that can be delivered across Victoria (in partnership with schools) that encourage conversations about mental health and its impacts on young carers and other young family members (refer to section 19.12.3). This should receive a dedicated funding stream within the overall program funding.

As an example of a creative program, Satellite Foundation launched It's A Mad World in November 2020, 'an online showcase of different perspectives on mental health, created by those with lived experience and the Satellite Foundation. Using different mediums, we share stories of the funny and the sad, the happy and the mad, when navigating the complex world of mental health'.[249] Originally planned as a live performance project, It's A Mad World was adapted to a two-week online exhibition due to COVID-19.

19.12.2 Providing young carers with access to support workers

The mental health system must be responsible for actively supporting young carers.

Many young carers do not reach out for support, and some actively try to stay under the radar of services. As the Productivity Commission observed, young carers may not self-identify as carers, or may hide their caring role because they 'are concerned about intervention from child protection services'.[250]

Mr Morgan said that although his mother had case managers, he and his brother did not engage with support services.[251] Part of the reason for this was that his family 'lived in a constant fear of being separated from each other … I felt like engaging in help and telling people the extent of what was going on, that threat would be realised'.[252]

Case study:

Satellite Foundation

Satellite Foundation (Satellite) is a not-for-profit organisation founded in Melbourne in 2009. Co-founder Ms Rose Cuff said it was established in recognition that 'approximately 250,000 children and young people in Victoria live with a parent or carer who has a mental illness'.

> Satellite Foundation seeks to contribute to positive outcomes for children, young people, their families, and communities, where a parent has a mental illness or mental health challenges.

Satellite's range of creative programs and activities aim to offer safe and welcoming spaces for connection and peer support, strengthening skills and sharing ideas.

Satellite seeks to provide young people with opportunities to share their experiences and create ongoing connections. Ms Cuff said:

> These young people need experiences other than their caring role, and need to feel supported and connected in order for them to be optimistic for their future—to see a 'solution-enabled' future for themselves.

Satellite provides a range of free programs to children and young people aged 8–25, and has increased its offering of online programs in response to COVID-19. Satellite's programs include the following:

- **Satellite Connect** is a free online six-week program for people aged 17–23 years. The program includes a range of workshops designed to support adolescents and young adults to recognise their strengths and realise their potential. There is a weekend retreat at the end of the program.
- **Satellite Connect Youth** is an adapted version of Satellite Connect for adolescents aged 14–17 years.
- **At Home with Satellite** provides a selection of activity-based, self-care packs and online workshops for children and young people aged 8–16 years. It includes opportunities for creative expression, storytelling and peer connection.
- **Satellite Camps** provide three-day overnight programs for young people aged 10–15 years. The aims of the camp include providing respite for children and young people, reducing isolation through peer support, promoting healthy coping strategies, and encouraging longer-term interactions between participants.
- **Music, art and song writing workshops** are three-day, in-person programs for young people aged 11–14 years that provide supported opportunities for creativity and collaboration in a fun and safe space.

- **Photography workshops** are one or two-day, in-person programs for young people aged 10–16 years (approximately). The workshops provide a space for young people to explore different experiences, including mental health and wellbeing, and a chance to use creative practice to explore how they see the world.
- **It's a Mad World** is an online exhibition where people with lived experiences can share different perspectives on mental health, creating a space to talk and laugh freely.

Satellite operates on three principles—connect (recognising the importance of belonging and fostering a sense of community), support (providing supportive and safe environments), and empower (putting young people at the heart of its work).

A recent graduate of a Satellite Connect program described her experience:

> I do not have the right words to accurately articulate how wonderful and amazing this program has been and how much this program has touched my life. I feel like I have made more progress in the past six weeks with Satellite Connect, than I have in eight years seeing psychologists on and off. I am so grateful for everything that the Satellite Foundation has blessed my life with.

Satellite has support from Emerging Minds, an organisation dedicated to advancing the mental health and emotional wellbeing of Australian infants, children, adolescents and their families. Satellite also works closely with a number of community, mental health and arts-based organisations, providing opportunities for research and collaboration. In June 2020, Satellite received funding from the Commonwealth Government to boost its supports for children and young people during the COVID-19 pandemic.

Source: Satellite Foundation, <www.satellitefoundation.org.au>, [accessed 18 October]; *Witness Statement of Rose Cuff*, 2 July 2019; Rose Cuff, Correspondence to RCVMHS, 2020; The Honourable Greg Hunt MP, Commonwealth Minister for Health, Media Release: COVID-19: Support for Children and Young People, 17 June 2020, <www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/covid-19-support-for-children-and-young-people>, [accessed 9 September 2020]; Emerging Minds, Who we are, <www.emergingminds.com.au/about/who-we-are>, [accessed 14 December 2020].

To provide more intensive support for young carers, the Commission recommends that the scope of the FaPMI program be broadened by the end of 2022, including by enabling each Adult and Older Adult Area Mental Health and Wellbeing Service to employ new workers who will be dedicated to providing support to young carers in their local environment and increasing the amount of brokerage funding available to help young carers with practical needs (refer to section 19.11.2).

The Commission's recommendation for dedicated support workers draws on a current research project based in Austria—the Village Project—which is outlined in Box 19.4.

Box 19.4: The Village Project

The Village Project is a four-year research project that seeks to improve development and wellbeing outcomes for children of parents with a mental illness. The Village Project has two core elements—improving how children in that situation are identified and strengthening child-focused support networks.[253]

As well as early identification of children in families affected by mental illness, the project is seeking to ensure children have a range of informal and formal supports available to provide them with the support that they need and want.

The project's approach to early intervention includes the 'collaborative village approach' to strengthening child-focused support networks.

> According to the project concept, for installing the support network within the [collaborative village approach], informal support sources will be activated as a primary source, and supplemented by formal support, where needed. The project draws on community-capacity building approaches, developing a supportive network of allies around a person.[254]

An important part of the project methodology is the concept of 'child voice' to ensure the child is at the centre of their own care and supported to identify their own formal and informal support networks.[255]

The research group is supported by a 'competence group'. This group consists of six lived experience experts—adolescents and young adults who have a parent with a mental illness.[256]

FaPMI is a Victorian Government–funded program launched in 2007. The program recognises the impact of mental illness on family members, particularly dependent children. Program delivery is via adult area mental health services.[257] One of the program's objectives is to '[e]stablish and strengthen service networks in partnership with consumers and carers to provide a coordinated and collaborative response to the needs of families where a parent has a mental illness.'[258]

A statewide coordinator for FaPMI sits within the Bouverie Centre, and Victorian Government funding enables one fulltime-equivalent coordinator position to be employed in each adult mental health service. The coordinators 'offer a range of services including secondary consultations, and joint consultations with the parent/family to enable conversations with clients and families about the potential impact of mental illness, especially on children.'[259] The coordinators are also involved in building resources and workforce development initiatives and building collaborative practices between sectors.[260]

FaPMI plays an important role in supporting families and improving services' responses to families where a parent has a mental illness. However, the Commission considers that more intensive supports, focused primarily on the everyday and long-term needs of the young carer, are needed in addition to the existing scope of the FaPMI program.

The scope of the FaPMI program will be broadened to include support workers for young carers across the state. At least 32 fulltime-equivalent support workers for young carers should be based across the 22 mental health and wellbeing adult and older adult service areas. Support to young carers will be provided by Adult and Older Adult Area Mental Health and Wellbeing Services on an outreach basis in the young carer's local environment (these workers will be in addition to the FaPMI coordinator role currently located in each adult area mental health service). Each Adult and Older Adult Area Mental Health and Wellbeing Service will have at least one support worker, with the Commission recommending an additional 10 workers given some areas will have additional resourcing requirements based on geographic and demographic need. Access to a support worker will be available to young carers in a variety of relationships of care and support, such as a sibling or grandparent, not just people caring for a parent.

The role of support workers will include:

- supporting young carers, including through active follow-up and outreach
- working with the young carer to identify their existing informal support network (which could include grandparents and other relatives, friends and neighbours) and identify gaps that could be filled with more formal supports (for example, tutoring or transport to school if a parent is unwell)
- identifying how existing support gaps can be filled and facilitating meetings with the young person's existing network as well as formal supports to plan how to collectively support the young person
- connecting young carers to other forms of support (including in liaison with existing FaPMI coordinators), including brokerage and helping them to apply for other forms of financial assistance.

The aim of the Commission's recommendation is not only to fund support workers for active follow-up and outreach but also to help young carers to develop strong support networks of their own that they can draw on for support long term, as needed.

Importantly, the ability to get help from a support worker will not be limited to circumstances where a family member is actively connected with a mental health service as a consumer. Young people may require support even when a family member experiencing mental illness or psychological distress is not accessing treatment, care and support themselves. Given that many young carers in need of help from a support worker will be under the age of 18, it will be critical for the support workers to establish a relationship with the young carer's parent/s, guardian, or other family member/s as well, depending on the individual circumstances. Delivery of this program will be based on individual as well as local needs, noting that young carers in rural and regional areas may have quite different support needs from those in metropolitan areas. An appropriate change to the program name should be considered to reflect this change in scope.

While funded as part of an existing government program, this new approach to support will require creativity. The expanded FaPMI program should explore new ways of proactively engaging with young people to ensure they feel safe, supported and understood.

19.12.3 Strengthening identification and referral pathways through the mental health and wellbeing and education systems

In addition to actively supporting young carers, the mental health and wellbeing system must play a stronger role in identifying young carers and referring them to supports. The education system can also play an important role given it is a consistent and non-stigmatised service in the lives of most children and young people.

The Commission recommends that the Department of Health improves identification and referral pathways through the mental health and wellbeing system and works with the Department of Education and Training to strengthen these pathways in the education system.

In the mental health system, research indicates that clinicians do not 'routinely engage with their clients about parenting, children's needs, or family functioning'.[261] The Commission's recommendations in this chapter intend to rectify this. There is also often a gap in identifying the needs of children and young people outside of a parent–child relationship, such as siblings, grandchildren, nieces and nephews.

In the future mental health and wellbeing system, it will become more common to engage with consumers not just as individuals but by taking into account their family and other relationships as well. This will play an important role in identifying more young carers and other children and young people in a family who may need support.

Personal story:

Emily John

Emily* is 18 years old and has been a carer for her mother her whole life. Emily was 13 when her mother experienced her first mental health crisis and was admitted as an inpatient.

> I remember the ward seeming old and outdated, so it was really scary.

Emily has been the primary support for her mother since that crisis. However, she finds there is little consistency in how hospitals involve family in treatment and has generally found that 'no matter what age, they never really listen to what I have to say'.

> I am a big advocate for my mum. I have done it all my life. It was difficult when I was underage and lived at home by myself when my mum was admitted. I didn't want to tell the hospital I was home by myself because I felt that it was going to get other people involved.

Following her mother's first inpatient admission, the Families where a Parent has a Mental Illness (FaPMI) program connected Emily with young carer support services. This support provided Emily with respite away from her caring role as well as a supportive environment where she could learn more about mental illness with other young people going through the same experiences.

> When I was in the young carers program I'd get movie tickets and they would organise outings for us. They took me out of my situation and gave me a little bit of respite.
>
> FaPMI gave me a lot of opportunities both as a carer and a kid that has a parent with a mental illness. They ran programs over the school holidays for kids living with parents who have a mental illness to help us understand mental illness more. The programs are fun and you feel supported because everyone there has a parent with a mental illness.

Emily credits FaPMI with providing her with the skills and support to explore opportunities as a peer support worker.

> FaPMI also gave me the opportunity to become a peer support leader. I have developed a voice because of the opportunities they have given me over the last six years. I have sat on panels and participated in a forum discussion with case workers and others working in the mental health system.

Source: *Witness Statement of 'Emily John' (pseudonym)*, 15 July 2020.

Note: *Name has been changed in accordance with an order made by the Commission.

The *FaPMI Program Guidelines* include the following guidance:

- 'Ensure consumers who are parents, and their children, are routinely identified.'[262]
- 'Dependent children and young people whose parent has a mental illness will have their own support needs recognised by their parent's mental health service or other participating service, therefore having their own mental health optimised.'[263]

The improved approach to identification must become a routine part of contact with new youth and adult mental health clients, with referrals and supports then offered to children and young people as needed (including to the new support workers and family- and carer-led centres). Practitioners should engage with consumers in a way that includes their family and important relationships, including children and young people in their care.

In relation to the education system, the Commission welcomes the recent work of the Department of Education and Training to support young carers, such as developing a policy and guidance for schools (published in November 2020) on identifying and supporting young carers. This guidance includes the ability to record the status of a student as a young carer in school record-keeping systems.[264] The Department of Education and Training has also partnered with Little Dreamers and PROJECT ROCKIT to 'build the capacity of school staff to recognise and support young carers to stay engaged in school'.[265] However, as established throughout this chapter, the role of caring for someone living with a mental illness is distinct from other types of caring roles. Young carers of a family member experiencing mental illness or psychological distress have reasons to try to avoid identification by services, largely driven by experiences of stigma and discrimination, and the fear of statutory child protection involvement.

The Commission has therefore determined a need to go further to ensure the education system becomes an environment where young mental health carers feel safe to disclose their circumstances and can be connected with supports.

Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect* outlines in more detail how education settings are priority environments where mental health and wellbeing can be promoted. It also establishes that supporting children and young people to get help and providing inclusive environments where students are encouraged to participate is critical to supporting better long-term outcomes.

There is a significant opportunity to build awareness of the needs and circumstances of young mental health carers into new and existing programs for mental health support in schools. The Commission notes that some Victorian Government programs have recently been boosted, and in some instances rollout brought forward, in light of COVID-19.[266]

It is recommended that the Department of Health partners with the Department of Education and Training to explicitly build young mental health carers into existing and future programs focused on the mental health and wellbeing of students. For example, staff training and school mental health and wellbeing officer roles could be expanded to include training in how to identify young mental health carers and to talk to them about their challenges and support needs; how to engage with parents and families of young carers; as well as how to provide up-to-date information about available support services and networks.

As well as expanding existing mental health programs in schools to include young mental health carers, a non-government organisation will be funded to co-design creative programs that can be delivered in partnership with schools, as discussed in section 19.12.1. These programs will encourage conversations about mental health and its impacts on young carers and other family members.

Mr Justin Heazlewood, a witness before the Commission, said that adults must assert a duty of care towards young carers, rather than waiting for children to make the first move to ask for help.[267] The education system is a critical setting for this type of outreach. In his witness statement, Mr Heazlewood shared his ideas for creatively reaching out in schools:

> There should be an increase in targeted education of children from primary school age about mental illness. This should coincide with a proactive attempt to identify any children who may be caring for parents with a mental illness. This could be done through a questionnaire or interviews. A special performance or talk could be created with the express purpose of educating children and encouraging them to come forward at the end of the session and nominate that they may be in a position of needing help. (Similar to the Life Education vans, we need a mental illness "mothership" which could trundle from school to school and be unusual and exciting in its design, like a huge alien brain.) Again, it would be devised solely for the purpose of educating about mental illness, mental health and self-care.[268]

It is the Commission's intent that through a stronger focus on early identification of young carers via both the mental health and wellbeing system and the education system, young carers will be able to get the supports they need (including support workers and brokerage funding) in a more supportive and timely way than is currently the case.

DOH.0003.0001.0584

19.13 Families, carers and supporters across the Commission's recommendations

Finally, the Commission acknowledges that many of the matters families and carers raised during its inquiry were problems that stem from the consumer experience. Seeking to make things better for consumers in the future mental health and wellbeing system, as well as in broader community settings, has been a natural extension for many families, carers and supporters of their focus on the needs of the person for whom they care.

The Commission has made recommendations on a wide range of matters raised by families, carers and supporters throughout this report. These reforms are interconnected and should be considered as a whole.

1 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 269.

2 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, 2019, para. IV.

3 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 270.

4 *Witness Statement of 'Rebecca Thomas' (pseudonym)*, 12 July 2019, para. 37.

5 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, 2019, para. IV.

6 *Witness Statement of Dr Brendan O'Hanlon*, 17 June 2020, para. 38.

7 Elizabeth Clark-Polner and Margaret S. Clark, 'Understanding and Accounting for Relational Context Is Critical for Social Neuroscience', *Frontiers in Human Neuroscience*, 8:127 (2014), 1–14 (p. 1).

8 Australian Bureau of Statistics, *General Social Survey, Summary Results, Australia 2019: Table 4: Social Experiences by Sex and Health Characteristics*, 2020, Table 4.3.

9 Beyond Blue, What Is Mental Health, <www.beyondblue.org.au/the-facts/what-is-mental-health>, [accessed 8 November 2019].

10 *Witness Statement of David Pearl*, 11 May 2020, para. 13; *Witness Statement of Dave Peters*, 22 July 2020, para. 25.

11 Australian Bureau of Statistics, General Social Survey: Summary Results, Australia, 2014, <www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/2014>, [accessed 5 November 2020].

12 Australian Bureau of Statistics, *General Social Survey, Summary Results, Australia 2019, Table 4: Social Experiences by Sex and Health Characteristics, Table 4.3*.

13 Australian Bureau of Statistics, *General Social Survey: Summary Results, Australia 2014, Table 10.3*; Australian Bureau of Statistics, *General Social Survey, Summary Results, Australia 2019, Table 4: Social Experiences by Sex and Health Characteristics, Table 4.3*.

14 *Witness Statement of Dr Paul Denborough*, 11 May 2020, para. 15.

15 Graham Gee and others, Chapter 4: Aboriginal and Torres Strait Islander Social and Emotional Wellbeing, in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Canberra: Commonwealth of Australia, 2014), pp. 55–68 (p. 56).

16 *Witness Statement of Mary O'Hagan*, 16 June 2020, para. 91.

17 Department of Welfare, *White Paper for Social Welfare: Principles, Guidelines, Recommendations, Proposed Policies and Programmes for Developmental Social Welfare in South Africa* (Pretoria, South Africa, 1997), p. 12.

18 Department of Welfare, p. 12.

19 *Witness Statement of Dr Paul Denborough*, 2020, para. 48.

20 *Witness Statement of Dr Paul Denborough*, 2020, para. 48.

21 *Witness Statement of Professor Patrick McGorry AO*, 22 June 2020, para. 89.

22 *Witness Statement of Indigo Daya*, 12 May 2020, para. 86.

23 Department of Human Services, *Recognising and Supporting Care Relationships: A Department of Human Services Policy Framework*, 2006, p. 15.

24 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, 2019, para. I(1).

25 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, 2019, para. I(3).

26 *Charter of Human Rights and Responsibilities Act 2006* (Vic), sec. 38(1).

27 *Charter of Human Rights and Responsibilities Act 2006* (Vic), sec. 13(a); Victorian Civil and Administrative Tribunal, *Kracke v Mental Health Review Board and Ors (General)* [2009] VCAT 646, para. 620.

28 *Charter of Human Rights and Responsibilities Act 2006* (Vic), sec. 17.

29 United Nations, *Convention on the Rights of Persons with Disabilities*, 6 December 2006, p. 3.

30 *Witness Statement of Dr Melissa Petrakis*, 11 May 2020, para. 2.

31 *Witness Statement of Marie Piu*, 17 July 2019, para. 8.

32 *Witness Statement of Marie Piu*, para. 8.

33 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 366.

34 Commonwealth Department of Health and Ageing, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers*, 2013, p. 26.

35 Commonwealth Department of Health and Ageing, p. 26.

36 *Witness Statement of Dr Margaret Leggatt AM*, 11 July 2019, para. 7.

37 Wellways, About Us, <www.wellways.org/about-us>, [accessed 15 October 2020].

38 Wellways, History, <www.wellways.org/about-us/history>, [accessed 15 October 2020].

39 Sandy Jeffs and Margaret Leggatt, Chapter 12: Sharing the Caring, in *Out of the Madhouse: From Asylums to Caring Community?* (North Melbourne: Australian Scholarly Publishing, 2020), pp. 187–199 (p. 187).

40 Jeffs and Leggatt, p. 195.

DOH.0003.0001.0586

41 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 269.

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

43 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 366.

44 *Witness Statement of Dr Melissa Petrakis*, para. 2.

45 Tandem, *Submission to the RCVMHS: SUB.0002.0030.0088*, 2019, p. 1.

46 Tandem, *Annual Report 2018–19*, 2019, pp. 14–15.

47 Tandem, *Submission to the RCVMHS: SUB.0002.0030.0088*, p. 3.

48 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, 2020, p. 1107.

49 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 1107.

50 Department of Health and Human Services, *Recognising and Supporting Victoria's Carers: Victorian Carer Strategy 2018–22*, 2018, p. 8.

51 *Witness Statement of Dr Melissa Petrakis*, paras. 30–31; *Joint Witness Statement of 'Aaron Robinson' and 'Kristy Robinson' (pseudonyms)*, 12 June 2020, para. 5; Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 274; Anonymous 240, *Submission to the RCVMHS: SUB.0002.0023.0047*, 2019, p. 3.

52 *Witness Statement of Dr Brendan O'Hanlon*, para. 30.

53 *Witness Statement of 'Erin Davies' (pseudonym)*, 1 July 2020, para. 81.

54 *Witness Statement of Professor Bruce Bonyhady AM*, 16 June 2020, para. 41.

55 *Witness Statement of Professor Bruce Bonyhady AM*, para. 41.

56 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, pp. 874–875.

57 Mental Health Carers Australia, *Let's Care for Our Carers: Mental Health Carers Australia Federal Election Policy Platform*, 2019, p. 6.

58 RCVMHS, *Carers Human-Centred Design Focus Group—Melbourne, Session 12: Record of Proceedings*, 2019.

59 *Witness Statement of 'Anna Wilson' (pseudonym)*, 3 August 2020, para. 7.

60 RCVMHS, *Carer Human-Centred Design Focus Group—Crisis Response: Record of Proceedings*, 2020.

61 RCVMHS, *Carer Human-Centred Design Focus Group—Crisis Response: Record of Proceedings*.

62 Mind Australia, *Mind's Approach to Working with Families and Carers*, 2014, p. 9.

63 Mind Australia, p. 9.

64 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 274.

65 *Witness Statement of Marie Piu*, para. 52.

66 *Witness Statement of Rose Cuff*, 2 July 2019, paras. 24–25.

67 *Witness Statement of Rose Cuff*, para. 29.

68 *Witness Statement of Rose Cuff*, para. 26.

69 Department of Health and Human Services, *Recognising and Supporting Victoria's Carers: Victorian Carer Strategy 2018–22*, p. 12.

70 *Witness Statement of 'Nathan Turner' (pseudonym)*, 8 April 2020, para. 30.

71 *Witness Statement of 'Nathan Turner' (pseudonym)*, para. 9.

72 *Witness Statement of Jesse Morgan*, 3 July 2019, para. 11.

73 *Witness Statement of Jesse Morgan*, para. 13.

74 *Witness Statement of Denna Healy*, 26 May 2020, para. 29.

75 Commissioner for Senior Victorians, *Submission to the RCVMHS: SUB.1000.0001.1667*, 2019, p. 17.

76 *Witness Statement of Dr Margaret Leggatt AM*, para. 47; *Witness Statement of Marie Piu*, para. 13; Anonymous 474, *Submission to the RCVMHS: SUB.0002.0024.0039*, 2019, p. 1.

77 *Witness Statement of Dr Margaret Leggatt AM*, para. 47.

78 *Witness Statement of Marie Piu*, para. 13.

79 *Witness Statement of Marie Piu*, para. 14.

80 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 472.

81 Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027*, 2017, p. 9.

82 RCVMHS, *Aboriginal Carers Human-Centred Design Focus Group: Record of Proceedings*, 2020.

83 RCVMHS, *Aboriginal Carers Human-Centred Design Focus Group: Record of Proceedings*.

84 Hands on Health Australia, *Submission to the RCVMHS: SUB.0002.0030.0030*, 2019, p. 3.

85 Hands on Health Australia, p. 3.

DOH.0003.0001.0587

86 *Evidence of Kali Paxinos*, 18 July 2019, p. 1290.

87 *Evidence of Kali Paxinos*, p. 1293.

88 African Australian Communities Leadership Forum, *Submission to the RCVMHS: SUB.0002.0030.0133*, 2019, p. 3.

89 Multicultural Centre for Women's Health, *Submission to the RCVMHS: SUB.0002.0030.0303*, 2019, p. 7.

90 Ethnic Communities' Council of Victoria, *Submission to the RCVMHS: SUB.0002.0029.0366*, 2019, p. 10.

91 *Witness Statement of Paris Aristotle AO*, 30 June 2020, para. 30.

92 *Witness Statement of Paris Aristotle AO*, para. 30.

93 Gemma Muir and others, *Caring During Coronavirus: Results of the COVID-19 Carer Survey*, 2020, p. 2.

94 Muir and others, p. 3.

95 Muir and others, p. 3.

96 Muir and others, p. 4.

97 Muir and others, p. 6.

98 Muir and others, p. 5.

99 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 868.

100 *Mental Health Act 2014* (Vic), secs. 11(1)(k)–11(1)(l).

101 *Carers Recognition Act 2012* (Vic), sec. 9.

102 Department of Health and Human Services, *The Victorian Charter Supporting People in Care Relationships*, 2016.

103 *Mental Health Act 2014* (Vic), sec. 346(2)(g).

104 Department of Health and Human Services, *Recognising and Supporting Victoria's Carers: Victorian Carer Strategy 2018–22*, p. 29.

105 Commonwealth Government, *National Standards for Mental Health Services*, 2010, pp. 2–3.

106 Department of Health and Human Services, *Working Together with Families and Carers: Chief Psychiatrist's Guideline*, 2018, p. 6.

107 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 2.

108 Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2019–20*, p. 34; *Witness Statement of Kym Peake*, 24 July 2019, para. 93.

109 National Mental Health Commission, *Sit Beside Me, Not Above Me*, 2019, p. 16.

110 *Witness Statement of Angus Clelland*, 5 June 2020, para. 109.

111 *Witness Statement of Peter Kelly*, 29 May 2020, para. 190.

112 *Witness Statement of Peter Kelly*, para. 191.

113 *Witness Statement of Dr Paul Denborough*, 2020, para. 43.

114 *Witness Statement of Peter Kelly*, para. 190.

115 *Witness Statement of Dr Brendan O'Hanlon*, para. 38.

116 *Witness Statement of Dr Brendan O'Hanlon*, para. 48.

117 *Witness Statement of Angus Clelland*, para. 111.

118 Melissa Petrakis and others, *Implementation and Sustainability of Family-Inclusive Practices (FIPs): Briefing Note to the Royal Commission into Victoria's Mental Health System. Abbotsford, Victoria: Tandem*, 2020, p. 1.

119 *Witness Statement of Dr Paul Denborough*, 2020, para. 15.

120 *Witness Statement of Dr Brendan O'Hanlon*, para. 14.

121 RCVMHS, *Mildura Community Consultation—May 2019*.

122 *Witness Statement of Indigo Daya*, para. 84.

123 *Witness Statement of Indigo Daya*, para. 83.

124 *Witness Statement of Indigo Daya*, para. 83.

125 *Witness Statement of Dr Brendan O'Hanlon*, para. 37.

126 *Witness Statement of Dr Brendan O'Hanlon*, para. 67.

127 *Witness Statement of Dr Brendan O'Hanlon*, para. 43.

128 *Witness Statement of Dr Brendan O'Hanlon*, para. 44.

129 Tandem, *Submission to the RCVMHS: SUB.0002.0030.0088*, p. 6.

130 *Witness Statement of Marie Piu*, para. 25.

131 RCVMHS, *Carer Human-Centred Design Focus Group—Information Sharing: Record of Proceedings*, 2020.

132 *Witness Statement of Chris Thomas*, 2 July 2019, para. 19.

133 Anonymous 324, *Submission to the RCVMHS: SUB.0002.0032.0063*, 2019, pp. 1–2.

134 Orygen, The National Centre of Excellence in Youth Mental Health, *We're in This Together: Family Inclusive Practice in Mental Health Services for Young People*, 2019, p. 9.

135 Annegret Kampf and Bernadette McSherry, 'Confidentiality in Therapeutic Relationships: The Need to Develop Comprehensive Guidelines for Mental Health Professionals', *Psychiatry, Psychology and Law*, 13.1 (2006), 124–131 (p. 125).

136 Bernadette McSherry, 'Health Professional-Patient Confidentiality: Does the Law Really Matter?', *Journal of Law and Medicine*, 15 (2008), 489–493 (p. 493).

137 Ian Bidmeade, *Paving The Way: Review of Mental Health Legislation in South Australia Report*, 2005, p. 8.

138 Bidmeade, p. 24.

139 Royal Commission into Family Violence, *Report, All Volumes*, 2016, Volume 1, p. 155.

140 *Mental Health Act 2014* (Vic), sec. 346(2)(g).

141 *Mental Health Act 2014* (Vic), sec. 346(2)(h).

142 *Mental Health Act 2014* (Vic), sec. 3(1).

143 *Mental Health Act 2014* (Vic), sec. 23.

144 Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2019–20*, p. 72.

145 Department of Health and Human Services, *Working Together with Families and Carers: Chief Psychiatrist's Guideline*, pp. 15–20.

146 *Witness Statement of Marie Piu*, para. 27.

147 Petrakis and others, p. 2.

148 Jeffs and Leggatt, p. 192.

149 *Witness Statement of Angus Clelland*, para. 109.

150 *Witness Statement of Dr Brendan O'Hanlon*, para. 49.

151 *Witness Statement of Dr Brendan O'Hanlon*, para. 48.

152 *Witness Statement of Dr Brendan O'Hanlon*, para. 39.

153 The Bouverie Centre, About Us, <www.bouverie.org.au/about-us>, [accessed 4 August 2020].

154 The Bouverie Centre, Vision, Mission and Values, <www.bouverie.org.au/about-us/vision-mission-values>, [accessed 5 August 2020].

155 The Bouverie Centre, *From Individual to Families a Client-Centred Framework for Involving Families*, p. 12.

156 The Bouverie Centre, *From Individual to Families a Client-Centred Framework for Involving Families*, p. 12.

157 The Bouverie Centre, *From Individual to Families a Client-Centred Framework for Involving Families*, p. 5.

158 The Bouverie Centre, *From Individual to Families a Client-Centred Framework for Involving Families*, p. 14.

159 The Bouverie Centre, *From Individual to Families a Client-Centred Framework for Involving Families*, p. 14.

160 Alfred Health, *Submission to the RCVMHS: SUB.0002.0028.0156*, 2019, p. 20.

161 Mary Olson, Jaakko Seikkula and Douglas Ziedonis, *The Key Elements of Dialogic Practice in Open Dialogue: Fidelity Criteria*, 2014, p. 2.

162 Jaakko Seikkula and others, 'Five-Year Experience of First-Episode Nonaffective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-up Outcomes, and Two Case Studies', *Psychotherapy Research*, 16.2 (2006), 214–228 (p. 215).

163 Piers Gooding, 'Can Laws "Commit" Governments to Provide Mental Health Services? A Role for Human Rights in Securing Resources', in *Innovations in Global Mental Health* (Switzerland: Springer, 2019), pp. 1–23 (pp. 15–16).

164 Sebastian von Peter and others, 'Open Dialogue as a Human Rights-Aligned Approach', *Frontiers in Psychiatry*, 10:387 (2019), 1–6 (p. 5).

165 von Peter and others, pp. 1 and 5.

166 von Peter and others, p. 5.

167 Alfred Health, p. 20.

168 Alfred Health, p. 20.

169 *Witness Statement of Dr Brendan O'Hanlon*, para. 56.

170 *Witness Statement of Dr Brendan O'Hanlon*, para. 57.

171 *Witness Statement of Dr Brendan O'Hanlon*, para. 56.

172 NorthWestern Mental Health, Multiple Family Group at Inner West Area Mental Health Service, <www.youtube.com/watch?v=11wwuHp20AQ&feature=youtu.be>, [accessed 11 August 2020].

173 Barbara K. Stuart and Danielle A. Schlosser, 'Multifamily Group Treatment for Schizophrenia', *International Journal of Group Psychotherapy*, 59.3 (2009), 435–440 (pp. 435–436); The Bouverie Centre, Structured Family Inclusive

Practices, <www.bouverie.org.au/support-for-services/our-specialist-areas/specialist-area-structured-family-inclusive-practices>, [accessed 3 June 2020].

174 Stuart and Schlosser, p. 439.

175 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 512.

176 Department of Health and Human Services, *Lived Experience Workforce Positions in Victorian Public Mental Health Services*, 2017, p. 15.

177 Department of Health and Human Services, *Lived Experience Workforce Positions in Victorian Public Mental Health Services*, p. 17.

178 For example, building on and/or adopting SHARC's organisational readiness training available at SHARC, SHARC Peer Worker Model, <www.sharc.org.au/peer-support/peer/>, [accessed 12 November 2019]; Mental Health Coalition, Lived Experience Workforce Toolkit for Organisations, <www.mhcsa.org.au/toolkit/>, [accessed 12 November 2019].

179 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 507, 516–517 and 520.

180 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 520.

181 *Carers Recognition Act 2012* (Vic), sec. 7(a)(i).

182 Tandem, *Submission to the RCVMHS: SUB.0002.0030.0088*, p. 6.

183 The Bouverie Centre, Support for Services—FaPMI, <www.bouverie.org.au/support-for-services/fapmi>, [accessed 15 September 2020].

184 Department of Health and Human Services, *Victorian Risk Assessment and Management Panel Program Operational Guidelines*, 2016, p. 50.

185 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 883.

186 New South Wales Health, Family and Carer Mental Health Support Services and Programs, <www.health.nsw.gov.au/mentalhealth/services/carers/Pages/support.aspx>, [accessed 21 July 2020].

187 New South Wales Health, Family and Carer Mental Health Support Services and Programs, <www.health.nsw.gov.au/mentalhealth/services/carers/Pages/support.aspx>, [accessed 21 July 2020].

188 New South Wales Health, Family and Carer Mental Health Support Services and Programs, <www.health.nsw.gov.au/mentalhealth/services/carers/Pages/support.aspx>, [accessed 21 July 2020].

189 New South Wales Health, Program Framework: NSW Family and Carer Mental Health Program, 2017, p. 2.

190 Mental Health Carers NSW Inc., *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, p. 17.

191 Carers Victoria, *Submission to the RCVMHS: SUB.0002.0028.0712*, 2019, p. 6.

192 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 881.

193 *Witness Statement of 'Anna Wilson' (pseudonym)*, para. 60.

194 *Witness Statement of 'Anna Wilson' (pseudonym)*, para. 64.

195 *Joint Witness Statement of 'Aaron Robinson' and 'Kristy Robinson' (pseudonyms)*, paras. 4–5.

196 Services Australia, Carer Payment—How Much You Can Get: Single Allowance, <www.servicesaustralia.gov.au/individuals/services/centrelink/carer-payment/how-much-you-can-get>, [accessed 8 August 2020].

197 Services Australia, Carer Allowance—How Much You Can Get: Carer Allowance, <www.servicesaustralia.gov.au/individuals/services/centrelink/carer-allowance/how-much-you-can-get>, [accessed 8 August 2020].

198 Services Australia, Carer Supplement, <www.servicesaustralia.gov.au/individuals/services/centrelink/carer-supplement>, [accessed 8 August 2020].

199 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 283.

200 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 914.

201 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 868.

202 Productivity Commission, *Mental Health Inquiry Report, Volume 1*, 2020, p. 53.

203 Department of Health and Human Services, *Mental Health Carer Support Fund: Department of Health and Human Services Guidelines*, 2017, p. 12.

204 Tandem, Carer Support Fund, <www.tandemcarers.org.au/carer-support-fund.php>, [accessed 6 August 2020].

205 Tandem, *Annual Report 2018–19*, p. 15.

206 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 269.

207 Department of Health and Human Services, *Mental Health Carer Support Fund: Department of Health and Human Services Guidelines*, p. 15.

208 *Witness Statement of Dr Melissa Petrakis*, para. 24.

209 Commissioner for Senior Victorians, p. 17; *Witness Statement of Rita Brown*, 24 June 2020, para. 108.

210 *Witness Statement of Dr Melissa Petrakis*, para. 23.

211 *Witness Statement of Dr Melissa Petrakis*, para. 25.

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

213 Department of Health and Human Services, Families Where a Parent Has a Mental Illness (FaPMI) Program Guidelines, 2016, p. 5.

214 Department of Health and Human Services, Families Where a Parent Has a Mental Illness (FaPMI) Program Guidelines, p. 5.

215 Department of Health and Human Services, Families Where a Parent Has a Mental Illness (FaPMI) Program Guidelines, p. 5.

216 RCVMHS, *Bendigo Community Consultation—May 2019*.

217 RCVMHS, *Werribee Community Consultation—May 2019*.

218 *Witness Statement of 'Susan Trotter' (pseudonym)*, 22 July 2019, paras. 2. and 9.

219 *Witness Statement of 'Susan Trotter' (pseudonym)*, para. 20.

220 Sarah Coker and others, *Better Support: Understanding the Needs of Family and Friends When a Loved One Attempts Suicide*, 2019, p. 10.

221 RCVMHS, *Lived Experience of Bereavement Session, Human-Centred Design Focus Group Full Transcript: Record of Proceedings*, 2020.

222 National Suicide Prevention Taskforce, *Interim Advice Report: Towards a National Whole-of-Government Approach to Suicide Prevention in Australia*, 2020, p. 54.

223 Coker and others, pp. 26–27.

224 Coker and others, p. 8.

225 Coker and others, pp. 51–52; Beyond Blue, Self-Care for the Supporter, <www.beyondblue.org.au/the-facts/suicide-prevention/worried-about-someone-suicidal/self-care-for-the-supporter>, [accessed 8 October 2020].

226 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 453.

227 Department of Health and Human Services, HOPE (Hospital Outreach Post-Suicidal Engagement) Initiative: Service Guidelines, 2018, pp. 1–2.

228 Department of Health and Human Services, HOPE (Hospital Outreach Post-Suicidal Engagement) Initiative: Service Guidelines, p. 1.

229 Black Dog Institute, *What Can Be Done to Decrease Suicidal Behaviour in Australia? A Call to Action*, 2020, p. 7.

230 Roses in the Ocean and Beacon Strategies, *Evidence Review: Suicide Prevention Peer-Led Warmline Service Models*, 2020, p. 8.

231 Commonwealth Department of Health, *Peer Workforce Role in Mental Health and Suicide Prevention: Primary Health Networks Guidance*, 2019, p. 3.

232 Roses in the Ocean and Beacon Strategies, p. 3.

233 Roses in the Ocean, *Concept Paper—SP Peer Care Connect (Suicide Prevention Warm Line)*, 2020, p. 3.

234 Roses in the Ocean, p. 3.

235 Roses in the Ocean, p. 3.

236 Peach Tree, Online Peachy Groups, <peachtree.org.au/online-peachy-groups/>, [accessed 16 December 2020]; Peach Tree, Facebook: Peach Tree Call Back Service, <www.facebook.com/peachtreeperinatal/photos/a.327789763955656/3062917423776196/?type=3&theater>, [accessed 16 December 2020].

237 *Witness Statement of 'Michael Silva' (pseudonym)*, 22 June 2020, para. 63; *Witness Statement of Denna Healy*, para. 51; *Witness Statement of Jesse Morgan*, para. 11.

238 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 911.

239 *Witness Statement of Marie Piu*, para. 52.

240 Ingrid Zechmeister-Koss and others, 'Supporting Children Who Have a Parent with a Mental Illness in Tyrol: A Situational Analysis for Informing Co-Development and Implementation of Practice Changes', *BMC Health Services Research*, 20:326 (2020), 1–15 (p. 2).

241 Zechmeister-Koss and others, p. 2.

242 Jacqueline Sin and others, 'Understanding the Experiences and Service Needs of Siblings of Individuals with First-Episode Psychosis: A Phenomenological Study', *Early Intervention in Psychiatry*, 6.1 (2012), 53–59 (p. 53).

243 Orygen, *Circle of Support: Supporting Families and Their Involvement in Youth Mental Health*, 2020, p. 9.

244 RCVMHS, *Young Carer Human-Centred Design Focus Group: Record of Proceedings*, 2020.

245 RCVMHS, *Young Carer Human-Centred Design Focus Group: Record of Proceedings*.

246 *Witness Statement of Rose Cuff*, para. 29.

247 *Witness Statement of Denna Healy*, paras. 40 and 51; *Witness Statement of Justin Heazlewood*, 22 April 2020, para. 76.

248 *Witness Statement of Rose Cuff*, para. 33.

249 Satellite Foundation, It's A Mad World, <www.satellitefoundation.org.au/2020/11/its-a-mad-world/>, [accessed 18 November 2020].

250 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, p. 876.

251 *Evidence of Jesse Morgan*, 12 July 2019, p. 853.

252 *Evidence of Jesse Morgan*, p. 853.

253 Zechmeister-Koss and others, p. 2.

254 Zechmeister-Koss and others, p. 2.

255 Village Project, About Us, <https://www.village.lbg.ac.at/about>, [accessed 6 August 2020].

256 Village Project, About Us, <https://www.village.lbg.ac.at/about>, [accessed 6 August 2020].

257 Department of Health and Human Services, Families Where a Parent Has a Mental Illness (FaPMI) Program Guidelines, p. 1.

258 Department of Health and Human Services, Families Where a Parent Has a Mental Illness (FaPMI) Program Guidelines, p. 1.

259 *Witness Statement of Rose Cuff*, para. 9.

260 *Witness Statement of Rose Cuff*, para. 9.

261 Melinda Goodyear and others, 'Standards of Practice for the Adult Mental Health Workforce: Meeting the Needs of Families Where a Parent Has a Mental Illness: Family-Focused Practice Standards', *International Journal of Mental Health Nursing*, 24.2 (2015), 1–12 (p. 2).

262 Department of Health and Human Services, 'Families Where a Parent Has a Mental Illness (FaPMI) Program Guidelines', p. 2.

263 Department of Health and Human Services, Families Where a Parent Has a Mental Illness (FaPMI) Program Guidelines, p. 4.

264 Department of Education and Training, Young Carers—Identification and Support: The Role of Schools in Identification, Response and Support, <www2.education.vic.gov.au/pal/young-carers-identification-and-support/guidance/role-schools-identification-response-and>, [accessed 6 November 2020]; Department of Education and Training, Young Carers—Identification and Support: Policy, <www2.education.vic.gov.au/pal/young-carers-identification-and-support/policy>, [accessed 6 November 2020].

265 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: Extra Funding Boosts Innovative Projects For Carers, 11 February 2020, <www.premier.vic.gov.au/extra-funding-boosts-innovative-projects-carers>, [accessed 6 November 2020].

266 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: Supporting Students Through The Pandemic, 7 August 2020, <www.premier.vic.gov.au/supporting-students-through-pandemic>, [accessed 11 September 2020]; The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: More Mental Health Support For Victorian Students, 11 September 2020, <www.premier.vic.gov.au/more-mental-health-support-victorian-students>, [accessed 11 September 2020].

267 *Witness Statement of Justin Heazlewood*, para. 72.

268 *Witness Statement of Justin Heazlewood*, para. 68.

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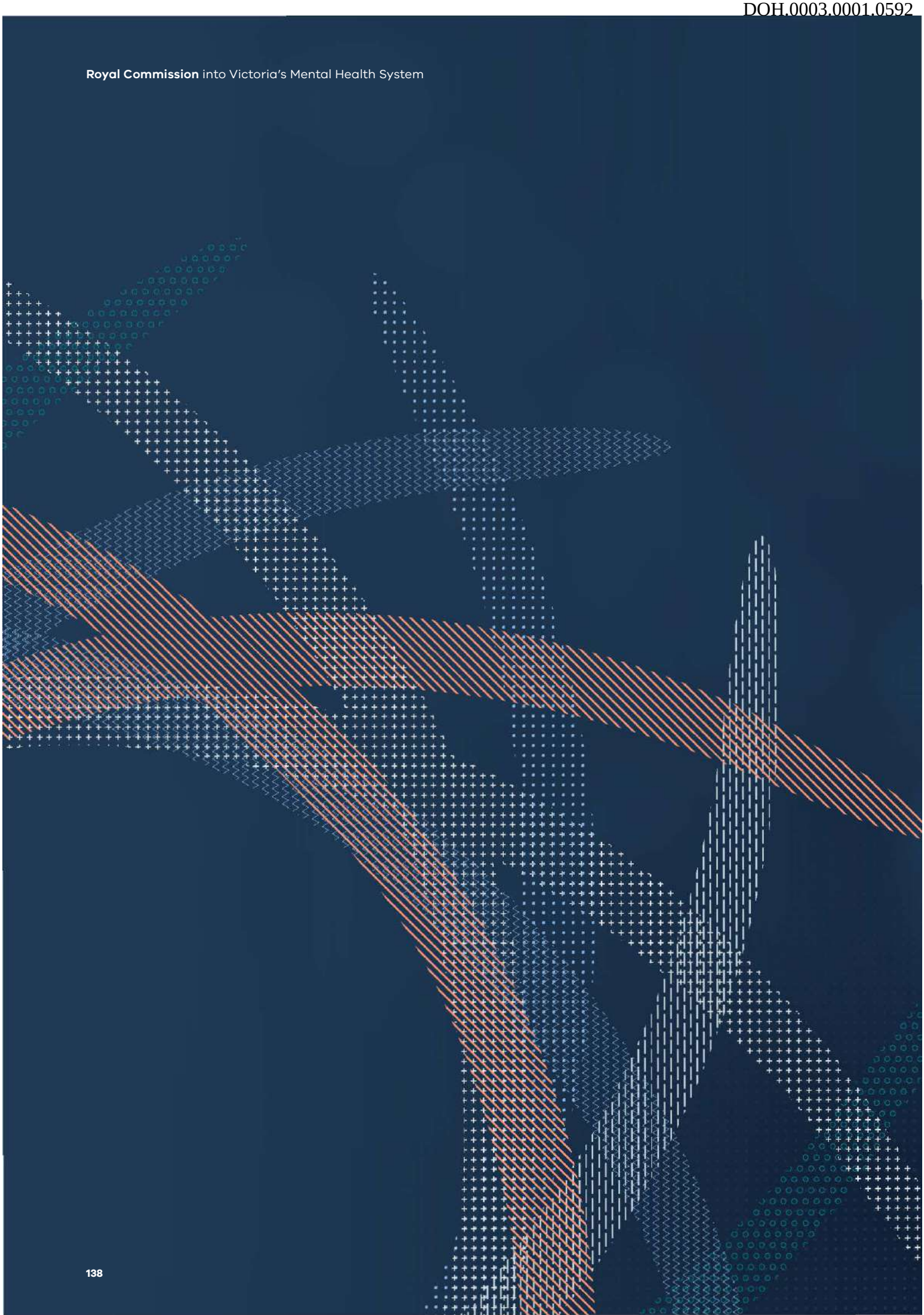

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Chapter 20

Supporting Aboriginal social and emotional wellbeing

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Recommendation 33:

Supporting Aboriginal social and emotional wellbeing

The Royal Commission recommends that the Victorian Government:

1. build on the interim report's recommendation 4 to support Aboriginal social and emotional wellbeing, and resource the Social and Emotional Wellbeing Centre to establish two co-designed healing centres.
2. resource Infant, Child and Youth Area Mental Health and Wellbeing Services to support Aboriginal community-controlled health organisations by providing primary consultation, secondary consultation and shared care.
3. resource Aboriginal community-controlled health organisations to commission the delivery of culturally appropriate, family-oriented, social and emotional wellbeing services for children and young people.
4. resource the Victorian Aboriginal Community Controlled Health Organisation, in partnership with an Infant, Child and Youth Area Mental Health and Wellbeing Service, to design and establish a culturally appropriate, family-oriented service for infants and children who require intensive social and emotional wellbeing supports.

20.1 Aboriginal social and emotional wellbeing

Social and emotional wellbeing means being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life.[1] Witnesses and submissions from Aboriginal people and community-controlled organisations made clear to the Commission the courage and strength of Aboriginal communities, and the protective role of culture, identity and connection to country for social and emotional wellbeing.[2]

In the face of significant challenges stemming from invasion, dispossession and ongoing systemic racism and marginalisation,[3] Aboriginal communities remain resilient. The Commission recognises the leadership and ingenuity of many Aboriginal Elders, communities and community-controlled organisations in supporting better social and emotional wellbeing outcomes for Aboriginal people.

The Commission is grateful to the many Aboriginal people and organisations who have invested their trust in the Commission and shared their individual and collective experiences of pain, trauma and resilience. The Commission agrees with evidence before it that Victoria's mental health system has failed to meet the needs of Aboriginal people.[4] The mental health system has failed to genuinely recognise or reckon with the many ways in which it has excluded Aboriginal people, and it has failed to acknowledge the ways in which it has contributed to or exacerbated mental illness.[5] Perhaps most devastatingly, it has failed to change.

The Commission also acknowledges the significant contribution of the Victorian Aboriginal Community Controlled Health Organisation, which developed the *Balit Durn Durn* report to support the Commission's deliberations. In the report, CEO, Jill Gallagher described the 'direct relationship between poor mental health and wellbeing, and loss of land, culture, identity, self-worth and the breakdown of traditional kinship structures and roles' within Aboriginal communities.[6] Speaking about the community consultations undertaken in the development of the report, Ms Gallagher noted:

> Despite the levels of loss, grief, health anxieties and racism felt in Aboriginal Communities, many interviewees were incredibly passionate about their work and optimistic about the future. Interviewees showed a deep commitment to their own and their family's healing and social and emotional wellbeing.[7]

Ms Gallagher also discussed the devastating impact—felt worldwide—of the death of African American man George Floyd in the United States of America, while being arrested:

> Floyd's death triggered demonstrations and protests globally that also had enormous reverberations in Victoria and across Australia. It reminded us how we must be prepared to address the injustices and ongoing impacts of colonisation if we ever wish to see improved health and wellbeing outcomes in Aboriginal Communities.[8]

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The Royal Commission into Victoria's Mental Health System follows many royal commissions and inquiries—spanning several decades—that have highlighted the systemic failure of government agencies and social institutions to discharge their responsibilities to Aboriginal people and communities. The breadth and depth of this failure is more than adequately documented in multiple royal commission reports.[9] These shortcomings are frequently compounded by a failure to fully implement the resulting recommendations or to adequately evaluate the impact of recommendations that are implemented.[10]

In recognition of both the urgent need for reform and the efficacy of taking a social and emotional wellbeing approach to mental health, the Commission's interim report recommended a suite of reforms to support Aboriginal community-controlled health organisations to provide comprehensive care for Aboriginal consumers (refer to Box 20.1).[11]

Building on, and consistent with, the reforms described in the interim report, the additional reforms in this chapter are founded on the principles of self-determination—'that Aboriginal Victorians hold the knowledge and expertise about what is best for themselves, their families and their communities.'[12]

The recommended reforms include funding for the delivery of healing centres to complement the social and emotional wellbeing services delivered by Aboriginal community-controlled health organisations. The focus on healing marks a further shift away from the crisis-driven care that characterises much of the state's current response to mental illness.[13]

The chapter also includes a suite of reforms to provide children and families with early, culturally safe and flexible support through Aboriginal-led organisations in partnership with mental health services. Aboriginal children and young people will be able to access specialist mental health services, family-oriented therapeutic treatment, care and support and intensive multidisciplinary care delivered within community settings. These reforms focus squarely on treatment, care and support being delivered through Aboriginal organisations.

The Commission also recognises that many Aboriginal people access mainstream mental health services for treatment, care and support.[14] It is therefore incumbent on the mental health system to provide culturally safe, responsive and inclusive mental health and wellbeing services.[15] This chapter describes how reforms to increase the safety, responsiveness and inclusiveness of mental health and wellbeing services for all consumers will recognise and provide tangible benefits for Aboriginal consumers.

The Commission's aspiration is for a mental health and wellbeing system where Aboriginal self-determination is respected and upheld in the design and delivery of treatment, care and support, and where Aboriginal people can choose to receive care within Aboriginal community-controlled organisations, within mainstream services or a mix of both. Irrespective of where treatment, care and support is delivered for Aboriginal people, communities and families, it is fundamental that it is safe, inclusive, respectful and responsive.

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Figure 20.1: The current state of Aboriginal mental health and the case for change

31%

One in three Aboriginal people experience high or very high levels of psychological distress. That is about 2.5 times the non-Aboriginal rate

77%

of Indigenous people aged 18–24 who had experienced very high or high psychological distress **had not seen a health professional**

33%

of Aboriginal Victorians have been diagnosed with a mental or behavioural condition. **This is nearly 1.6 times the non-Aboriginal rate**

55%

The number of presentations to Victorian hospital emergency departments by Aboriginal people increased by **55%** between 2012–13 and 2015–16

4x

The rate of mental health-related emergency department presentations for Indigenous Australians was more than **4 times that for non-Aboriginal**

33%

of organisations providing health care to Aboriginal people provided trauma-informed social and emotional wellbeing services—**88% of these services were Aboriginal community-controlled organisations**

47%

of Aboriginal people have a relative who was forcibly removed from their family due to stolen generations policies in Victoria. Transgenerational trauma continues to affect Aboriginal people in Victoria

19%

The total burden of disease among Aboriginal people attributable to mental illness and substance use disorders*

16x

In Victoria, nearly one in 10 Aboriginal children are in out-of-home-care, which is nearly 16 times the rate of non-Aboriginal children^

Source: Adapted from VACCHO, Balit Durn Durn, Strong brain, mind, intellect and sense of self, 2020, p.19; *Australian Institute of Health and Wellbeing, Indigenous Health and Wellbeing <www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing>, [accessed 14 January 2021]; ^Department of Health and Human Services, Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement, 2018, p. 19.

20.2 Aboriginal social and emotional wellbeing in the interim report

The Commission's terms of reference directed the Commission to consider how to improve mental health outcomes, taking into account best practice and person-centred treatment and care models for people from Aboriginal and Torres Strait Islander backgrounds.[16]

The interim report discussed the ways in which colonisation, racism, discrimination, marginalisation and compounding intergenerational trauma have had a profound and enduring impact on mental health outcomes for Aboriginal people.[17]

Mental health outcomes and suicide rates among Aboriginal people are confronting:

- Poor mental health and substance use disorders have been estimated to account for as much as 14 per cent of the health gap between Aboriginal and non-Aboriginal people.[18]
- Research indicates that one in three Aboriginal people experience high or very high levels of psychological distress—almost three times the rate for non-Aboriginal people.[19] One study found that twice as many Aboriginal adolescents as non-Aboriginal adolescents (aged 18–24 years) experience considerable psychological distress.[20]
- The national suicide rate for Aboriginal people is estimated to be twice the rate of the general population;[21] suicide among Aboriginal people generally occurs at a much younger age.[22]
- Aboriginal children and young people accounted for 30 per cent of all suicide deaths by Australian children and young people in 2016; this is despite Aboriginal children and young people only representing 3–4 per cent of children and young people overall.[23]
- Aboriginal people aged 15–24 years are estimated to be over five times more likely to die by suicide than their non-Aboriginal peers.[24]

As discussed in Chapter 32: *Reducing compulsory treatment*, Aboriginal people are also over-represented in relation to compulsory treatment orders in comparison to the rest of the Victorian population, making up approximately three percent of clients placed on compulsory treatment orders.[25] While the causes of this over-representation are unclear, international analysis indicates that people from culturally diverse, marginalised and economically disadvantaged backgrounds are more likely to be treated compulsorily.[26] Consequently, the over-representation of Aboriginal people on compulsory treatment orders should be understood in the context of the effects of '(inter)generational trauma, racism, discrimination, marginalisation and disadvantage' on the health and wellbeing of Aboriginal people.[27]

The interim report also discussed the protective role of Aboriginal people's connection to country and culture,[28] which is a source of strength in the face of ongoing oppression.[29] It described the centrality of Aboriginal family and kinship connections to an Aboriginal person's mental health and the need for a holistic approach to understanding health and social and emotional wellbeing in Aboriginal communities:

> We need holistic responses that are developed and led by Aboriginal people and community organisations in partnership.[30]

Mainstream biomedical explanatory and treatment models for mental illness are considered at odds with Aboriginal cultural understandings of mental health, which are based on beliefs about the inextricable connections between the physical, emotional and spiritual wellbeing of a person, their community and the environment.[31] These domains of life are believed to be closely interconnected and explained by understanding the whole. As highlighted in the *Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy National Consultancy Report*, for Aboriginal people:

> Health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well-being of their communities.[32]

The shorthand term 'social and emotional wellbeing' describes this understanding of mental health. Dr Graham Gee, Clinical Psychologist and Senior Research Fellow at the Murdoch Children's Research Institute, explained:

> Social and Emotional Wellbeing (SEWB) is a complex term that for many Aboriginal people refers to a holistic view of health that includes mental wellbeing and mental health disorders—but importantly, it links the mental health of individual and families, and the wellbeing of whole communities, to more than physical, emotional and mental wellbeing. SEWB from an Aboriginal perspective, recognises that mental health is also shaped by connections to culture, land, extended kinship, the ancestors, and spirituality. The other important part of SEWB that distinguishes it from conventional understandings of mental health is that these connections are influenced not only by social determinants of health, but also by historical, political and cultural determinants. Historical, political and cultural factors shape the presentation and meaning of how mental health symptoms are understood for Aboriginal clients, in many different ways.[33]

As Figure 20.2 shows, this holistic view is not limited to connections between the mind and the body: it also captures Aboriginal people's connections to land, spirit, spirituality and ancestors, culture and community, family and kinship.[34]

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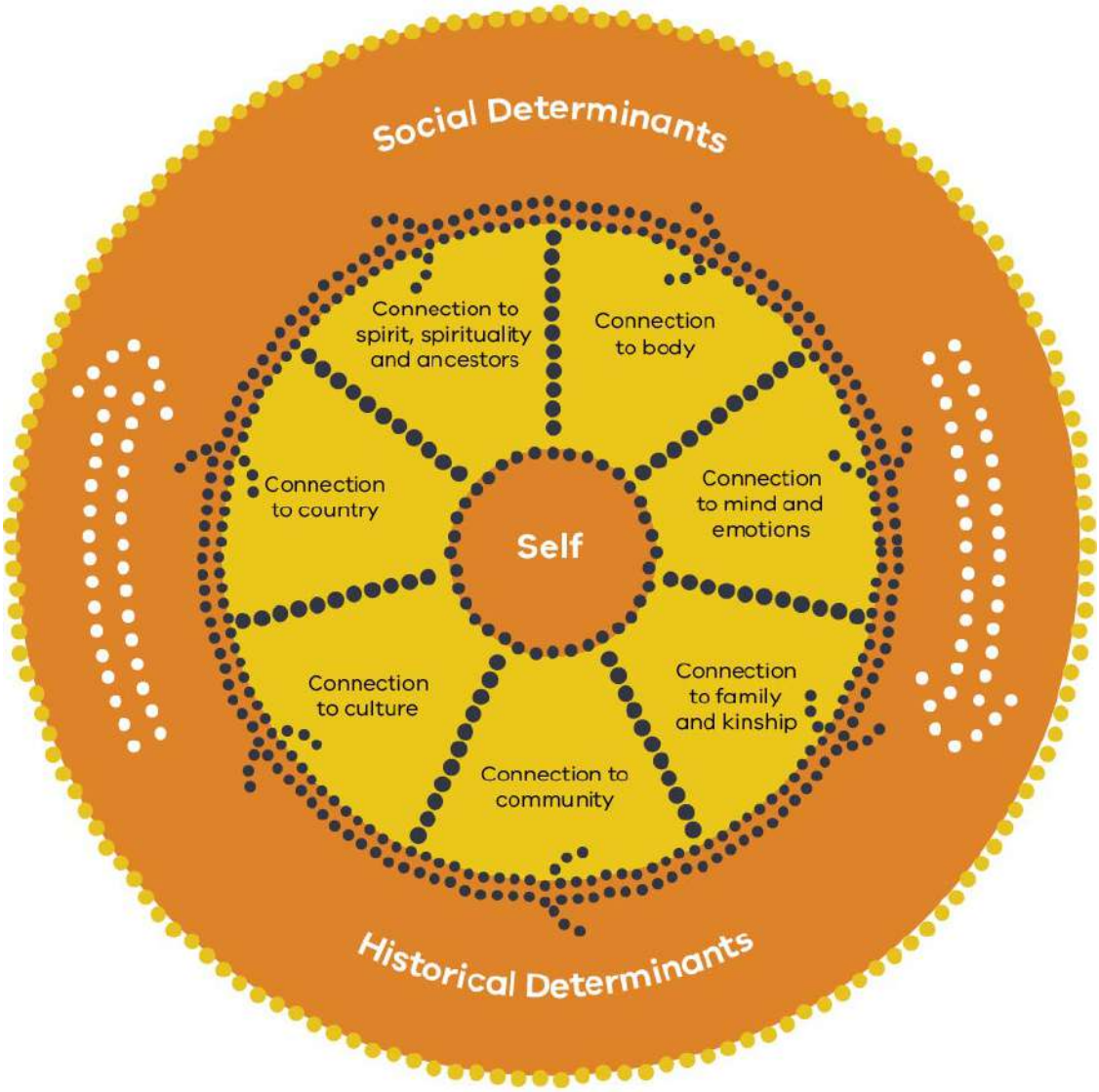
Figure 20.2: Aboriginal social and emotional wellbeing



This conception of self is grounded within a collectivist perspective that views the self as inseparable from, and embedded within, family and community.

Source: Reproduced from Graham Gee and others, 'Chapter 4: Aboriginal and Torres Strait Islander Social and Emotional Wellbeing', in Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (Canberra: Commonwealth of Australia, 2014), pp. 55–68.

The interim report acknowledged the urgent need to address mental illness in Aboriginal communities and the central role of self-determined Aboriginal social and emotional wellbeing services in promoting Aboriginal social and emotional wellbeing.[35]

The Commission received several proposals from Aboriginal witnesses and community-controlled organisations advocating for the expansion of multidisciplinary models of care that apply the Aboriginal concept of social and emotional wellbeing. The Commission consequently recommended in its interim report, the expansion of Aboriginal social and emotional wellbeing services, supported by a new Aboriginal Social and Emotional Wellbeing Centre (refer to Box 20.1).

Box 20.1: Aboriginal social and wellbeing recommendation from the interim report

The Royal Commission recommends that the Victorian Government, through the Mental Health Implementation Office, expands social and emotional wellbeing teams throughout Victoria and that these teams be supported by a new Aboriginal Social and Emotional Wellbeing Centre. This should be facilitated through the following mechanisms:

- dedicated recurrent funding to establish and expand multidisciplinary social and emotional wellbeing teams in Aboriginal community-controlled health organisations, with statewide coverage within five years
- scholarships to enable Aboriginal social and emotional wellbeing team members to obtain recognised clinical mental health qualifications from approved public tertiary providers, with a minimum of 30 scholarships awarded over the next five years
- recurrent funding for the Victorian Aboriginal Community Controlled Health Organisation to develop, host and maintain the recommended Aboriginal Social and Emotional Wellbeing Centre in partnership with organisations with clinical expertise and research expertise in Aboriginal mental health. The centre will help expand social and emotional wellbeing services through:
  - clinical, organisational and cultural governance planning and development
  - workforce development—including by enabling the recommended scholarships
  - guidance, tools and practical supports for building clinical effectiveness in assessment, diagnosis and treatment
  - developing and disseminating research and evidence for social and emotional wellbeing models and convening associated communities of practice.

Source: Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019 p. 46.

20.3 The impact of intergenerational trauma, colonisation and systemic racism

Colonisation, racism, discrimination, marginalisation and the compounding impact of intergenerational trauma have had a profound and enduring impact on mental health outcomes for Aboriginal people.[36]

Aboriginal Victorians experience higher rates of poor mental health than non-Aboriginal Victorians.[37] In its submission, the Victorian Aboriginal Child Care Agency described the effect of intergenerational trauma:

> Aboriginal peoples conceptualise 'trauma' as a way of understanding and describing the effects of interpersonal and collective forms of violence on their peoples. The term collective trauma considers the incidence and effects of individual traumatic events as well as the social and psychological trajectories in which the consequences of colonisation are aligned with the deterioration of social norms, values and cultural practices of a community. Aboriginal community members often share experiences of trauma, resulting in entire communities managing symptoms simultaneously, shifting cultural norms and breaking down social relations and traditional roles within families and communities.[38]

Some Aboriginal people are at higher risk of experiencing the intergenerational effects of trauma and mental illness. Among the most disadvantaged are members of the Stolen Generations, children in out-of-home care and those with a history of incarceration.[39] Almost half (47 per cent) of Aboriginal people in Victoria have a relative who was forcibly removed under Stolen Generations policies.[40] About 40 per cent of people of the Stolen Generations aged 50 years or older experience poor mental health attributed to the trauma of removal.[41]

Victoria, along with Western Australia and South Australia, consistently have the highest proportions of their populations born before 1972 who, in multiple surveys conducted from 2002 to 2014–2015, report being forcibly removed.[42] As the Healing Foundation submitted to the Commission, Aboriginal people in Victoria carry the legacy of trauma caused by the forcible removal of children from Aboriginal families.[43]

A first-of-its-kind study commissioned by the Healing Foundation provided comprehensive data to illustrate the direct link between the removal of Aboriginal children and symptoms of trauma in families and their descendants. The study also documented higher levels of health, economic and social disadvantage in the affected families and the consequences of the trauma experienced.[44]

Aboriginal organisations told the Commission:

> The prevalence of [poor] mental health within Victorian Aboriginal communities can be directly related to the loss of land, culture, identity, self-respect, self-worth and the breakdown of traditional roles within communities. Systemic racism has been a significant factor in ensuring Aboriginal communities remain fragmented and disjointed and has supported the social isolation, trauma and depression of many Aboriginal communities' members.[45]
>
> It is important for the Royal Commission to understand that colonial violence is not a stagnant piece of history. Intersecting systemic racism and systemic sexism keep Aboriginal and Torres Strait Islander women trapped in violent situations and cycles of trauma. The mental health system can present as yet another form of violence.[46]

Post-invasion policies not only disrupted family attachments, but severed Aboriginal peoples' attachment to their land, cultures and identities. The historical trauma experienced by Aboriginal people can have intergenerational impacts across entire communities as well as on individuals and families.[47] The intergenerational nature of trauma has significant implications for the mental health and wellbeing of children and young people in particular,[48] and requires culturally appropriate service responses to address the needs of these communities.[49]

The 'devastating impact' of trauma on Aboriginal culture and health also limits Aboriginal people's access to mainstream support services.[50] Many Aboriginal communities face challenges, such as alcohol abuse and forms of violence, that did not exist before colonisation.[51] Lack of access to early support for trauma, plus social or cultural determinants of health, can result in a 'cascade of problems',[52] which compound intergenerationally (as described in Chapter 15: *Responding to trauma*).

The Commission agrees that responding to these experiences requires a mental health workforce that understands how intergenerational trauma affects Aboriginal people's trust of services and willingness to seek help,[53] as well as the 'intersections between systemic racism, family violence, trauma and mental health stigma'.[54] Mr Andrew Jackomos PSM, Executive Director, Aboriginal Economic Development, Department of Jobs, Precincts and Regions, a Yorta Yorta man, told the Commission:

> The issues that impact on the health and well-being for our community is complex, inter-related and driven by a range of environmental factors. The legacy of intergenerational trauma is still very present in past, present and subsequent generations. Isolated reforms that happen in one pocket of the service system will not effectively address these complex issues.[55]

Dr Gee described the interplay between historical, political and cultural determinants that influence Aboriginal social and emotional wellbeing in addition to social determinants:

> historical determinants include the impact of past government policies and cultural displacement that has been experienced by whole of cultural groups and communities, or conversely, the extent to which communities have managed to maintain cultural continuity. Political determinants include sovereignty, unresolved issues of land and control of resources, and self-determination. These are not abstract concepts. They effectively shape the environments and circumstances into which Aboriginal children are born. They heavily influence the types of coping skills and resources that people can draw upon, including the community and relationship networks that are central for recovery.[56]

The effect of intergenerational trauma and the associated social and economic disadvantage is evident across multiple domains, such as in the criminal justice, prison, family violence, child protection and mental health systems.[57]

As discussed in the interim report, the Commission has heard considerable concerns from Aboriginal organisations and experts about the intersections between the mental health and justice systems for Aboriginal people.[58] Systemic racism and intergenerational trauma contribute to the over-representation of Aboriginal people in the Victorian justice system—Aboriginal children and young people are 14 times more likely than their non-Aboriginal peers to be under youth justice supervision,[59] and adults are 12 times more likely to be in prison or community corrections.[60]

The Victorian Aboriginal Legal Service described the effect that interactions with the justice system can have on Aboriginal Victorians:

> The impact of the legal system on mental health is particularly acute for Aboriginal peoples, given the lack of cultural safety and ongoing discrimination and racism within the system. This is even more aggravated for Aboriginal people in contact with the criminal justice system, where the impacts for social and emotional wellbeing are devastating, particularly for Aboriginal people in custody.[61]

Aboriginal people make up 10 per cent of the homeless population, despite comprising less than one per cent of the Australian population. Aboriginal Housing Victoria noted that 17 per cent of the Aboriginal population in Victoria had contact with homeless services in 2018.[62] Children and young people make up more than half of the Aboriginal people in contact with homeless services in Australia.[63] Research indicates that approximately one-third of young people become homeless within a year of leaving care; the over-representation of Aboriginal children in care may therefore go some way to explaining the high rates of homelessness among Aboriginal young people.[64] One in 10 Aboriginal children are in out-of-home care—which is nearly 16 times the rate of non-Aboriginal children.[65] There is noticeable overlap between out-of-home care and contact with the justice system; research suggests 64 per cent of Aboriginal young people in the criminal justice system were also in contact with child protection.[66]

The *Always Was, Always Will Be Koori Children* report by the Commission for Children and Young People, an investigation into the circumstances of Aboriginal children and young people in out-of-home care in Victoria, noted the following:

> The trajectory from out-of-home care to youth justice is a disturbing reality for many young people. This is particularly the case for Aboriginal young people. Research has found that Aboriginal young people are particularly vulnerable to becoming immersed in a cycle of contact with the criminal justice system. The cycle is intensified by contributing factors such as limited education and employment opportunities, drug and alcohol dependence and insecure accommodation.[67]

Evidence suggests that parental mental illness is a contributing factor to children being placed in out-of-home care. The *Always Was, Always Will Be Koori Children* report indicated that more than 60 per cent of the children reviewed as part of the report's Taskforce 1000 investigation 'came to the attention of child protection as a result of parental mental health issues in combination with other risk factors', and that parental mental illness was also the reason many children could not be returned.[68] The report pointed to the cycle of out-of-home care within many Aboriginal families, stemming from poor outcomes for Aboriginal young people leaving care, including unresolved trauma and abuse, children being dislocated from their families, culture and identity, homelessness, the trajectory into the justice system, poor education outcomes and limited employment opportunities.[69] The report stated:

> It was quite clear that many parents of the 980 children we saw [during the report's Taskforce 1000 investigation] had been in the care of the state and the state pushed them out of the door ill-prepared. The same thing sadly seems to be happening to the current generation of Koori kids leaving care.[70]

Always Was, Always Will be Koori Children also found high rates of mental illness in Aboriginal children in out-of-home care, with more than one in five children in the Taskforce 1000 investigation experiencing mental illness. The report noted that eight per cent of children who were identified as experiencing mental illness were under five years old.[71] The report's findings reflect those of the Victorian Auditor-General in its 2019 *Child and Youth Mental Health* report, which found that children in out-of-home care had up to five times higher rates of mental health problems and double the rate of suicide attempts compared with the general population.[72]

These findings align with research indicating that exposure to repeated trauma and prolonged adversities experienced during childhood—especially during particular developmental periods—increases the risk of developing mental illness.[73] Trauma experienced at an early developmental stage can affect a person's 'sense of self, safety and trust' and has the 'strongest connection to adult mental health issues, illness, self-harm and suicide'.[74]

Experiences of intergenerational trauma may also act as a barrier to accessing services. As noted by witness Mr Adam Burns, Senior Mental Health Clinician at Melbourne Health's Wadamba Wilam:

> The historical trauma experienced by many communities, families and individuals contributes to a distrust of all mainstream support services and a reluctance to access any services that may assist with SEWB [social and emotional wellbeing]. Additionally, the experiences of historical and intergenerational trauma have robbed people of many of the key elements of SEWB and they do not feel comfortable in accessing culturally specific services and supports. Historical and intergenerational trauma is all-pervasive and influences every interaction with support services and systems.[75]

For example, distrust of mainstream services stemming from historical trauma can leave parents reluctant to seek out support services, including mental health treatment, care and support, for fear that to ask for support may result in child notifications and contact with child protection.[76] This may lead to families failing to get necessary or timely health, mental health and social supports. It also points to the need for Aboriginal organisations to be adequately resourced in order to provide comprehensive mental health and wellbeing services for children and families.

20.4 Lack of cultural safety and cultural responsiveness in mainstream services

Ms Helen Kennedy, Chief Operations Officer of the Victorian Aboriginal Community Controlled Health Organisation, told the Commission about the 'profound distrust' many Aboriginal people have of mainstream services.[77] The Victorian Aboriginal Health Service highlighted the 'misinformed assumptions, negative judgement, overt and covert racism and a total lack of cultural understanding from mainstream services'[78] that many of its clients are exposed to. The service also noted that these experiences can mean that people might only seek out services once a crisis occurs.[79]

In a study involving 755 Aboriginal people in Victoria, nearly one-third of participants reported that they had experienced racism in health settings. This included being a target of racist names, jokes or teasing, being told they 'didn't belong in Australia', or hearing comments based on stereotypes of Aboriginal Australians, in health settings in the preceding year.[80] Research also indicates that experiencing racism in health settings is associated with increased psychological distress.[81] The Commission is aware of the negative impact of racism on Aboriginal people's mental health. An Aboriginal community-controlled organisation staff member described the work they do advocating for clients due to racism within mainstream settings:

> The real issue is institutional racism. It is really, really sickening. We have to continuously advocate for Community members while they are at mainstream services and its very time intensive, that's when resources come into it. We get a different response, if we are accompanying them, especially if it's by a registered nurse or someone with authority, they don't get the same response that an Aboriginal person presenting by themselves would.[82]

In addition to overt racism, the day-to-day practices and policies of health services can be culturally unsafe for Aboriginal people. The Commission has been told that the approach of many mainstream mental health services is problematic for Aboriginal communities.[83] Research indicates that the failure of health professionals to recognise and respond to cultural differences and communication gaps can reduce positive health outcomes for Aboriginal consumers, or even increase the risk of life-threatening outcomes.[84] Research also indicates that communication barriers between health professionals and Aboriginal people undermine relationships, and may result in Aboriginal people feeling alienated and disengaging from healthcare.[85]

Witnesses and submissions described the ways in which the mental health system is insensitive to the needs of Aboriginal people and Aboriginal spirituality is misunderstood. Aunty Nellie Flagg, witness, respected Elder and a Taylor-Charles, told the Commission:

> The [mental health] system does not understand Aboriginal spirituality ... My family has been afraid of people judging them for their mental health issues. They have been afraid to talk about it for fear of being labelled mental or being unable to hold a job.[86]

Ms Tamara Lovett's personal story describes her experiences within mental health services.

Personal story:

Tamara Lovett

Tamara Lovett is a Gunai and Gunditjmara woman who has lived in Melbourne her whole life. She has experienced mental health challenges since she was young.

During her first pregnancy, Tamara established a good relationship with a GP, whom she felt she could be open and honest with. She asked for a referral to a psychiatrist as a way of protecting her mental health during her pregnancy, but she had a negative experience when she saw the psychiatrist at a hospital.

> A lot of the time when I have tried to access help it is not culturally safe. Sometimes I can get help but it doesn't fit. They automatically jump to a diagnosis. My mental health makes sense when you listen to my life story.

After her child was born, Tamara was facing homelessness due to a stressful living situation. She connected with Wadamba Wilam, a program that supports Aboriginal people who are experiencing homelessness and require support around their social and emotional wellbeing. She says that along with her GP, Wadamba Wilam has been her only source of help.

> Wadamba [Wilam] works from a strengths based approach and were able to help me see things in a more positive light. They believed my journey and didn't try and diagnose me or blame me for my past. My case workers listened and took my journey on board.

Tamara is not comfortable using mainstream services, as she believes that workers don't understand or respond to her cultural needs.

> They are just fixed on a diagnosis and also on medications, but that's not the therapy I wanted. They are also limited on time, rushed and don't listen. And you never see the same people, which means you have to keep re-telling traumatic events over and over again.

Tamara has since worked at Wadamba Wilam as a lived experience case manager, and as an Aboriginal Mental Health Outreach Worker within community health services. In the future, Tamara would like to see more services that are culturally safe, and more funding for Aboriginal-specific workers in clinical settings.

> We need more Aboriginal people working in both mainstream and Aboriginal mental health services.

Source: *Witness Statement of Tamara Lovett*, 16 July 2019; *Wadamba Wilam: Renew Shelter*, <assets.neaminational.org.au/assets/Resources/Services/1e24a31933/Booklet_WadambaWilam_V2.2_DIGITAL.pdf>, [accessed 21 December 2020].

20.5 Self-determination as the foundation of reform

The right to Aboriginal self-determination is enshrined in international law.[87] In 2009, the Commonwealth Government indicated support for the United Nations Declaration on the Rights of Indigenous Peoples, which provides a framework for action with self-determination at the core.[88] A vast number of policies and programs developed over several decades at the national level have highlighted the importance of redressing the historical and ongoing inequities in health, social and economic outcomes for Aboriginal people. However, most have failed to genuinely adopt principles of self-determination, and thus have failed to effect genuine change in mainstream services.[89] More than two decades ago, Aboriginal leader Rob Riley described this as 'administrative genocide'.[90] He linked the mental health status of Aboriginal people to the fact that 'they have not been empowered to make decisions about their lives and the lives and futures of their children', but instead have been forced into a 'co-dependency between the community and the bureaucracy'.[91]

Perhaps the most significant of these policies, in terms of missed opportunity, is the Closing the Gap initiative. The Australian Medical Association noted that the Closing the Gap initiative was considered ground-breaking when it was established in 2007, but its weakness was that 'Aboriginal and Torres Strait Islander people themselves were not part of the decision-making process'.[92] It said:

> The unacceptable progress against the Closing the Gap targets is reflective of the need to better incorporate the knowledge of Aboriginal and Torres Strait Islander people into policies and programs and include them in the negotiating process. This has long been called for.[93]

In its 10-year review, the Closing the Gap Steering Committee noted the failure to meet health targets for Aboriginal people and urged policy makers to re-orient their approach, rather than cancel funding for the initiative. In particular, the Steering Committee recommended focusing on the underlying structural factors shaping health, ensuring better cooperation between governments, and respecting 'Indigenous people's right to self-determination in efforts to improve their health'.[94]

In response, a new Partnership Agreement on Closing the Gap 2019–2029 has been established as an agreement between the Coalition of Aboriginal and Torres Strait Islander Peak Organisations and the Council of Australian Governments.[95] The objectives of the agreement include sharing 'ownership of, and responsibility for, a jointly agreed framework' as well as advancing Aboriginal and Torres Strait Islander 'involvement, engagement' and autonomy through equitable participation, shared authority and decision-making'.[96]

Recently, the Productivity Commission highlighted the need to ensure genuine self-determination in relation to Aboriginal policies and programs. Research undertaken in the development of the Productivity Commission's *Indigenous Evaluation Strategy* found minimal input by Aboriginal people into evaluations, with only 30 per cent of evaluations of Aboriginal specific policies and one of the 56 evaluations of mainstream policies and programs involving Aboriginal people in evaluation planning and decision making.[97] Concerningly, the research also noted 'more than half of the mainstream policy or program evaluations that mentioned or provided results for Aboriginal and Torres Strait Islander people did not report engaging with Aboriginal and Torres Strait Islander people.'[98]

At the state level, the current Victorian Government has made a strong commitment to self-determination through the treaty process driven by the First Peoples' Assembly of Victoria and supported by a truth and justice process (refer to Box 20.2). The Commission recognises the profound harm that has been caused to Aboriginal peoples throughout Australia's history. It shares the view that an equitable and reconciled society can only become a reality once the injustices committed against Aboriginal people are publicly acknowledged and remedied. The Commission therefore lends its full support behind the truth and justice initiative introduced by the Victorian Government working in partnership with the First People's Assembly of Victoria.

Box 20.2: Victoria's truth and justice process

In July 2020, the Victorian Government announced that it will be establishing a truth and justice process to formally acknowledge the past and present-day injustices committed against Aboriginal Victorians.[99] The government will work with the First People's Assembly of Victoria—a democratically-elected body made up of Aboriginal leaders—to develop the terms of reference for the process and ensure Aboriginal communities are heard in all stages of its planning, design and implementation.[100]

Victoria's truth-telling process is an historic move, being the first of its kind in Australia. It will make Victoria the only Australian jurisdiction to action the 'treaty' and 'truth' elements of the *Uluru Statement from the Heart*, the proposal for constitutional reform signed by Aboriginal people from all over Australia in 2017 to recognise and support their sovereignty.[101]

The establishment of a truth-telling process in Victoria is modelled on similar reconciliation initiatives overseas—such as truth commissions held in Canada and New Zealand—where public hearings established the scale and impact of human rights abuses committed against First Nations peoples, and made the findings of those inquiries a permanent and unassailable part of the public record.[102]

Truth-telling is a fundamental aspect of efforts to heal the wounds of the past and achieve reconciliation in Australia.[103]

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In the words of The Hon. Gabrielle Williams, Minister for Aboriginal Affairs:

> There is nothing more powerful than the truth. Because with honesty comes healing. It's going to take courage from all sides to uncover the truths of our past and understand ongoing impacts – establishing this process brings us one step closer to genuine reconciliation.[104]

For Aboriginal peoples, Australia's colonial history is characterised by violence and overt racism, consisting of massacres, land dispossession, the forced removal of children from families, the failure to pay workers' wages, and incarceration and deaths in custody.[105] These events have had a devastating impact on the lives of many Aboriginal people, causing trauma and disadvantage that has carried across generations.[106]

While many Australians have become aware of these wrongs, they do not have a proper understanding of their details and ramifications.[107] Other Australians have difficulty accepting that they occurred at all.[108] This public ignorance and denial has diminished the grief, loss and sense of injustice that Aboriginal people feel.

By aspiring to uncover past and present mistakes, Victoria's truth-telling process is a chance to acknowledge and redress the injustices that stand in the way of reconciliation, not only in Victoria, but also in Australia more broadly. It is an opportunity to open up a debate on prejudice, discrimination and racism, and to lay the ground for change that increases the inclusion of Aboriginal people in the political, economic and cultural spheres of society.

Furthermore, Victoria's truth-telling process is a means to building greater understanding among future generations with a view to ensuring the same wrongs are never repeated. As Reconciliation Australia, the national body on reconciliation, has put it:

> We cannot change the past but we can learn from it. We can make amends and we can ensure mistakes are never repeated. Our nation's past is reflected in the present and unless we can heal historical wounds, they will continue to play out in our country's future. Reconciliation can only truly evolve when the Australian community and our major institutions acknowledge and repair the wrongs of the past, understand their effects—and make sure that these wrongs, or similarly damaging actions, are not occurring today and are never repeated in the future.[109]

The Victorian Government has embedded self-determination into key Aboriginal policies, including the *Victorian Aboriginal Affairs Framework 2018–2023*, which commits government to achieve systemic and structural transformation to enable self-determination, and thereby support better outcomes for Aboriginal Victorians (refer to Box 20.3). Self-determination is also a fundamental requirement under the Victorian Government's Aboriginal health, wellbeing and safety strategic plan 2017–2027, *Korin Korin Balit-Djak*. It states that self-determination:

> means that rather than Aboriginal people merely being 'engaged' or 'consulted' as 'advisors' or 'co-designers' of services and policies, they are authorised and empowered to own, direct and make strategic decisions.[110]

It says that Aboriginal decision making should apply to the 'values and motivations on which a policy or program is based, strategic intent, policy or program design, funding and allocation of resources, implementation and operations, evaluation measures and definitions of success'.[111]

Box 20.3: Victorian Aboriginal Affairs Framework 2018–2023

In 2018, the Victorian Government refreshed the *Victorian Aboriginal Affairs Framework 2018–2023* in partnership with Aboriginal Victorians through broad and inclusive engagement. The framework is Victoria's overarching strategic framework for working with Aboriginal Victorians to drive improved outcomes.

The framework includes goals, indicators and measures to guide and track government progress to achieve positive outcomes for Aboriginal Victorians across six domains:

- children, family and home
- learning and skills
- opportunity and prosperity
- health and wellbeing
- justice and safety
- culture and country.[112]

The framework commits government to advancing Aboriginal self-determination. In doing so, the framework builds on and goes beyond previous government approaches, by recognising that to improve outcomes for Aboriginal Victorians, government must enable self-determination through systemic and structural transformation. The framework also requires that the government report on its efforts to enable self-determination in the annual *Victorian Government Aboriginal Affairs Report* and commits to establishing an Aboriginal-led evaluation and review mechanism to track government's progress against the framework.

The framework identifies four self-determination enablers as priority action areas:

- prioritise culture
- address trauma and support healing
- address racism and promote cultural safety
- transfer power and resources to communities.

It is envisaged that these enablers will help to eliminate structural and systemic barriers experienced by Aboriginal Victorians, so that they are empowered to own and drive change. The resulting quality and accessibility of services will lead to more Aboriginal Victorians using those services and experiencing improved outcomes.[113]

In the interim report, the Commission noted that self-determination in the context of mental health 'means transferring power and resources to Aboriginal communities to design and deliver their own mental health services while drawing on the skills and expertise of others where needed'.[114] This is consistent with evidence that programs encouraging self-determination and community governance show promising results for Aboriginal social and emotional wellbeing.[115]

Australian and international evidence suggests that self-determination is crucial to achieving lasting improvements in health and social outcomes for Aboriginal people.[116] This can include the positive effects for Aboriginal people from personally participating in self-determination processes, such as an increased sense of control and the subsequent impact on mental health and wellbeing.[117] The Victorian Aboriginal Children and Young People's Alliance recommended the Commission '[r]einforce the role of self-determination as the foundation of improving the health and wellbeing of Aboriginal people in Victoria.'[118]

The implementation of the Commission's reforms will require the Victorian Government to apply the principles of self-determination towards improving outcomes for Aboriginal people. Ms Kennedy stated that:

> There is an opportunity to support real self-determination as part of implementing the recommendations of the Royal Commission.[119]

Mr Jackomos told the Commission that '[w]herever government comes into contact with the Aboriginal people and community, there is a place for self-determination' and highlighted that the Victorian Government's commitment to self-determination includes every area and level of government.[120] This means that self-determination must be at the core of the work undertaken by the agencies and departments implementing the Commission's recommendations.

Adhering to the principles of self-determination will help to ensure the process of implementing the reforms is as beneficial to mental health and wellbeing as the reforms themselves.[121] As Ms Kennedy explained:

> Given the legacy of institutional injustice, how governments work with Aboriginal communities is just as important as what actions governments take to improve mental health outcomes for Aboriginal people and communities.[122]

The Commission has identified key areas for reform to support social and emotional wellbeing for Aboriginal people based on the evidence presented by Aboriginal organisations and communities, and others. The Victorian Aboriginal Community Controlled Health Organisation noted that:

> The system-wide changes and self-determining principles that are proposed in the Interim Report offer a transformational opportunity to deliver meaningful outcomes for Aboriginal people.[123]

As described later in this chapter, the Commission's reforms focus on two areas: (1) supporting healing and (2) improving child and family mental health and wellbeing. However, the design and the delivery of these reforms should be determined by Aboriginal organisations and communities, with support from the Victorian Government.

Mr Jackomos also spoke of the importance of Aboriginal self-determination and involvement in relation to service design, implementation and monitoring, and just as importantly, in building the cultural competence and cultural safety of mainstream and other mental health and wellbeing services.[124] The Commission strongly suggests that the Victorian Government take note of his advice regarding the main enablers for compliance with the principles of self-determination. This includes the advice that:

- the service/program/initiative is identified by the community or is equally owned by the community
- community stakeholders are involved from the very start, rather than other parties designing a response and seeking endorsement for a model that has already been developed
- community members are central to the development, implementation and evaluation of the services
- the resources for service provision are transferred to the community for decision making, and service delivery is undertaken in a Koori-friendly location
- the services are managed and delivered by Aboriginal people where possible, with significant resources provided for personal and career development.[125]

20.6 The need for healing approaches

The Commission heard '[h]istorical and intergenerational trauma is all-pervasive and it influences every interaction with support services and systems.'[126] Abundant evidence before the Commission attests that '[r]econnection to culture is healing and is not supported in the current mental health system'.[127] Healing practices are recognised internationally for their 'effectiveness in addressing intergenerational trauma, improving wellbeing and reducing rates of suicide, incarceration, domestic and family violence and drug and substance abuse'.[128]

Ms Kennedy told the Commission:

> It is now broadly recognised, as described by the Healing Foundation, that unresolved trauma is directly related to the policies of past governments, resulting in the legacy of the stolen generations. Many of the problems prevalent today, such as substance abuse, mental illness and family violence are themselves rooted in a cycle of trauma. As described by the National Healing Foundation, healing involves the application of existing cultural knowledge, as well as the development of new ways to practice this in a contemporary context, in order to address trauma stemming from colonisation. Healing needs to be an intricate part of the processes of prevention as well as the treatment of mental health issues, supporting recovery and improving social and emotional well-being.[129]

The extensive and pervasive trauma that many Aboriginal people live with every day is profound, and it affects individuals, families, carers and supporters and broader communities.[130] Often, the impacts of historical and intergenerational trauma limit the extent to which Aboriginal people can receive social and emotional wellbeing support.[131] These impacts are highly varied and can have life-long consequences on people.[132] In complex cases, some trauma experiences—such as historical or intergenerational traumas—can lead to Aboriginal people falling 'through the gaps of standard service provision',[133] as explained in Chapter 15: *Responding to trauma*. Mr Burns told the Commission:

> Addictive behaviours such as heavy, problematic AOD [alcohol and other drug] use and gambling often prevent people from accessing the healing and enriching parts of culture, community, country, spirituality, ancestry and family. Another key factor that detrimentally impacts SEWB [social and emotional wellbeing] relates to people not having their basic needs of housing, food, safety and belonging met. Exposure to and experiences of all types of violence and abuse, in addition to the lack of sense of agency, also often forms a major barrier to positive intervention, healing and support.[134]

Aboriginal organisations and witnesses have called on the Commission to promote and embed healing practices in social and emotional wellbeing services in Aboriginal communities.[135] Further, submissions have called for increased investment in healing centres or places. Such programs would support people to address the impact of trauma on themselves, families, carers and supporters.

As Ms Kennedy told the Commission:

> My plea is that we focus more on supporting our communities, individuals and families to address that underlying trauma and in the context of preventative responses. I am a big advocate for us to have a much greater focus on providing support services that focus on healing models.[136] ... Healing needs to be an intricate part of the processes of prevention as well as the treatment of mental health issues, supporting recovery and improving social and emotional well-being. No amount of conventional Western mental health approaches will be enough without concurrent investment and focus on traditional and contemporary healing.[137]

It is the Commission's position that healing approaches are fundamental to supporting the mental health of Aboriginal people.[138] Focusing on healing gives Aboriginal people a platform to strengthen and support their resilience, healing, and trauma recovery through fostering connection to Country, kinship and culture.[139]

20.6.1 The role of healing

The historical and continuing trauma within many communities requires healing practices to support Aboriginal social and emotional wellbeing. In its submission to the Commission, the Healing Foundation described healing as:

> the process by which people come to a stronger sense of self-identity and connection and through this are able to address the distress that they experience changing how they are able to interact. Healing involves a holistic and ongoing approach that is deeply rooted in culture and addresses physical, social, emotional, mental, environmental and spiritual wellbeing.[140]

The concept of healing is critical in the context of intergenerational traumas and for people experiencing ongoing adversities. As noted in Chapter 15*: Responding to trauma,* acknowledging trauma and its impacts on people can be fundamental to long-term recovery:

> An understanding of an individual's story of trauma is critical to the healing journey, and is interwoven with the stories of that person's family and community. Victim survivors, including children, need to have their stories heard and acknowledged so that they can commence or continue their healing journeys.[141]

Healing can be a 'lifelong process' of seeking to find 'a balance between the good and the bad things in one's life'.[142] Healing enables mental health to be recognised as part of a holistic and interconnected Aboriginal view of health; embracing 'social, emotional, physical, cultural, and spiritual dimensions of health and wellbeing'.[143] Critically, this approach does not focus on 'symptom reduction', but instead works to strengthen culture, community connection, reduce social disadvantage and build empowerment.[144]

Healing approaches are underpinned by four pillars of recovery (refer to Figure 20.3). 'These pillars can improve outcomes across a range of health and wellbeing domains, especially in terms of mental health'[145] and include:

> - 'safety—creating safe spaces, healing places and identifying safe people to support healing
> - identity—building a strong cultural identity by reconnecting to our cultural values and practice
> - reconnection—rebuilding our relational support systems with family, community and services that can support us
> - trauma awareness—learning about the impacts of trauma on our minds, bodies and spirits so we can find paths to healing'.[146]

20.6.2 Healing practices

Engaging in healing practices can be highly therapeutic for individuals, families and groups. Healing practices are deeply entwined with self-determination, with healing being a part of a 'collective process of self-determination [that] enables Aboriginal and Torres Strait Islander people to identify and deal with the underlying causes of trauma'.[147]

Healing can be delivered in many forms, including programs,[148] services,[149] or centres.[150] Healing centres, for example, 'incorporate traditional and Western practices, operate with Aboriginal and Torres Strait Islander spirituality and culture at their core, and may be situated on custodial land or a site of local significance'.[151]

Traditional healing practices can include talking circles, sweat lodges, smudging, drumming, traditional crafts and dancing, bush medicine, healing songs and healing ceremonies. Collectively, these processes '[reinstate and reconnect] Aboriginal and Torres Strait Islander communities to their core cultural value systems, where obligations and reciprocity were central to community survival'.[152]

Participation of Elders is a key element of traditional healing practices. Elders may impart important cultural knowledge to young people through storytelling, walking through country identifying native plants and discussing their uses.[153] Aunty Nellie Flagg described her vision for a healing program that incorporated Elder wisdom to support early parenting:

> I have a fantasy of 'Aunty's Places' where families can go to live, learn and be themselves. We could teach parenting skills and help them learn how to do things they aren't good at. They could learn to cook and also learn to understand issues they have with their children and each other. If the kids are naughty, we can teach them how to be respectful.[154]

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Figure 20.3: Four Pillars of Indigenous Trauma Recovery

Source: Healing Foundation with M Adams and others, 'Towards an Aboriginal and Torres Strait Islander violence prevention framework for men and boys', 2017.

Evidence shows the profound value of healing centres in capturing, restoring and retaining cultural knowledge. Building this knowledge forms the cornerstone of healing; enriching culture, connection to community and country, spirituality, ancestry and family.[155] As one stakeholder told the Commission via the *Balit Durn Durn* report:

> My perfect scenario would be a healing space for us, whether it was land or a multi-purpose building that allowed cultural practice to occur; fire pits, yarning circles, specific areas where you have environmentally friendly therapeutic areas. That is the absolute dream. We need an Aboriginal Knowledge Place.[156]

In addition to traditional healing practices, some Western approaches are often incorporated. One-on-one or group sessions covering problems at school and at home, peer pressure, anger management, and sexual abuse can be used in tandem with traditional healing approaches.[157] The Commission understands that while traditional and Western approaches differ, '[b]oth approaches have their merits and should be part of a collaborative approach that seeks the best outcome for the person seeking help'.[158] In the *Balit Durn Durn* report, one woman told the story of her experiences of grief, trauma and healing through a combination of counselling and traditional healing practices. These excerpts are a small part of that story:

> A friend referred me to a neuro-psychotherapist and counsellor who specialised in childhood trauma and brain development. The thing that helped me – the area she specialises in – was helping me to understand how the way brain develops, from when we are growing in the womb, when we are born, and the crucial first weeks and months of our life ... My counsellor helped me realise my flight or fight response and that what worked for us when we were little, could no longer work for us as adults. We couldn't just hide in the closet or under the bed anymore ...
>
> It was then that I decided, I need to do something more ... I decided I needed to go home, back to Country ... I went back to the desert. There is a special place, for women only in our tribe. In the middle of nowhere there is this green place with gum trees, green bushes, bush foods, and water holes. My Aunties took me there and showed me that it was a special place for women to heal ... My five Aunties did a special ceremony for me. They had coals already heated covered in fresh gum leaves, so it was safe to lie on them. We have a lot of sandalwood trees out there; it has been part of our culture for thousands of years and it is a part of who we are. They used the sandalwood oil and ochre and covered my body in ochre and oil and sang in language about me being home ...
>
> The most beautiful thing about it as a grown woman, is that it felt like I was a little girl. I had a lot of my childhood taken away from me. To have that love and nurturing. It was being passed to me, that has been done to our women, for generations. These people who love you and want you to be better and want you to heal ...
>
> I had Western counselling and that has helped me. And my Aunties told to keep that connection back to Country...
>
> I realised that it was more than just one element that I needed. To heal from my past, my trauma, and my grief. I realised that I needed to go and seek all those elements to help me feel normal again.[159]

20.6.3 Outcomes of healing

Evidence indicates that there are many benefits of healing programs in the restoration and recovery from historical and intergenerational traumas experienced by Aboriginal people. Mr Jackomos said:

> I know from what I have witnessed over my lifetime and particularly in the last twenty years, that connectedness to culture, country and community is the foundation stone for building stronger individual and collective identities. I cannot over stress the importance of strong culture in building positive self-esteem, resilience and improved outcomes across the other determinants of health, including education, economic stability and community safety.[160]

This was echoed in the *Balit Durn Durn* report, where one young person described how, for young people who are not connected to Country, 'there's something that's inside that you know is missing. When you don't have that strong connection, it makes you vulnerable'.[161]

Healing practices strengthen a sense of self, 'such as self-worth, positive core beliefs and values, and coping skills that are related to things like being able to managing difficult emotions and strategies to cope with stress and adversity'.[162] These outcomes, alongside building connection to culture, community and peers, provide critical protection against mental illness arising from trauma.[163] Some studies suggest 'that empowerment programs have positive impacts on long-term health status and lead to a decrease in health disparities'.[164] Further, healing programs that establish or renew cultural identity have also been linked to decreased suicide rates among Aboriginal young people.[165]

Research indicates that healing programs that establish a strong sense of cultural identity can be protective against the development of mental illness:

> It has been shown that a strong sense of cultural identity can be protective against the development of psychiatric morbidity. It is likely that Aboriginal people who have strong family connections, know about their Aboriginal heritage, including their tribal group and traditional lands, and continue to live an Aboriginal lifestyle (the nature of which varies between Indigenous groups) are similarly protected.[166]

Further, healing supports the development of coping strategies that can be positive for the individual, family and community re-experiencing trauma or adversity. As Mr Burns explains:

> The key factors that protect SEWB [social and emotional wellbeing] are having access to community and community resources, awareness of cultural history, family and country, spending time on country, access to specific cultural groups (such as women and men's groups), contact with family and engagement in meaningful activity. The factors of SEWB can be utilised to promote healing and resilience from trauma, allowing the person to proactively manage their mental health and well-being using coping strategies that are positive for the individual, family and community.[167]

A review of social and emotional wellbeing programs (which include a focus on healing) found programs led to 'participants developing resilience, confidence and self-esteem, better recognising the causes of problems, and building communication, conflict management and negotiation skills.' The review also noted that '[h]ealing came as the result of dealing with grief and loss'.[168]

A 2016 Victorian evaluation of 13 gathering places (which undertake healing practices) found that increased social and emotional wellbeing is a major benefit of gathering places because they 'clearly support the development of social support networks and social connection'.[169] The evaluation also found 'physical health benefits from community members' attendance and participation in community health checks, chronic disease screening and specific health programs'.[170] Food security was a major theme across most gathering places.[171] From an Aboriginal holistic view, gathering places are crucial hubs for people to engage.[172]

International evidence also indicates the success of locally owned healing programs in Indigenous communities in Canada, New Zealand and the United States.[173] For example, the recent *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* in New Zealand found that some Māori communities have made substantial gains in reducing fragmentation between services by forming community collectives to provide frontline mental health functions, including mental health assessment, triage, early intervention, respite care and ongoing support.[174]

20.6.4 Contexts for healing

In Victoria, successful healing programs, services and centres share several common characteristics. These include being Aboriginal-led and designed, promoting healing and wellbeing, and being culturally safe.[175]

Figure 20.4 depicts the core characteristics of Indigenous healing.

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Figure 20.4: Core characteristics of Indigenous healing

Indigenous ownership, design and evaluation of services	Informed by an Indigenous, not a Western, worldview and using culturally sensitive screening and assessment tools
Holistic and multidisciplinary approach	Addressing mental, physical, emotional and spiritual needs with a focus on familial and community interconnectedness, as well as connectedness to the environment and the spiritual realm
Centrality of culture and spirituality	Cultural renewal is seen by some as an essential precursor to healing
Informed by history	Being cognisant of the historical source of trauma, rather than focusing too strongly on the individual pathology
Adopting a positive, strength-based approach	Recognising and promoting the resilience of Indigenous people
Preventative and therapeutic strategies	Rather than reactive responses that merely seek to reduce symptoms
Commitment to healing	As a process—a journey that takes time rather than a one-off event
Commitment to adaptability, flexibility and innovation	Programs must be inclusive to ensure they reach people who may not have strong cultural ties and to incorporate localised practices
Utilisation of particular approaches best suited to the Indigenous context	Programs to include approaches such as narrative therapy, group processes and a combination of Western and traditional practices, such as the use of traditional healers or Ngangkari

Source: Aboriginal and Torres Strait Island Health Foundation, 'Healing Centre, Final Report–21 December 2012'. Adapted from Catherine Caruana, C Family Relationships Quarterly No.17, Healing Services for Indigenous People <aifs.gov.au/cfca/publications/family-relationships-quarterly-no-17/healing-services-indigenous-people>.

Case study:

Wulgunggo Ngalu

The Wulgunggo Ngalu Learning Place (Wulgunggo Ngalu) is a joint initiative of the Aboriginal community and the Victorian Government under the Victorian Aboriginal Justice Agreement. It opened in 2008 in Yarram, Gippsland.

Wulgunggo Ngalu is a residential learning place, accommodating up to 18 men. The program offers voluntary attendance; however, people may be directed to attend by the courts. Shaun Braybrook ACM, General Manager of Wulgunggo Ngalu, said:

> [Wulgunggo Ngalu] is a place that helps Aboriginal men understand what it means to be an Aboriginal today. Through the use of culture we support the men to address their offending behaviours and the effect these behaviours have on them, their families and our communities.

Aboriginal Elders provide leadership and communicate traditional cultural values, in keeping with the name 'Wulgunggo Ngalu', from the local Aboriginal language, Gunai/Kurnai. 'Wulgunggo' means 'which way' and 'Ngalu' means 'together'.

Mr Braybrook said Wulgunggo Ngalu places issues of culture and identity at the centre of its operations and promotes cultural connection at multiple levels, including with the physical environment, with the staff, through the cultural content of programs and activities and with community.

He noted that Aboriginal values and physical protocols are reflected in Wulgunggo Ngalu's environment; for example, its bush location, firepit, dance circle, multiple shared living spaces and accommodation for Elders and visitors. The physical building was designed by an Aboriginal architect to reflect the blue wren, a totem of the local Aboriginal community.

Mr Braybrook explained that all core staff at Wulgunggo Ngalu are Aboriginal men who act as strong role models and '[w]eave into the fabric of [Wulgunggo Ngalu] Koori ways of communicating and doing business'.

The program provides an opportunity to engage in a range of activities, such as education, community work and learning new skills, many of which are directed at increasing cultural knowledge and strengthening identity. These include the Aboriginal Cultural Immersion Program, Koori Art and Design (an on-site TAFE program) and ceremony activities. Mr Braybrook said Wulgunggo Ngalu also includes cultural elements in its other programs wherever possible, such as in its family violence programs.

Photo credit: Wulgunggo Ngalu Learning Place

The vocational and recreational activities at Wulgunggo Ngalu also provide residents with opportunities to interact positively with the local community, such as by performing dance ceremonies at local events.

Uncle Warren Marks, a member of the Stolen Generations and participant of the program, said the program was a turning point in his life.

> It was a start of a new journey ... If you let them teach you and listen to what they say ... you realise who you are, where you come from and what you stand for. You know how you got here but how you can fix yourself up and make your family proud.
>
> You come here just as a black fella, I left here as a black fella who had become an elder, somebody who had learnt about his culture as well.

Another participant in the program said.

> [Wulgunggo Ngalu] is a special place to finally be able to heal from the life I was so caught up in which was so toxic, the life I thought I would never get out of, the ultimate success I needed in order to grow and change my life forever.

A qualitative evaluation of the program was completed in 2013, and one of its many findings was that the program had improved its participants' cultural identity. The evaluation also stated that the program creates 'an environment that encourages men to reflect, share stories, discuss issues and bond with other men, laying critical foundations for any process of change'.

The program was awarded a prestigious International Corrections and Prisons Association (ICPA) award in October 2010.

Source: Shaun Braybrook ACM, *Correspondence to the RCVMHS*, 2020; Corrections Victoria, Community Programs, <www.corrections.vic.gov.au/community-corrections/community-programs/community-programs>, [accessed 30 November 2020]; *Wulgunggo Ngalu Learning Place*, Final Evaluation Report, May 2013; Vimeo, Warren Marks_WNLP2019_V2, <www.vimeo.com/350095550>, [accessed 18 December 2020].

Healing programs and centres have diverse contexts, settings and functions, including but not limited to:

- **education**: Ms Kennedy described to the Commission an effective and 'economically efficient' example of a healing program in an education setting, the Murri School program:

> The Murri program is a holistic educational framework that consists of a range of activities such as counselling and healing camps, which are designed to address the intergenerational trauma experienced by Aboriginal children at a [Queensland] school. Though the cost per individual student is slightly higher than the state average, the net benefit far outweighs the initial outlay. For every added dollar invested in the Murri Healing program, there was a return of $8.85. Kids had lower rates of mental illness, had less contact with the justice and child protection systems, and achieved a higher educational standard, all whilst saving an estimated 6.5 million. This was for only 230 students, indicating the opportunity for significant saving.[176]

- **health and physical lifestyle**: Some healing programs incorporate a diverse range of social and emotional wellbeing approaches, including a focus on health and physical lifestyle. The availability of different approaches can be particularly beneficial when whole families are involved. As Mr Gee told the Commission:

> combining exercise, healthy lifestyle and cultural activities were associated with increases in resilience and decreases in psychological distress, without specifically addressing mental health as a topic in the program. These types of programs can take a whole of family approach (e.g., where the whole family participates) and may provide opportunities for health checks, and mental health awareness that results in counselling and support later.[177]

- **drugs and alcohol**: Some healing services relate specifically to drug, alcohol and rehabilitation needs of Aboriginal people. For example, Wadamba Wilam provides 'a small but significant service offering to people who have fallen through the gaps in standard service provision'. This healing program is 'unique in that it has multi-agency involvement and provide holistic, intensive, long-term support for their multiple healthcare, cultural, social and housing needs'.[178]
- **family violence**: Some healing services are delivered in the context of supporting people experiencing family violence or to support perpetrators to stop using violence. The Commission has heard that healing approaches to family violence are holistic and 'sensitive to the trauma and impact of family violence on individuals and families as well as the accumulated trauma experienced by Aboriginal people and communities as a result of colonisation'.[179]

The diversity of healing practices across these different settings and contexts provides meaningful support for Aboriginal people in critical life stages, including support to people experiencing trauma. Witness, Daniel Bolger, a proud Noonuccal Aboriginal man and founder of Got Ya Back, described his experience at the Bunjilwarra Koori Youth Healing Centre:

> I went to Melbourne Magistrates' Court for a bail hearing. The judge indicated I could get bailed to the Bunjilwarra Koori Youth Healing Centre. The Koori Youth Healing Centre is an Aboriginal youth rehab centre. Andy Brigham, a worker from there, came and talked to me in a visiting area. That was the first time for a while that I had normal conversation. He knew everything about the system. He did the assessment straight away, he explained the process and didn't make any promises … It was a real special place. I finally had workers around me that I got along with and that cared about me. To me, the place was run perfect.[180]

20.6.5 Supporting healing practices in Victoria

The Commission concurs that supporting healing is essential to improved Aboriginal social and emotional wellbeing and recognises that the Aboriginal Social and Emotional Wellbeing Centre is best placed to co-design and deliver an initial two healing centres with communities. These new healing centres will be developed based on local Aboriginal needs.[181] Further, the new healing centres may seek to:

- provide a place for Aboriginal-led trauma-informed healing that integrates traditional and contemporary practice
- restore language, knowledge systems, kinship and Aboriginal customs
- create paid employment opportunities for Elders who will play a critical role in the healing of young people and communities.[182]

This approach is in line with the Healing Foundation's identification of ownership, design and evaluation by Aboriginal people as a core characteristic of healing centres (refer to Figure 20.4).

These healing centres could also include:

- residential services, allowing time for healing in a culturally appropriate and trauma-informed environment
- access to and the provision of wellbeing supports
- treatment options that both prevent and support people experiencing crisis
- community services to inreach and contact a person for follow-up in the community on discharge.

The Commission believes there is enormous opportunity to embed and align healing practices through the Commission's reformed mental health and wellbeing system. In considering how the system will embed healing within its services, the Commission encourages future programs to heed evidence underpinning effective healing programs. This includes healing centres:

> - '[being] developed to address issues in their local communities
> - [being] driven by local leadership
> - [being] based upon well-developed evidence and theory base
> - combining both western methodologies and traditional healing in their treatment theory base
> - [being] informed about and understand[ing] the impact of colonisation and intergenerational trauma and grief
> - building upon individual, family and community capacity through the acquisition of knowledge and skills
> - incorporating strong evaluation frameworks
> - [having] a proactive rather than reactive focus'.[183]

Healing centres are also delivered through a multidisciplinary workforce, which comprises teams 'with a mix of clinical and non-clinical workers and Aboriginal and non-Aboriginal staff', providing 'culturally responsive, coordinated clinical and practical supports in the one place'.[184] This may include lived experience and peer support workers.

The Commission has heard that central to establishing healing centres is equipping and supporting staff to deliver trauma-informed treatment, care and support[185] and that '[t]rauma-informed and healing-based approaches should be the cornerstone of all care practices' for Aboriginal people.[186] Thus, the Statewide Trauma Centre (as described in Chapter 15: *Responding to trauma*) will be critical to support Aboriginal people attending the centres and the workforce.

As one staff member from an Aboriginal organisation told the Commission via the *Balit Durn Durn* report:

> My days are filled with high complexity and high trauma from listening to people's stories. Sometimes I just have to leave the office. I wish we had a place at the office where I could just curl up. Sometimes I need time to recover and I don't want to take sick pay, because I'm not sick. I don't want to have to go and get a doctor's certificate for something that's part of my role, I would like an understanding around that. I would like the policy makers to know, it's not us making an excuse, sometimes you can't take on anymore, you can't even look people in the face, you are done – I would like for there to be some respect around that.[187]

Practitioners have also stated that further investment and evaluation of healing approaches is essential to 'help families stay safely together'.[188] This is because the efficacy of healing approaches can be difficult to determine, given that (as this chapter has identified):

> - 'healing practices are diverse
> - the goals of healing are diverse
> - clients have diverse reasons for seeking healing
> - success can occur at different levels—individual, community, environment, cosmos
> - healing is ongoing and long term by nature'.[189]

The reforms proposed throughout this chapter recognise the profound effects of historical and intergenerational traumas on Aboriginal people. The Commission acknowledges the critical need for further investment in healing centres to support people experiencing complex and pervasive adversities. It is the vision of the Commission that through these reforms, and others identified in this chapter, the mental health and wellbeing system will create a paradigm shift supporting 'intergenerational healing and resilience'.[190]

20.7 Supporting Aboriginal children and young people

Victoria's Aboriginal population is relatively young; the 2011 census data reported that the median age for Victorian Aboriginal people was 22 years of age, compared with 37 years of age for non-Aboriginal Victorians. The data indicated that more than half of Victoria's Aboriginal population were less than 25 years old.[191]

Aboriginal children and young people are disproportionately represented in the mental health system; 2.5 per cent of child and youth mental health service clients identified as Aboriginal, despite making up only 1.4 per cent of all Victorians aged 0–24.[192] Aboriginal children are also nearly three times as likely to experience high or very high levels of psychological distress than non-Aboriginal children; however, it is unclear whether the reported rates of mental health service access for Aboriginal children and young people matches the need for care.[193] Only one in four Aboriginal children experiencing traumatic life events are accessing appropriate services.[194]

Aboriginal children and young people may face considerable challenges related to intergenerational trauma and associated disadvantage that leave them at risk of experiencing childhood adversity and mental illness.[195] Trauma and adversity in childhood has been closely linked with negative physical, social and mental health outcomes in childhood, adolescence and adulthood.[196] Research indicates that adverse childhood experiences—such as abuse and neglect, exposure to family violence and having a parent with lived experience of mental illness requiring high-intensity supports, alcohol and or substance use, or history of engagement with the criminal justice system—increase the risk of mental illness.[197] Within Aboriginal communities, research indicates that childhood and family adversity has a substantial effect on mental health and wellbeing; Aboriginal children are exposed to multiple risk factors for mental illness, such as exposure to violence, living in households with drug and alcohol use and addiction, not living with both parents and being bullied.[198] As identified by the Commission for Children and Young People:

> **Like other First Nations children, Aboriginal children and young people continue to be disproportionately impacted in their developmental years by negative outcomes in key domains such as maternal, physical and mental health, homelessness and intergenerational trauma.[199]**

Dr Tim Moore, Senior Research Fellow at the Murdoch Children's Institute, giving evidence in a personal capacity, described to the Commission a range of risk and protective factors that affect infant development. These include:

- the social and physical conditions in which families conceive and raise young children—the social determinants of health that 'shape health and wellbeing'
- socioeconomic status— 'from the point of conception, the higher a person's socioeconomic status, the healthier they (and their children) are likely to be throughout their life'
- transgenerational risk factors— 'risks that can be transmitted from one generation to the next'.[200]

Dr Moore described two ways risks can be transmitted across generations:

> The first form of transmission is genetic: when parents have been exposed to adverse experiences (including nutrition, environmental toxins, nurturing behaviour and social stress) that have produced changes to their epigenome, these changes can sometimes be passed onto their children, even if the children develop in optimal conditions themselves. ... The second mode of transmission is environmental: children often 'inherit' the same social and environmental conditions (including poverty or trauma) that have created physical or mental health problems for their parents, thereby increasing the children's risk of physical and mental health problems.[201]

The Commission recognises that improving the social and emotional wellbeing of Aboriginal children and young people requires genuine acknowledgement and engagement with the legacy of trauma that continues to negatively affect families and communities. This includes recognising that experiences of mental illness in children and young people cannot be considered in isolation from the social and emotional wellbeing of parents and families, and that solutions must focus on both children and young people and their families and communities. Dr Moore emphasised to the Commission that 'while services are important for giving infants the best chance of good health and wellbeing, the social conditions in which they and their families live have a greater impact on their health and development'.[202]

Similarly, Professor Helen Milroy, Professor of Child and Adolescent Psychiatry at the University of Western Australia, Commissioner on the National Mental Health Commission, and a descendant of the Palyku people of the Pilbara region, told the Commission:

> The mental health system has been set up with a framework that has better application to physical health, trying to deal with symptoms as they present rather than dealing with the underlying causes for poor mental health. A child's best chance at having good mental health is to be born healthy, grow up in a loving and supportive family and community with good access to services, education and support as needed throughout development.[203]

Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing* emphasises the importance of delivering developmentally appropriate care to infants and children and the need to support the mental health and wellbeing of parents, particularly during the perinatal period (prospective or new parents from conception until 24 months after birth).[204] As outlined in that chapter, experiences of mental illness and psychological distress may negatively impact on a person's adjustment to parenting and their capacity to care for a newborn, disrupting the parent-infant relationship.[205] This disruption can then affect an infant's development, behaviour and relationships,[206] which may also negatively impact on transition into early education. The reforms outlined in that chapter focus on providing developmentally appropriate mental health and wellbeing treatment, care and support for young children and their families. The Commission recognises the additional challenges many Aboriginal children and families face.

The Commission also acknowledges the role of intergenerational trauma in the continued disproportionate representation of Aboriginal children and young people in out-of-home care in Victoria, and the impact of out-of-home care on the social and emotional wellbeing of children, families and communities.[207] The Victorian Aboriginal Children and Young People's Alliance told the Commission:

> The removal of an Aboriginal child from their home, community and culture affects the whole community—and without allowing us to do the work our community needs, the approach of the current system is inflicting further harm on families, children, carers and our workforce.[208]

The *Always Was, Always Will Be Koori Children* report made it clear that the child protection system too often fails to preserve, promote and develop cultural safety and connection for Aboriginal children in out-of-home care.[209] It highlighted:

> non-compliance with legislative and practice requirements for cultural planning and inadequate inclusion and engagement with Aboriginal family, programs and community in decision-making, [which] have resulted in the dislocation from culture and family for large numbers of Aboriginal children in out-of-home care.[210]

The Commission heard that parents need support to address experiences of mental illness that have resulted in children being removed.[211] The Aboriginal community-controlled organisation, Djirra, described an expectation that mothers will 'fix their mental health with no real support to do so'.[212] The organisation argued for a 'shift towards providing or linking parents, particularly mothers, with meaningful support and services to address their mental health issues, not punishing them'.[213]

The Commission is encouraged by the Victorian Government's announcement in late 2020 of funding to support the reform of out-of-home care services and to support Aboriginal children and family services. This includes funding to ensure Aboriginal community-controlled organisations have case management control for Aboriginal children, in accordance with *Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement*, and for the piloting of Aboriginal family support teams.[214] The Commission also recognises that long-term, multisector reform is required to respond to the over-representation of Aboriginal children and young people experiencing mental illness in out-of-home care, in contact with the justice system and at risk of homelessness. This multisector approach is the foundation of the Commission's recommendation to develop a *Mental Health and Wellbeing Outcomes Framework* to drive collective responsibility and accountability for mental health and wellbeing outcomes across government portfolios described in Chapter 3: *A system focused on outcomes*.

20.7.1 Early intervention

Aboriginal organisations and experts emphasised the importance of early intervention to support the mental health of children and young people. Ms Kennedy told the Commission of the need for early intervention to help deal with the impacts of intergenerational trauma:

> I believe that the impact of trauma on Aboriginal children and families is a major undetected, underestimated and misunderstood determinant of the poorer mental health outcomes seen in the adult Aboriginal population. Given the high prevalence of mental illness and a large, rapidly growing population, there is an urgent need to address this with new solutions and better, more accessible culturally responsive services and initiatives. In other words, we must prioritise and strengthen early intervention and prevention approaches for Aboriginal children.[215]

Early intervention is identified as one of the most effective ways to reduce the occurrence or impact of adverse childhood experiences. In particular, this includes support for parents within the first two years of their child's life.[216] Early intervention crosses multiple service systems. Professor Frank Oberklaid AM OAM, a paediatrician at The Royal Children's Hospital and Co-Group Leader of Child Health Policy, Equity and Translation at the Murdoch Children's Institute, told the Commission of the 'need to build the capacity of the universal services accessed by parents and children—childcare, schools, local doctors and nurses and other community-based services—to identify and deal with problems early.'[217] He also told the Commission:

> Many of the children currently seen by tertiary mental health services have problems that could and should have been dealt with at an earlier stage in the community before they deteriorated. There is hardly a child I see in my practice that does not make me wonder why I did not see that child sooner.[218]

The Victorian Aboriginal Children and Young People's Alliance spoke about the central role of Aboriginal communities in supporting children and families to prevent the break-up of families:

> It really does take a village to raise a child, and through building relationships with families we can see the ongoing protective role of culture and community that will continue throughout families lives. Despite this – there is a significant lack of investment in early intervention – and very little of it goes to Aboriginal families and those that need it most.[219]

Evidence to the Commission identifies a need for Aboriginal children and young people to have 'access to culturally safe, therapeutic family strengthening services and early intervention',[220] and 'well-resourced Aboriginal community controlled health services'.[221] The Commission for Children and Young People identified these services as vital, noting that in the '[a]bsence of easily accessible, culturally appropriate support services to strengthen the capacity of families to provide optimal care, the trajectory to child protection intervention is increasingly the outcome for many Aboriginal children and their families'.[222]

The interim report recommendation for the expansion of social and emotional wellbeing teams across Victoria's community-controlled health organisations is designed to encourage the early detection of mental illness and provide social and emotional wellbeing services within communities. The functions of the teams, which include linking into support services, engaging with families and communities and providing assertive outreach services such as home visits, will support early intervention within Aboriginal communities.

As noted in the interim report, the social and emotional wellbeing teams will initially focus on Aboriginal adults (aged 16 years or older), and the Aboriginal Social and Emotional Wellbeing Centre will continue to build the evidence base for best practice and clinical effectiveness in working with Aboriginal children and younger people.

The Commission acknowledges that the current mental health system does not provide the necessary early intervention and therapeutic care to support Aboriginal children and families. As the Victorian Aboriginal Child Care Agency told the Commission:

> We contend that the social and emotional wellbeing needs of our children, young people and families are not currently being met by the mental health service system, it is not responsive to the specific needs of the Victorian Aboriginal community. Aboriginal children and young people are vulnerable to a lifetime of social and emotional wellbeing concerns due to the early exposure to risk factors creating a pathway into poor mental health and mental illness.[223]

The Commission recognises the need for immediate reforms to provide mental health and wellbeing supports for children and families while the Aboriginal Social and Emotional Wellbeing Centre develops models of care for children and young people. The following reforms are designed to support Aboriginal organisations to deliver a range of clinical and therapeutic services for children and families, to support early intervention, family healing and provide wrap-around multidisciplinary care for children and families most in need.

20.7.2 Partnering with child and youth mental health and wellbeing services

The interim report identified the need for and benefits of Aboriginal people being able to access culturally appropriate mental health services through Aboriginal community-controlled health organisations. It is the Commission's position that Aboriginal children and young people should be able to access the same level of culturally appropriate services. Professor Milroy noted that understanding 'cultural norms is essential when assessing a child's behaviour' pointing out that '[p]icking up the early warning signs can be difficult in children and more so within a cross-cultural context'.[224]

Evidence to the Commission described the difficulties Aboriginal consumers face in accessing treatment, care and support in the current 'crisis driven' mental health system.[225] The Victorian Aboriginal Children and Young People's Alliance noted the impact of the system on access to mental health services for Aboriginal children:

> The crisis response of the public mental health system means gaining early intervention access to their services is difficult, access to a psychiatrist for an urgent review and diagnostic clarification is impossible – which considerably delays the commencement of appropriate treatment.[226]

It is the Commission's position that Aboriginal children and young people need access to both well-resourced Aboriginal community-controlled health services and culturally safe mainstream mental health and wellbeing services, which work in partnership.

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Case study:

Workin' with the Mob

Workin' with the Mob is an Aboriginal family therapy program delivered by the Bouverie Centre and funded by La Trobe University and the Victorian Department of Health.

Because many Aboriginal families are unable to travel to the Bouverie Centre, which is located in Brunswick, Melbourne, it offers an outreach model providing families with the option of single-session family therapy in their home. Families who access the Workin' with the Mob program may be seeking help to resolve worries that are affecting the whole family or individuals within the family. These challenges might include family violence, complex post-traumatic stress disorder, sexual abuse, children living in out-of-home care and alcohol and other drug use.

As well as collaborating with families in relation to presenting issues, the Centre also works with families on preventing ongoing transgenerational trauma.

Clarisse Slater, a Yorta Yorta and Kamilaroi woman and Cultural Consultant and Workforce Development Trainer at the Bouverie Centre, said the Workin' with the Mob program is congruent with Aboriginal culture:

> It assumes the whole family and the community are significant for the person with the problem and takes a whole system approach which respects the role of Elders and family members. It also recognises that a person's context—their country, history and culture—are meaningful for the identity and experiences of the individual.

Ms Slater explained the Bouverie Centre recognises that cultural safety is central to the Workin' with the Mob program:

> The culturally respectful and holistic approach used in the Workin' with the Mob program is endorsed by Community, other Aboriginal agencies and the families that we work with.

Most families only attend the program for one session. However, the Bouverie Centre tells all families they are welcome to return.

The Bouverie Centre and La Trobe University also run a university-level postgraduate qualification in family therapy. It is specifically designed for Aboriginal workers who are currently working in the community. Non-Aboriginal family workers from Aboriginal organisations who have been endorsed by their organisation are also eligible to take part. A review of the program undertaken by the Lowitja Institute described the training program as tailored to meet the needs of Aboriginal families: 'a hand-in-glove fit with Aboriginal people in terms of being holistic, contextual and trauma-informed'.

Source: Elliott, A, McIlwaine, F, Stone, N & Proctor, K 2015, *The Bouverie Centre's Aboriginal Family Therapy Training Program: Impact Analysis Report*, The Lowitja Institute, Melbourne;

The Bouverie Centre, Correspondence to the RCVMHS, 2020.

Aboriginal community-controlled health organisations will be supported to provide care in partnership with the new Infant, Child and Youth Area Mental Health and Wellbeing Services, as described in Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing*. These partnerships will allow Aboriginal community-controlled health organisations to connect with paediatric mental health specialist expertise in the infant, child and family mental health and wellbeing service stream to support young consumers. This could include primary consultations, such as specialists working alongside primary care providers seeing consumers in communities, and secondary consultations to allow health professionals to seek advice from specialists. Specialist services will also be available to provide secondary consultation through universal services, such as maternal and child health services to support parents and families. Aboriginal community-controlled health organisations may also partner with mainstream mental health and wellbeing services to provide continuous shared care for young clients to support transitions to and from mainstream acute services (such as hospitals), where necessary.

More information about shared care partnerships can also be found in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*.

20.7.3 Family therapeutic services

Evidence before the Commission identified the importance of approaching child mental health within the context of children's families and relationships. Professor Louise Newman AM, Professor of Psychiatry at the University of Melbourne and Practising Perinatal and Infant Clinician, told the Commission:

> Ideally, a clear model for the provision of mental health care for infants and young children needs to include an understanding of the importance of the early developmental period and the role of families/carers in shaping development during this period. The focus of support and intervention includes both the parents/carers and the infant/child and is based on a model that recognises the significance of attachment relationships and context.[227]

She explained that this requires 'comprehensive assessment of the child in the context of their family and caretaking relationships ...', in collaboration with families, and that this approach is likely to mitigate the risks of misdiagnosis and over-diagnosis of children.[228]

Similarly, Professor Harriet Hiscock, Paediatrician at the Centre for Community Child Health, Director of the Health Services Research Unit at The Royal Children's Hospital and speaking in a personal capacity, recommended that professionals should not just work with the child, but rather should work in partnership with the whole family. She said:

> This approach has been evaluated and found to improve the developmental progress of children, parent-child interactions and the psychological functioning of parents, families and children.[229]

Witnesses and Aboriginal organisations also stressed to the Commission that the social and emotional wellbeing of children and young people must be understood in the context of family and community experiences. The Victorian Aboriginal Child Care Agency described the vital role of family in daily life and in social and emotional wellbeing:

> The family network dominates community and family life, governing social interactions. Aboriginal people are connected through kinship, possessing a shared sense of identity, care, responsibility and control. This inter-connectedness is applied to healing by adopting a whole family and community response to addressing [social and emotional wellbeing].[230]

The agency's submission stated that involving family in mental health services helps to ensure connection to family is strong, which can help reduce risk factors, and that '[a] family orientated approach is vital to promoting resilience and sustainable recovery'.[231]

The Commission recognises that collective and family-oriented approaches are vital in addressing the negative effect of intergenerational trauma and associated disadvantage on the social and emotional wellbeing of children and families. As described earlier in this chapter, those impacts are often experienced at the level of the extended family. Mr Jackomos described this shared experience as follows:

> As an Aboriginal person, you feel and suffer the consequences of the many, as you also celebrate our collective successes. Mental health and related illnesses, along with suicide and self-harm, imprisonment and child protection intervention has impacted significantly on my family, my children and extended family, and myself.[232]

Family-inclusive practice

Evidence before the Commission identified the benefits of family-inclusive practice for supporting people experiencing mental illness, families, carers and supporters. The state-wide service, Bouverie Centre, describes family-inclusive practice as 'activities which directly involve members of the client's family and social network in their care and treatment.'[233] This is discussed in more detail in Chapter 19: *Valuing and supporting families, carers and supporters*. As detailed in that chapter, family-inclusive practices include a range of methods, theories and styles, including single-session support, behavioural family therapy and multiple group family therapy. The range of family-inclusive practices (or family therapies) allows services to better identify and target treatment approaches for consumers in consideration of their condition and its impacts within the relational context.

Research indicates a range of benefits of family-inclusive practices or family therapies. In its 2008 report, *Family Relationships and Mental Illness: Impacts and Service Responses*, the Australian Institute of Family Studies noted the potential for family services to:

> [s]creen for, identify and deal with mental health problems as they become evident in the therapeutic process ... [and] not only address the impact of mental health problems on couple and family relationships, including parenting, but also the impact of these family relationships on mental health and wellbeing.[234]

Ms Sandra Keppich-Arnold, Director of Operations and Nursing at Alfred Health's Mental and Addiction Health, emphasised to the Commission that '[b]est practice service responses for young people *must* be family inclusive and ensure the family system is considered'.[235]

Dr Robyn Miller, CEO of McKillop Family Services, emphasised the importance of family-inclusive practice for children and families in contact with child protection, particularly those in residential care:

> Children have a hunger for family connection. There is a great gap in the mental health system where clinicians do not have training to think systemically or to think family. If you can engage family members to be believing and bear witness to the suffering of the child, the child will get better faster. It is so simple, but it is complicated to do and frequently in mental health and in residential care, clinicians are much more focused on the placement and the child as an individual, rather than recognising that physical separation from family does not equate with emotional separation for the child or young person.[236]

Family-inclusive practice in Aboriginal social and emotional wellbeing services

Family-oriented therapeutic care recognises the effect of intergenerational trauma on individuals, families and communities. The Bouverie Centre, which delivers family therapeutic services, identifies transgenerational trauma and grief and loss experienced by Aboriginal people, particularly for Stolen Generations survivors, as one of the major issues for Aboriginal families presenting to the service. The Workin' with the Mob case study provides an overview of the Bouverie Centre's approach to Aboriginal family therapy.

Single-session Aboriginal family therapy

The Bouverie Centre developed Single-Session Family Consultation which combines family consultation with single-session therapy.[237] The benefits of Single-Session Family Consultation are discussed in more detail in Chapter 19: V*aluing and supporting families, carers and supporters,* and in Chapter 13: *Supporting the mental health and wellbeing of young people.*

Evidence to the Commission indicates that Single-Session Family Consultation can be valuable for young people and families,[238] by providing initial support to families who can then use their own resources as well as brief support from therapists.[239]

There is also emerging evidence supporting the delivery of Single-Session Family Consultation for Aboriginal families. One study described the perspectives of two Aboriginal family counsellors from the Bouverie Centre who use single-session approaches with Aboriginal families:

> Brief therapy fits in with building hope that change can happen. It feels really good to be shifting my initial [scepticism]. Just listening and actually making it about what the family want to talk about, is a decolonising approach. It's reconciling all that past imposition of a worker/therapist wanting to direct the session: 'We're going to talk about this because this is the priority,' instead of actually just meeting the person and saying: 'What would you like to get out of today?'—'What's the biggest thing for you today?' I think it's really respecting the person and family.[240]

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> 'What are your best hopes from us meeting today?' I just ask that one question and it's that question that starts it all—the way that I view any individual, couple, or family who go to therapy is like they are asking for help—and in that, hope is implicit. Any person that walked in the door has come because they have hope.[241]

As described in the Workin' With the Mob case study earlier in this chapter, the Bouverie Centre and La Trobe University partnered to develop and deliver a postgraduate qualification in family therapy. Students come from Aboriginal community-controlled organisations and mainstream services, including family violence, children, justice and drug and alcohol services. To reduce barriers to accessing further education, workers without undergraduate degrees but who have worked in and contributed to the field are eligible for the course.[242] To address other barriers to study:

- training is provided within the community, so that the university 'comes to them'
- the program enables a safe and empowering climate in which the considerable skills and knowledge of the students are built upon
- student places within the course are sponsored
- supervision is provided for two years post-training to support the implementation of family therapy skills.[243]

The Commission heard that increasing and upskilling the Aboriginal workforce is vital to improving the availability of culturally responsive care.[244] In its survey of Aboriginal health workers for the *Balit Durn Durn* report, the Victorian Aboriginal Community Controlled Health Organisation identified that the vast majority of participants were interested in pursuing education to upskill but that factors such as cost, organisational capacity and lack of access for workers in regional areas were barriers to further study.[245]

The Commission acknowledges both the importance of family and kinship ties in Aboriginal social and emotional wellbeing, and the need to respond to the role of intergenerational trauma in the social and emotional wellbeing of children, young people and families. Aboriginal organisations have stressed the need to ensure 'there is a focus on children, and children within family and community to support generational change'[246] and for 'Aboriginal children and young people have access to culturally safe, therapeutic family strengthening services and early intervention'.[247]

In Victoria's future mental health system, the Victorian Aboriginal Community Controlled Health Organisation will be supported to commission the delivery of family-oriented, therapeutic care to children and young people. This approach will allow Aboriginal community-controlled health organisations to provide both clinical support (through partnerships with mental health services as outlined above) and therapeutic treatment, care and support to children and young people within communities.

The Victorian Government will provide ongoing funding to the Victorian Aboriginal Community Controlled Health Organisation to commission the delivery of culturally congruent, family-oriented, social and emotional wellbeing services. Recognising the critical link between parent-child social and emotional wellbeing, families with Aboriginal children should be able to access family therapy. The Commission has identified the following parameters as relevant based on a range of evidence and in consultation with the Bouverie Centre's Indigenous Family Therapy team:

- family therapy should come at no cost to the family
- families should be provided with the choice, where possible, for an Aboriginal family therapist to see them
- families should be provided with the choice, where appropriate, for the first session to be held offsite at their home, or in a neutral setting of the family's choice
- families should be offered a single-session approach with the possibility of the family returning for more sessions if requested or required, with the set number of sessions determined by the family in partnership with the family therapist. Clinical reviews should take place at regular intervals
- families should be provided with the option to have the case manager included in the sessions if they wish
- families with children in out-of-home care should be prioritised.[248]

The Victorian Aboriginal Community Controlled Health Organisation should also be funded to ensure that funded family therapy providers can provide secondary consultation to Aboriginal workers in their own agencies. The Commission understands that demand for Aboriginal family therapy far outweighs the availability of services, with the Bouverie Centre, a major provider of family therapy services, only being able to meet 50 per cent of demand.[249] It is expected that with appropriate resourcing and enhanced communication about the program, demand will further increase. The Commission is aware that the Bouverie Centre is undertaking a process to staff and structure a family therapy walk-in service for Aboriginal families based on feedback from families.[250] The Victorian Government should consider development of a proof of concept of this model for future investment.

Critical to sustainable delivery of these services will be the Victorian Government's ongoing investment in developing the Aboriginal family therapy workforce and in supporting and nurturing the professional development of graduate cohorts, including through mentoring.[251] Furthermore, the Victorian Government should provide funding to the Victorian Aboriginal Community Controlled Health Organisation to ensure that a comprehensive evaluation is undertaken of Aboriginal family therapy services to support continuous improvement and to inform future investment.

Personal story:

Jessie

Jessie* is an Aboriginal Heath Liaison Officer (AHLO), helping Aboriginal patients and families navigate services and offering cultural support across multiple hospitals. Jessie provides cultural advice to colleagues through education sessions, meetings and at times one on one. Jessie said their motivation for working in the role is that they have always wanted to bring about better outcomes for their mob and others.

Jessie said they feel well supported culturally by their employer, and can access other external supports.

> I have supervision with a social worker monthly, and my manager. There is a local Aboriginal group which I use to debrief, and [the Victorian Aboriginal Community Controlled Health Organisation] has an Improving Care of Aboriginal Patients (ICAP) Zoom group monthly for peer support.

However, the AHLO role has limited pathways for career progression. Jessie said that while this role suits them, the lack of pathways makes it hard to attract young people.

Jessie's employer is very supportive and has offered a number of training opportunities and the flexibility to undertake additional work outside their normal working hours.

Prior to this role, Jessie worked as a counsellor and would like to use these skills more in their current role.

> [The health service] tend[s] to use the people employed in specific roles—for example, counsellors to counsel ... regardless of cultural safety and comfortability.

Jessie would also like to see the AHLO role cover other parts of the hospitals too.

> I would like to see people at different points in their care. With ED, a lot of people come in over the weekend when no one is around. An ED support worker could support people coming through with mental health issues and may improve situation and response if done by an Aboriginal worker with the mob. Currently the AHLO doesn't get to see this mob as they are in and out—I only see them if they come back and haven't self-discharged, which makes it hard to follow up.

Source: RCVMHS, *Interview with 'Jessie'*, (pseudonym), August 2020.

Note: *Name has been changed to protect privacy.

20.7.4 Intensive multidisciplinary treatment, care and support for children and families

Throughout its deliberations, the Commission heard extensive evidence regarding the need for intensive therapeutic services for some children and families. As outlined in Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing*, too often, children and families are in crisis before they can access vital comprehensive treatment, care and support. Witnesses and Aboriginal organisations have impressed on the Commission the need for intensive, multidisciplinary wrap-around services to support Aboriginal children and families.

The Victorian Aboriginal Community Controlled Health Organisation identified the need to invest in 'multi-disciplinary social and emotional wellbeing teams' consisting of 'psychologists, general practitioners, psychiatrists, social workers, counsellors, Aboriginal social and emotional wellbeing and mental health workers, Aboriginal health practitioners, and mental health nurses' to support families and communities. The organisations also stressed that to 'ensure self-determination and cultural safety Aboriginal staff must be in leadership roles within these multi-disciplinary teams'.[252]

The Victorian Aboriginal Children and Young People's Alliance discussed several models of intensive, therapeutic family services across Aboriginal communities. This includes the Keela Borron wrap-around child and family service operated by the Ballarat and District Aboriginal Co-operative[253] (refer to Box 20.4).

The Victorian Aboriginal Children and Young People's Alliance identified multiple benefits of delivering models of child and family therapeutic wrap-around services designed for Aboriginal children and families, particularly families in or at risk of contact with child protection.[254] For example, such models recognise the time required to engage with and gain the trust of families, who may have experienced negative interactions with government services. They also recognise that the unique stresses and complexities of issues facing Aboriginal families may require ongoing and flexible approaches, including linking in with multiple services to support families. One member of the Alliance described to the Commission their organisation's approach:

> We engage and continue to engage, whether that be dozens and dozens of phone calls or door knocks, whatever it takes. It takes time to build trust and a relationship. And the talking doesn't stop—we talk to other service providers and systems including education, housing, police and legal centres to advocate on behalf of our clients to ensure they are getting fair treatment and proper access. If we are making progress with our families—we don't close the case.[255]

The member went on to describe their success with one family, telling the Commission, '[I]t took two years of intensive work to get that family where they are today—but it kept seven children out of the system, and it is our hope that it broke the cycle'.[256]

Box 20.4: Ballarat and District Aboriginal Co-operative—Keela Borron wrap-around child and family services[257]

Keela Borron in Wathaurong language means 'speak children' and is an innovative demonstration project that is designed to work with parents of Aboriginal children, where moderate to severe parental mental illness puts the child at risk of entering the child protection system.

With a core value of listening to the voices of the children, this project aims to support the healing of families and to strengthen cultural connections. The project also supports family reunification, where the parent's mental illness has already resulted in child protective services involvement. A trauma-informed view of the complexities faced by Aboriginal communities is at the forefront, with the aim to build resilience and self-determination.

Keela Borron recognises the need to be flexible, innovative, culturally focused and safe. The service delivery model is based on an intensive case management and a wrap-around model of care. While the safety and protection of children is at the forefront of this program, the core functions of this project model include mental health assessment and commencement of treatment, care coordination, linking in to health and social support needs, advocacy and parental skills development.

Some of the group programs established under Keela Borron include psychoeducation, Circle of Security, mental health self-management, parenting skills, mindfulness and stress reduction, communication skills and life skills programs. It has a cultural support worker who ensures the work the organisation does is culturally appropriate, and links to community, family and culture are maintained and strengthened.

The ongoing mental health support has proved to be invaluable to the overall success of client participation. The flexibility of Keela Borron to deliver programs such as Circle of Security to meet the needs of individuals has been appreciated by clients. Outcome measures have also highlighted improvements in mental health over a 12-month period, a reflection of how specialist mental health care and intense support can lower levels of depression, stress and anxiety.

Witnesses and Aboriginal organisations also emphasised the importance of self-determination in relation to the design and delivery of treatment, care and support. Ms Kennedy described the need to empower communities through 'co-design [which means] generating ideas, testing them and making decisions about how these ideas could shape responses to [social and emotional wellbeing]'.[258] Ms Kennedy further explained that this involves a 'shift in power, responsibility and control … so that Aboriginal consumers and communities become active partners in designing, shaping and resourcing services, programs, and activities rather than being passive recipients of those things'.[259] However, the Commission heard that this is not always the way that services for Aboriginal communities are designed and delivered:

> **despite commitments to Aboriginal self-determination in words we are yet to see the transfer of power, control and resources that true self-determination requires. We are still coming up against a system that isn't designed for us, where investments and policies trickle down to Aboriginal communities as an afterthought.[260]**

Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing*, recommends the establishment of two residential short-stay family centres to support infants, children and families. Both centres will be developed in consultation with Aboriginal communities and with an explicit focus on ensuring they are culturally appropriate and safe for Aboriginal children and families to access.

Furthermore, the Commission recognises that the unique challenges faced by many Aboriginal children and families necessitates an additional reform, specific for Aboriginal communities,[261] and developed by Aboriginal communities. As has been made clear to the Commission, the mental health system has too often failed to respond effectively or swiftly to the trauma within Aboriginal communities or to understand the impact of disadvantage and oppression on social and emotional wellbeing.[262] Aboriginal organisations have emphasised that 'Aboriginal led approaches to healing and recovery from trauma responses'[263] are integral to fulfilling the Victorian Government's commitment to self-determination.

The Commission supports Aboriginal communities being empowered to design, deliver, evaluate and continuously improve services that meet the needs of Aboriginal children and families.

Consequently, the Victorian Government must resource the Victorian Aboriginal Community Controlled Health Organisation to design and establish a culturally appropriate, family-oriented service for infants and children who require intensive social and emotional wellbeing supports. This should be done in partnership with an Infant, Child and Youth Area Mental Health and Wellbeing Service. The Victorian Government, through its self-determination reform framework, acknowledges that 'Aboriginal Victorians hold the knowledge and expertise about what is best for themselves, their families and their communities'.[264] It recognises that to enable self-determination, power and resources must be transferred to communities so that they are 'empowered to own and drive safe, relevant and accessible responses to meet their needs'.[265] In delivering on this reform, the Victorian Government must be led by the Victorian Aboriginal Community Controlled Health Organisation, in partnership with Aboriginal community-controlled organisations, on all aspects of the design and delivery of the model, including in determining the most appropriate agencies to lead delivery of the service.

20.8 The Aboriginal health workforce

The Commission has heard compelling evidence about the need for and benefits of Aboriginal roles within mental health services. Access to lived experience workers, including peer support workers, can contribute to recovery and healing from trauma.[266] Evidence indicates that there is a need to increase access to Aboriginal peer support roles, with 72 per cent of respondents from one Aboriginal workforce survey noting 'more cultural mentoring and peer supports would make their job easier'.[267] In the context of Aboriginal mental health and wellbeing, peer support roles undertake a similar support role to liaison officer roles. These roles, typically staffed by Aboriginal people, are demonstrated to improve mental health outcomes for Aboriginal people.[268] They support consumers to navigate and access services[269] and can support services to work more effectively with Aboriginal families through 'cultural expertise, liaison and co-case management'.[270]

Ms Kennedy described to the Commission how Aboriginal liaison officer roles support the work of local mental health and wellbeing services:

> An example of a mainstream Aboriginal mental health initiative is the Koori Mental Health Liaison Officer (KMHLO) program run in Victoria. Whilst these roles are only based in approximately 8 services, their work includes supporting Aboriginal patients, building links between Aboriginal mental health service (AMHSs) and ACCOs [Aboriginal community-controlled organisations], providing culturally sensitive practice advice to clinicians and other mental health workers, participating in health promotion activities, and providing cross-cultural training in collaboration with ACCOs.[271]

The Commission has heard of the importance of a workforce that understands the unique perspectives that Aboriginal people have of social and emotional wellbeing. At the Victorian Aboriginal Children and Young People's Alliance roundtable, one member told the Commission:

> The work our staff do with families goes to the heart of trauma experienced in Aboriginal communities. A western and clinical concept of mental health, does not adequately understand or adequately address this trauma—and this is why so many Aboriginal families fall through the gaps.
>
> But our workforce does understand. They see the whole person and see the cultural, social and historic impact of this trauma on their lives. They often understand it because they are part of the Community and they are best placed to work with our families.
>
> The cultural knowledge and understandings are invaluable.[272]

The Commission recognises the considerable 'cultural load' borne by Aboriginal health workers, many of whom are exposed to high levels of distress and trauma experienced by Aboriginal consumers, without sufficient opportunities to debrief or receive support.[273] Given the small number of Aboriginal health workers in mainstream mental health services,[274] these workers may be the sole Aboriginal voice in an organisation. The Commission suggests that services should be supported to increase the number of Koori mental health liaison officers across each service setting. The Commission has also heard that the lack of Aboriginal representation in management and across all levels of health services is a barrier to delivering safe and responsive health care.[275]

Significant workforce reform will be critical to create culturally safe services that meet the needs of Aboriginal people using Victoria's mental health and wellbeing services, as well as to create culturally safe workplaces that support the retention, and social and emotional wellbeing, of an Aboriginal workforce. In Chapter 33: *A sustainable workforce for the future*, the Commission details priority measures to improve the wellbeing of the workforce, including coordinating the development and delivery of tailored resources, professional supports and communities of practice for Aboriginal practitioners. This will go some way towards the necessary changes to create culturally safe workplaces. The Commission supports the government's commitment to grow the recruitment and retention of the Aboriginal workforce in the health sector, through the funding of training grants to increase the workforce participation of Aboriginal people 'in both clinical and non-clinical roles at all levels of the health and human services system'.[276]

20.9 Culturally safe and responsive mainstream services

A large proportion of Aboriginal people rely on mainstream services for their health care, either due to lack of access to Aboriginal community-controlled health organisations or a preference for mainstream services.[277] The 2014 *Contributing Lives* review found that, nationally in 2012–13, slightly less than half (47 per cent) of Aboriginal people used Aboriginal community-controlled health organisations for their primary health services.[278]

According to Census data, Aboriginal people make up 0.8 per cent of Victoria's population,[279] yet they comprise 2.8 per cent of people using clinical public mental health care, indicating they are overrepresented in these services.[280] Consequently, mainstream services need to be culturally responsive to the needs of Aboriginal people:

> There is a role for culturally specific organisations, but all organisations need to be culturally competent. For example, I think VAHS [Victorian Aboriginal Health Service] is pretty unique in providing a safe clinical space for Aboriginal people, but we do need to recognise that not all Aboriginal people want to go to a culturally specific health service. All organisations have to be culturally competent, regardless of whether they are targeting a particular cultural population.[281]

The Commission has heard that some mainstream services—such as Mildura Base Hospital and Goulburn Valley Health[282]—have built cultural competency through partnerships with Aboriginal community-controlled health organisations. However, a 2014 Victorian Auditor-General report indicated that such collaboration is not the norm.[283]

In the future, the Commission expects that the entities supporting the design and delivery of the new mental health and wellbeing system will work closely with Aboriginal people to support their social and emotional wellbeing. The new Mental Health and Wellbeing Promotion Adviser, recommended in Chapter 4: *Working together to support good mental health and wellbeing*, will work in close partnership with Aboriginal organisations to identify how to best support the social and emotional wellbeing of Aboriginal communities through the Statewide Plan for the Promotion of Mental Health and Wellbeing and the Prevention of Mental Illness.

It is the Commission's position that the new mental health and wellbeing system must respond to the diverse needs of Aboriginal people and be able to adapt its approach to ensure that all people get the right service, at the right time, in their local area. The Commission has identified that the way services are planned, funded and monitored is critical to creating a system that is innovative, respects the needs and preferences of individuals and is adaptive to changing needs. The new commissioning approach, detailed in Chapter 28: *Commissioning for responsive services,* will continue to progress the self-determination of Aboriginal services to Aboriginal people. The interim regional bodies—and, when established, the Regional Mental Health and Wellbeing Boards recommended in Chapter 5: *A responsive and integrated system*—will work towards advancing Aboriginal self-determination by progressively supporting Aboriginal organisations and communities to lead decisions on Aboriginal social and emotional wellbeing services. The Commission recognises that the genuine involvement of Aboriginal organisations and Aboriginal communities more broadly in the design and delivery of mental health care is integral to supporting self-determination.

Requirements under the new community model

The new mental health and wellbeing system will design and deliver services in relation to the needs of their communities. This is discussed in more detail in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*. Partnering with a range of community organisations will be integral to meeting the needs of Victoria's diverse populations. This includes working with community-led organisations supporting diverse populations, including LGBTIQ+ communities, culturally diverse communities and people with disabilities. It is expected that mental health services will partner with Aboriginal community-controlled health organisations and Aboriginal community-controlled organisations to improve access to, and the cultural safety and responsiveness of, mainstream mental health services.

The Commission acknowledges that a person's identity is the construct of a range of intersecting factors, such as age, race, gender, sexuality, cultural background and disability, and that the new mental health and wellbeing system needs to be able to respond to the different needs that people have. An intersectional approach supports greater inclusion and equality, and will underpin the diverse communities mental health and wellbeing framework detailed in Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population*.

The new mental health and wellbeing system will better engage the knowledge and expertise of Aboriginal consumers, families, carers and supporters. Aboriginal people will lead decision making in the design and delivery of Aboriginal social and emotional wellbeing services, and mainstream mental health services will engage with Aboriginal people to ensure their services are responsive to Aboriginal social and emotional wellbeing. Together with a greater emphasis on trauma-informed practice, these reforms are expected to deliver a more culturally safe system. The reforms will significantly increase the capability of the workforce to adopt trauma-informed approaches and ensure cultural safety, as well as providing training and support for consumers, families and carers to take on leadership roles in the new system. A more detailed description of these reforms can be found in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress* and Chapter 19: *Valuing and supporting families, carers and supporters*.

Aboriginal people experiencing homelessness or insecure housing, substance use or addiction and engagement in the criminal or youth justice system will receive more coordinated and integrated supports in the new system. A more 'joined-up' approach will prevent people from falling through the cracks between systems, and ensure that supports are more holistic and responsive to the range of factors that can affect social and emotional wellbeing. Further detail regarding the joined-up approach between specialist mental health and other service systems is described in Chapter 16: *Supported housing for adults and young people,* Chapter 22: *Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction* and Chapter 23: *Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems*.

Suicide prevention and response

The Commission's reforms as described in Chapter 17: *Collaboration for suicide prevention and response* aim for a more compassionate and comprehensive approach to suicide prevention and response. The reforms recognise the disproportionate incidence of suicide in Aboriginal communities and include a commitment to implement culturally safe community 'gatekeeper' training that is developed and delivered by Aboriginal people. In addition, the social and emotional wellbeing teams in Aboriginal community-controlled health organisations, which the Commission's interim report recommended, will provide postvention bereavement support services for Aboriginal people.

Collaboration will be critical for suicide prevention and response, and, indeed, is the guiding theme informing all initiatives outlined in this chapter. As stated in Chapter 1: *The reform landscape*, it is only with collaboration—between communities, organisations and all tiers of government—that meaningful change can occur.

1 Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027*, 2017, p. 50.

2 *Witness Statement of Helen Kennedy*, 15 July 2019, para. 8; *Evidence of Helen Kennedy*, 16 July 2019, p. 1049; Victorian Aboriginal Child Care Agency, *Submission to the RCVMHS: SUB.0002.0030.0027*, 2019, p. 5; Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, 2020, p. 24; *Witness Statement of Andrew Jackomos PSM*, 11 July 2019, para. 41(c).

3 *Witness Statement of Aunty Nellie Flagg*, 9 July 2019, paras. 3–14; *Evidence of Aunty Nellie Flagg*, 16 July 2019, pp. 1042–1044; Commission for Children and Young People Victoria, *Always Was, Always Will Be Koori Children: Systemic Inquiry into Services Provided to Aboriginal Children and Young People in Out-of-Home Care in Victoria*, 2016, p. 3.

4 *Witness Statement of Aunty Nellie Flagg*, paras. 42–48; *Evidence of Andrew Jackomos PSM*, 16 July 2019, pp. 50–51 and 55.

5 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, pp. 16–17; *Witness Statement of Andrew Jackomos PSM*, p. 55.

6 Victorian Aboriginal Community Controlled Health Organisation, p. 11.

7 Victorian Aboriginal Community Controlled Health Organisation, p. 11.

8 Victorian Aboriginal Community Controlled Health Organisation, p. 10.

9 These include the Royal Commission into Aboriginal Deaths in Custody (1991) Indigenous Law Resources, Royal Commission into Aboriginal Deaths in Custody, <www.austlii.edu.au/au/other/IndigLRes/rciadic/index.html>, [accessed 17 December 2020]; Commonwealth Government, *Bringing Them Home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, 1997; Victoria Protecting Victoria's Vulnerable Children Inquiry, *Report of the Protecting Victoria's Vulnerable Children Inquiry, Volume 3*, 2012; Commonwealth Government, *Australian Government Response to the Royal Commission into Institutional Responses to Child Sexual Abuse*, 2018.

10 Deloitte Access Economics, *Review of the Implementation of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody*, 2018, p. 701; Aboriginal and Torres Strait Islander Peak Organisations, *Redfern Statement*, 2016, p. 7.

11 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 465.

12 Victorian Government, *Self–Determination Reform Framework*, 2019, p. 6.

13 *Witness Statement of Professor Dan Lubman*, 28 May 2020, para. 99; *Witness Statement of Georgie Harman*, 2 July 2020, para. 159.

14 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 469.

15 *Witness Statement of Helen Kennedy*, para. 34.

16 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, 2019, para. I(4.1).

17 Victorian Aboriginal Legal Service, *Submission to the RCVMHS: SUB.0002.0030.0226*, 2019, p. 23; *Witness Statement of Helen Kennedy*, para. 98(a); *Witness Statement of Emma King*, 18 July 2019, para. 22; Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027*, p. 10.

18 Australian Institute of Health and Welfare, *Australian Burden of Disease Study: Impact and Causes of Illness and Death in Aboriginal and Torres Strait Islander People 2011*, 2016, p. 98.

19 Australian Institute of Health and Welfare, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, 2015, p. 50.

20 Peter S Azzopardi and others, Health and Wellbeing of Indigenous Adolescents in Australia: A Systematic Synthesis of Population Data, *The Lancet*, 391.10122 (2018), 1–17 (p. 9).

21 Department of Health and Human Services, *Victorian Suicide Prevention Framework 2016–25*, 2016, p. 2.

22 Department of Health and Human Services, *Victorian Suicide Prevention Framework 2016–25*, p. 2.

23 Professor Patricia Dudgeon and others, *Solutions That Work: What the Evidence and Our People Tell Us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report* (School of Indigenous Studies, University of Western Australia, 2016), p. 7.

24 Professor Patricia Dudgeon and others, p. 7.

25 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

26 Susan Walker and others, Clinical and Social Factors Associated with Increased Risk for Involuntary Psychiatric Hospitalisation: A Systematic Review, Meta-Analysis, and Narrative Synthesis, *The Lancet Psychiatry*, 6.12 (2019), 1039–1053 (p. 1050); Lisa Brophy, Cath Roper and Kellie Grant, Risk Factors for Involuntary Psychiatric Hospitalisation, *The Lancet Psychiatry*, 6.12 (2019), 974–975 (p. 974); *Witness Statement of Professor Lisa Brophy*, 29 April 2020, para. 25; Phoebe Barnett and others, Ethnic Variations in Compulsory Detention under the Mental Health Act: A Systematic Review and Meta-Analysis of International Data, *The Lancet Psychiatry*, 6.4 (2019), 305–317 (p. 305).

27 Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027*, p. 10.

28 Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027*, p. 2.

29 Professor Patricia Dudgeon and others, p. 93.

30 *Evidence of Andrew Jackomos PSM*, para. 1084.

31 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 474.

32 Pat Swan and Professor Beverley Raphael, *Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy: National Consultancy Report*, 1995, p. 7.

33 *Witness Statement of Dr Graham Gee*, 10 July 2019, paras. 6–7.

34 *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, ed. by P. Dudgeon, H. Milroy and R. Walker (Canberra: Commonwealth of Australia, 2014), p. 57.

35 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 478–479.

36 Swan and Raphael, p. 7; Yin Paradies, Ricci Harris and Ian Anderson, *The Impact of Racism on Indigenous Health in Australia and Aotearoa: Towards a Research Agenda, Discussion Paper No.4*, 2008, p. 3; Sigrid Herring and others, The Intersection of Trauma, Racism, and Cultural Competence in Effective Work with Aboriginal People: Waiting for Trust, *Australian Social Work*, 66.1 (2013), 104–117 (pp. 107–108).

37 Victorian Aboriginal Legal Service, p. 23; *Witness Statement of Helen Kennedy*, para. 98(a); Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027*, p. 10.

38 Victorian Aboriginal Child Care Agency; citing Graham John Gee, *Resilience and Recovery from Trauma among Aboriginal Help Seeking Clients in an Urban Aboriginal Community Controlled Health Organisation*, 2016, p. 25

39 *Witness Statement of Dr Graham Gee*, para. 20.

40 Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027*, p. 16.

41 Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Stolen Generations and Descendants: Numbers, Demographic Characteristics and Selected Outcomes*, 2018, p. 30, Table 3.1.

42 Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Stolen Generations and Descendants: Numbers, Demographic Characteristics and Selected Outcomes*, p. 13.

43 Healing Foundation, *Submission to the RCVMHS: SUB.1000.0001.5482*, 2019, p. 1.

44 Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Stolen Generations and Descendants: Numbers, Demographic Characteristics and Selected Outcomes*, p. vii.

45 Victorian Aboriginal Community Services Association Limited, *Submission to the RCVMHS: SUB.0002.0015.0002*, 2019, p. 3.

46 Djirra, *Submission to the RCVMHS: SUB.0002.0029.0288*, 2019, p. 2.

47 Indian and Northern Affairs Canada, *Evaluation of Community-Based Healing Initiatives Supported Through the Aboriginal Healing Foundation: Final Report*, 2009, pp. 48–49.

48 *Witness Statement of Adam Burns*, 8 July 2019, para. 20.

49 *Evidence of Professor Helen Milroy*, 16 July 2019, p. 1089.

50 *Witness Statement of Adam Burns*, para. 22.

51 Australian Human Rights Commission, *Social Justice Report 2011: Aboriginal and Torres Strait Islander Social Justice Commissioner*, 2011, p. 138.

52 *Witness Statement of Professor David Forbes*, 27 June 2019, para. 28.

53 Djirra, p. 44.

54 Djirra, p. 43.

55 *Witness Statement of Andrew Jackomos PSM*, para. 90.

56 *Witness Statement of Dr Graham Gee*, para. 8.

57 *Witness Statement of Andrew Jackomos PSM*, para. 14.

58 Victorian Aboriginal Legal Service, p. 2; Djirra, p. 26; *Witness Statement of Helen Kennedy*, para. 21.

59 Aboriginal Affairs, *Victorian Government Aboriginal Affairs Report 2018* (Department of Premier and Cabinet, 2018), p. 22.

60 Aboriginal Affairs, p. 24.

61 Victorian Aboriginal Legal Service, p. 3.

62 Aboriginal Housing Victoria, *Submission to the RCVMHS: SUB.0002.0028.0003*, 2019, p. 12.

63 Aboriginal Housing Victoria, pp. 11–12.

64 Aboriginal Housing Victoria, pp. 11–12.

65 Department of Health and Human Services, *Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement*, 2018, p. 19.

66 Children's Court of Victoria, *Submission to the RCVMHS: SUB.0002.0032.0026*, 2019, p. 12.

67 Commission for Children and Young People Victoria, *Always Was, Always Will Be Koori Children: Systemic Inquiry into Services Provided to Aboriginal Children and Young People in Out-of-Home Care in Victoria*, p. 97.

68 Commission for Children and Young People Victoria, p. 50.

69 Commission for Children and Young People Victoria, p. 97.

70 Commission for Children and Young People Victoria, p. 97.

71 Commission for Children and Young People Victoria, p. 94.

72 Victorian Auditor-General's Office, *Child and Youth Mental Health*, 2019, p. 15.

73 *Witness Statement of Dr Robyn Miller*, 7 August 2020, para. 89; Vincent J Felitti and others, 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults', *American Journal of Preventive Medicine*, 14.4 (1998), 245–258 (p. 251).

74 *Witness Statement of Professor Louise Harms*, 23 May 2020, para. 9.

75 *Witness Statement of Adam Burns*, paras. 22–24.

76 *Witness Statement of Dr Graham Gee*, para. 32.

77 *Witness Statement of Helen Kennedy*, para. 34.

78 Victorian Aboriginal Health Service Co-Operative Ltd., *Submission to the RCVMHS: SUB.1000.0001.2460*, 2019, p. 13.

79 Victorian Aboriginal Health Service Co-Operative Ltd., p. 13.

80 Margaret A. Kelaher, Angeline S. Ferdinand and Yin Paradies, Experiencing Racism in Health Care: The Mental Health Impacts for Victorian Aboriginal Communities, *Medical Journal of Australia*, 201.1 (2014), 44–47 (p. 45).

81 Kelaher, Ferdinand and Paradies, p. 1.

82 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 50.

83 *Witness Statement of Helen Kennedy*, para. 36.

84 Australian Institute of Health and Welfare and Australian Institute of Family Studies, *Improving the Accessibility of Health Services in Urban and Regional Settings for Indigenous People: Closing the Gap Clearinghouse*, 2013, p. 8.

85 Ivan Lin, Charmaine Green and Dawn Bessarab, "Yarn with Me": Applying Clinical Yarning to Improve Clinician—Patient Communication in Aboriginal Health Care, *Australian Journal of Primary Health*, 22.5 (2016), 377–382 (p. 377).

86 *Witness Statement of Aunty Nellie Flagg*, paras. 36 and 39.

87 General Assembly, United Nations, *International Covenant on Economic, Social and Cultural Rights, Entry into Force: 3 January 1976, in Accordance with Article 27*, 16 December 1966, p. 1.

88 ANTaR, UN Declaration on the Rights of Indigenous Peoples, <antar.org.au/campaigns/un-declaration-rights-indigenous-peoples>, [accessed 21 December 2020].

89 Victorian Aboriginal Child Care Agency, p. 29.

90 Rob Riley. From exclusion to negotiation: the role of psychology in Aboriginal social justice /discussion paper (Curtin Indigenous Research Centre ; No. 1/1997. Gunada Press, Curtin University, Perth WA as cited in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing*, ed. by Pat Dudgeon, Helen Milroy and Roz Walker, Second Edition (Canberra: Commonwealth of Australia, 2014), pp. xvi–xvii.

91 Rob Riley. From exclusion to negotiation: the role of psychology in Aboriginal social justice /discussion paper (Curtin Indigenous Research Centre); No. 1/1997. Gunada Press, Curtin University, Perth WA as cited in Pat Dudgeon, Milroy, and Walker, pp. xvi–xvii.

92 Dr Tony Bartone, A New Way Forward to Closing the Gap, *Australian Medicine*, 31.17 (2019), p. 23.

93 Bartone, p. 23.

94 Close the Gap Campaign Steering Committee for Indigenous Health Equality, *A Ten–Year Review: The Closing the Gap Strategy and Recommendations for Reset*, 2018, p. 4.

95 Coalition of Aboriginal and Torres Strait Islander Peak Organisations and Council of Australian Governments, *Partnership Agreement of Closing the Gap 2019–2029*, 2019, p. 1.

96 Coalition of Aboriginal and Torres Strait Islander Peak Organisations and Council of Australian Governments, p. 4.

97 Productivity Commission, *Indigenous Evaluation Strategy Background Paper*, 2020, pp. 8–9.

98 Productivity Commission, pp. 8–9.

99 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: Delivering Truth And Justice For Aboriginal Victorians, 11 July 2020, <www.premier.vic.gov.au/delivering-truth-and-justice-aboriginal-victorians>, [accessed 15 December 2020].

100 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: Delivering Truth And Justice For Aboriginal Victorians.

101 Referendum Council, The Uluru Statement from the Heart, <ulurustatement.org/the-statement>, [accessed 15 December 2020].

102 World Economic Forum, Can Truth and Reconciliation Commissions Heal Divided Nations?, <www.weforum.org/agenda/2019/02/do-truth-and-reconciliation-commissions-heal-divided-nations>, [accessed 15 December 2020].

103 Joint Select Committee on Constitutional Recognition, Parliament of Australia, 6. Truth-Telling, <www.aph.gov.au/Parliamentary_Business/Committees/Joint/Former_Committees/Constitutional_Recognition_2018/ConstRecognition/Final_Report/section?id=committees%2Freportjnt%2F024213%2F26675>, [accessed 15 December 2020].

104 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: Delivering Truth And Justice For Aboriginal Victorians.

105 Reconciliation Australia, *The State of Reconciliation in Australia*, 2016, p. 9.

106 Reconciliation Australia, p. 9.

107 Reconciliation Australia, p. 80.

108 Reconciliation Australia, p. 80.

109 Reconciliation Australia, p. 9.

110 Department of Health and Human Services, *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017-2027*, 2017, p. 20.

111 Department of Health and Human Services, *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017-2027*, p. 20.

112 Victorian Government, *Victorian Aboriginal Affairs Framework: 2018–2023*, 2018, p. 30.

113 Victorian Government, *Victorian Aboriginal Affairs Framework: 2018–2023*, p. 11.

114 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 472.

115 Pat Dudgeon and others, *Effective Strategies to Strengthen the Mental Health and Wellbeing of Aboriginal and Torres Strait Islander People*, 2014, p. 2.

116 Professor Larissa Behrendt, Dr Miriam Jorgensen and Dr Alison Vivian, *Self-Determination: Background Concepts —Scoping Paper 1*, pp. 3 and 12–13; Chris McDonald and Lisanne Raderschall, *OECD Regional Development Working Papers: Indigenous Community Capacity and Multi-Level Governance* (Organisation for Economic Co-operation and Development, 2019), p. 5; Human Rights and Equal Opportunity Commission, Social Justice and Human Rights for Aboriginal and Torres Strait Islander Peoples, 2003, p. 4.

117 *Witness Statement of Andrew Jackomos PSM*, paras. 58–60.

118 Victorian Aboriginal Children and Young People's Alliance, *Submission to the RCVMHS: SUB.0002.0028.0546*, 2019, p. 8.

119 *Witness Statement of Helen Kennedy*, para. 55.

120 *Witness Statement of Andrew Jackomos PSM*, para. 81.

121 Victorian Aboriginal Children and Young People's Alliance, p. 18; *Witness Statement of Andrew Jackomos PSM*, para. 58.

122 *Witness Statement of Helen Kennedy*, para. 69.

123 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 20.

124 *Witness Statement of Andrew Jackomos PSM*, para. 45.

125 *Witness Statement of Andrew Jackomos PSM*, para. 87.

126 *Witness Statement of Adam Burns*, para. 24.

127 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 41.

128 Healing Foundation, Healing Centres, <healingfoundation.org.au/community-healing/healing-centres/>, [accessed 14 December 2020].

129 *Witness Statement of Helen Kennedy*, para. 82.

130 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, pp. 29–33.

131 *Witness Statement of Adam Burns*, para. 22.

132 Tracey Varker and others, *What Is the Link Between Trauma and Mental Illness? Report Prepared for the Royal Commission into Victoria's Mental Health System. Phoenix Australia—Centre for Posttraumatic Mental Health: Melbourne*, 2020, pp. 11–13.

133 *Witness Statement of Adam Burns*, para. 11.

134 *Witness Statement of Adam Burns*, paras. 17–18.

135 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, pp. 39–41; Victorian Aboriginal Children and Young People's Alliance, p. 27; Victorian Aboriginal Health Service Co-Operative Ltd., p. 4.

DOH.0003.0001.0654

136 *Evidence of Helen Kennedy*, p. 1056.

137 *Witness Statement of Helen Kennedy*, para. 82.

138 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 41.

139 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 39.

140 Healing Foundation, Submission to the RCVMHS: SUB.1000.0001.5482, p. 13.

141 Family Safety Victoria, *Nargneit Birrang: Aboriginal Holistic Health Framework for Family Violence*, 2019, p. 21.

142 Jane McKendrick and others, *Aboriginal and Torres Strait Islander Healing Programs—A Literature Review*, 2017, p. 31.

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

144 *Witness Statement of Dr Graham Gee*, para. 20.

145 Healing Foundation, *Submission to the RCVMHS: SUB.1000.0001.5482*, p. 15.

146 Healing Foundation, *Submission to the RCVMHS: SUB.1000.0001.5482*, p. 15.

147 Healing Foundation, *Submission to the RCVMHS: SUB.1000.0001.5482*, p. 14.

148 *Witness Statement of Dr Graham Gee*, para. 15.

149 *Witness Statement of Andrew Jackomos PSM*, para. 113.

150 *Witness Statement of Helen Kennedy*, para. 28.

151 Healing Foundation, Healing Centres.

152 Healing Foundation, *Submission to the RCVMHS: SUB.1000.0001.5482*, p. 16.

153 McKendrick and others, p. 31.

154 *Witness Statement of Aunty Nellie Flagg*, para. 49.

155 Healing Foundation, *Healing Centres Final Report*, 2012, p. 16.

156 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 35.

157 McKendrick and others, p. 31.

158 *Witness Statement of Professor Helen Milroy*, 15 July 2019, para. 61.

159 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, pp. 30–33.

160 *Witness Statement of Andrew Jackomos PSM*, para. 26.

161 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 45.

162 *Witness Statement of Dr Graham Gee*, para. 22.

163 *Evidence of Helen Kennedy*, pp. 1048–1049.

164 McKendrick and others, p. 45.

165 *Witness Statement of Helen Kennedy*, para. 28.

166 McKendrick and others, p. 13.

167 *Witness Statement of Adam Burns*, para. 14.

168 Cammi Murrup-Stewart and others, Aboriginal Perceptions of Social and Emotional Wellbeing Programs: A Systematic Review of Literature Assessing Social and Emotional Wellbeing Programs for Aboriginal and Torres Strait Islander Australians Perspectives, *Australian Psychologist*, 54.3 (2019), 171–186 (p. 183).

169 The University of Melbourne, Indigenous Health Equity Unit, *Health and Wellbeing Outcomes of the Aboriginal and Torres Strait Islander Gathering Place Model in Victoria: A Place for Inclusion, Connection and Empowerment: Final Report*, 2016, p. v.

170 The University of Melbourne, Indigenous Health Equity Unit, p. v.

171 The University of Melbourne, Indigenous Health Equity Unit, p. v.

172 The University of Melbourne, Indigenous Health Equity Unit, p. 27.

173 McKendrick and others, p. 2 and 22–40.

174 New Zealand Government, *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*, 2018, p. 84.

175 Family Safety Victoria, p. 10.

176 *Witness Statement of Helen Kennedy*, para. 27.

177 *Witness Statement of Dr Graham Gee*, para. 22.

DOH.0003.0001.0655

178 *Witness Statement of Adam Burns*, para. 11.

179 Family Safety Victoria, p. 24.

180 *Witness Statement of Daniel Bolger*, 28 June 2019, para. 35.

181 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 39.

182 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 39.

183 McKendrick and others, p. 2.

184 *Witness Statement of Helen Kennedy*, para. 93.

185 *Witness Statement of Helen Kennedy*, para. 85.

186 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 51.

187 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 51.

188 *Witness Statement of Dr Robyn Miller*, para. 33.

189 McKendrick and others, p. 45.

190 Dr Naomi Ralph and others, *Healing the Past by Nurturing the Future: Perinatal Support for Aboriginal and Torres Strait Islander* Parents Who Have Experienced Complex Childhood Trauma—Workshop One Report*, 2018, p. 17; *Witness Statement of Dr Graham Gee*, para. 20.

191 Australian Bureau of Statistics, Media Release: National: Aboriginal and Torres Strait Islander Australia Revealed as 2011 Census Data is Released, 12 June 2012, <www.abs.gov.au/websitedbs/censushome.nsf/home/CO-63?opendocument&navpos=620>, [accessed 21 December 2020].

192 Victorian Auditor-General's Office, *Child and Youth Mental Health*, p. 83.

193 Victorian Auditor-General's Office, *Child and Youth Mental Health*, p. 71.

194 Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027*, p. 19.

195 Commission for Children and Young People Victoria, *Submission to the RCVMHS: SUB.1000.0002.0002*, 2019, p. 6.

196 Ariane Marie-Mitchell and Rashel Kostolansky, A Systematic Review of Trials to Improve Child Outcomes Associated With Adverse Childhood Experiences, *American Journal of Preventive Medicine*, 56.5 (2019), 756–764 (pp. 756–757).

197 Dr Stephen Carbone, *Evidence Review: The Primary Prevention of Mental Health Conditions*, 2020, p. 15.

198 Asterie Twizeyemariya and others, Risks for Mental Illness in Indigenous Australian Children: A Descriptive Study Demonstrating High Levels of Vulnerability: Risks for Mental Illness in Indigenous Australian Children, *The Milbank Quarterly*, 95.2 (2017), 319–357 (p. 320).

199 Commission for Children and Young People Victoria, *Submission to the RCVMHS: SUB.1000.0002.0002*, p. 6.

200 *Witness Statement of Dr Tim Moore*, 2 June 2020, para. 17.

201 *Witness Statement of Dr Tim Moore*, para. 17.

202 *Witness Statement of Dr Tim Moore*, para. 18.

203 *Witness Statement of Professor Helen Milroy*, para. 26.

204 Queensland Health, *Caring for a Person Experiencing Mental Illness in the Perinatal Period*, 2010, p. 37.

205 Joint Commissioning Panel for Mental Health, *Guidance for Commissioners of Perinatal Mental Health Services, Volume 2: Practical Mental Health Commissioning*, 2012, p. 6.

206 Louise Newman and others, Early Origins of Mental Disorder—Risk Factors in the Perinatal and Infant Period, *BMC Psychiatry*, 16:270 (2016), 1–8 (p. 5).

207 Victorian Aboriginal Children and Young People's Alliance, p. 20 and 23; Victorian Aboriginal Child Care Agency, p. 16.

208 Victorian Aboriginal Community Controlled Health Organisation, *RCVMHS and Alliance Meeting Summary Report*, 28 April 2020, p. 5.

209 Commission for Children and Young People Victoria, *Always Was, Always Will Be Koori Children: Systemic Inquiry into Services Provided to Aboriginal Children and Young People in Out-of-Home Care in Victoria*, p. 78.

210 Commission for Children and Young People Victoria, p. 11.

211 Victorian Aboriginal Community Controlled Health Organisation, *RCVMHS and Alliance Meeting Summary Report*, p. 6.

212 Djirra, p. 21.

213 Djirra, p. 21.

214 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: A Fairer Future For Aboriginal Victorians, 24 November 2020, <www.premier.vic.gov.au/fairer-future-aboriginal-victorians>, [accessed 22 December 2020].

215 *Witness Statement of Helen Kennedy*, para. 15.

216 Carbone, p. 16.

217 *Witness Statement of Professor Frank Oberklaid AM OAM*, 9 June 2020, para. 42.

218 *Witness Statement of Professor Frank Oberklaid AM OAM*, para. 43.

219 Victorian Aboriginal Community Controlled Health Organisation, *RCVMHS and Alliance Meeting Summary Report*, p. 15.

220 Rumbalara Aboriginal Co-operative Ltd, *Submission to the RCVMHS: SUB.0002.0029.0426*, 2019, p. 3.

221 Commission for Children and Young People Victoria, *Submission to the RCVMHS: SUB.1000.0002.0002*, p. 36.

222 Commission for Children and Young People Victoria, *Always Was, Always Will Be Koori Children: Systemic Inquiry into Services Provided to Aboriginal Children and Young People in Out-of-Home Care in Victoria*, p. 53.

223 Victorian Aboriginal Child Care Agency, p. 5.

224 *Witness Statement of Professor Helen Milroy*, para. 31.

225 *Witness Statement of Professor Dan Lubman*, para. 99; *Witness Statement of Georgie Harman*, 4 July 2019, para. 159.

226 Victorian Aboriginal Community Controlled Health Organisation, *RCVMHS and Alliance Meeting Summary Report*, p. 8.

227 *Witness Statement of Professor Louise Newman AM*, 1 May 2020, para. 40.

228 *Witness Statement of Professor Louise Newman AM*, para. 40.

229 *Witness Statement of Professor Harriet Hiscock*, 1 May 2020, para. 55.

230 Victorian Aboriginal Child Care Agency, p. 44.

231 Victorian Aboriginal Child Care Agency, p. 45.

232 *Witness Statement of Andrew Jackomos PSM*, para. 10.

233 The Bouverie Centre, *From Individual to Families a Client-Centred Framework for Involving Families*, p. 5.

234 Elly Robinson, Bryan Rodgers and Peter Butterworth, *Family Relationships and Mental Illness: Impacts and Service Responses*, 2008, p. 11.

235 *Witness Statement of Sandra Keppich-Arnold*, 18 May 2020, para. 98.

236 *Witness Statement of Dr Robyn Miller*, para. 102.

237 The Bouverie Centre, *From Individual to Families a Client-Centred Framework for Involving Families*, p. 12.

238 Alfred Health, *Submission to the RCVMHS: SUB.0002.0028.0156*, 2019, p. 20.

239 Jason John Westwater and others, A Mixed Methods Exploration of Single Session Family Therapy in a Child and Adolescent Mental Health Service in Tasmania, Australia, *Australian and New Zealand Journal of Family Therapy*, 41.3 (2020), 258–270 (p. 258).

240 Alison Elliott, James Dokona and Henry Doussa, Following the River's Flow: A Conversation about Single Session Approaches with Aboriginal Families, *Australian and New Zealand Journal of Family Therapy*, 41.3 (2020), 249–257 (p. 250).

241 Elliott, Dokona and Doussa, p. 251.

242 Alison Elliott and others, *Aboriginal Family Therapy Training Program Impact Analysis Report*, 2015, p. 5.

243 Elliott and others, p. 7.

244 *Witness Statement of Andrew Jackomos PSM*, para. 118.

245 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, pp. 27–28.

246 Bendigo and District Aboriginal Co-operative, *Submission to the RCVMHS: SUB.0002.0029.0071*, 2019, p. 8.

247 Rumbalara Aboriginal Co-operative Ltd, p. 3.

248 The Bouverie Centre, *Correspondence to the RCVMHS*, 2020.

249 The Bouverie Centre, *Correspondence to the RCVMHS*.

250 The Bouverie Centre, *Correspondence to the RCVMHS*.

251 Elliott and others, p. 25.

252 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 44.

253 Victorian Aboriginal Community Controlled Health Organisation, *RCVMHS and Alliance Meeting Summary Report, p.* 6–7.

254 Victorian Aboriginal Community Controlled Health Organisation, *RCVMHS and Alliance Meeting Summary Report*, pp. 6–17.

255 Victorian Aboriginal Community Controlled Health Organisation, *RCVMHS and Alliance Meeting Summary Report*, p. 17.

256 Victorian Aboriginal Community Controlled Health Organisation, *RCVMHS and Alliance Meeting Summary Report*, p. 17.

257 Victorian Aboriginal Community Controlled Health Organisation, *RCVMHS and Alliance Meeting Summary Report*, pp. 6–7.

258 *Witness Statement of Helen Kennedy*, para. 71.

259 *Witness Statement of Helen Kennedy*, para. 71.

260 Victorian Aboriginal Community Controlled Health Organisation, *RCVMHS and Alliance Meeting Summary Report*, p. 33.

261 Victorian Auditor-General's Office, *Accessibility of Mainstream Services for Aboriginal Victorians*, 2014, p. xii.

262 *Witness Statement of Helen Kennedy*, para. 32.

263 *Witness Statement of Helen Kennedy*, para. 32.

264 Victorian Government, *Victorian Aboriginal Affairs Framework: 2018–2023*, 2018, p. 22.

265 Victorian Government, *Victorian Aboriginal Affairs Framework*: 2018–2023, p. 11.

266 *Witness Statement of Indigo Daya*, 12 May 2020, para. 49(c).

267 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 27.

268 *Witness Statement of Helen Kennedy*, paras. 41–42.

269 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 50.

270 *Witness Statement of Professor Helen Milroy*, para. 70.

271 *Witness Statement of Helen Kennedy*, para. 41.

272 Victorian Aboriginal Community Controlled Health Organisation, *RCVMHS and Alliance Meeting Summary Report*, p. 26.

273 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0114.0001, Balit Durn Durn Report*, p. 28.

274 *Witness Statement of Helen Kennedy*, para. 44.

275 *Witness Statement of Andrew Jackomos PSM*, para. 118.

276 Department of Health and Human Services, *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017–2027*, p. 50.

277 *Witness Statement of Helen Kennedy*, para. 37.

278 National Mental Health Commission, *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services, Volume 2: Every Service Is a Gateway Response to Terms of Reference*, 2014, p. 81.

279 Australian Bureau of Statistics, 2016 Census Quick Stats: Victoria, <quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/2?opendocument>, [accessed 13 February 2020].

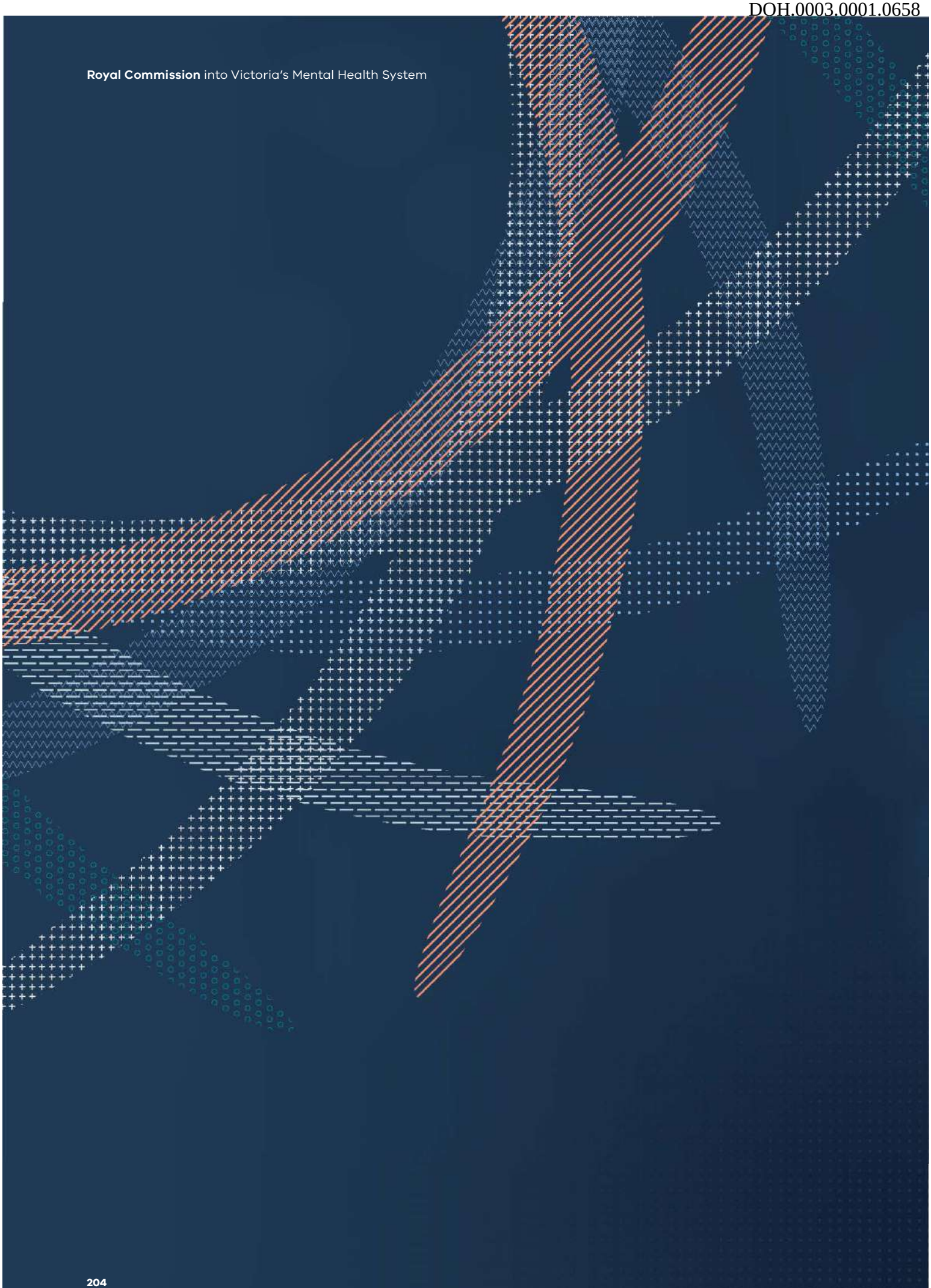
280 Department of Health and Human Services, *Victoria's Mental Health Services Annual Report 2018–19*, 2019, p. 20.

281 *Witness Statement of Dr Mariam Tokhi*, 12 May 2020, para. 42.

282 Victorian Auditor-General's Office, *Accessibility of Mainstream Services for Aboriginal Victorians*, p. 27.

283 Victorian Auditor-General's Office, *Accessibility of Mainstream Services for Aboriginal Victorians*, p. xii.

DOH.0003.0001.0658



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Chapter 21

Responding to the mental health and wellbeing needs of a diverse population

Recommendation 34:

Working in partnership with and improving accessibility for diverse communities

The Royal Commission recommends that the Victorian Government:

1. ensure the active engagement of Victoria's diverse communities throughout the process of planning, implementing and managing the reformed mental health and wellbeing system.
2. legislatively provide that the Secretary of the Department of Health is responsible for the delivery of a mental health and wellbeing system that responds to the needs of Victoria's diverse communities and promotes access and equity of outcomes, with this function able to be delegated to the Chief Officer for Mental Health and Wellbeing (refer to recommendation 45(1)).
3. ensure that the Mental Health and Wellbeing Division:

   a. collects, analyses and reports on data on the mental health and wellbeing of Victoria's diverse communities for planning and funding purposes and to improve transparency in mental health and wellbeing outcomes for diverse communities;
   b. ensures that Victorians, regardless of first or preferred language, hearing, literacy or neurocognitive ability, have access to appropriate mental health and wellbeing information and means of communication throughout the mental health and wellbeing system;
   c. enables Victoria's diverse communities and community-led organisations to:

      - design and deliver mental health and wellbeing information and awareness campaigns; and
      - assist their communities to navigate the mental health and wellbeing system.

4. by the end of 2021, provide recurrent funding to Switchboard Victoria to deliver its Rainbow Door program, at scale, to support people who identify as lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning to navigate and access the mental health and wellbeing system.
5. enable the development of digital technologies to support the delivery of language services that assist access to and engagement with mental health and wellbeing services.

21.1 A safe, inclusive and responsive mental health and wellbeing system for people from diverse communities

Victoria's population is diverse, growing and changing.[1] Victorians speak more than 200 different languages,[2] follow or practise a broad range of religions,[3] and identify with many characteristics based on age, gender, ability, sexuality, ethnicity and culture.[4] To effectively meet the needs of Victoria's diverse population, it is critical that the mental health and wellbeing system is safe, responsive and inclusive. Furthermore, it must have the foresight and capability to anticipate and respond to the needs of Victoria's evolving population into the future.

Victoria's mental health system has not delivered safe, responsive or inclusive treatment, care and support for many people from diverse communities and social groups.[5] The Commission heard compelling evidence of the many ways, large and small, that the system excludes people from diverse communities, and the consequences of this exclusion for mental health and social and economic participation. Witnesses also described to the Commission the detrimental impacts of discrimination—including discrimination experienced within, and through exclusion from, the mental health system—on their mental health and wellbeing.[6]

The Commission recognises steps the Victorian Government has taken to invest in and support the inclusion and participation of Victoria's diverse communities. The Victorian Government's stated position is that 'Equality is not negotiable in Victoria'.[7] The Victorian Government has clearly articulated the need to 'foster inclusion, participation and equality of opportunity [and to] redesign services to respond to the needs of diverse communities and remove barriers to participation'.[8]

In 2015 the Victorian Government established Australia's first (LGBTIQ+) Equality portfolio, overseen by a Minister for Equality, and a Victorian Commissioner for Gender and Sexuality (recently retitled the Commissioner for LGBTIQ+ Communities). The portfolio 'champions diversity and inclusion through developing whole-of-government policy and programs to support LGBTIQ+ communities' and is supported by an LGBTIQ+ Communities Taskforce that includes a Health and Human Services Working Group. The Victorian Multicultural Commission, constituted under the *Multicultural Victoria Act 2011* (Vic), aims to promote the full participation of Victoria's culturally diverse communities in the social, cultural, economic and political life of Victoria, including through equitable access to government services.

Recognising the distinct yet comparable strengths and challenges faced by diverse communities and social groups in Victoria, the current Victorian Government has also recently brought together the youth, LGBTIQ+, multicultural affairs, women's, disability and other portfolios within the Department of Families, Fairness and Housing.

Box 21.1 notes the other chapters of this report in which the mental health and wellbeing of specific communities and social groups are considered.

Box 21.1: Consideration of communities and social groups across this report

Throughout this report, the Commission has considered the mental health and wellbeing needs and experiences of many different communities and social groups. Other chapters within this report focus on:

- young people, as explored in Chapter 13: *Supporting the mental health and wellbeing of young people*
- older people, as described in Chapter 14: *Supporting the mental health and wellbeing of older people*
- Aboriginal communities, as explored in Chapter 20: *Supporting Aboriginal social and emotional wellbeing*
- people living in rural and regional Victoria, as described in Chapter 24: *Supporting the mental health and wellbeing of people in rural and regional Victoria*.

This chapter examines the experiences and mental health and wellbeing needs of people from Victoria's culturally and linguistically diverse communities, LGBTIQ+ people and people living with disabilities.

The Victorian Government must now bring the knowledge and intelligence of diverse communities—and supporting government portfolios—together with the Mental Health and Wellbeing Division of the Department of Health and the Mental Health and Wellbeing Commission. Together, a plan must be established to ensure the mental health and wellbeing system meets the needs of diverse communities now and into the future, putting the rhetoric around inclusive and responsive services into action.

Achieving this will require coordinated and systematic reform across every domain of the mental health and wellbeing system, including the funding, commissioning, design and delivery of services and the governance, leadership and workforces that underpin the system.

The Victorian Government must also enhance system-wide data collection and analysis and ensure there is transparency in relation to the mental health access and experiences of Victoria's diverse communities compared with the general population. The Victorian Government must establish system-wide accountability for the mental health and wellbeing of Victoria's diverse cohorts. It must also publicly report against targets—developed in consultation with diverse communities—that measure mental health and wellbeing outcomes for diverse communities and that demonstrate change over time.

At a minimum, improving mental health and wellbeing outcomes for Victoria's diverse communities will require:

- a reduction in all forms of stigma, discrimination, hate speech and vilification, as explored in Chapter 25: *Addressing stigma and discrimination*
- strategies to promote mental health and wellbeing and prevent mental illness that recognise and respond to the needs of diverse communities; this is described further in Chapter 4: *Working together to support good mental health and wellbeing*
- acknowledgment of the capacity of existing and emerging community leaders and community-led organisations to engage and support the mental health of their communities and to facilitate access to mental health services
- a mental health and wellbeing system that is safe, inclusive and responsive to all communities; this is explored further in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*
- the availability of ethno- or cohort-specific specialist services to provide tailored mental health and wellbeing responses where required, as outlined in Chapter 5: *A responsive and integrated system* and Chapter 15: *Responding to trauma*.

The Victorian Government must invest in building partnerships with Victoria's diverse communities to identify community priorities and community-led solutions. The government should consider its investment in working alongside diverse communities as a necessary and effective mechanism to improve mental health and wellbeing outcomes for diverse populations.

The reforms proposed in this chapter are intended to build a future where all Victorians have an equal opportunity to experience good mental health and wellbeing. Victoria's future mental health and wellbeing system will ensure people from diverse communities receive safe, inclusive and responsive treatment, care and support, free from stigma and discrimination. The future system will also empower Victoria's many diverse communities and community-led organisations to support the mental health and wellbeing of their members.

21.2 Mental health of diverse communities

As outlined in the interim report, some diverse communities are both at an increased risk of experiencing mental illness in comparison with the general population and less likely to access mental health services. There are many factors that contribute to the increased risk of mental illness in diverse communities. The World Health Organization notes the increased risk of mental illness in 'population subgroups … because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, interrelated with gender'.[9] In evidence to the Commission, people from diverse communities and community-led organisations stated that experiences of discrimination and stigma negatively affect mental health and wellbeing and access to services; this is discussed further in sections 21.2.2 and 21.2.3.

The Commission recognises that people have and identify with many attributes. Everyone has many layers to their identity that affect their daily interactions, their access to power and privilege and their experience of mental health. This is sometimes referred to as 'intersectionality' (refer to Box 21.2).

Box 21.2: Intersectionality

The interim report identified intersectionality as a way to understand and respond to the diversity of Victoria's population. Drawing on the Victorian Government's 2019 *Everybody Matters: Inclusion and Equity Statement*, the interim report described intersectionality as:

> A theoretical approach that understands the interconnected nature of social categorisations—such as gender, sexual orientation, ethnicity, language, religion, class, socioeconomic status, gender identity, ability or age—which create overlapping and interdependent systems of discrimination or disadvantage for either an individual or group.[10]

Ms Adriana Mendoza, Manager of Victorian Transcultural Mental Health, emphasised the value of intersectionality as a framework for responding to diversity, telling the Commission:

> This will assist service providers to identify how overlapping identities can impact on a person's overall sense of self and how they are perceived within different social contexts. People have overlapping identities (such as 'female', 'migrant', 'person of colour') and these identity points do not exist independently of each other. Some identity points can result in privilege, while others can result in disadvantage. This may depend on the particular social context and how a particular identity point is perceived by society.[11]

21.2.1 Diverse communities in Victoria

LGBTIQ+ people

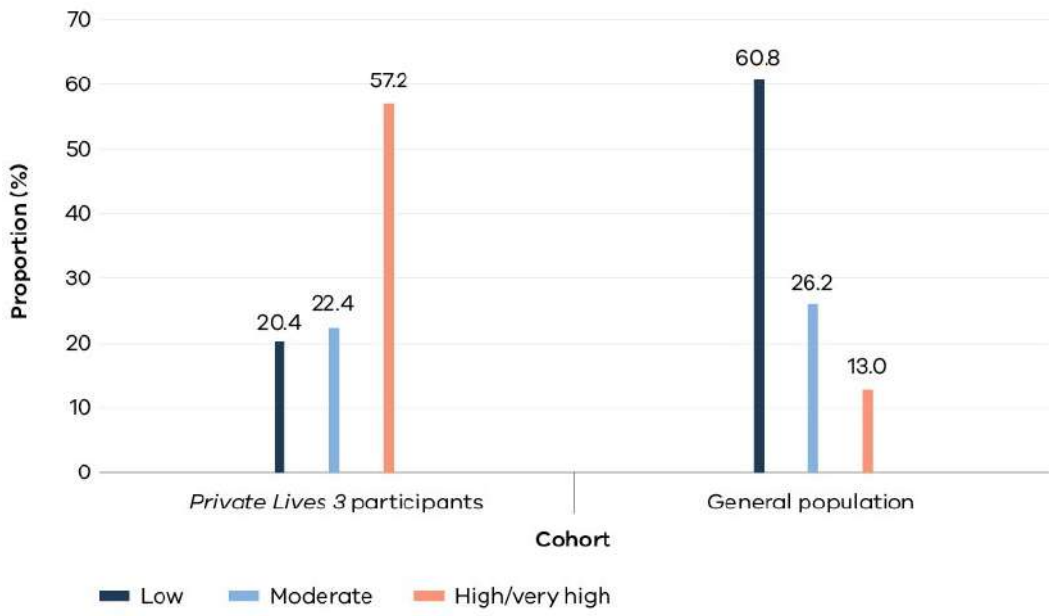
People from LGBTIQ+ communities are at greater risk of mental illness, self-harm and suicide than heterosexual and cisgender populations.[12] The 2017 Victorian Population Health Survey found that the proportion of the adult LGBTIQ+ population who had ever been diagnosed with anxiety or depression is 44.8 per cent, compared with 27.4 per cent of the total Victorian population.[13] Furthermore, the 2020 *Private Lives 3: The Health and Wellbeing of LGBTIQ People in Australia* report identified that 57 per cent of LGBTIQ+ survey respondents reported high or very high levels of psychological distress in comparison with the general population[14] (refer to Figure 21.1). The *Private Lives 3* report also identified higher rates of suicidal ideation (suicidal thoughts) in LGBTIQ+ respondents than in the general population[15] (refer to Figure 21.2). Younger LGBTIQ+ people are at particularly greater risk of suicide, with young LGBTIQ+ people aged 16–27 being five times more likely to attempt suicide than their peers.[16] Transgender people aged 18 or older are nearly 11 times more likely to attempt suicide in their lifetime, and people with an intersex variation aged 16 or older are nearly six times more likely to attempt suicide in their lifetime compared with the general population.[17]

Despite being at an increased risk of experiencing mental illness, the Commission heard that many LGBTIQ+ people are reluctant to use mainstream mental health services, often because of previous negative experiences with the system.[18] Research undertaken by the Lifeline Research Foundation shows that more than 71 per cent of LGBTIQ+ participants chose not to use a crisis support service during their most recent personal or mental health crisis. Many participants said this was because they expected to experience discrimination based on their sexuality, gender identity or another stigmatised or minority identity.[19] Past negative experiences of mental health services when young can deter transgender, gender diverse and intersex people from seeking treatment, care and support, despite having a higher risk of mental illness or psychological distress compared with the general population.[20]

In their witness statement, Ro Allen, Victorian Commissioner for LGBTIQ+ Communities, explained to the Commission that:

> Trans and gender diverse people face persistent challenges in navigating the health and mental health system. In part, this may be because people providing care and services were taught that gender incongruence is a mental illness.[21]

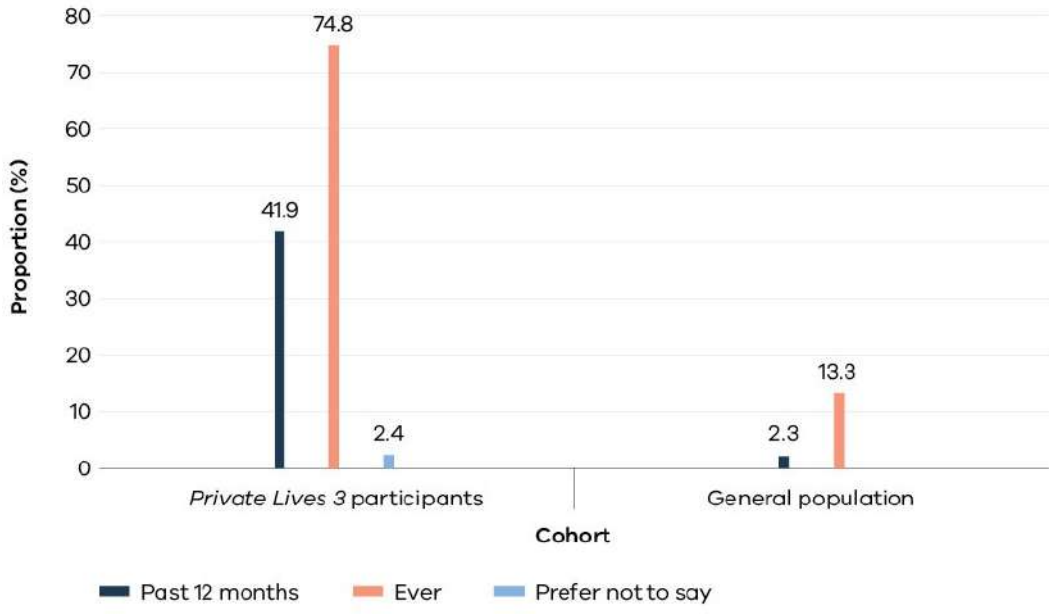
Figure 21.1: Proportion of *Private Lives 3* participants experiencing low, moderate or high/very high psychological distress, Australia



Source: Hill and others, *Private Lives 3: The Health and Wellbeing of LGBTIQ People in Australia* p. 46.

Note: Sample size n = 6,676. The Kessler Psychological Distress Scale was used to classify respondents as having either low, moderate or high/very high psychological distress according to criteria used by the Australian Bureau of Statistics.

Figure 21.2: Proportion of *Private Lives 3* participants experiencing suicidal ideation in the past 12 months, Australia



Source: Hill and others, *Private Lives 3: The Health and Wellbeing of LGBTIQ People in Australia* p. 50.

Note: Sample size n = 6,799.

Culturally and linguistically diverse communities

Some culturally and linguistically diverse communities are at an increased risk of mental illness. Research indicates that refugees and asylum seekers experience mental illness and suicidal behaviour at significantly higher rates than the general population.[22] They are also at greater risk of developing a range of psychological disorders including post-traumatic stress disorder, anxiety and depression arising from their pre-migration experiences or during settlement in Australia.[23] Mr Paris Aristotle AO, CEO of Foundation House, the Victorian Foundation for Survivors of Torture, described the extreme pre-arrival trauma experienced by some Foundation House clients:

> one of the key features of refugee trauma derives from the objectives of the persecutory regime from which people have fled. Such regimes use torture to deliberately remove control from people's lives in order to subjugate and make an example of them, thereby suppressing challenges to their authority by others.[24]
>
> The loss of control and constant threat of violence, characteristic of the refugee experience, creates a chronic sense of fear, intense anxiety and loss of hope for the future, often leading to severe depression.[25]

Due to a lack of available or quality data, it is difficult to estimate the prevalence of mental illness in culturally diverse communities.[26] The 2017–18 National Health Survey found that the prevalence of mental illness among people who spoke a language other than English at home was less than the general population (10.1 per cent compared with 21.6 per cent),[27] but this is likely to misrepresent the true level of mental illness in these communities. This is because, in addition to a lack of adequate data collected within mental health services, people from some culturally diverse communities may be reluctant to seek treatment, care and support due to stigma and discrimination.[28]

The Commission is aware that there are lower than expected numbers of young people from refugee and newly arrived migrant backgrounds presenting to mental health services.[29] Young people born in several regions outside Australia are at high risk of not obtaining the mental health services they need.[30] Overall, people from culturally diverse communities typically present to services when they have higher intensity needs, suggesting there are barriers to early intervention and care.[31] While being less likely to access mental health services, people from refugee and migrant backgrounds are more likely than the general population to be admitted to inpatient units[32] and are over-represented on compulsory treatment orders, making up 23 per cent of active compulsory treatment consumers in Victoria in 2019–20.[33]

There is also evidence suggesting that while international tertiary students living in Australia are at higher risk of experiencing mental illness,[34] they also underutilise healthcare and other support services.[35] An investigation by the Victorian Coroner's Prevention Unit noted that international students who died by suicide were less likely to have accessed mental health services than domestic students.[36] The investigation concluded there was 'an underlying systemic issue with engaging international students in mental health treatment in Australia'.[37]

People with disabilities

People with a disability or restrictive long-term health condition (conditions that restrict everyday activities) also have higher than average rates of mental illness. It is estimated that the prevalence of mental illness is as high as 57.9 per cent for people with profound or severe 'core activity' limitations (for example, limitations related to mobility, self-care or communication) and 42.2 per cent for people with other disabilities or restrictive long-term health conditions.[38] In comparison, around 13.7 per cent of people without these conditions live with mental illness.[39] It is estimated that between 20 and 57 per cent of people living with acquired or neurodevelopmental disabilities also have a mental illness, although it is likely that mental illness is underdiagnosed for people whose communication skills are limited.[40]

People with disabilities also face barriers to accessing appropriate treatment, care and support.[41] For example, research indicates a discrepancy between the prevalence of mental illness and the uptake of mental health services for people with disabilities.[42] Other research indicates that children with intellectual disabilities are less likely to receive mental health care in comparison with children in the general population.[43]

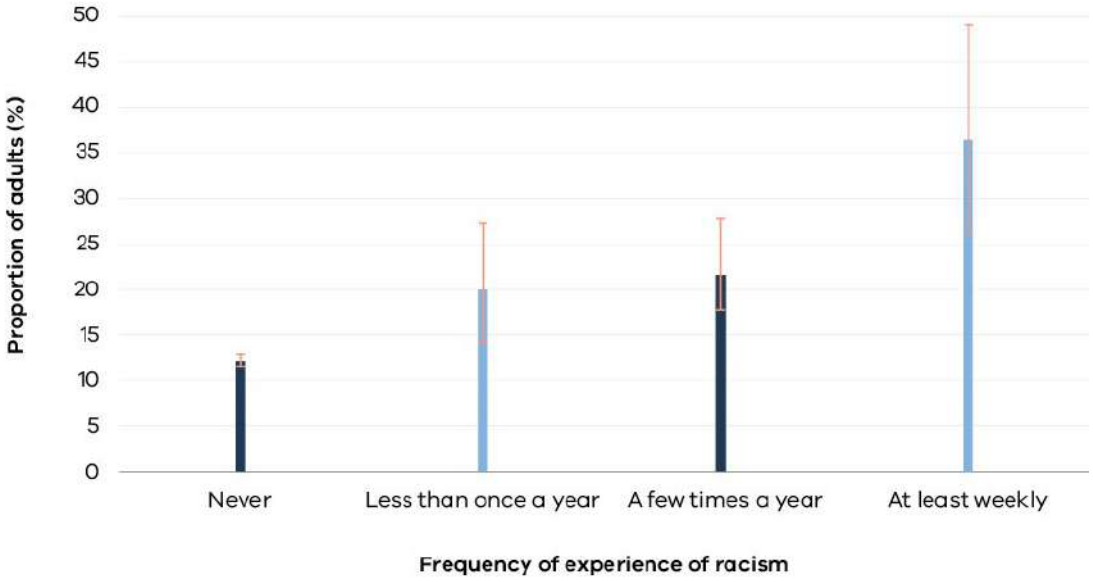
21.2.2 The impact of discrimination

The Commission has identified the need for substantial reform to reduce experiences of stigma and discrimination for people from diverse communities. Reducing mental health stigma within diverse populations is a key reform area for the Commission, discussed further in Chapter 25*: Addressing stigma and discrimination*.

The World Health Organization has identified discrimination as a factor increasing the risk of mental illness.[44] Research indicates a clear relationship between experiences of discrimination and increased risk of mental illness. For example, a meta-analysis that included 293 studies indicated a strong association between experiencing racism and reporting poorer mental health.[45] Findings from the 2014 Victorian Population Health Survey indicate Victorian adults who frequently experience racism are almost five times more likely than those who do not experience racism to have poor mental health (refer to Figure 21.3).[46] The findings also suggested that experiences of racism increase as socioeconomic status declines.[47]

The Commission has heard compelling evidence regarding the negative impact of discrimination on mental health and wellbeing and on a person's ability to access mental health services. Across many diverse communities, experiences of discrimination contribute to mental illness. For example, high levels of harassment and discrimination from strangers towards LGBTIQ+ people[48] and experiences of racism or faith-based discrimination among people from diverse faith or cultural backgrounds[49] are linked to psychological stress and other mental illnesses.[50] Experiences of discrimination for deaf and hard-of-hearing people are also linked to higher prevalence of mental illness.[51] Discrimination can also extend to the marginalisation of 'non-traditional' families, which in turn can make it more difficult for families, carers and supporters to support someone living with mental illness and maintain their own wellbeing.[52]

Figure 21.3: Proportion of adults with high or very high psychological distress by frequency of experiences of racism, Victoria, 2017



Source: Department of Health and Human Services, *Racism in Victoria and what it means for the health of Victorians*, 2017, p. 16.

Note: Data were age-standardised to the 2011 population of Victoria. 95% CI = 95 per cent confidence interval.

The minority stress model suggests that people from socially stigmatised population groups are exposed to unique chronic stressors that negatively affect their mental health and wellbeing.[53] As Ro Allen explained:

> LGBTIQ people do not suffer from poorer mental health by virtue of who we are, but rather because of experiences of discrimination and violence based on sexuality, gender identity or intersex status. This can include actual experiences of discrimination or violence, and vigilance against the possibility of discrimination or violence. This is sometimes referred to as 'minority stress'.[54]

For people with disabilities, experiences of discrimination, marginalisation, violence and abuse are associated with poor mental health.[55] Victoria's *Absolutely Everyone: State Disability Plan 2017–2020* identifies the impact of such minority stress on people with disabilities:

> Discrimination and a lack of inclusion have a negative effect on a person's health, both directly and indirectly. Constantly dealing with barriers, discrimination and negative attitudes brings about anxiety, stress and ill-health.[56]

Newly arrived or emerging migrant populations and asylum seekers may be at increased risk of being subject to racism, an experience that can be fuelled by negative media portrayals.

Professor Rob Moodie, Deputy Head of School and Professor of Public Health at the University of Melbourne, told the Commission:

> Mainstream Australia, particularly through the agency of tabloid media and shock jocks and shock janets, is incredibly effective in stigmatising and discriminating against certain groups. In relation to the recently arrived groups, South Sudanese people have been particularly targeted in Victoria.[57]

Mr George Yengi, a witness before the Commission, described how racism and discrimination negatively impacts on mental health in African migrant communities:

> Racism and discrimination also play a big part in contributing to mental health issues in my community. For example, these experiences are common in day to day life: someone sees a black African walking down the street and crosses the road; people act fearful in they see a group of young Africans walking together; and someone call the police because Africans are at the local park. These types of things take away that person's sense of belonging in Australia.[58]

More recently, the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) reported that enquiries about racism have increased since the COVID-19 pandemic began, with anonymous reports of racism during the early period of the pandemic in Victoria in 2020 more than doubling.[59] VEOHRC also identified a change in the nature of these reports, with increased reporting of discrimination and vilification, 'suggesting a shift away from racial discrimination at work or in employment towards racial abuse and other unfair treatment on the street, on public transport or online'.[60]

Discrimination is also a barrier to accessing treatment, care and support. Anticipated or actual discriminatory behaviour by health professionals may deter people from seeking help, particularly if they have had negative experiences of the system in the past. The Commission heard from the African Australian Communities Leadership Forum that:

> Black people see using mental health services as a degrading and alienating experience: the last resort. They perceive that the way services respond to them mirror some of the controlling and oppressive dimensions of other institutions in their lives, e.g. exclusion from schools, contact with police and the criminal justice system. There is a perception that mental health services replicate the experiences of racism and discrimination of African Australian and black people in wider society, particularly instances where individuals have experienced the more controlling and restricting aspects of treatment.[61]

LGBTIQ+ consumers may be reluctant to disclose matters relating to their sexual identity and relationships to mental health and related services if services are not considered 'safe spaces' for LGBTIQ+ people.[62] In the *Private Lives 2* survey, nearly 34 per cent of LGBTIQ+ Australians said they 'usually or occasionally' hide their sexual orientation or gender identity when approaching services to avoid possible discrimination and abuse.[63] Mind Australia told the Commission that LGBTIQ+ people report 'negative experiences of the health and mental health service system and medical professionals, ranging from ignorance to outright prejudice and discrimination'.[64] Furthermore, some LGBTIQ+ people in Victoria have been exposed to harmful conversion practices conducted covertly as counselling, psychology or religious activities; this is explored further in Box 21.3.

Box 21.3: Prohibiting conversion practices

In November 2020 the Suppression (Conversion) Practices Prohibition Bill 2020 was introduced into the Victorian Parliament to 'denounce and prohibit change or suppression practices (sometimes referred to as 'conversion practices') which describe harmful practices that seek to change or suppress an individual's sexual orientation or gender identity'.[65]

Commissioner for LGBTIQ+ Communities, Ro Allen, described conversion practices as 'typify[ing] out-dated and harmful beliefs about sexuality, gender identity and intersex status'.[66] This was echoed by a report by the Human Rights Law Centre, La Trobe University and Gay Lesbian Health Victoria, called *Preventing Harm, Promoting Justice: Responding to LGBT Conversion Therapy in Australia*, which found that 'conversion therapy practices ... have had a major and lasting impact on the mental health and wellbeing ... [including] depression, thoughts of self-harm and suicide, and more acute forms or mental ill-health triggered by particular interventions'.[67] Furthermore, the report found that conversion practices breach the right to health for LGBT people and represent a violation of the right to health enshrined in the *International Covenant on Economic Social and Cultural Rights*.

If enacted, the new laws will:

- establish of a civil response scheme established within VEOHRC
- promote understanding of the prohibition on change or suppression practices
- provide VEOHRC with the powers to consider and respond to reports of change or suppression practices from any person, as well as launch investigations where there is evidence of serious or systemic change or suppression practices
- introduce new criminal offences, including for people who subject others to change or suppression practices, and for any person who takes or arranges to take another person from Victoria for the purpose of subjecting them to change or suppression practices.

In the second reading of the Bill, Victorian Attorney-General, The Hon. Jill Hennessy, noted that:

> These are practices which have no basis in medicine; there is no evidence that sexual orientation or gender identity can be changed or suppressed. Not only are change or suppression practices ineffective, they are deeply harmful and can cause long-term mental health issues and, in the most tragic of cases, suicide. A disproportionate number of LGBTIQ+ people experience poor mental health outcomes and suicidality ...

> Change or suppression practices often involve the subtle and recurrent messaging that with faith and effort a person can change or suppress their sexual orientation or gender identity. However, change or suppression practices are not only religious or faith based and can take other forms, including counselling, psychotherapy and support groups. In all cases however, these practices are based on a flawed ideology or pseudoscience that a person can be 'broken' due to their sexuality or gender identity. This could not be further from the truth.[68]

Witnesses also described to the Commission how discrimination can be provoked or influenced by public events or circumstances. Ro Allen described to the Commission the impact that public negative commentary regarding the Australian marriage law postal survey had for many people from LGBTIQ+ communities:

> The public debate was highly stressful for many LGBTIQ people, and, in my opinion, the negative public commentary further emboldened people to be hateful and violent towards LGBTIQ people.[69]

A study undertaken by the Australia Institute and the National LGBTI Health Alliance indicated that 'experiences of verbal and physical assaults (perpetrated against people who identify as LGBTIQ+) more than doubled in the three months following the announcement of the postal survey compared with the prior six months'.[70] The study also found an increase in reported anxiety, depression and stress among LGBTIQ+ people in the months following the announcement of the survey.[71]

Efforts to address discrimination are crucial to supporting good mental health and wellbeing for Victoria's diverse communities. Chapter 25: *Addressing stigma and discrimination* explores this in further detail, recommending a suite of reforms to address mental health discrimination. The Commission is aware that the Victorian Government has committed to a range of efforts to address discrimination more broadly including through initiatives delivered through its anti-racism action plan, the development of its LGBTIQ+ strategy, and efforts to reduce faith-based discrimination, gender inequality, conversion practices and hate speech. The Commission considers these efforts to be foundational to supporting the mental health of Victoria's diverse communities and encourages the Victorian Government to continue to resource and support these efforts.

21.2.3 Stigma in diverse communities

While stigma associated with mental illness or psychological distress persists throughout Victoria, in some communities the stigma is so great that mental illness is 'very much a hidden phenomenon'.[72] Talking about his experiences as an African migrant, Mr Yengi described perceptions of mental illness in the South Sudanese community as:

> almost like a taboo thing, it's not a thing. And it's like, you know, it's called a Westerner's illness. So, it's like a white person's thing, you know, because we don't know what it is; it's never explained to us when we're growing up and never explained that you may feel this.[73]

Similarly, the Centre for Multicultural Youth described a multicultural youth worker noting that 'we try to refer someone to headspace, and they won't go. There is stigma associated. Or the perception that "headspace is a place that white people go"'.[74]

Foundation House described the view of many of its clients from Syrian and Iraqi communities:

> Mental health is rarely spoken about within community. 'This is how I am' is a common view within community about mental health issues—a normalising reaction—it is a norm to be suffering.[75]

Attitudes towards mental illness may also stem from differences between how mental illness is treated within the health systems of some migrants' countries of origin. For example, in some countries, mental health services only extend to custodial or hospital treatment for very ill patients and psychotic consumers.[76]

Beliefs about other people's attitudes—particularly a fear that people with mental illness are viewed negatively—are part of the reason people do not seek help.[77] In its submission, Jewish Care suggested that the 'specific religious and cultural traditions of the Jewish community have at times created hurdles to the effective prevention, identification and support of individuals and families affected by mental ill health'.[78] These hurdles, which the Commission notes are not exclusive to the Jewish community, include an emphasis on keeping mental illness 'within the family' to avoid shame and concerns about the impact of disclosure in the small and close-knit nature of the community.[79]

Similarly, a witness, Mr Adwin Town told the Commission:

> Many Asian cultures, including Chinese culture, can be very conservative and inward looking when it comes to mental health ... Chinese people often do not want to talk about mental health problems, as they do not want to be seen as abnormal. I believe that people in the Chinese community are much less open about mental health than people in Western communities. This conservative culture often means that when Chinese people have issues with their mental health they do not disclose them to their friends and family or reach out to help-lines or other available services.[80]

Experiences of stigma in relation to mental illness can be amplified by experiences of discrimination relating to other attributes such as gender, sexuality or disability.[81] For example, discrimination based on sexuality or gender may affect the mental health of those identifying as LGBTIQ+, especially young people.[82] In many parts of the Western world, homosexuality was itself considered a mental illness until the 1970s, and being trans or gender diverse was listed in the *Diagnostic and Statistical Manual of Mental Disorders* until 2018.[83] Stigma may also discourage trans people from accessing care. Associate Professor Michelle Telfer, a General Paediatrician, and Adolescent Medicine Physician and Head of the Department of Adolescent Medicine at The Royal Children's Hospital, explained:

> One of the main barriers preventing TGD [trans or gender diverse] young people from accessing mental health services is the feeling of shame towards their own identity and the shame of not conforming to society's expectations in relation to gender and gender expression. This is referred to as internalised transphobia and often manifests as a result of the negative experiences TGD people have when expressing themselves to their family, peers or broader society.[84]

In summary, the Commission agrees with the Multicultural Centre for Women, which noted that:

> The specific ways that mental illness is described, understood and experienced can be different across linguistic, ethnic and cultural communities, and can be shaped by shared beliefs about health, wellness and spirituality. However, the negative consequences of stigma and misinformation about mental health are universal.[85]

Personal story:

Aynur and Hafize Coskun

Aynur and Hafize Coskun are mother and daughter. Andy, their husband and father, respectively, migrated to Australia as a child and went on to build a life here. He died as a result of suicide after experiencing depression and psychological distress. Aynur and Hafize described Andy as being intelligent, smart, raw and loud. They said that he could get along with anyone.

But according to Aynur, everything changed in 2017:

> Andy came up to me and said 'Honey, I feel funny. There's something funny inside me; something is wrong inside'. He kept saying, 'There's something black. You don't understand'. He couldn't explain it to me.

Aynur and Hafize reflected that they come from a tight-knit community, but that they felt so much judgment after Andy's suicide. All of a sudden, people were looking for a reason and something to blame it on. Aynur recalled that time:

> We were not completely isolated, but we felt isolated from the community, because we felt so much judgement. The kids stopped going to Friday prayers. Going into crowded places like the mosque was hard, because we felt judged. People don't whisper quietly ... I needed someone to talk to, but no-one understood.
>
> In our religion, if a person takes his life, he's not accepted. You can't even do a prayer for your loved one and bury him.

After Andy's death, the family had many visitors—family, friends, neighbours, people from the community, people from the footy club and Andy's work. Aynur reflected that many of them cannot understand mental health, so they would speculate about other reasons for his suicide. 'It just showed that there is not enough awareness about mental health,' she said.

Aynur and Hafize said Andy had repeatedly sought help through the public mental health system, and had seen various health professionals in the lead up to his death, but he found the process very frustrating, as did the family. They did not get any information as carers about how to support or care for Andy at home.

> The hospital should have given us information. Even a pamphlet or a key contact number would have been helpful. There were enough of us in the room that if one of the doctors had said something to one of us, then one person would have picked up on what the other person didn't. They could have told us what to Google.

Despite all of the frustrations, grief and loss, the family has used their experience to raise awareness in their community. Aynur told the Commission:

> Having been through this, our family wants to raise awareness about mental health. [M]y son has hosted some fundraising boxing matches, and online challenges.
>
> But I think that there is a flaw in the system that is not simply a funds issue ... All the money in the world is not going to fix the issues. We need to fix the problem ... [T]he systems are already in place—they're just not working properly.

Source: *Joint Witness Statement of Aynur Coskun and Hafize Coskun*, 29 May 2020.

21.3 Experiences of diverse communities in the mental health system

The Commission recognises that individuals and specific social groups have unique experiences and challenges that negatively affect mental health and wellbeing, and that preclude access to mental health treatment, care and support. In examining these experiences, the Commission found that diverse communities share many common themes in their experiences of treatment, care and support. Key themes include lack of safety, responsiveness and inclusiveness and challenges navigating the mental health system.

The Commission also identified the important role of community-led organisations in providing treatment, care and support and helping community members to access safe, inclusive and responsive mental health care.

21.3.1 Lack of safety, responsiveness and inclusiveness

The Commission has heard compelling evidence that mainstream mental health services can be unsafe for people from diverse communities.[86] A submission from an LGBTIQ+ community organisation described how people from LGBTIQ+ communities, for example, are often 'hyper-vigilant and fearful of mainstream or universal mental health services'.[87] Katie Larsen, General Manager of Diversity, Inclusion and Participation at Mind Australia, told the Commission that for many people from LGBTIQ+ communities, 'the experience of accessing mental health services can be harmful and re-traumatising due to experience of stigma and discrimination, even when unintentional'.[88] Within inpatient settings, LGBTIQ+ people may experience discrimination from staff as well as abuse, harassment and violence from patients.[89] Transgender people can face particular challenges in accessing safe and secure services:[90]

> There are few places to obtain care in Victoria where trans and gender diverse people feel safe and secure, with such services largely being provided by a small number of specialist general practice, community health and hospital services that are concentrated in Melbourne.[91]

For asylum seekers and refugees, pre-arrival exposure to highly traumatic events, including torture,[92] increases the risk of mental illness,[93] which may then be exacerbated by the assessment and referral process within Victoria's mental health system. The Victorian Refugee Health Network explained:

> For people from refugee backgrounds this is problematic, as it relies on people telling their story, often of torture or other traumatic events, as part of the intake process, and then being referred to see someone else, where this story may need to be told again. This is re-traumatising, and functions as a barrier to engaging with mental health services.[94]

The Australian Federation of Disabilities emphasised the relationship between mental illness and experiences of trauma—such as violence, abuse and neglect—for many people with disabilities, and the harm then caused through 'coercion in the mental health system' by the use of seclusion and restrictive practices.[95] People living with autism have described hospital interactions in relation to mental health as 'ineffective, traumatic or destructive', commenting that they have felt 'profoundly misunderstood and unsupported when they had attempted to obtain care'.[96]

The Commission has been told that some health professionals displayed a lack of understanding of basic cultural safety. That is, care was provided without 'respect for culture, knowledge, experience, [or where there was] assault on a person's identity of dignity'.[97] For example, in some instances, LGBTIQ+ people take on the dual role of being treated by, as well as educating, the mental health workforce on LGBTIQ+ matters, particularly around (incorrect) assumptions that their mental illness is directly related to their identity, sexuality or intersex status.[98] The Y-Change submission cited a young transgender consumer who described feeling culturally unsafe within the mental health system:

> When I started accessing services for help, no-one was educated enough to support me as a trans person. Barely anyone could even call me by my correct pronouns or the correct name. It made me feel so unsafe. I can't unpack trauma when I don't even feel safe in the room. I don't think it's too big of an ask that the mental health professional I'm seeing calls me by my correct name—I don't feel like I've ever been asking for a lot.[99]

Deaf Victoria noted the difficulty of finding mental health professionals who understand deaf identity and the experiences of deaf and hard-of-hearing people.[100] The organisation noted that 'assessments and treatments used by mental health professionals are often not "deaf-friendly" and do not recognise the cultural and linguistic differences needs of these individuals'.[101]

The Commission also heard a range of evidence regarding the lack of access to appropriate language services and communications resources.[102] This poses a clear risk to the safety of people from linguistically diverse communities and consumers who face challenges communicating.[103] Access to and quality of language services is discussed further in section 21.4.

Access to inclusive services is also a challenge for people living with disability. Women with Disabilities Victoria discussed the inaccessibility of services for women with disabilities, including 'lack of physical access and a recurrent focus being on their disability, rather than their health concerns'.[104] Amaze described the lack of 'autism friendly environments' due to factors like the built environment, lighting, acoustics, design and the lack of provision of non-verbal communication as a barrier to accessing mental health services for people with autism.[105]

Mental health services were also described in submissions to the Commission as being almost exclusively 'Western'[106] in their approach to mental health and wellbeing, resulting in services that fail to adequately acknowledge or respond to the beliefs, experiences and needs of people from different cultures. Ms Mendoza discussed the differences in the way mental health is considered by some culturally diverse communities, and the impact of this on care:

> CALD [culturally and linguistically diverse] people are often conscious that their understanding of or views on mental health issues may be different to those of the mental health clinicians. This arises due to the existence of different explanatory models—that is, different ways of understanding what is happening in our body, our minds and what responses are needed.[107]
>
> CALD people may associate their mental health outcomes with their own beliefs, which are often connected to the individual's culture or religion. For example, a CALD person may believe that a challenge in their life reflects their relationship with God, whereas the relevant mental health clinician may not understand this association and approach the situation from another perspective. The result is that there are two different narratives with the potential to cause misunderstandings and barriers to effective service provision.[108]

The African Australian Leadership Forum recommended that:

> Western health practices and beliefs should be balanced against the health practices and beliefs of other cultures, absorbing and using different techniques where appropriate. We should also consider alternative strategies in casework: for example, group work and other therapeutic methods, and natural medicine.[109]

Similarly, Mr Aristotle described the benefits of 'using language that resonated on a more spiritual level, and incorporating rituals such opening and closing the group with prayer' for a support group for mothers, developed in collaboration with South Sudanese community members.[110]

As outlined in more detail in Chapter 19: *Valuing and supporting families, carers and supporters*, carers from diverse communities may also experience lack of safe, responsive and inclusive care within mental health services. Research indicates immigrant and refugee carers may face a lack of 'high quality, culturally appropriate and accessible support services'.[111] Tandem described the difficulties LGBTIQ+ family members can face being provided with information by health professionals.[112] Similarly, Carers Victoria told the Commission it had:

> been advised of examples where an [LGBTIQA+] carer with medical power of attorney has been ignored and dismissed by a doctor; and of other carers having to deliberately deceive hospital staff about their relationship with the patient in order to maintain contact during the hospital stay.[113]

At a roundtable hosted by the Commission with culturally diverse community-led organisations, one participant commented on the failure of mental health services to recognise and be responsive to the ways in which families are conceptualised in culturally diverse communities, explaining that:

> Fracturing of relationships is what the current mental health system does well. It does this not because staff don't care and because they need a cook book on culture to refer to as a how-to guide, but because the system supports a homogenous, monocultural, individualistic, biomedical approach to recovery with one of the world's most diverse populations.[114]

Overall, evidence submitted to the Commission describes a mental health system that frequently fails to listen to, understand or respond to the needs of Victoria's diverse communities. As summed up by a participant during community consultations:

> People from marginalised or priority groups, including migrant and refugee communities, report that when accessing mental health services, they do not feel heard, do not feel safe and do not feel understood.[115]

21.3.2 Navigating the mental health system

Many people told the Commission about the difficulties of finding and accessing timely and appropriate mental health services.[116] As outlined in Chapter 8: *Finding and accessing treatment, care and support*, the mental health system is complex, consisting of Victorian Government, Commonwealth Government, private and non-government services that are not well integrated.[117] In addition, the mental health system is not well connected to other support services that people living with mental illness and psychological distress often require, such as disability services, housing and social services.[118] This complex and fragmented system can leave people without access to appropriate and timely treatment, care and support.

These difficulties can be compounded by cultural and language barriers for migrant communities, and communications challenges for people who are deaf or hard of hearing, and people with limited communication skills.[119]

Dr Elizabeth Deveny, CEO of the South Eastern Melbourne Primary Health Network, noted that the current process for accessing services is convoluted and relies on people having the appropriate resources and language skills or being able to call on people who do, such as family:

> you may have a family member that lives in Warrnambool and in order to find services, you may have to contact multiple organisations and hope that someone answers the phone, knows what services exist and whether they are available. This also assumes that the consumer has the money and time to make calls, can speak English and, if it is a family member, is in a position to advocate for their relative in need of a service.[120]

In addition, consumers are sometimes responsible for 'building their own bridge between primary and tertiary [specialist] services in Victoria's mental health system', including transferring patient information between services.[121] This adds to the complexity of navigating services for diverse communities.

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Personal story:

Rafi

Rafi* was 17 and living in Melbourne when he told his family overseas that he was gay.

> I was battling with my depression, and then I came out with my sexuality. I was born into a Muslim family, I left the religion, and I came out with my sexuality. So these two things turned everything upside down for me. My family disowned me, threatening to kill me.

Rafi's family stopped supporting him financially and he became homeless. The threats intensified and he said he felt helpless.

> In my home country the punishment for anyone who comes out as an LGBT person or in an LGBT relationship, they get killed in public on the street. And people have to see that so that they don't do it again or someone doesn't dare to do it. So when I say that I think I had it in my heart that I wanted to escape, I wanted to escape.

Rafi experienced trauma and mental health challenges from an early age.

> I'm brown, dark Indian brown, not Middle Eastern brown. So I put up with a lot of extended family abuse, trauma and torture for that. According to them, I am a weak child compared to a Middle Eastern strong manly child.

When Rafi was admitted to an emergency department after attempting suicide in Melbourne, he said that the staff did not believe what he was saying about his family, the threats and punishment he would experience in his home country. He also reflected on the cultural difficulties he faced while he was receiving treatment, care and support.

> Doctors used to talk in front of me as if I don't know any English. I'm not good at English, but still, they used to talk in front of me as if I don't know any English.
>
> I did not eat hospital food because I didn't grow up eating pork and things like that. I had a different food.

Rafi said that the doctors contacted his family overseas against his wishes and told them about his mental health challenges. He also said that staff planned to return him to his family, until the Department of Home Affairs and a psychiatrist intervened. Rafi described the importance of that intervention: 'If that senior psychiatrist had not trusted me, I would be dead today.'

Rafi has built a family of choice in Australia and spends his time volunteering and supporting others to access mental health supports.

Source: RCVMHS, *Interview with 'Rafi' (pseudonym),* November 2020.

Note: * Name has been changed to protect privacy.

The siloed nature of the mental health sector also makes it hard to access joined-up services that allow people to move between culturally safe mainstream and community-led services, such as those offered by LGBTIQ+ service providers.[122] The fragmentation of services can mean there is no clear entry point into the system or easily available information showing what culturally safe services are available for diverse communities, where these are located, and what the eligibility criteria are. One submission noted:

> Consumers who have been in the service system for some time commented on what a difference for the better it would have made if the knowledge they had now had been available to them when they first entered the system. As one consumer who now works as peer worker put it: There are a lot of things you learn after seven years [in the system] that would have been helpful to know in the first six months.[123]

For people with disabilities, who frequently rely on the help of carers or advocates to access services,[124] navigating between disability and mental health services is particularly problematic. Poor referral processes between services, and a lack of pathways in, out of and between mental health and disabilities services, can leave people without access to mental health care.[125] The Commission has heard that health professionals may also struggle to find appropriate mental health services for consumers with disabilities. Amaze told the Commission that not only do people with autism and their carers 'find it hugely difficult to navigate the mental health system, but health professionals also find this challenging'.[126]

Navigating the mental health system can be particularly challenging for people with complex needs and those who have contact with multiple service systems, such as health, housing and employment. Dr Ruth McNair AM, a GP at the LGBTIQ+ friendly Northside Clinic, told the Commission she believes this is especially true for 'emerging or marginal groups [who] have less ability to understand the system and to navigate the system … as well as being more marginal in terms of their mental health'.[127] Dr McNair further noted the difficulties faced by LGBTIQ+ communities in regional and rural Victoria:

> We also don't have readily identifiable LGBTI expert counsellors in rural and outer urban settings, so I think this is a major limitation. And I see this in my client group: a lot of patients come to our clinic from rural or outer urban areas of Melbourne and Victoria.[128]

Lack of affordability is also an impediment to accessing services. From the perspective of transgender people, the Commission heard that:

> The cost to rural and regional people of accessing services, especially medical gender affirmation services, play a major part in limiting service access. In some cases, these services can be regarded as life-saving healthcare because of the associated risks of depression, self-harm, and suicide that trans and gender diverse people can face.[129]

Telephone and online support services are an important entry point to the mental health system for many consumers. However, technology-based services may not always be suited to members of culturally diverse communities, who can face language and cultural barriers and may lack access to the necessary technology.[130] Mainstream helpline and online services also appear less likely to be used by LGBTIQ+ communities.[131] Lifeline identified that '[t]here are a number of marginalised communities that Lifeline is aware are not accessing our crisis support services to the extent required.'[132] The Centre for Multicultural Youth also identified a lack of responsiveness among youth mental health websites, which demonstrate 'little if any acknowledgement of cultural diversity or of the additional barriers, or alternative understandings of mental illness offered'.[133]

21.3.3 The role of community-led organisations

As outlined in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*, communities play an important role in supporting the mental health and wellbeing of community members. The Commission recognises community-led organisations play a vital role in supporting diverse communities and delivering treatment, care and support, often outside formal government systems. The non-government, peer-led nature of many community-led organisations can be empowering for community members,[134] particularly for people who, for a range of reasons, have been unable to access care or who have not experienced safe, responsive and inclusive care in government services.

For migrant, refugee and asylum seeker populations, community groups and community-led organisations are a significant source of settlement support, including through the provision of housing, foodbanks, employment and language services.[135] For LGBTIQ+ people, who are twice as likely as non-LGBTIQ+ Australians to have no or minimal contact with their biological families,[136] community-led organisations across Victoria can be essential sources of social connection and peer support and advice. Ro Allen described the rise of LGBTIQ+ organisations in 'the face of discrimination and rejection from families and communities' and the community response to HIV/AIDS as 'testament to the resilience and focus of LGBTIQ communities'.[137]

Community-led organisations are an important source of stigma education and mental health literacy, as well as a range of community mental health supports. Submissions stressed the need for mental health services to work with a range of community mental health 'gatekeepers'—such as church and mosque leaders, youth groups and other community services—to provide tailored mental health literacy programs and offer opportunities for people to seek advice.[138]

Experts and community-led organisations have also impressed upon the Commission the essential role that such organisations play as conduits between community members and mental health services. As trusted sources of information and support, community-led organisations are often the 'front door' to mental health care for diverse community members. In its submission, Jewish Care discussed the important role of ethno-specific services as 'soft' entry points to mainstream mental health services.[139] These organisations can help consumers from culturally diverse or faith-based communities to overcome obstacles to accessing treatment, care and support, such as fear and mistrust of mainstream services, and cultural and religious barriers.[140]

Similarly, Ro Allen told the Commission:

> A vital element for success is LGBTIQ community ownership of design as well as the delivery of supports or programs. This is the notion of 'by community, for community' and is important to ensure sensitive and effective design and delivery. It also supports LGBTIQ community engagement and fosters LGBTIQ community willingness to connect with the support or program.[141]

The Commission also heard that Switchboard is an important source of LGBTIQ+ peer-led support.[142] Switchboard's programs, including its Rainbow Door program, are further discussed in a case study overleaf.

Despite the breadth of support offered by community-led organisations, the funding currently available to such organisations is insufficient to meet the demand.[143] The Commission understands that reliance on insecure government and philanthropic grants significantly limits the capacity of organisations to deliver services.[144] Short-term funding programs do not take into account the time needed to develop the necessary community trust and partnerships in diverse communities that is required for programs to be successful. Many community programs may only be beginning to gain momentum when their funding ceases.[145]

The African Australian Leadership Forum pointed out that predominantly grants-based funding of community-led organisations can disadvantage new and emerging communities:

> African Australian communities have limited experience in sourcing and managing funding or grants. There is a severe a lack of support for and guidance on applying for funding from mainstream budgets. Those that receive any ... [are] time-limited [grants] and are too small or make any impact to do not run for long enough to allow evaluation of the possible impact of the project.[146]

Ms Mendoza also told that Commission that while smaller community-led organisations set up to support new and emerging communities are in a good position to work with people of culturally diverse backgrounds, 'they require external support, recognition and capacity building when it comes to responding to mental health, trauma and suicidal behaviour'.[147]

Case study:

Switchboard's Rainbow Door

Switchboard Victoria is a not-for-profit public benevolent institution (charity) and community-controlled service established in 1991. Switchboard supports the health and welfare of LGBTIQA+ people, their families, allies and communities. Examples of services provided by Switchboard include:

- 'QLIFE Teleweb Services', providing telephone/webchat peer support services for the LGBTIQA+ community
- 'Out and About', a statewide community visitors' scheme for older LGBTIQA+ people that seeks to reduce social isolation and build services' capacity to meet thee needs of older LGBTIQA+ people
- a suicide prevention program, which supports integrated research, training, community and partnership activities to address the complexities of suicide in LGBTIQA+ communities
- the QTIPoC Project, supporting capacity building within Switchboard and beyond to address the needs of QTIPoC (queer, transgender and intersex people of colour) communities.

In 2020, as part of the state's response to COVID-19, the Victorian Government provided 12-month funding for Switchboard's Rainbow Door program. Rainbow Door is a free helpline providing mental health information, support and referrals to LGBTIQA+ Victorians, their friends and families.

Sarah Marlowe, Chair of Switchboard Victoria's Board, said Rainbow Door was established to support people from LGBTIQA+ communities to access safe and inclusive care. Rainbow Door links LGBTIQA+ people and their supporters to culturally safe services for support with a range of areas including mental health, family violence, alcohol and other drugs, housing, sexual assault, elder abuse and general health. The service can be accessed via email, phone and text message.

Sarah explained that in the absence of safe and inclusive services, many in LGBTIQA+ communities, have formed networks of support for each other. However, Sarah noted that LGBTIQA+ communities also need access to mental health services.

> I love my community, as I love and am deeply committed to the value of peer support. But on their own, these things are simply not enough. LGBTIQA+ people need, and deserve, the additional support of specialist mental health and other services, and the safe intake and advocacy support required to access them.

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Rainbow Door builds on the existing peer-driven support services to the community including QLIFE, a counselling helpline. Sarah said such services are critical to members of the community seeking support.

> Through my training and the work, I came to understand that 'peer' means safe. Callers often asked for reassurance that I was a member of the community. They felt safe to talk knowing I too had faced experiences like internalised stigma, and the challenges of coming out, of finding community and relationships, and of building a life as part of a minority community.

All Rainbow Door staff are experienced specialist workers with case management, suicide intervention and risk assessment skills. They can provide family violence risk assessment and safety planning and assist with access to LGBTIQA+ friendly services and connections to advocacy or advice.

Sarah said advocacy and support to navigate the service system is crucial, especially for people in urgent need of care, and that Rainbow Door helps to fill a critical service gap. Sarah also recognises that alongside LGBTIQA+ community-controlled organisations like Switchboard, mainstream mental health services play an important role in delivering care for LGBTIQA+ people.

> Mainstream services should always be an option, offering the empowerment of choice. However, in order for that choice to be realised, we need the state wide intake and referral service, Rainbow Door, which helps LGBTIQA+ navigate the mental health system with a peer and opens the way for LGBTIQA+ people to be referred into the services they need.

Source: Switchboard, *Correspondence to the RCVMHS*, 2020; Rainbow Door, About Us, <rainbowdoor.org.au/about-us>, [accessed 17 November 2020]; *Launch of the Rainbow Door*, speech by Sarah Marlowe, 28 September 2020.

Personal story:

Titan Debirioun

Titan is a 21-year-old recording artist who moved to Australia from Sudan in 2004.

He is part of a group that designs and co-designs music programs in his neighbourhood of Tarneit, in the west of Melbourne. Young people can 'drop in' to the program, which runs for four hours per week, be with their friends and learn how to make music. Titan said the music can help the young people talk about their emotions.

> A lot of the kids start making musical tracks where it's like 'I'm this, I'm that', focussing on surface level things, which is cool. But then after a while they start breaking that down and talking about everything else that's happening in their life. It becomes like a form of meditation—they get all their emotion out that they don't usually get out or they don't want to talk about.

Titan also works with Foundation House, a service that supports people from refugee backgrounds who have experienced torture or other traumatic events. He helps the South Sudanese community connect with mental health services.

> Foundation House wanted me to talk about how they could access the community better, how the program could serve the community better and how they could improve their services. I was able to see all the services that I never knew were available. I felt like there were services I might have used, or people in my neighbourhood, but we didn't know about it.

Titan's work with Foundation House involves acting as a bridge between organisations and his community. He talks to people about issues and services, runs workshops and talks to Foundation House about how it can better reach the community. Titan reflected that while his community is using services more, there is a way to go.

> The people they're really trying to reach have a distrust of services that's hard to break down—that takes time and we've been working on it for a while now. Building trust in communities has a lot to do with educating people about services, and not just about service[s], about mental health in general.
>
> So when young people go through things, the older generation is the one who is supposed to assist them and that's not happening because they don't know about mental health or they feel embarrassed about it or that it's something taboo.
>
> Services need to be reaching the kids that are at home saying 'I'm never going to talk to another person about my emotions', 'I'm never going to talk to this organisation' or 'white people don't understand me' because a lot of people feel like that.

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Titan also works with the Centre for Multicultural Youth with young people and students from other migrant backgrounds. He is part of the Shout Out program, where he talks to organisations about how cultural and diversity training can help their workplace be more inclusive and culturally responsive. Titian spoke of the importance of supporting the mental health of the migrant community:

> I'm glad the Royal Commission is taking migrant mental health seriously and is starting to realise that there are holes and gaps. I think it is essential to start dealing with those holes and gaps because at the end of the day their future is Australia's future as well, so it's important to invest as much as you can to make sure they have equal ground mentally, physically, socially, economically—and the right to prepare themselves for what they want in the future and who they want to become.

Source: *Witness Statement of Titan Debirioun*, 19 June 2020.

21.4 Language and communications services

Communication between mental health staff and consumers is of paramount importance in the delivery of safe, and high-quality mental health treatment, care and support.[148] In mental health settings, consumers are often required to 'comprehend and express difficult and often subtle meanings concerned with emotional experience and interpersonal relationships'.[149] This is of course made significantly more challenging when mental health staff and consumers do not speak a common language or have a similar level of proficiency in a common language. In these circumstances, the work of a professional interpreter or translator to bridge the communication gap is of utmost importance.[150]

Many witnesses and stakeholders described the importance of interpreter services for effective communication between consumers and health professionals in mental health settings, noting that too often these services are not made available. As explained by Deaf Victoria:

> The mental health system as a whole is inaccessible for deaf and hard of hearing people, particularly those who use Auslan as their preferred language. Deaf and hard of hearing people who use Auslan have frequently complained about Auslan/English interpreters not being provided upon request, which is a common issue across the entire Victorian hospital and health sector.
>
> Hospitals are notorious for failing to provide Auslan interpreters upon request. Staff are not trained properly in regards to booking Auslan/English interpreters and often have the assumption that Auslan/English interpreters are not available after hours.[151]

Online and printed mental health resources are also frequently inaccessible for people who are deaf or hard-of-hearing. For example, online videos may not be captioned or produced in an Auslan version.[152]

Similarly, Ms Kylie Scoullar, General Manager of Direct Services at Foundation House, told the Commission:

> There needs to be effective communication between mental health professionals and persons with refugee backgrounds—this means that health services must engage qualified interpreters when required and translate health information/documentation.[153]

There are many issues that can result from a lack of access to, or use of, professional interpreters where one is required. In 2006 the Victorian Transcultural Psychiatry Unit published guidelines for working effectively with interpreters in mental health settings. The guidelines asserted that:

> Inadequate communication will limit the capacity of a mental health staff member to:
>
> - develop a therapeutic relationship
> - understand the experience and point of view of the client
> - understand the cultural context of behaviour
> - conduct an assessment
> - formulate a diagnosis
> - decide, together with the client, an appropriate program of treatment
> - monitor the illness
> - evaluate the effectiveness, and any adverse effects, of treatment
>
> Where communication between a mental health staff member and client is inadequate, diagnostic and treatment errors are to be expected. Such errors may include:
>
> - under-estimation or over-estimation of severity of psychopathology
> - failure to correctly identify the type of psychopathology present
> - diagnosis of psychopathology that is not present
>
> Inadequate communication will result in a limited or distorted understanding by the client of:
>
> - the role of the mental health professional
> - the role of the service
> - the nature of the illness
> - the purpose of treatment or medication
> - side-effects of medication.[154]

Throughout its deliberations, the Commission heard concerning examples of the use of family members—including children—to translate between mental health professionals and consumers,[155] which contravenes the (former) Department of Health and Human Services' *Languages Services Policy*.[156] The Ethnic Communities' Council of Victoria identified several ways in which the use of family members as interpreters can lead to poor outcomes:

> This practice has clear risks of miscommunication, and some patients may be unwilling to fully open up about their mental health issues in the presence of family members. Reliance on family can also be problematic because family relationships may be a cause of poor mental health in the first place (such as in cases of intergenerational conflict, separation and domestic violence). It is a practice that greatly increases the likelihood of adverse health outcomes.[157]

The Commission also heard of consumers being unable to request or access language services professionals of a certain gender; consumers being allocated interpreters who are not from the same cultural background; and interpreters lacking experience in the area of mental illness. Mr Aristotle described to the Commission the importance of interpreter choice in cases of sexual violence:

> Ensuring the client can choose the gender of their counsellor and interpreter is fundamental to enabling the client to feel safe and more comfortable. The ethnic and faith background of service providers may also be pertinent.[158]

Consumers in rural and regional communities face significant additional barriers to accessing language services. At the North Eastern Victoria Roundtable, participants told the Commission about the difficulties migrant communities faced in accessing proper health care due to the lack of interpreter services available in their primary language, and ignorance on the part of medical practitioners about the obligation to provide language services when required. One participant recounted a mental health care provider informing them that 'we don't know how to work with international people'.[159]

The same participant highlighted further problems faced by people living in rural and regional areas without proper access to interpreters:

> Services are refusing to use interpreters, or [claim that] the cost of interpreters is to be paid for by the patients themselves or the patient need[s] to come back later with someone from their family to interpret for them. Children are being used to interpret for patients in mental health appointments.[160]

Undersupply of services is also an issue in relation to some languages spoken by recently arrived migrants, where interpreters are not yet available in numbers sufficient to service their communities.[161] Another participant at North Eastern Victoria Roundtable noted that many of the humanitarian migrants in their region spoke languages that were relatively uncommon. The participant identified the lack of availability of interpreters in the appropriate languages for the communities that had settled in the region as a barrier to delivering care, noting:

> it's just about not being organised to have booked in the interpreters in time, they're not those common languages that you can just pick up the phone and get somebody on the end of the line.[162]

Foundation House cited a leader and elder of the Karen community (an ethnic group from Myanmar) who noted:

> I was rung one night by the hospital to interpret for a community member who had been admitted for mental health treatment because the hospital had been unable to get an interpreter.[163]

Participants at the North Eastern Victoria Roundtable also spoke of the need for more holistic settlement support for newly arrived refugee communities.[164] It was suggested that this support should include access to English language programs to develop more confidence in learning and studying and engaging in local community life, social and economic participation and support to understand and navigate the health system, including mental health services.[165]

One mental health professional explained:

> if CALD [culturally and linguistically diverse] community members could find jobs or a sense of purpose, a way to contribute positively to their community, my caseload would be significantly reduced.[166]

Another participant described a lack of resources to support settlement:

> [There is an] under resourced settlement model in this region, [a] lack of meaningful orientation to understand our health systems ... leading to lack of prevention and treatment of mental health amongst this community ... [W]e don't have the niche services that specialise in working with CALD [culturally and linguistically diverse] communities that are available in the other cities. Local mainstream mental health services are not equipped to work with CALD communities, [lack] competency and understanding of working with a cultural lens, cultural sensitivities and ... trauma informed based best practice.[167]

Furthermore, evidence to the Commission emphasised the importance of providing communications that meet the cultural and literacy needs of different communities, which may require more than translating written material from English.[168] For example, the Victorian Refugee Health Network submission identified a lack of suitable mental health resources for people from refugee backgrounds, including resources to improve mental health literacy:

> Information in community languages is a current gap within the mental health and broader health system. This requires working with communities to determine the most appropriate messaging relating to mental health and mental health services and also the most appropriate means of communication. For some communities, this means the provision of written materials in community languages, for others this may be audio or pictorial resources. However, this must be tailored based on consultation with communities about which resources work or make sense to them, how the messages can be shaped to better meet their needs, and the most effective means of communicating information. It is important that information is not only provided through interpreters but through a range of other mediums.[169]

A lack of appropriate material can leave consumers and families without important information about diagnosis and care.[170] Foundation House told the Commission that clients had reported mental health services had removed them from their patient lists because the clients had failed to respond to appointment notifications in English, which they did not understand.[171] The organisation also noted examples of clients leaving hospital with discharge summaries (reports prepared by health professionals describing treatments received and future care needs) in English.[172] Foundation House cited a Karen community member who explained:

> I know of someone in the community who was discharged from hospital after treatment for mental illness. The discharge plan was only in English and the family was only given 10–15 minutes explanation at the hospital of what the patient needed at home. There were no home visits once the person returned home and the family really struggled to manage and there was enormous pressure and stress for all the family.[173]

21.4.1 The language services workforce in Victoria

In Victoria interpreters are typically engaged as independent contractors paid through a language services provider, although some hospitals employ in-house interpreters.[174]

Victorian Government policy states that interpreters and translators should have credentials from the National Accreditation Authority for Translators and Interpreters (NAATI) at the Certified Interpreter or Certified Translator level.[175] NAATI-approved tertiary training institutions, including RMIT University and Monash University, provide coursework ranging from diploma to postgraduate studies in interpreting and translating, together with professional development activities.[176]

Evidence to the Commission indicates that there are not currently enough professionally credentialled interpreters providing language services in mental health services.[177] For example, less than half of interpreter services within health settings in 2015–16 were delivered by interpreters with professional NAATI accreditation.[178]

The Federation of Ethnic Communities Councils Australia report, *Australia's Growing Linguistically Diversity: An Opportunity for a Strategic Approach to Language Services Policy and Practice*, identified significant variations in the number of NAATI-credentialled interpreters across new and emerging languages,[179] noting that with NAATI testing unavailable in some languages, 'language service providers recruit individuals to work as "interpreters" without credentials'.[180] The report identified the 'invisible cohort' of non-credentialled interpreters as concerning, noting:

> These workers expose agencies (including hospitals and courts) and their non-English speaking clients to significant risk. Quality of the language service, and understanding of the ethics and role of interpreters, will vary depending on the interpreter's previous experience and training. Agencies and organisations engaging non-credentialed 'interpreters' through language service providers are reliant on the providers for assurance of quality and expertise. While many organisational policies require a certain level of NAATI credential for interpreters who are sourced to provide language services (for example, professional level accreditation), in many cases where an interpreter with that level of accreditation is not available, a lesser accreditation will be accepted.[181]

The report also found that interpreting and translating sector is largely underpinned by casual employment and contracting,[182] with interpreters working across multiple language services providers to maximise workload.[183] The report identified that this industry structure provided little incentive for upskilling interpreters.[184] For example, language providers have a disincentive to fund upskilling of the workforce given that 'the benefit of any such investment will also be enjoyed by the company's competitors'.[185] The cost of NAATI testing can also be 'prohibitive' for many interpreters, particularly if they are not eligible for funding through the Commonwealth Government's FEE-HELP scheme.[186] As the report notes, '[f]or many, the cost of gaining a higher accreditation is not justified given the low income that they draw from working as an interpreter.'[187]

In 2020 a NAATI-certified specialist health interpreter accreditation program was introduced.[188] However, the Commission understands that accreditation does not specifically require knowledge of the mental health system or a command of mental health terminology.[189]

In its submission, the Ethnic Communities' Council of Victoria explained:

> interpreters are largely a subcontracted workforce, and ... the ECCV is aware that interpreters are sometimes unwilling to provide their services for mental health consultations. Anecdotal evidence suggests that interpreters sometimes find the medical language complex to translate and the content distressing, particularly when there are personal traumas involved. It is important therefore to provide specialised training on mental health for interpreters, and brief them about how to manage their own self-care, and to provide opportunities for debriefing when it is desired.[190]

21.4.2 Victorian Government reviews of language services and health communications

In July 2016 the Victorian Government announced an independent review of Victorian Government procurement of language services.[191] The aim of the review was to:

> consider how the Government can best ensure access to the necessary volume and quality of language services (interpreters) to meet the current and future needs of Victorians from diverse linguistic backgrounds and also those who are Deaf or hard of hearing.[192]

The government has not made the findings of the review public. However, in July 2018 the government announced whole-of-government language services reforms to improve remuneration for interpreters and translators delivering services to government and funded agencies and who are employed on a casual/contract basis.[193] This included $21.8 million in funding for new minimum pay rates that equated to an approximately 30 per cent increase on the previous remuneration rates and a regional service charge to compensate for travel time to delivering services in regional Victoria.[194]

The government has also funded a general interpreter scholarship program since 2003. Each year, the scholarship program supports development of the language services workforce in languages where there is an identified or emerging need.[195]

Further insight into language and translation services for diverse communities in Victoria was provided by the Victorian Ombudsman in December 2020, with the publication of a report into the detention and treatment of nine public housing towers during the COVID-19 'hard lockdown' in July 2020.[196] This hard lockdown meant residents could not leave their homes for a period of up to two weeks.

The hard lockdown saw individuals, groups and organisations stepping forward to support community members, including to provide information and peer support, as well ensuring people were able to access culturally appropriate food.[197] However, the response exposed gaps in both the government's engagement with the affected communities, and in the delivery of culturally responsive health messaging and access to translation services.

In the first instance, the Ombudsman's report noted that the records of the Department of Health and Human Services appeared to underestimate the proportion of people living in the towers from non–English speaking backgrounds.[198] The report also identified that the decision to lock down the towers was made without consultation or engagement with multicultural community leaders,[199] which the Deputy Chief Health Officer acknowledged was not optimal. Consultation after this point was also 'reactive in nature, driven in part by community concern about the way the lockdown was announced and implemented',[200] although the Ombudsman noted that consultation and engagement subsequently improved.

Concerningly, the Ombudsman found significant delays in the distribution of translated written materials, which meant that 'materials explaining the purpose and terms of the lockdown in community languages were not distributed until the fifth and sixth days of the intervention'.[201] While qualified interpreters were embedded at the housing tower estates, they were not engaged until the second day of the lockdown. During that time, community members acted as informal interpreters.[202]

The Ombudsman explored the experiences of residents, some of whom did not speak English and did not understand the reason for the lockdown and for whom the experiences of law enforcement are associated with past negative experiences. The Deputy Chief Health Officer told the Ombudsman:

> Knowing the demographics of the populations in these towers, I was acutely aware … that these were populations which came from countries [where], when the police came knocking at your door, people disappeared and didn't come back. And, you know, not universally obviously, but there was a significant number of people who had been detained against their will before, who had been victims of torture under dictatorships, and that this was likely to cause significant trauma and distress for them.[203]

21.5 Transforming mental health and wellbeing treatment, care and support for diverse populations

The Commission recognises the Victorian Government's commitment to improving access to and the quality of treatment, care and support for diverse communities. This is evident in a range of legislation, policies and guidelines focused on diverse communities, spanning several decades, a selection of which are provided in Box 21.4.

These include legislation enshrining a range of rights for people from diverse communities; whole-of-government policies that support inclusion and equity and mental health service policies to provide health services with clear guidelines about their responsibilities in relation to delivering safe, responsive and inclusive treatment, care and support.

Box 21.4: A selection of Victorian legislation, policies and initiatives to support outcomes for Victoria's diverse communities

The Multicultural Victoria Act 2011 (Vic): The Act provides a whole-of-government framework that recognises the contribution of cultural, racial, religious and linguistic diversity in Victoria.[204]

Equal Opportunity Act 2010 (Vic): All Victorian Government departments and service providers have a positive duty under the Equal Opportunity Act to take reasonable and proportionate measures to identify and eliminate discrimination.[205]

Charter of Human Rights and Responsibilities Act 2006 (Vic): The Victorian Charter of Human Rights and Responsibilities Act sets out the basic rights of Victorians to live with freedom, respect, equality and dignity and requires public authorities to act compatibly with the Charter.[206]

The Racial and Religious Tolerance Act 2001 (Vic): The Act prohibits behaviour that incites or encourages hatred, serious contempt, revulsion or severe ridicule against another person or group of people because of their race and/or religion.[207]

The Mental Health Act (Vic): The Act sets out that 'persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to'.[208]

Multicultural Policy Statement: This whole-of-government statement outlines a vision to enable every Victorian to participate fully in society, remain connected to their culture and ensure we all have equal rights, protections and opportunities.[209]

LGBTIQ+ Strategy: Development of a whole-of-government LGBTIQ strategy is currently underway. The *LGBTIQ+ Strategy* will guide the work of the Victorian Government to support equitable outcomes for LGBTIQ+ people in Victoria.[210]

State Disability Plan: This plan guides the Victorian Government's vision for an inclusive Victoria, which supports people with a disability to live satisfying everyday lives.[211]

Victoria's 10-Year Mental Health Plan: The plan states that the Victorian Government will design and deliver services and support in a way that promotes equitable access and safe and inclusive services for people with diverse cultural, religious, racial, linguistic, sexuality and gender identities.[212]

Language Services Policy and Accompanying Guidelines: *How to Work with Interpreters and Translators*: Supports the department and its funded services in responding to the needs of linguistically diverse people, including migrants, refugees and asylum seekers and those using a form of sign language. The policy identifies when language services should be offered to clients based on legislative requirements and best practice service delivery.[213]

Delivering a mental health system that responds to the needs of Victoria's diverse communities also requires an explicit focus on—and genuine, ongoing, engagement with—core concepts such as cultural responsiveness,[214] cultural safety[215] and cultural humility.[216]

The Victorian Government defines cultural responsiveness as:

> health care services that are respectful of, and relevant to, the health beliefs, health practices, culture and linguistic needs of diverse consumer/patient populations and communities. [Cultural responsiveness] describes the capacity to respond to the healthcare needs of diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organisational, professional and individual.[217]

Cultural safety, a concept often used when considering the needs of First Nations peoples, including Aboriginal people,[218] requires creating an environment:

> where there is no assault, challenge or denial of their identity, of who they are and what they need.[219]

Ms Mendoza also discussed the concept of cultural humility, which is 'the awareness that we do not have all the answers and need to learn from each other'.[220] Ms Mendoza added that 'culturally responsive practice recognises a dynamic and ongoing process of responding to diversity' and emphasised the importance of an intersectional approach to understand the needs of communities.[221]

Achieving system-wide delivery of safe, responsive and inclusive treatment, care and support means that responsibility simply cannot rest solely with individual mental health services.[222] The Victorian Government will need to address systemic challenges to improving access to and quality of care, and support health services to embed responsiveness in the planning, design and delivery of services. It must also ensure the mental health and wellbeing system has access to appropriate specialist services to support diverse communities. This includes high-quality communications and language services, secondary consultation services and specialist services for consumers where required. Figure 21.4 shows some of the key challenges to improving the responsiveness of the mental health and wellbeing system.

21.5.1 Building responsiveness across the system

While there are examples of individual mental health services and health professionals providing safe, responsive and compassionate treatment, care and support, the Commission considers that these efforts are largely undermined by inadequate system level support and accountability. This is despite the well-intentioned objectives of legislation, policies and guidelines to improve outcomes for Victoria's diverse communities and social groups, such as those outlined in Box 21.4. Ms Mendoza told the Commission:

> While it is promising to see positive steps being taken by the mental health sector, this has not been standardised across the mental health system. This means that culturally appropriate services are currently driven by individual champions of change rather than by entire organisations or state-wide policies. Sometimes the authorising environment does not oblige or encourage organisations to adopt such services.[223]

Evidence indicates that the current government requirements and reporting processes for access to and quality of treatment, care and support for diverse communities are insufficient to facilitate progress towards delivering responsive care.[224]

For example, the Victorian Auditor-General reported that while departments are required under the Multicultural Victoria Act to report annually to the Minister for Multicultural Affairs and to the Victorian Parliament on their achievements in multicultural affairs for the previous financial year, they 'cannot give assurance that their services are meeting client needs'.[225] It is not clear if or how departments and health services are using this reporting to improve service delivery. The Auditor-General concluded that 'current reporting requirements do not hold service delivery departments sufficiently accountable for their performance with culturally and linguistically diverse (CALD) communities'.[226] The Commission proposes that the Multicultural Affairs portfolio revises its annual reporting to more transparently demonstrate where service delivery efforts could be improved or lag in their responsiveness to culturally diverse communities. It should also include targets for reporting that are developed and agreed with service delivery departments.

Mr Aristotle identified a lack of strong measures associated with diversity and intersectionality within health services' Statements of Priorities, noting that without explicit expectations and accountability requirements, 'the risk is always present of resources being directed to areas (of a health service) that attract greater departmental, ministerial and public scrutiny'.[227]

Figure 21.4: Key challenges faced by mental health services in delivering culturally responsive treatment, care and support

Systemic

- Challenges to capturing cultural diversity in patient-centred care information systems
- Problems with data, measurement of performance, indicators and benchmarks
- The need for tools and instruments for assessing cultural competence in health settings
- Use of biomedical models of service delivery, which prevent holistic approaches to treatment (e.g. using traditional methods of healing)
- Absence of appropriate resources to embed and follow cultural responsiveness guidelines
- Invisibility of cultural diversity in major systems and procedures (e.g. policies and accreditation)
- Treatment of cultural diversity as an 'add-on' and token to the overall work of health services
- Integration and mainstreaming of diversity initiatives has resulted in the loss of focus on cultural diversity

Organisational

- Need for planning and reporting on cultural diversity
- Managing cultural diversity among competing priorities
- Lack of understanding about of cultural competence and failure to incorporate cultural diversity into all areas of core business
- Lack of support from the organisational leaders or management about cultural diversity responsiveness
- Absence of benchmarks and guidelines for successful outcomes in cultural diversity
- Lack of critical mass of some ethnic communities in regional areas to justify cultural diversity needs
- Lack of appropriate data and information on diverse clients

Professional

- Need to deliver culturally responsive services in busy environments
- Lack of training of professionals for cultural diversity (e.g. doctors, nurses, other staff)
- Limited effectiveness of interpreters or appropriateness of translations
- Absence of specialists and expertise to support cultural diversity work
- Difficulties with cross-cultural training (e.g. high costs, lack of impact across agencies)
- Lack of interpreters in some languages or regions

Individual

- Lack of understanding of cultural competence in health service settings
- Prejudicial attitudes to particular diverse groups
- Cultural diversity initiatives seen as 'special' treatment of diverse groups
- Inability to understand and work with cultural needs (e.g. male consent for female consumers)

Source: Adapted from Gurjeet Gill and Hurriyet Babacan, Developing a Cultural Responsiveness Framework in Healthcare Systems: An Australian Example, *Diversity and Equality in Health Care*, 9 (2012), 45–55.

Participants in the Commission's community consultations raised funding and procurement models as a mechanism to encourage engagement with diverse communities. One person said:

> At the moment, we don't have funding models that say: [we] will reward the system for being more responsive to culture [or] that … have anything in [their] accountability or service agreements … [that] says we're actually going to reward you for establishing and consolidating [a] relationship with this community. We don't have a funding system that establishes the core outcomes that we think will improve the situation for people more generally and encourages and rewards the system to find the answers and to be innovative.[228]

The Victorian Multicultural Commission also identified a need to strengthen departmental funding agreements 'to ensure that funded agencies monitor and report on the diversity of their clients/patients and compare them with the demographics of the area they service'.[229]

Evidence to the Commission identified a lack of data collection in relation to diverse communities and their access to and experiences of mental health services. For example, there is a lack of data related to sexual orientation, gender identity and intersex status collected in mental health services,[230] and a lack of detailed data about the experiences of LGBTIQ+ consumers within the mental health system.[231] Rainbow Health Victoria, Thorne Harbour Health and Switchboard Victoria explained:

> Historically, mainstream services and coronial processes have not gathered data that represents the experience of LGBTIQ people within the mental health and suicide prevention system, and staff have voiced a lack of confidence and competence in sensitively and appropriately asking these questions.[232]

There is also a lack of disaggregated data in relation to culturally diverse communities,[233] including whether interpreters were provided when required.[234] The Centre for Multicultural Youth stated that lack of 'up to date, accurate, publicly available settlement data'[235] is a barrier to planning, designing and delivering services for new and emerging communities. One participant in the Commission's community consultation described culturally diverse communities as 'invisible', noting the lack of health department reports containing specific data on the way people from migrant communities use the system. The participant concluded that 'what we know about outcomes for the general population we systematically don't know about immigrant and refugee populations'.[236]

Disabilities organisations also identified a need for improved data collection and reporting in relation to 'mental health needs, access to services and outcomes' of people with intellectual disabilities and for this information to be made 'publicly available and monitored'.[237]

Lack of coronial data in relation to diverse communities is also a barrier to understanding and responding to suicide. Deaf Victoria pointed to a lack of available data relating to suicide deaths among deaf people, which 'significantly hinders attempts to design, implement and evaluate suicide prevention initiatives for the Deaf community'.[238] Lack of coronial reporting in relation to LGBTIQ+ status also undermines efforts to address the disproportionate prevalence of suicide in among LGBTIQ+ people.[239] The Coroners Court of Victoria discussed the challenges of identifying suicide rates among culturally diverse communities due to variations in the way information relating to place of birth, languages spoken and cultural belonging is recorded in the Victorian Suicide Register.[240] The Coroners Court noted that they suspected they were not capturing all people who identify as members of LGBTIQ+ communities, and in the absence of 'any independent means to confirm gender identity and sexual identity [they] are unable to confirm whether [they] are under-reporting the frequency and, if so, how and why the under-reporting has occurred'.[241]

Strengthening system-wide accountability relies on sufficiently detailed and disaggregated data to understand levels of access, services used, experiences and outcomes of care relating to culturally diverse communities, LGBTIQ+ people and people with disabilities. In this context, disaggregated data means data that is broken down by different demographics and attributes relevant to diverse communities, which is important because aggregation can hide or mask information about specific populations. Detailed data is also an essential tool for planning and designing services that meet the needs of communities.[242]

21.5.2 Safe, responsive and inclusive mental health services

The majority of people from diverse communities access treatment, care and support within mainstream services, either out of preference,[243] or due to an inability to obtain alternative services.[244] The Commission heard that developing separate services for all cohorts is neither feasible nor desirable, and that mainstream services need to improve the way care is delivered for all Victorians:

> You can't build capacity within the system to address every minority. So, it's not about doing that. It's about recognising that the important element here is the attitude of the mainstream system towards minority [cohorts] and about how it is that the mainstream system in adopting a different attitudinal approach to minorities is able then to access the resources that are potentially available.[245]
>
> LGBTIQ+ consumers have the same spectrum of mental health issues as the general population and are entitled to be able to access safe, appropriate, mainstream services on the same basis as their heterosexual counterparts, without being discriminated against or traumatised/re-traumatised. In addition, the reality is that we cannot put the onus to cater to an entire population group on already tightly stretched specialist services, no matter how good they may be. And for many LGBTIQ+ people, for example those in rural areas currently, there will be little choice but to rely on mainstream mental health services at some point in their illness.[246]

Case study:

Victorian Transcultural Mental Health

Victorian Transcultural Mental Health advocates for cultural safety and responsiveness in mental health services for all members of the Victorian community. Dr Anita Tan, Manager of Victorian Transcultural Mental Health, explained that the unit helps services consider how mental health, cultural differences and structural inequities interact and implement practices and structures that promote equitable access to mental health services.

> **Cultural safety is a key practice principle for providing person-centred, holistic and equitable mental health care and negotiating power in service encounters.**

Victorian Transcultural Mental Health partners with clinical and community-managed mental health services to improve its cultural responsiveness to diverse populations. Collaborations between Victorian Transcultural Mental Health and a partner typically last around three years. The partnerships include a focus on engagement to understand the organisation's culture and environment, and sustainability to ensure there is significant and enduring change.

Victorian Transcultural Mental Health also delivers face-to-face and online learning that applies intersectionality and cultural safety to service design and delivery. Group learning includes reflective practice conversations, which help teams to respond to ethical challenges, and clinical discussions, which concentrate on the cultural identity of the consumer and how this may affect their mental health assessment or treatment options. The unit also engages directly with communities and their allies to build their capacity to talk about mental health issues and get the right support.

A companion website, LGBTQIntersect, promotes the development of culturally safe mental health services for LGBTIQ+ people from multicultural communities.

Dr Tan said that while people from culturally diverse backgrounds are well placed to identify their own needs and treatment preferences, they face significant barriers.

> **It is important to acknowledge the cultural and social forces that silence people and curtail life opportunities. Service providers must learn from individuals, families and groups, about how they understand wellbeing, distress, and recovery and use formal support services and support networks. The onus is on professionals, organisations and service systems to provide safe spaces, understand the powerful determinants of social and emotional wellbeing, and build human solidarity.**

Source: Dr Anita Tan, *Correspondence to the RCVMHS*, 2020.

As outlined in *Victoria's 10-Year Mental Health Plan*, mental health services are required to provide 'equitable access and safe and inclusive services for people with diverse cultural, religious, racial, linguistic, sexuality and gender identities'.[247] The Commission heard examples of organisations focused on delivering services that meet the needs of diverse communities. Witnesses and experts identified several core components of these services. These include:

- designing and delivering services that reflect the needs of different communities.[248] This requires organisations to understand the populations they are serving. For example, Mr Tass Mousaferiadis, Chair of the Board of Star Health, and Kent Burgess, Acting CEO of Star Health, told the Commission:

> Our view is that all sub-population groups (such as LGBTIQ+ people, culturally and linguistically diverse (CALD) people, women and young people) require a nuanced service. For a service to be truly inclusive for all those sub-population groups, and able to deal with a diverse range of needs, it needs to be able to reflect the communities that it is actually working with.[249]
>
> To acquire the knowledge of what your community needs, you have to understand who your community is. There are many ways you can do that, such as looking at simple demographic data, holding focus groups, doing consultations or holding community advisory forums. There is a whole range of tools and mechanisms that you can use to tap into and understand what your community thinks.[250]

- respecting the knowledge and expertise within communities and taking a co-design and co-delivery approach to mental health services. The Commission heard numerous examples of health services partnering with community organisations to provide culturally responsive care.[251] Ms Mendoza told the Commission:

> The mental health system can provide culturally appropriate services through pursuing meaningful partnerships between community mental health organisations. Nowadays where there is a tender for services, we see organisations identifying limitations in [their] services and choosing to collaborate with other organisations with the appropriate expertise. This in itself shows cultural humility, which is the awareness that we do not have all the answers and need to learn from each other.[252]

- recognising and respecting a diversity of conceptions of mental health. Mr Aristotle stressed the need for providers to 'be aware of their own (and their organisation's) world-views, values, philosophies and explanatory models, as well as those of service recipients and their communities'.[253] A health professional in a roundtable of culturally diverse organisations also identified the need for a cultural shift across the mental health system:

> There is no doubt that we need to invest in increasing the size of the mental health workforce but we also need to invest in qualitative aspects of care, especially in relation to cultural safety for our diverse population. However, equally we need to invest in initiatives that will result in a cultural shift in the mental health system, where lived experience, diverse explanatory models and cultural perceptions of mental health are valued equally alongside the clinical knowledge and expertise of our workforce.[254]

- embedding cultural responsiveness in health professional education and training. This would ensure services are respectful to, and understand the basic needs of, diverse communities, including the capability to refer clients to appropriate services. This includes understanding the importance of inclusive language, such as avoiding assumptions of heterosexuality and cisgender identity.[255] In discussing the needs of LGBTIQ+ people, the Mind Australia submission refers to this as 'LGBTIQ+ 101 … to ensure there is a no harm approach and a basic level of cultural safety is provided'.[256]
- creating safe and welcoming spaces for diverse communities. Dr Mariam Tokhi, a GP at DPV Health, explained in a personal capacity the positive impact of recognising diverse communities in the physical environment of health services:

> Healthcare spaces can be really important meeting spaces and support spaces for people on the margins. We need to make sure that there is overt welcome and cultural safety for people who are in minorities and who are struggling. For example, it can be really valuable to have an Aboriginal flag, a rainbow sticker or a 'Refugees Welcome Here' sign in the waiting room. And for those things to be more than tokenism, there needs to be a reflection that people are invited to share their struggles and hopes for their health and wellbeing here. These tokens signal that there are trained medical professionals—and administrative and allied health staff here—who can demonstrate realness, respect and care for people from different cultures.[257]

- employing representative workforces. The Centre for Multicultural Youth identified the benefits of bicultural workers for young people and families:

> Bicultural mental health workers are important resources in the mental health service system. These roles are critical in 'brokering'—that is, building trust and helping young people and families navigate mental health services, and helping services more adequately respond to these communities.[258]

Ms Nicole Bartholomeusz, the CEO of cohealth, told the Commission:

> At cohealth, we attempt, as much as possible, to ensure that our workforce reflects the communities that we serve to bring a level of cultural safety into the workplace. For example, if a client of Sudanese or Burmese background attends one of our clinics, they see one of their own people. Or, if someone who has been unemployed long term, has alcohol and drug issues, walks into a clinic, they should work with a peer worker who has the same kind of social experience or background. This is about breaking down barriers between client and care provider. We have seen that when people walk in the front door and see their own people, or people they can feel comfortable with, it breaks down the barriers between client and care provider, and the client achieves much better outcomes.[259]

- promoting accountability for cultural responsiveness at the leadership level within organisations. Ms Mendoza stressed the importance of leadership to ensure that good practice is not reliant on individual clinicians:

> Those in leadership roles play a crucial part in developing sustainable policies and practices within the mental health system. By having leaders learn about how their organisation can be more culturally sensitive and responsible, these practices are more likely to continue beyond the tenures of individual clinicians and workers. Clinicians and interpreters who work directly with [culturally and linguistically diverse] people need good practices embedded in the system.[260]

In her witness statement, Dr Mariam Tokhi described to the Commission the core components of a responsive health service (refer to Box 21.5).

Box 21.5: Hallmarks of a health service that is responsive to diversity—Dr Mariam Tokhi

A service that is responsive to diversity has an underpinning mission to serve all people in its community. In order to do that, the service actively gathers information about the needs of community members and patients, so that it can recognise the challenges and understand better the barriers that vulnerable populations and outpatients face in accessing quality health care.

A service that is responsive to diversity has an ethos of treating all people with respect and warmth. It works in partnership with those people, rather than working hierarchically. It has flexible engagement with clients and referrers, recognising that people who are out of the mainstream face extra challenges with understanding and engagement, and so need that flexible engagement.

A service that is responsive to diversity has skilled staff across administration, program management and in clinic areas who are sensitive to the challenges that vulnerable patients face. Having sensitive staff is easier said than done because you really need to upskill staff across all kinds of perspectives in the service.

We need ready access to interpreting services and community liaison support. We need the ability to actively follow up clients who are difficult to engage. Follow-up might happen through community support workers, case support workers or liaison officers.

A team approach to healthcare provision is really important in order to understand diversity and to work through the challenges of meeting different people's needs. As part of that team approach, there needs to be support and linkages between clinicians, non-clinical support workers and patients, so that we can request and give help to people who need it.[261]

21.5.3 Access to specialist care

The Commission considers that statewide services for diverse communities are critical to supporting people with higher levels of need, and it has identified several roles for statewide services within the reformed mental health and wellbeing system, as outlined in Chapter 5: *A responsive and integrated system*. These roles include sharing expertise with Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services so that people can receive treatment, care and support close to home; working with these services to deliver treatment, care and support through, for example, shared care arrangements; and to deliver services directly.

Statewide services are an important source of treatment, care and support for many people within diverse communities. Examples of these include services supporting:

- refugees and asylum seekers, such as Foundation House, Cabrini Asylum Seeker and Refugee Health Hub Specialist Mental Health Service and Monash Health Refugee Health and Wellbeing
- people with dual disabilities, such as the Victorian Dual Disability Service at St Vincent's Hospital, Melbourne,[262] the Centre for Developmental Disability Health at Monash and two Mental Health and Intellectual Disability Initiative programs
- transgender people, such as the gender clinics at Monash Health and The Royal Children's Hospital.[263]

In addition to services offering treatment, care and support, statewide services can support other mental health services to improve the safety and responsiveness of their treatment, care and support. An example of this is Victorian Transcultural Mental Health Services, which is discussed in a case study in this chapter. The Commission also heard evidence in relation to the benefits of programs such as the Rainbow Tick accreditation system,[264] 'which organisations can use to assess how [LGBTIQ+] inclusive they are and identify areas for improvement'.[265]

As discussed in detail in Chapter 5: *A responsive and integrated system*, there is limited data available to understand demand for specialist services,[266] and underinvestment has constrained the growth of services. Evidence indicates that specialist services are unable to meet growing demand for some diverse populations.[267] Foundation House identified 'considerable capacity constraints' in relation to specialist clinical services, which affects their capacity to provide specialist supports to mental health services and to deliver care directly to clients.[268] As discussed in Chapter 28: *Commissioning for responsive care*, the department will develop a plan for each statewide service, which will include planning for statewide trauma and dual disability services.

Personal story:

Alex Smith

Alex* moved to Melbourne in 2004 and has worked in Melbourne and in regional Victoria. Alex identifies as a trans masculine person.

Alex's first interaction with the mental health system was around 2009, at 25 years of age. Alex described being admitted to the emergency department of a large public hospital after self-harming.

> I remember that I was told by staff in the emergency department that I was very silly and that I shouldn't do this again because the hospital needed the beds for people who were actually sick. I was discharged from the emergency department and there was no follow-up in relation to my mental health.

At about this time, Alex signed up for counselling provided by a specific LGBTIQ+ health service. Alex self-referred based on online research. While Alex found that the counsellors were helpful, they were students who moved on quickly. Alex experienced this high turnover of counsellors at a number of community services over the years and said it was tiring to have to retell their story.

In 2010 Alex contacted an employee assistance program and told them about feelings of discomfort associated with gender identity.

> The counsellor I spoke to told me that they didn't have the expertise in matters of gender .... They did not offer a referral to another service. After this experience, I didn't call my work's employee assistance program again. I felt ashamed and rejected following this experience, and I did not disclose my gender-related issues to a mental health professional for another [six] years.

After some time interstate, Alex returned to regional Victoria.

> At this time, I really needed mental health support ... I didn't try to access any counselling or mental health services in my region because ... I believed that it would be more likely that I would encounter ignorant and discriminatory attitudes about my gender identity, which made me feel really isolated and distressed.

Later, when trying to access specific LGBTIQ+ services in Melbourne, Alex experienced long waiting lists.

> I was only able to access counselling services over the telephone after approximately two months of being on the wait list. This was too little and too late ... I believe things might have turned out very differently if I had received appropriate counselling during this time.

Alex found support when transitioning by accessing an online peer support group run by a Victorian trans and gender diverse advocacy organisation.

> This group was absolutely vital to me ... as I was able to access health information and practical and emotional support from a community of peers having the same experiences that I was having.

Alex would like to see a publicly accessible database of mental health practitioners who are trans and gender diverse–aware, as well as peer support for trans and gender diverse people interacting with emergency departments and acute mental health services. Alex would also like to see LGBTIQ+ awareness training that covers the unique needs and experiences of trans and gender diverse people, and a better conversation about managing privacy in LGBTIQ+ specialist mental health services.

Source: *Witness Statement of 'Alex Smith' (pseudonym),* 17 July 2019.

Note: * Name has been changed in accordance with an order made by the Commission.

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Specialist services for transgender and gender-diverse people have reported significant increases in demand, leading to long wait times for care.[269] The Victorian Government's Lesbian, Gay, Bisexual, Trans, Gender Diverse, and Intersex Taskforce found:

> Waiting times for both paediatric and adult services are unacceptable ... Some people with very complex mental health conditions require much more specialist multidisciplinary support than they receive while waiting for service access. The significant risk of suicide by [trans and gender diverse] people on waiting lists was discussed. The [trans and gender diverse] community is concerned about an increasing number of people accessing mental health services in severe distress.[270]

The report also noted that:

> Access for [trans and gender diverse] people from culturally and linguistically diverse backgrounds was ... especially problematic. Monash Health representatives reported there are 201 languages spoken within its general referral population.

In Chapter 5: *A responsive and integrated system*, the Commission suggests that, in the immediate term, the Victorian Government will need to address the underinvestment in services, and that the expansion of services will need to be informed by planning that ensures additional resourcing goes to the areas of greatest need. The Commission asserts that the need and demand for diverse cohort-specific specialist services must be a key consideration in future planning and investment in specialist services.

21.6 A new approach to supporting the mental health and wellbeing of Victoria's diverse communities

A key tenet of the Commission's recommended reforms is the right for all Victorians to access safe, responsive and inclusive treatment, care and support. The reforms recognise the need for a fundamental shift in the way mental health and wellbeing is understood and the way mental health services are designed and delivered. More broadly, the Commission recognises that access to safe, responsive and inclusive treatment, care and support is only one factor that influences a person's mental health and wellbeing, and that it will take the collective effort of the Victorian community and a range of government departments and agencies to effect change.

Mental health and wellbeing services must offer treatment, care and support that responds to the diverse needs of the many communities and people they serve. To meet these needs, the Victorian Government must ensure the needs of diverse cohorts are at the centre of planning, strategy, monitoring and leadership. Put simply, improving mental health and wellbeing system access and equity of outcomes for Victoria's diverse cohorts will require far more than good intentions.

Inequity of mental health outcomes between social groups is neither inevitable nor intractable. During its deliberations, the Commission heard of several examples of innovative programs and initiatives designed to support the mental health needs of Victoria's diverse communities.[271] Many of these initiatives have been led by community leaders, community-led organisations or individual mental health services. While these initiatives are commendable, the significant and persistent inequities in access and equity of outcomes between diverse populations and the broader population point to the need for a systemic approach to supporting the mental health and wellbeing of diverse communities. As described throughout this report, the 'one-size-fits-all' approach that characterises much of the current mental health system must be replaced with a system that responds respectfully and compassionately to all Victorians. This includes planning, designing and delivering care in partnership with local communities, and providing timely specialist services for those who need them.

As described in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*, community mental health and wellbeing services will be expected to deliver programs that provide tailored treatment, care and support to specific local communities. These programs will have an in-depth understanding of the community-specific services that operate in their area. Through appropriate planning processes, Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will identify, develop and deliver programs or supports for specific groups in their communities. Such programs or supports will typically be for people whose needs are not being met in mainstream services, and who are at risk of high levels of poor mental health.

The Commission expects that responding to the needs of Victoria's diverse populations will be the core business of mental health and wellbeing services. Furthermore, because no two communities in Victoria are alike, services are expected to offer specific programs in addition to offering treatment, care and support that responds to diverse needs within their local communities.

The Commission considers that providers, including provider partnerships, will deliver safe, responsive and inclusive care in the reformed mental health and wellbeing system, as outlined in Chapter 28: *Commissioning for responsive services*. Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will be expected to partner with providers to deliver services that meet the needs of the communities they serve. They will be encouraged to form partnerships, including with organisations that deliver cohort or population-specific services.

The recommendations made in this chapter provide direction on the additional, deliberate actions the Victorian Government must take to improve mental health and wellbeing treatment, care and support for Victoria's diverse communities. They have been designed to ensure the unique needs of Victoria's diverse populations and social groups are front and centre of broader reform efforts. The reforms also aim to ensure the performance of government in reforming the mental health and wellbeing system is measured not only by improvements to mental health and wellbeing outcomes overall but also its reduction of inequity of outcomes across Victoria's social groups.

21.6.1 Increasing accountability for the delivery of safe, responsive and accessible treatment, care and support for diverse communities

There is a clear need for increased accountability in relation to improving access to, and the quality of, mental health treatment, care and support for Victoria's diverse communities. Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance* outlines the Commission's recommendations for establishing effective governance and strengthening the accountability of Victoria's mental health and wellbeing system. It establishes that a Chief Officer for Mental Health and Wellbeing, appointed in legislation and reporting to the Secretary of the Department of Health, will be the system manager of the mental health and wellbeing system. Additionally, the government will be held to account through establishing a new statutory Mental Health and Wellbeing Commission.

The recommended arrangements will ensure mental health and wellbeing services are responsive, high quality, safe, integrated and coordinated, and that appropriate priority is given to mental health and wellbeing in government decision making. Critically, the reforms also recognise that people who use the system can provide great insight into challenges and opportunities, and they should lead and inform decision making.

It is the Commission's position that delivering a mental health and wellbeing system that is accessible, equitable, transparent, accountable and responsive to the needs of Victoria's diverse communities is the responsibility of the most senior levels of system leadership. Accordingly, the Commission has determined that the Chief Officer for Mental Health and Wellbeing will be responsible for delivering a mental health and wellbeing system that promotes equities of outcomes, among other functions referred to in Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*.

Under these arrangements, the Chief Mental Health and Wellbeing Officer will be required to:

- plan, develop, commission and promote at the state level a range of services in relation to mental health and wellbeing and suicide prevention and response that are person-centred, human rights–based, comprehensive, integrated, safe, inclusive, equitable, free from stigma, and responsive to Victoria's diverse communities
- collect, compile and analyse data about mental health and wellbeing services for the purposes of:
  - planning, funding, managing, monitoring, evaluating and improving mental health and wellbeing services provided by mental health service providers
  - improving understanding of the mental health and wellbeing needs and the service use of diverse communities to improve access and equity of outcomes
  - conducting research into mental illness, mental health and wellbeing, and related fields.

The Commission expects that these changes will significantly elevate the mental health and wellbeing system leaders' focus on Victoria's diverse communities and social groups for several reasons. First, as described in Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*, the Chief Officer for Mental Health and Wellbeing will perform the functions of the Secretary, as specified in the new Mental Health and Wellbeing Act. The Chief Officer will ensure the mental health and wellbeing system responds to diverse communities and supports equity of access and outcomes. Given that the Chief Officer is a statutory appointment at Deputy Secretary level that reports to the Secretary of the Department of Health, this position will ensure there is clear accountability for delivery of a mental health and wellbeing system that serves Victoria's diverse communities. This requires effective and senior leadership from the Chief Officer.

Second, as also described in Chapter 27, the Mental Health and Wellbeing Commission will play a fundamental role in holding government to account for the overall performance, quality and safety of the mental health system, including public health and prevention efforts. The Mental Health and Wellbeing Commission will need to give due consideration to the system's performance in delivering services that meet the needs of Victoria's diverse communities, and in reducing inequity of access and outcomes compared with the broader population. Furthermore, given the powers conferred to it, it will be uniquely placed to identify and inquire into matters relating to the performance, quality and safety of the mental health and wellbeing system for diverse communities, if and as it sees fit.

Third, as described in Chapter 26: *Rebalancing mental health laws—a new Mental Health and Wellbeing Act*, the recommended primary objective of the new Mental Health and Wellbeing Act will support efforts to focus on the good mental health and wellbeing of Victoria's diverse communities and social groups. For example, the Act will include a primary objective to achieve the highest standard of mental health and wellbeing by:

- promoting conditions in which people can experience good mental health and wellbeing
- reducing inequities in access to, and the delivery of, mental health and wellbeing services
- providing a diverse range of comprehensive, safe and high-quality mental health services.

This will encompass the need for mental health and wellbeing services to be respectful of, and to take into account, the needs, preferences and values of culturally diverse communities.

Fourth, the Chief Officer will also undertake a strong stewardship role in supporting the new Regional Mental Health and Wellbeing Boards to successfully perform their functions. With responsibility for planning, funding and monitoring mental health and wellbeing services that are inclusive of diverse communities, the Chief Officer will ensure Regional Boards understand the current and anticipated diversity of their regions, assess the needs of their regions with that in mind, and fulfil their objectives. This includes the commissioning of ethno- or cohort-specific services and with due consideration of the needs of diverse communities.

Finally, the Secretary will be required to submit to the minister an annual report containing, among other things, details about how the Department of Health is meeting its functions. The Chief Officer will report on how the department is ensuring services respond to the needs of diverse groups and that data is being collected, compiled and analysed to improve understanding of the mental health needs and service use of diverse communities. This will complement broader reporting efforts regarding diverse communities that will form part of the recommended Mental Health and Wellbeing Outcomes Framework, in Chapter 3: *A system focused on outcomes*.

21.6.2 Partnering with communities

The Commission recognises that communities are best placed to understand the mental health and wellbeing needs of their members and to support the delivery of safe, responsive and inclusive services. Consultation must involve meaningful and ongoing engagement with communities in relation to the design and delivery of services.[272] Community organisations are also a key part of Victoria's mental health system; *Victoria's 10-Year Mental Health Plan* identified the need to support 'specialist community-controlled organisations to deliver services'[273] to diverse communities. Yet, as noted earlier in the chapter, short-term and insecure funding is a barrier for community-led organisations to deliver ongoing programs and expand services to meet demand. The Commission's proposed reforms will ensure the active involvement of diverse communities across the continuum of the mental health and wellbeing system, from the planning and design of services to the monitoring and evaluation of outcomes and in the delivery of community care and support.

Development of a diverse communities' mental health and wellbeing framework

The Chief Officer for Mental Health and Wellbeing will be required to ensure the active engagement of Victoria's diverse communities throughout the process of planning, implementing and managing the reformed mental health and wellbeing system. As an immediate priority, the Chief Officer should convene a diverse communities' working group to provide expert advice and guidance on the development of a diverse communities' mental health and wellbeing framework and a blueprint for action. This should be co-chaired with the relevant Deputy Secretary of the Department of Families, Fairness and Housing.

The framework should acknowledge the broad range of factors that affect the mental health and wellbeing of diverse cohorts, and align with and complement existing government policies. These include the government's forthcoming LGBTIQ+ strategy, anti-racism action plan and the state's disability plan. The framework should set a series of short- and long-term strategic priorities for delivering safe and inclusive mental health treatment, care and support in Victoria. It should include the promotion of good mental health and wellbeing and support capability uplift of ethno- or cohort-specific specialist mental health services to meet the service standards described in Chapter 28: *Commissioning for responsive services*. The framework should inform the government's future activities in relation to the mental health and wellbeing of diverse communities. The framework should be developed in partnership with the Department of Families, Fairness and Housing, and be informed by the Victorian Multicultural Commission and the Commissioner for LGBTIQ+ Communities. Input should also be sought from the Statewide Trauma Service described in Chapter 15: *Responding to trauma* and the Mental Health and Wellbeing Promotion Adviser described in Chapter 4: *Working together to support good mental health and wellbeing*. The Victorian Government should adequately resource and fund priority activities identified in the framework and ensure activities are funded for a period sufficient to evaluate efficacy.

This approach has been recommended by several witnesses and ethno-specific and community-led organisations, which have emphasised the need to consider the experiences of diverse communities through an intersectional framework.[274] As outlined by Rainbow Health Victoria:

> The recognition of age, class, gender, race, sexuality, cultural background and disability offers a framework for inclusive consideration of multiple intersecting disadvantage. People who are LGBTIQ and from an Aboriginal and Torres Strait Islander or culturally and linguistically diverse background, or who have a disability can face multiple, compounding disadvantages, and are more likely to delay, avoid or prematurely cease mental health care. The effectiveness of programs and supports depends on intersectional needs being recognised and addressed in policy and service design, and service delivery.[275]

Disability organisations submitted to the Commission that:

> In order to support Victoria's mental health system in becoming one that is more responsive, and accessible to, people with disabilities ... evidence demonstrates a need to apply an intersectional, gender-sensitive and a public health approach, across all aspects of the mental health system.[276]

Evidence to the Commission described the benefits of developing an intersectional framework like the *Family Violence, Everybody Matters: Inclusion and Equity Statement*, which was developed in response to the Royal Commission into Family Violence (refer to Box 21.6).

Box 21.6: Everybody Matters: Inclusion and Equity Statement[277]

Taking an intersectional approach is at the heart of achieving greater inclusion and equity. This is why intersectionality is the overarching framework that sits at the core of this Statement. An intersectionality framework acknowledges the dynamics of power and social inequality in our society. It recognises that:

- people have many layers and are characterised by multiple, complex social characteristics that are interconnected or intertwined
- embedded within the multiple social characteristics are dimensions of perceived power and/or inequality
- the social characteristics are properties of the individual and of the social environment or worlds in which individuals live. The characteristics and their significance are therefore dynamic and may change.

Intersectionality helps us to understand how power differences can impact across multiple social characteristics and environments in which they are experienced. Adopting an intersectional framework approach:

- enables the identification of barriers to safety and access to services that individuals experience due to discrimination on the basis of Aboriginality, gender, sex, sexual orientation, gender identity, ethnicity, colour, nationality, refugee or asylum seeker background, migration or visa status, language, religion, ability, age, mental health, socioeconomic status, housing status, geographic location, medical record or criminal record
- enables the service system to better understand and respond to the complexity and spectrum of family violence experienced and perpetrated by people with a diverse range of social characteristics
- works towards creating and sustaining a service system that is inclusive, safe, responsive and accountable for all.

Community organisations as a gateway to mental health and wellbeing treatment, care and support

The role of community organisations in supporting the mental health and wellbeing of diverse communities must be acknowledged, and additional recurrent funding should be made available to allow organisations to deliver care that meets the needs of their communities.

To facilitate this, the Mental Health and Wellbeing Division should—with the input and advice of the Department of Families, Fairness and Housing—distribute additional recurrent funding to support community organisations and peak bodies to:

- design and deliver tailored mental health information and awareness campaigns that respond to community need
- assist diverse communities to navigate Victoria's mental health and wellbeing system.

To enable community organisations to deliver effective and meaningful support, funding should:

- support a mix of short- and long-term projects to suit the needs of communities
- as far as practicable, reduce the administrative burden on grant applicants and recipients
- be advertised in languages other than English, including Auslan, with all media files captioned
- be prioritised for Deaf community leaders and organisations, young people with a disability, and emerging communities.

Supporting Switchboard Victoria's Rainbow Door

The Commission believes that the significantly increased risks of mental illness faced by LGBTIQ+ people and the barriers they face when seeking to access culturally safe treatment, care and support warrants an immediate and targeted response.

As identified earlier, difficulty navigating the mental health system to ensure access to safe, responsive and inclusive services is a barrier to LGBTIQ+ people obtaining treatment, care and support. Telephone and web-based services, such as those provided by Switchboard, are an important source of support for LGBTIQ+ people.[278] As a specific LBGTIQ+ service, Switchboard can reduce the barriers to accessing care for people who are reluctant to use mainstream services.[279] Respondents in Lifeline-funded research regarding access to, and use of, crisis support services by LGBTIQ+ people described their experiences with mainstream crisis support services:

> Getting assigned a random call centre operator is a gamble I am not able to risk when I'm already in a heightened state of distress. The chance that I could be matched with someone who is well meaning–but ignorant–is high, and even a small misstep, or misunderstanding on their part … could be the straw that breaks my resolve to not harm myself.[280]
>
> [I] don't have a lot of faith in the public system so I use informal supports while I wait for a psych/GP appointment. [I] also have quite a stigmatised illness and have had a bunch of bad experiences with counsellors, psychologists and specialists before so don't have a lot of trust for practitioners I don't already know/aren't explicitly at LEAST queer friendly.[281]
>
> Telephone and web counselling services are known to not be knowledgeable about LGBTI+ terminology, experiences, community, etc. I don't want to access a service, only to spend all the time educating the person who is supposed to be supporting me.[282]

Switchboard receives referrals from mainstream helplines, such as Lifeline and Beyond Blue, for callers who identify as LGBTIQ+ and for callers wanting to talk about sexuality or gender expression. Switchboard also refers callers in crisis to Lifeline, although negative experiences of crisis services such as Lifeline may deter LGBTIQ+ people from accessing the service.[283]

Multiple witnesses and submissions emphasised the important role that Switchboard Victoria has played in delivering services to the LGBTIQ+ community for nearly 20 years, and the need for increased, secure funding to meet demand.[284] Switchboard is largely staffed by volunteers and receives limited ongoing funding—currently the only ongoing state government funding the organisation receives is through bloodborne virus prevention program funding through the Department of Health.[285] Switchboard does not currently receive any ongoing funding for mental health services.[286] In their joint submission, Rainbow Health, Thorne Harbour and Switchboard described the organisation's funding as 'tenuous' and identified a need for 'urgent, ongoing investment'.[287]

In 2020 the Victorian Government provided short-term funding to Switchboard to commence a pared down version of Rainbow Door—the program that the organisation had developed during the COVID-19 pandemic to provide mental health assessment and short-term case management for LGBTIQ+ people, and to link them to culturally safe mental health services. Switchboard developed the Rainbow Door program in recognition of the growing need for a pathway for LGBTIQ+ people from immediate crisis response into appropriate statewide mental health services. Key components of the Rainbow Door include:

> A dedicated single intake point for LGBTIQA+ communities
>
> A spectrum of support provided by the Switchboard service including information, support, intake and assessment, risk assessment, safety planning case and case planning, management, and evaluation
>
> Information and warm referrals to a range of other services including acute and community mental health, family violence, family support, parenting support, and child protection.[288]

Switchboard described the way Rainbow Door will build on and support LGBTIQ+ inclusive mental health and wellbeing treatment, care and support:

> One of the exciting prospects of the Rainbow Door is that it would work as a wraparound service that builds on the work already underway in the sector for LGBTIQA+ inclusion. This would be achieved by Rainbow Door staff inviting callers to stay connected to Switchboard in the earlier stages following a warm referral and let us know if they experience a block to service or have a bad experience. This would allow Switchboard to identify service gaps and work alongside mental health providers to provide real time feedback and build capacity that will support the mental health needs of LGBTIQA+ people.[289]

Ongoing and secure funding will allow Switchboard to continue to build the Rainbow Door services, providing LGBTIQA+ people with a safe entry point into the mental health system through a dedicated mental health linkage service. This funding will be sufficient to allow Switchboard to:

- operate Rainbow Door seven days a week
- undertake extensive marketing and communications activities to support awareness of the service
- employ program management, team leaders, helpline and case management staff, including specialist positions such as dedicated Aboriginal, culturally diverse and disability roles
- support access to mental health counselling for populations that face significant barriers to access services, such asylum seekers, international students and young people
- undertake comprehensive and long-term evaluation of Rainbow Door.

21.6.3 Improving the collection and use of data

The Commission has identified the need for improved data collection and analysis to support improved service delivery and better system administration, research, innovation and evaluation. The Mental Health and Wellbeing Division, in partnership with the Department of Families, Fairness and Housing, and the Commissioner for LGBTIQ+ Communities, must undertake a comprehensive review of mental health and wellbeing data with the primary objective of improving the transparency of mental health access and outcomes for diverse communities, and informing future planning and investment. This should form part of broader reforms related to data collection across the system detailed in Chapter 35: *New approaches to information management*.

The review should:

- map existing Victorian mental health datasets (including administrative and survey data)
- identify inconsistencies across Victorian datasets and surveys in relation to the mental health of diverse cohorts and describe the implications of these inconsistencies
- provide recommendations to improve data collection and analysis in line with the objectives described above
- provide recommendations for mechanisms for oversight of implementation of data reform efforts.

As an immediate priority, to increase transparency in access to language services within mental health services, the Chief Officer for Mental Health and Wellbeing, together with the Multicultural Affairs portfolio, should revise data collection requirements relating to language services use to include:

- the proportion of consumers who were offered an interpreting service
- the proportion of consumers requesting or requiring an interpreter
- consumers' first or preferred languages (including Auslan) where an interpreter was required or requested
- interpreter fulfilment rates.

21.6.4 Improving language and communication services

Good communication between mental health staff and consumers is the foundation of responsive mental health services and is vital to delivering effective and safe care.[290] It is therefore imperative that the Victorian Government implements several key reforms to ensure availability of, access to, and quality of, language and communications services. These include reforms to ensure all Victorians, regardless of first or preferred language, hearing, literacy or neurocognitive ability, have access to appropriate mental health information and means of communication throughout the mental health and wellbeing system. These reforms will enable the development of user-centric digital technologies that support the delivery of accessible, confidential, timely language services for mental health and wellbeing.

Although recommendations relating to whole-of-government arrangements for Victorian Government services is outside of the terms of reference of this Commission, the Commission considers the reliance on independent contractors and the casualisation of the workforce in the language services sector[291] as factors limiting the provision of quality and timely language services in mental health settings. The Commission acknowledges the Victorian Government's significant investment in language services in recent years and various efforts to improve the pay and working conditions of contractor and casually employed interpreters. It also acknowledges programs aimed at improving the quality and availability of language services, including in new and emerging languages. The Commission supports further reform in relation to government procurement and purchasing of language services, and a move to models of interpreter and translator engagement that reduce contracting arrangements, improve interpreter job security and employment conditions, and support increased professionalisation of the workforce. With regard to interpreters and translators within mental health settings and upskilling of knowledge and capability in mental health settings, the Commission has determined a need for the following reforms.

Increasing the supply of interpreters with specialist mental health knowledge

To improve the capacity of the interpreter workforce to deliver professional mental health interpreting services, the Commission recommends that the Mental Health and Wellbeing Division of the Department of Health, working in partnership with NAATI, language services professionals, registered training organisations and consumers, designs a certified specialist mental health interpreter accreditation course. The course will support the credentialling of certified mental health interpreters who will be competent to interpret complex, highly specialised and sensitive communication in mental health settings. To support the upskilling and availability of interpreters for the Deaf community, the Victorian Government should also provide ongoing funding to support delivery of the specialist NAATI-certified Auslan/English interpreters and Deaf interpreters mental health training course. These services received once-off funding in 2018 through the Disability Advocacy Innovation Fund through the Office of Disability at the (former) Department of Health and Human Services.

To support the uptake of these courses, the Victorian Government should develop and provide scholarships for specialist mental health interpreters. Priority should be given to interpreters who speak the languages of emerging communities or who provide language services for the deaf community. The Statewide Trauma Service should provide input into the development of these courses, both of which should include a focus on the mental health impacts of trauma and delivery of trauma-informed care, including management of any vicarious trauma experienced at work.

Furthermore, the Victorian Government should ensure there are financial incentives for mental health and wellbeing services to engage certified mental health interpreters, and that accredited interpreters are provided with continuing professional development at no cost to the interpreter. Interpreters should be required and supported to update their certification at appropriate intervals.

Ensuring interpreter use in mental health settings

The former Department of Health and Human Services' *Language Services Policy* provides comprehensive guidance for 'departmental staff at all levels and funded organisations in the planning and provision of language services'.[292] The Commission agrees with the assertions made in the policy that the provision of language services is a quality and safety issue, and that 'use of language services alone does not mean that the obligation to provide culturally safe and appropriate services has been met'.[293] The policy asserts that a consumer's English proficiency:

> should not be assumed to be at a sufficient level. It is important for clients to be offered an interpreter service. Departmental and funded organisations are responsible for ensuring clients are made aware of:
>
> (a) their right to communicate in their preferred language
> (b) when and how to ask for an interpreter
> (c) provision of an interpreter is at no cost to the client
> (d) interpreters are professionals and confidentiality is part of their code of conduct
> (e) interpreters are also there to assist the clinician.[294]

It also asserts that:

> Departmental services and funded organisations are responsible for providing appropriate language services when:
>
> (a) the client requests an interpreter or expresses a need to communicate in their preferred language, and/or
> (b) staff are unable to effectively communicate with a client.[295]

The Victorian Government must ensure that, as a matter of equity, quality and safety, all Victorian mental health and wellbeing services are aware of, are supported to adhere to, and are measured against their adherence to the *Language Services Policy*. Furthermore, the Victorian Government must provide training and opportunities to support mental health workers and professional interpreters to learn how to work effectively with each other.[296]

The Commission firmly agrees that departmental services and funded organisations have a role in promoting language services, including by 'using a range of communication methods, such as prominent signage displaying the National Interpreter Symbol, posters and brochures in client contact areas, reception areas, in other public areas, and on websites'.[297]

Increasing the availability of in-language and accessible mental health information

It is also vital that communication resources are available in a range of languages and formats to suit different health literacy levels and cognitive capabilities.[298] Aspergers Australia identified the need for 'clear, plain English (and translations where required) ... to ensure people can find services and applications processes must be streamlined and accessible, not filled with jargon and obstacles'.[299] The Ethnic Communities' Council of Victoria identified emerging communities as 'generally most in need of support with their health literacy and understanding of the Victorian mental health system'.[300]

In delivering on its responsibilities to provide a mental health and wellbeing system that is responsive to the needs of diverse communities, the Victorian Government must ensure the following:

- All mental health information provided via Victorian Government websites or digital platforms should be available in key languages and Auslan. Video files should be captioned.
- At least 5 per cent of all mental health campaign advertising budget should be spent on multicultural media. This is in line with existing government policies.[301]
- All public mental health campaigns should include representation of diverse cohorts and should be available in languages other than English. Multicultural media channels should be used where possible.
- Quality, accessibility and relevant translated mental health literature, visual and audio resources should be developed by commissioning the co-design of material with relevant communities. The co-design of resources for new and emerging communities should be an immediate priority.

The Commission recommends the Victorian Government, as part of the responsibilities of the Chief Health Mental Health and Wellbeing Officer, invests in improving the quality, accessibility and relevance of translated mental health literature, visual and audio resources through commissioning the co-design of material with relevant communities. The co-design of resources for new and emerging communities and the deaf community should be an immediate priority.

Strengthening the standards for data collection on interpreting and translating services

The lack of sufficient data collection in relation to language services access makes it difficult to estimate the level of need for interpreting services within mental health services.[302]

An independent review of interpreting services in Victoria found that:

> improved data collection, reporting and analysis has the potential to:
>
> - improve access. Identify emerging trends and system service gaps in order to respond to consumer needs and reduce the risks associated with failure to supply quality and timely services
> - improve efficiency. Enable assessment of the effectiveness and efficiency of workforce utilisation, support and inform workforce development initiatives and innovative service models
> - inform procurement. Performance data across departments drives superior contract management and drives the strategic response of providers through access to market share information and comparative performance information.[303]

The *Standards for Data Collection on Interpreting and Translating Services* assist government departments, program areas and funded agencies that regularly use interpreting and translating services to improve their own understanding of the needs of their client group, and monitor the accessibility of the services they provide.[304] The standards require departments and funded agencies to collect data relating to client demographics, expenditure and in-house staff. However, data collection reporting on language services providers is optional, and the lack of detailed data collected around the provision of language services within health settings suggests that mental health services are not collecting and/or reporting on this data. The Commission recommends that the Victorian Government strengthen the *Standards for Data Collection on Interpreting and Translating Services* to require the collection of data around language services. As identified above, this would include at a minimum:

- the number of consumers who were offered an interpreting service
- the number of consumers requesting or requiring an interpreter
- consumers' first or preferred languages (including Auslan) where an interpreter was required or requested
- interpreter fulfilment rates
- the NAATI certification level of the deployed interpreter
- wait times for interpreters.

Supporting innovation in language services

Evidence suggests that, overall, the delivery of language services in Victoria has changed little over the past decade or more. Services in Victoria are delivered almost entirely on site or via telephone, with little use of digital technologies. The COVID-19 pandemic has seen a substantial shift towards remote service delivery within health care, including increased use of videoconferencing and telephone consultations—that is, 'telehealth'. At The Royal Melbourne Hospital, for example, video interpreting appointments have increased from 10–15 appointments per month before COVID-19 to 100–200 per month during Melbourne's lockdowns.[305]

However, the shift towards remote services has several potential drawbacks, such as poor video or audio quality[306] that can interrupt the flow of information.[307] Such impediments to communication can be a barrier to accessing reliable health information for most people, but especially for people with limited English proficiency.

The shift to remote services also has the potential to exclude those with no access to technology and/or low digital literacy, which may particularly affect older generations and those with limited or no English. In her witness statement, Dr Tokhi discussed the disproportionate impact of the move to telehealth on 'vulnerable' populations, noting:

> we're going to start doing a lot more telehealth consultations in the face of this COVID-19 pandemic, and it's a real challenge to be able to set up a face-to-face consultation via Skype with someone whose English isn't great, or who doesn't have a great internet connection on their phone, or even reliable phone credit. Both those technological issues—booking appointments online and having telehealth consultations—are obviously more apparent in vulnerable populations.[308]

The move to telehealth during the pandemic has occurred with little technological or digital improvements to help transition both health services and communities to this model.

An independent review of language services in Victoria identified booking systems and technology platforms as being two areas ripe for innovation. The review found that each agency 'employs different strategies on managing interpreter bookings to maximise efficiencies and control costs relating to onsite service delivery' and described one opportunity to:

> drive system efficiency is the adoption of sophisticated booking systems and protocols that:
>
> - Support the efficient scheduling of bookings, such that multiple non-English speaking clients at the one location are serviced during the booking period, with extensions if needed;
> - Capture data relating to the number of occasions of service per scheduled booking; and
> - Ensure staff are adequately trained regarding the effective booking procedures.[309]

The Commission considers that there is a strong opportunity to foster innovation in technology solutions that enhance access to—and the experience of—language services use in mental health settings.

In delivering on this recommendation, the Mental Health and Wellbeing Division of the Department of Health, in collaboration with the Multicultural Affairs portfolio, should consider:

- undertaking a series of focus groups with mental health consumers who require an interpreter (including consumers from the Deaf community), mental health practitioners and administrative or support staff, and interpreters and language services providers, to understand the nuances of challenges in accessing or providing languages services in the context of state mental health service settings
- establishing a grants program to support the development of user-centric digital technology solutions that respond to any of the challenges identified in focus groups. For example, funded programs may support the development of technology solutions that:
  - make it easier for mental health consumers to advise they need an interpreter
  - make it easier for mental health practitioners or administrative support staff to book an accredited interpreter
  - quickly match an accredited interpreter with a health service making a request for one
  - improve the consumer and practitioner experience of using interpreters remotely using digital technologies
  - improve the capacity of health services to collect, monitor and report on language services use.

The Victorian Government should support the development of prototypes for the most promising solutions, as determined by a panel including representation from diverse mental health consumers, mental health staff and language services providers.

The Chief Mental Health and Wellbeing Officer should trial and commission the evaluation of these solutions in mental health and wellbeing services across the state. This initiative should be considered as part of broader innovation reforms considered in Chapter 36: *Research, innovation and system learning*.

1 Department of Premier and Cabinet, Victoria, *Victoria's Diverse Population: 2016 Census*, 2017.

2 Department of Premier and Cabinet, Victoria, p. 2.

3 Department of Premier and Cabinet, Victoria, p. 2.

4 Department of Health and Human Services, *Absolutely Everyone: State Disability Plan 2017–2020*, 2016, p. 9; Victorian Agency for Health Information, *The Health and Wellbeing of the Lesbian, Gay, Bisexual, Transgender, Intersex and Queer Population in Victoria: Findings from the Victorian Population Health Survey 2017*, 2020, pp. 4 and 8; Family Safety Victoria, *Everybody Matters: Inclusion and Equity Statement*, 2018, p. 9.

5 *Witness Statement of Commissioner Ro Allen*, 2 July 2019, paras. 79–103; *Witness Statement of Paris Aristotle AO*, 30 June 2020, paras. 60–73; *Witness Statement of Adriana Mendoza*, 2 July 2019, paras. 22–24; *Evidence of Dr Ruth McNair AM*, 17 July 2019, p. 1128; Amaze, *Submission to the RCVMHS: SUB.0002.0029.0457*, 2019, pp. 3–4; Australian Federation of Disability Organisations, Disability Resource Centre, Women with Disabilities Victoria, Women's Mental Health Network Victoria and Disability Justice Australia, *Submission to the RCVMHS: SUB.0002.0028.0223*, 2019, pp. 15–16.

6 *Witness Statement of Commissioner Ro Allen*, para. 32; *Witness Statement of Dr Ruth McNair AM*, 3 July 2019, para. 22.

7 The Honourable Daniel Andrews MP, Premier of Victoria, Australia's First Pride Centre, 20 May 2016, <www.premier.vic.gov.au/australias-first-pride-centre/>, [accessed 18 August 2020].

8 Victorian Government, *Victoria's Multicultural Policy Statement*, 2019, p. 30.

9 World Health Organization, *Social Determinants of Mental Health*, 2014, p. 9.

10 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 50; Family Safety Victoria, p. i.

11 *Witness Statement of Adriana Mendoza*, para. 19.

12 Thorne Harbour Health, Rainbow Health Victoria and Switchboard, *Submission to the RCVMHS:SUB.0002.0028.0150*, 2019, p. 10.

13 Victorian Agency for Health Information, p. 65.

14 Adam O Hill and others, *Private Lives 3: The Health and Wellbeing of LGBTIQ People in Australia*, 2020, p. 46.

15 Hill and others, p. 50.

16 National LGBTI Health Alliance, *Submission to the Productivity Commission Inquiry into Mental Health: Improving Mental Health to Support Economic Participation and Enhancing Productivity and Economic Growth*, 2019, p. 5.

17 National LGBTI Health Alliance, *Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People*, 2020, p. 2.

18 *Witness Statement of Commissioner Ro Allen*, paras. 80–82.

19 Lifeline Australia, *Submission to the RCVMHS: SUB.0002.0029.0151*, 2019, p. 22.

20 Department of Health and Human Services, *Victoria's 10–Year Mental Health Plan*, 2015, p. 22.

21 *Witness Statement of Commissioner Ro Allen*, para. 91.

22 Mental Health in Multicultural Australia, *Introductory Guide: Framework for Mental Health in Multicultural Australia towards Culturally Inclusive Service Delivery*, 2014, p. 7.

23 Victorian Refugee Health Network, *Submission to the RCVMHS: SUB.0002.0028.0703*, 2019, p. 2.

24 *Witness Statement of Paris Aristotle AO*, para. 20.

25 *Witness Statement of Paris Aristotle AO*, para. 22.

26 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, 2019, p. 31.

27 Australian Bureau of Statistics, *National Health Survey: First Results, 2017–18—Australia. Table 4: Long-Term Health Conditions by Population Characteristics*, 2018, Table 4.3.

28 RCVMHS, *Culturally and Linguistically Diverse People Roundtable: Record of Proceedings*, 2019.

29 Centre for Multicultural Youth, *Submission to the RCVMHS: SUB.0002.0032.0067*, 2019, p. 10.

30 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, p. 11.

31 Department of Health and Human Services, *Victoria's 10-Year Mental Health Plan*, 2015, p. 22.

32 Orygen, The National Centre of Excellence in Youth Mental Health, *Submission to the RCVMHS: SUB.2000.0001.0741*, 2019, p. 36.

33 Department of Health and Human Services, Client Management Interface/Operational Data Store 2019–20.

34 Orygen, *International Students and Their Mental Health and Physical Safety*, 2020, p. 3.

35 Orygen, p. 6.

36 Coroners Court of Victoria, Coroner Warns of Barriers to Mental Health Support for International Students, 14 January 2019, <www.coronerscourt.vic.gov.au/coroner-warns-barriers-mental-health-support-international-students>, [accessed 6 May 2020].

37 Coroners Court of Victoria, Coroner Warns of Barriers to Mental Health Support for International Students.

38 Australian Bureau of Statistics, *National Health Survey: First Results, 2017–18—Australia. Table 4: Long-Term Health Conditions by Population Characteristics*, 2018, Table 4.3.

39 Australian Bureau of Statistics, *National Health Survey: First Results, 2017–18—Australia. Table 4: Long-Term Health Conditions by Population Characteristics*, 2018, Table 4.3.

40 Department of Health and Human Services, *Intellectual Disability: 10–Year Mental Health Plan Technical Paper*, 2015, p. 3.

41 Australian Federation of Disability Organisations, Disability Resource Centre, Women with Disabilities Victoria, Women's Mental Health Network Victoria and Disability Justice Australia, p. 10.

42 Erin Louise Whittle and others, 'Barriers and Enablers to Accessing Mental Health Services for People With Intellectual Disability: A Scoping Review', *Journal of Mental Health Research in Intellectual Disabilities*, 11.1 (2018), 69–102 (pp. 69–70).

43 Julian Trollor, 'Making Mental Health Services Accessible to People with an Intellectual Disability', *Australian and New Zealand Journal of Psychiatry*, 48.5 (2014), 395–398 (p. 395).

44 World Health Organization, p. 17.

45 Paradies and others., 'Racism as a Determinant of Health: A Systematic Review and Meta-Analysis', *PLOS ONE* 10:9 (2015): 1–48, p. 1.

46 health.vic, Racism in Victoria and What It Means for the Health of Victorians, <www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/racism-in-victoria>, [accessed 19 December 2020].

47 health.vic, Racism in Victoria and What It Means for the Health of Victorians.

48 *Witness Statement of Commissioner Ro Allen*, paras. 35 and 79.

49 Angeline S Ferdinand, Yin Paradies and Margaret Kelaher, 'Mental Health Impacts of Racial Discrimination in Australian Culturally and Linguistically Diverse Communities: A Cross-Sectional Survey', *BMC Public Health*, 15:401 (2015), 1–14, p. 1.

50 Jeromey B Temple and Margaret Kelaher, 'Is Disability Exclusion Associated with Psychological Distress? Australian Evidence from a National Cross-Sectional Survey', *BMJ Open*, 8.5 (2018), 1–10 (p. 1); Lauren Krnjacki and others, 'Disability-Based Discrimination and Health: Findings from an Australian-Based Population Study', *Australian and New Zealand Journal of Public Health*, 42.2 (2018), 172–174 (p. 172).

51 Deaf Victoria, *Submission to the RCVMHS: SUB.1000.0001.1323*, 2019, pp. 5–6.

52 Department of Health and Human Services, *Victoria's 10–Year Mental Health Plan: Mental Health Workforce Strategy*, 2016, p. 22.

53 Ilan H Meyer, 'Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence', *Psychological Bulletin*, 129.5 (2003), 674–697 (p. 676).

54 *Witness Statement of Commissioner Ro Allen*, para. 32.

55 Australian Federation of Disability Organisations, Disability Resource Centre, Women with Disabilities Victoria, Women's Mental Health Network Victoria and Disability Justice Australia, p. 27.

56 Department of Health and Human Services, *Absolutely Everyone: State Disability Plan 2017–2020*, p. 12.

57 *Witness Statement of Professor Rob Moodie*, 9 June 2020, paras. 43–44.

58 *Witness Statement of George Yengi*, 4 July 2019, para. 18.

59 Victorian Equal Opportunity and Human Rights Commission, Reducing Racism During COVID-19, <www.humanrights.vic.gov.au/legal-and-policy/covid-19-and-human-rights/reducing-racism-during-covid-19/>, [accessed 20 December 2020].

60 Victorian Equal Opportunity and Human Rights Commission.

61 African Australian Communities Leadership Forum, Submission to the RCVMHS: SUB.0002.0030.0133, 2019, p. 5.

62 The Royal Australian and New Zealand College of Psychiatrists, Recognising and Addressing the Mental Health Needs of the LGBTIQ+ Population, <www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/recognising-and-addressing-the-mental-health-needs>, [accessed 20 December 2020].

63 William Leonard and others, *Private Lives 2: The Second National Survey of the Health and Wellbeing of Gay, Lesbian, Bisexual and Transgender (GLBT) Australians* (Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University, 2012), p. viii.

64 Mind Australia, *Submission to the RCVMHS: SUB.0010.0029.0372*, 2019, p. 68.

65 Parliament of Victoria, *Change or Suppression (Conversion) Practices Prohibition Bill 2020, Explanatory Memorandum, 2020.*

66 *Witness Statement of Commissioner Ro Allen,* para. 93.

67 Timothy W Jones and others, *Preventing Harm, Promoting Justice: Responding to LGBT Conversion Therapy in Australia, 2018,* p. 44.

68 Parliament of Victoria, *Parliamentary Debates (Hansard). Legislative Assembly Fifty–Ninth Parliament, First Session (26 November 2020), 2020,* p. 3723.

69 *Witness Statement of Commissioner Ro Allen*, para. 59.

70 *Witness Statement of Commissioner Ro Allen*, para. 60.

71 *Witness Statement of Commissioner Ro Allen*, para. 60.

DOH.0003.0001.0728

72 Ethnic Communities' Council of Victoria, *Submission to the RCVMHS: SUB.0002.0029.0366*, 2019, p. 3.

73 *Evidence of George Yengi*, 18 July 2019, p. 1250.

74 Centre for Multicultural Youth, p. 13.

75 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, p. 43.

76 Foundation House, p. 12.

77 *Witness Statement of Associate Professor Nicola Reavley*, 3 July 2019, para. 9.

78 Jewish Care Victoria, *Submission to the RCVMHS: SUB.0002.0025.0068*, 2019, p. 4.

79 Jewish Care Victoria, p. 4.

80 *Witness Statement of Adwin Town*, 16 July 2019, para. 7.

81 Multicultural Centre for Women's Health, *Submission to the RCVMHS: SUB.0002.0030.0303*, 2019, p. 6.

82 *Evidence of Associate Professor Michelle Telfer*, 17 July 2019, pp. 1180–1182.

83 *Witness Statement of Commissioner Ro Allen*, para. 89.

84 *Witness Statement of Associate Professor Michelle Telfer*, 1 July 2019, para. 53.

85 Multicultural Centre for Women's Health, p. 6.

86 Victorian Refugee Health Network, p. 10; Mind Australia, p. 68; *Witness Statement of Commissioner Ro Allen*, paras. 85–86.

87 Rainbow Families Victoria, *Submission to the RCVMHS: SUB.0001.0032.0086*, 2019, p. 1.

88 *Witness Statement of Katie Larsen*, 8 July 2019, para. 13.

89 *Witness Statement of Commissioner Ro Allen*, para. 85.

90 Penelope Strauss and others, *Trans Pathways: The Mental Health Experiences and Care Pathways of Trans Young People: Summary of Results*, 2017, p. 11.

91 Gateway Health, *Submission to the RCVMHS: SUB.0002.0029.0023*, 2019, p. 6.

92 *Witness Statement of Paris Aristotle AO*, para. 35.

93 Victorian Refugee Health Network, p. 2.

94 Victorian Refugee Health Network, p. 10.

95 Australian Federation of Disability Organisations, Disability Resource Centre, Women with Disabilities Victoria, Women's Mental Health Network Victoria and Disability Justice Australia, p. 10.

96 Amaze, p. 26.

97 Robyn Williams, 'Cultural Safety—What Does It Mean for Our Work Practice?', *Australian and New Zealand Journal of Public Health*, 23.2 (1999), 213–214 (p. 213).

98 *Witness Statement of Commissioner Ro Allen*, para. 87; *Evidence of Commissioner Ro Allen*, 17 July 2019, p. 1147.

99 Y-Change, *Submission to the RCVMHS: SUB.8000.0001.0051*, 2019, p. 27.

100 Deaf Victoria, p. 9.

101 Deaf Victoria, p. 9.

102 Victorian Refugee Health Network, pp. 7–8; Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, p. 50; Deaf Victoria, p. 9; Ethnic Communities' Council of Victoria, p. 6.

103 Department of Health and Human Services, *Language Services Policy*, 2017, p. 10.

104 Australian Federation of Disability Organisations, Disability Resource Centre, Women with Disabilities Victoria, Women's Mental Health Network Victoria and Disability Justice Australia, p. 15.

105 Amaze, p. 17.

106 Victorian Refugee Health Network, p. 9.

107 *Witness Statement of Adriana Mendoza*, para. 37.

108 *Witness Statement of Adriana Mendoza*, para. 38.

109 African Australian Communities Leadership Forum, p. 11.

110 *Witness Statement of Paris Aristotle AO*, paras. 110 and 116.

111 R Aryal, *Dealing With It Myself: Supporting Immigrant and Refugee Carers in Australia*, 2017, p. 3.

112 Tandem, *Submission to the RCVMHS: SUB.0002.0030.0088*, 2019, p. 9.

113 Carers Victoria, *Submission to the RCVMHS: SUB.0002.0028.0712*, 2019, p. 13.

114 RCVMHS, *Victoria Transcultural Mental Health Roundtable: Record of Proceedings*, 2020.

115 RCVMHS, *Victoria Transcultural Mental Health Roundtable: Record of Proceedings*.

116 Mind Australia, p. 9; Rainbow Families Victoria, p. 2; *Evidence of Dr Ruth McNair AM*, p. 1165.

117 Royal Commission into Victoria's Mental Health System, *Interim Report*, pp. 97–98.

118 *Witness Statement of Dr Neil Coventry,* 28 June 2019, para. 226*;* Mental Health Victoria and Victorian Healthcare Association*, Submission to the RCVMHS: SUB.0002.0029.0005,* 2019, p. 8.

119 Deaf Victoria, p. 10; *Witness Statement of Adriana Mendoza*, para. 31.

120 *Witness Statement of Dr Elizabeth Deveny*, para. 30.

121 *Witness Statement of Adriana Mendoza*, para. 31.

122 *Evidence of Dr Ruth McNair AM*, p. 1165.

123 Mind Australia, p. 19.

124 *Witness Statement of Professor Bruce Bonyhady AM*, 16 June 2020, paras. 69–70.

125 Office of the Public Advocate, *Submission to the RCVMHS: SUB.0002.0029.0448 (Submission 1)*, 2019, p. 46.

126 Amaze, p. 31.

127 *Evidence of Dr Ruth McNair AM*, p. 1165.

128 *Evidence of Dr Ruth McNair AM*, p. 1159.

129 Gateway Health, p. 6.

130 Centre for Multicultural Youth, p. 50.

131 Lifeline Australia, p. 22.

132 Lifeline Australia, p. 22.

133 Centre for Multicultural Youth, p. 50.

134 Iris Marion Young, Chapter 5: Civil Society and Its Limits, in *Inclusion and Democracy* (New York: Oxford University Press, 2000), pp. 154–167 (p. 166).

135 Asylum Seeker Resource Centre, Our Work, <https://asrc.org.au/>, [accessed 20 December 2020]; diversitat, Our Services, <https://diversitat.org.au/>, [accessed 20 December 2020].

136 *Witness Statement of Commissioner Ro Allen*, para. 37.

137 *Witness Statement of Commissioner Ro Allen*, paras. 63–64.

138 Ethnic Communities' Council of Victoria, p. 2; Victorian Refugee Health Network, p. 3; Centre for Multicultural Youth, p. 5.

139 Jewish Care Victoria, p. 5.

140 Jewish Care Victoria, pp. 4–5.

141 *Witness Statement of Commissioner Ro Allen*, para. 78.

142 *Witness Statement of Commissioner Ro Allen*, para. 74; *Witness Statement of Dr Ruth McNair AM*, paras. 37 and 47; Rainbow Families Victoria, p. 2.

143 Rainbow Health, Thorne Harbour Health and Switchboard, pp. 24–25.

144 Centre for Multicultural Youth, p. 19.

145 Centre for Multicultural Youth, p. 19.

146 African Australian Communities Leadership Forum, p. 7.

147 *Witness Statement of Adriana Mendoza*, para. 67.

148 Monash University, Mental Health Interpreting Guidelines for Interpreters, <research.monash.edu/en/publications/mental-health-interpreting-guidelines-for-interpreters>, [accessed 20 December 2020].

149 Monash University.

150 Monash University.

151 Deaf Victoria, pp. 9–10.

152 Deaf Victoria, p. 12.

153 *Witness Statement of Kylie Scoullar*, 16 July 2019, para. 47.

154 Tania Miletic and others, *Guidelines for Working Effectively with Interpreters in Mental Health Settings*, 2006, p. 6.

155 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*, 2020.

156 Department of Health and Human Services, *Language Services Policy*, 2017, p. 21.

157 Ethnic Communities' Council of Victoria, p. 6.

158 *Witness Statement of Paris Aristotle AO*, para. 8.

159 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

160 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

161 Foundation House, *Promoting the Engagement of Interpreters in Victorian Health Services*, 2013, p. 70.

162 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

163 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, p. 50.

164 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

165 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

166 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

167 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

168 *Witness Statement of Paris Aristotle AO*, para. 81.

169 Victorian Refugee Health Network, pp. 8–9.

170 Victorian Refugee Health Network, p. 7.

171 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, p. 26.

172 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, p. 26.

173 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, p. 26.

174 Victorian Government, *Using Interpreting Services: Guidelines on Policy and Procedures*, p. 17.

175 Department of Health and Human Services, *Language Services Policy*, p. 8.

176 RMIT University, Languages, Translating and Interpreting, <www.rmit.edu.au/study-with-us/social-science/languages-translating-and-interpreting>, [accessed 7 January 2021]; Monash University, Mental Health Interpreting: Professional Development Short Course, <www.monash.edu/study/courses/find-a-course/2021/mental-health-interpreting-pda1024>, [accessed 20 December 2020].

177 Deaf Victoria, pp. 7–8; Ethnic Communities' Council of Victoria, p. 5.

178 Aspex Consulting, *Independent Review of Victorian Government Procurement of Language Services*, 2017, p. 80.

179 Federation of Ethnic Communities' Councils of Australia, Australia's Growing Linguistic Diversity: An Opportunity for a Strategic Approach to Language Services Policy and Practice, 2016, p. 20.

180 Federation of Ethnic Communities' Councils of Australia, p. 25.

181 Federation of Ethnic Communities' Councils of Australia, p. 25.

182 Federation of Ethnic Communities' Councils of Australia, p. 35.

183 Federation of Ethnic Communities' Councils of Australia, p. 2.

184 Federation of Ethnic Communities' Councils of Australia, p. 36.

185 Federation of Ethnic Communities' Councils of Australia, p. 2.

186 Federation of Ethnic Communities' Councils of Australia, p. 2.

187 Federation of Ethnic Communities' Councils of Australia, p. 36.

188 National Accreditation Authority for Translators and Interpreters, Certified Specialist Health Interpreter, <www.naati.com.au/become-certified/certification/certified-specialist-health-interpreter/>, [accessed 20 December 2020].

189 National Accreditation Authority for Translators and Interpreters.

190 Ethnic Communities' Council of Victoria, p. 7.

191 Department of Health and Human Services, *Language Services Policy*, 2017, pp. 7 and 13.

192 Department of Health and Human Services, p. 13.

193 Victorian Government, Media Release: New Minimum Remuneration Rates for Interpreters, 12 July 2018, <fac.dhhs.vic.gov.au/news/new-minimum-remuneration-rates-interpreters>, [accessed 23 December 2020].

194 Victorian Government, Media Release: New Minimum Remuneration Rates for Interpreters.

195 Victorian Government, Interpreter Scholarships, <www.vic.gov.au/interpreter-scholarships>, [accessed 20 December 2020].

196 Victorian Ombudsman, *Investigation into the Detention and Treatment of Public Housing Residents Arising from a COVID-19 'Hard Lockdown' in July 2020*.

197 PRObono Australia, Community Sector Rallies Around Residents in Hard Lock Down, <probonoaustralia.com.au/news/2020/07/community-sector-rallies-around-residents-in-hard-lock-down/>, [accessed 21 December 2020].

198 Victorian Ombudsman, p. 151.

199 Victorian Ombudsman, p. 157.

200 Victorian Ombudsman, p. 157.

201 Victorian Ombudsman, p. 17.

202 Victorian Ombudsman, p. 17.

203 Victorian Ombudsman, p. 118.

204 *Multicultural Victoria Act 2011* (Vic), sec. 4

205 *Equal Opportunity Act 2010* (Vic), sec. 15

206 *Charter of Human Rights and Responsibilities Act 2006* (Vic), sec. 1(2).

207 *Racial and Religious Tolerance Act 2001* (Vic), secs. 7–8.

208 *Mental Health Act 2014* (Vic), sec. 11(1)(g).

209 Victorian Government, *Victoria's Multicultural Policy Statement*.

210 Department of Premier and Cabinet, *LGBTIQ+ Strategy Directions Paper*, 2020.

211 Department of Health and Human Services, *Absolutely Everyone: State Disability Plan 2017–2020*.

212 Department of Health and Human Services, *Victoria's 10–Year Mental Health Plan*.

213 Department of Health and Human Services, *Language Services Policy*.

214 *Witness Statement of Adriana Mendoza*, paras. 47–52.

215 *Witness Statement of Aunty Nellie Flagg*, 9 July 2019, paras. 36–38.

216 Cynthia Foronda and others, 'Cultural Humility: A Concept Analysis', *Journal of Transcultural Nursing*, 27.3 (2016), 210–217 (p. 210).

217 Commonwealth Department of Health, *Developing Aboriginal and Torres Strait Islander Cultural Capabilities in Health Graduates: A Review of the Literature*, 2014, p. 6 of Appendix B.

218 Commonwealth Department of Health, p. 6.

219 Williams, p. 213.

220 *Witness Statement of Adriana Mendoza*, para. 49.

221 *Witness Statement of Adriana Mendoza*, para. 50.

222 *Witness Statement of Adriana Mendoza*, para. 52.

223 *Witness Statement of Adriana Mendoza*, para. 52.

224 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, p. 11.

225 Victorian Auditor-General's Office, *Access to Services for Refugees, Migrants and Asylum Seekers*, 2014, p. 16.

226 Victorian Auditor-General's Office, *Access to Services for Refugees, Migrants and Asylum Seekers*, p. 23.

227 *Witness Statement of Paris Aristotle AO*, para. 134.

228 RCVMHS, *Culturally and Linguistically Diverse People Roundtable: Record of Proceedings*.

229 Victorian Multicultural Commission, *Correspondence to the RCVMHS: CSP.0001.0133.0001*, 2020, p. 2.

230 National LGBTI Health Alliance, *Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People*, pp. 6–8.

231 Drummond Street Services, *Submission to the RCVMHS: SUB.4000.0001.0373*, July 2019, p. 8.

232 Thorne Harbour Health, Rainbow Health Victoria and Switchboard, p. 42.

233 Victorian Auditor-General's Office, *Access to Mental Health Services*, 2019, p. 12; Ethnic Communities' Council of Victoria, p. 4.

234 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, p. 23.

235 Centre for Multicultural Youth, p. 43.

236 RCVMHS, *Culturally and Linguistically Diverse People Roundtable: Record of Proceedings*.

237 Australian Federation of Disability Organisations, Disability Resource Centre, Women with Disabilities Victoria, Women's Mental Health Network Victoria and Disability Justice Australia, p. 29.

238 Deaf Victoria, p. 8.

239 Hill and others, p. 119.

240 *Witness Statement of Jeremy Dwyer*, 17 July 2019, paras. 28–29.

241 Coroners Court of Victoria, *Correspondence to the RCVMHS: RES.0001.0028.0001, Response to Follow-up Questions*, 2020, p. 2.

242 *Witness Statement of Dr Elizabeth Deveny*, para. 11.

243 Mind Australia, p. 69; RCVMHS, *Culturally and Linguistically Diverse People Roundtable: Record of Proceedings*.

244 *Witness Statement of Dr Ruth McNair AM*, para. 24.

245 RCVMHS, *Culturally and Linguistically Diverse People Roundtable: Record of Proceedings*.

246 Mind Australia, p. 69.

247 Department of Health and Human Services, *Victoria's 10–Year Health Plan: Mental Health Workforce Strategy*, p. 14.

248 StarHealth, *Submission to the RCVMHS: SUB.0002.0028.0582*, 2019.

249 *Joint Witness Statement of Tass Mousaferiadis and Kent Burgess*, para. 32.

250 *Joint Witness Statement of Tass Mousaferiadis and Kent Burgess*, para. 34.

251 *Joint Witness Statement of Tass Mousaferiadis and Kent Burgess*, para. 39.

252 *Witness Statement of Adriana Mendoza*, para. 9.

253 *Witness Statement of Paris Aristotle AO*, para. 32.

254 RCVMHS, *Victoria Transcultural Mental Health Roundtable: Record of Proceedings*.

255 *Witness Statement of Commissioner Ro Allen*, para. 82.

256 Mind Australia, p. 70.

257 *Witness Statement of Dr Mariam Tokhi*, 12 May 2020, para. 28.

258 Centre for Multicultural Youth, p. 35.

259 *Witness Statement of Nicole Bartholomeusz*, para. 36.

260 *Witness Statement of Adriana Mendoza*, para. 58.

261 *Witness Statement of Dr Mariam Tokhi*, paras. 11–15.

262 St Vincent's Hospital Melbourne, Victorian Dual Disability Service, <www.svhm.org.au/our-services/departments-and-services/v/victorian-dual-disability-service>, [accessed 4 November 2019].

263 Department of Premier and Cabinet, *Discussion Paper for the Victorian LGBTIQ Strategy*, 2020, p. 10.

264 Mind Australia, p. 70; Rainbow Families Victoria, p. 1.

265 *Witness Statement of Commissioner Ro Allen*, para. 103.

266 Department of Health and Human Services, Client Management Interface/Operational Data Store.

267 Monash Health, *Submission to the RCVMHS: SUB.7000.0003.0001*, 2019, p. 74.

268 Monash Health, p. 74.

269 health.vic, LGBTI Taskforce and Health and Human Services Working Group, <www2.health.vic.gov.au/about/populations/lgbti-health/lgbti-taskforce>, [accessed 4 December 2020].

270 health.vic, Trans Health Services Model Workshop Report, <www2.health.vic.gov.au/about/publications/ResearchAndReports/trans-health-services-model-workshop-report>, [accessed 20 December 2020].

271 *Witness Statement of Nicole Bartholomeusz*, 9 June 2020, paras. 35–36; *Witness Statement of Dr Elizabeth Deveny*, 8 June 2020, para. 11; *Joint Witness Statement of Tass Mousaferiadis and Kent Burgess*, 20 May 2020, paras. 32–40.

272 RCVMHS, *Victoria Transcultural Mental Health Roundtable: Record of Proceedings*.

273 Department of Health and Human Services, *Victoria's 10–Year Mental Health Plan*, p. 21.

274 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, p. 3; Living Positive Victoria, Thorne Harbour Health and Positive Women, Victoria, *Submission to the RCVMHS: SUB.0002.0029.0332*, 2019, p. 5.

275 Rainbow Health, Thorne Harbour Health and Switchboard, p. 33.

276 Australian Federation of Disability Organisations, Disability Resource Centre, Women with Disabilities Victoria, Women's Mental Health Network Victoria and Disability Justice Australia, p. 9.

277 Family Safety Victoria, p. 15.

278 *Witness Statement of Commissioner Ro Allen*, 2 July 2019, paras. 73–74; *Witness Statement of Dr Ruth McNair AM*, 3 July 2019, para. 47.

279 *Evidence of Commissioner Ro Allen*, 17 July 2019, pp. 1149–1150

280 Andrea Waling and others, Understanding LGBTI+ Lives in Crisis, 2019, p. 26.

281 Waling and others, p. 26.

282 Waling and others, p. 40.

283 Switchboard, Correspondence to the RCVMHS, 2020, p. 10.

284 *Witness Statement of Commissioner Ro Allen*, para. 74; Rainbow Families Victoria, p. 2; Thorne Harbour Health, Rainbow Health Victoria and Switchboard p. 25.

285 Rainbow Health, Thorne Harbour Health and Switchboard, Submission to the RCVMHS: SUB.0002.0028.0150, 2019, pp. 24–25.

286 Rainbow Health, Thorne Harbour Health and Switchboard and Switchboard, p. 25.

287 Rainbow Health, Thorne Harbour Health and Switchboard and Switchboard, p. 25.

288 Switchboard, p. 7.

289 *Switchboard,* p. 9.

290 Foundation House, *Promoting the Engagement of Interpreters in Victorian Health Services*, p. vi; Ethnic Communities' Council of Victoria, p. 6.

291 Victorian Government, *Using Interpreting Services: Guidelines on Policy and Procedures*, p. 17; Federation of Ethnic Communities' Councils of Australia, p. 35.

292 Department of Health and Human Services, *Language Services Policy*, p. 7.

293 Department of Health and Human Services, *Language Services Policy*, p. 9.

294 Department of Health and Human Services, *Language Services Policy*, p. 16.

295 Department of Health and Human Services, *Language Services Policy*, p. 16.

296 *Witness Statement of Adriana Mendoza*, para. 34.

297 Department of Health and Human Services, *Language Services Policy*, p. 14.

298 health.vic, Health Literacy Enabling Communication and Participation in Health, <www2.health.vic.gov.au/about/publications/policiesandguidelines/Health-literacy-enabling-communication-and-participation-in-health>, [accessed 20 December 2020].

299 Aspergers Victoria, *Submission to the RCVMHS: SUB.1000.0001.4501*, 2019, p. 17.

300 Ethnic Communities' Council of Victoria, p. 7.

301 Victorian Government, Ensuring We Reach All Victorians with Our Communications, <www.vic.gov.au/ensuring-we-reach-all-Victorians-with-our-communications>, [accessed 20 December 2020].

302 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868*, p. 25.

303 Aspex Consulting, *Victorian Language Services Procurement Reform Final Project Report*, p. 46.

304 Office of Multicultural Affairs, *Victorian Government Standards for Data Collection on Interpreting and Translating Services*, p. 1.

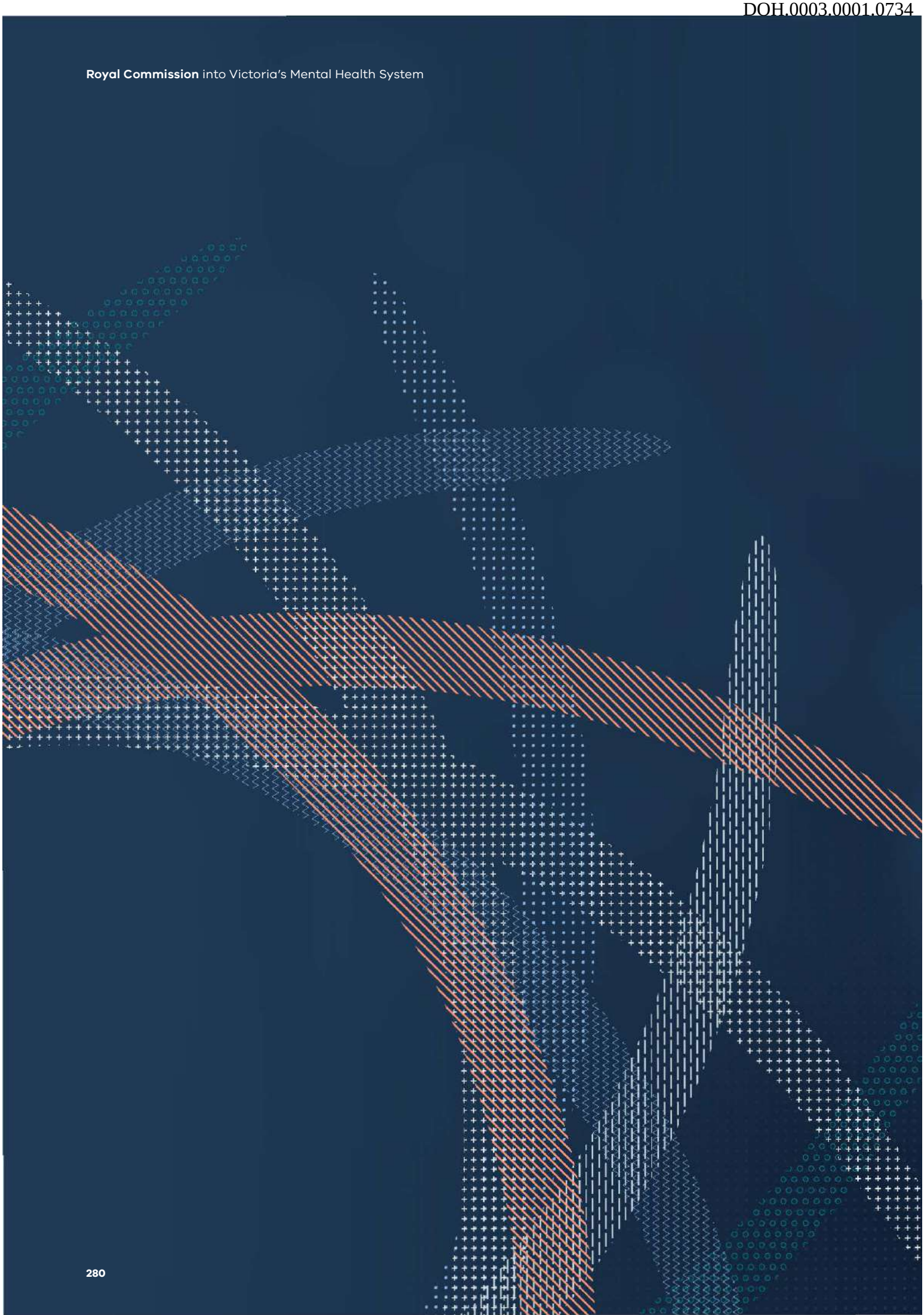
305 Judy Mullan, Remote Interpreting Services Are Essential for People with Limited English—During COVID-19 and Beyond, The Conversation, 5 August 2020, <theconversation.com/remote-interpreting-services-are-essential-for-people-with-limited-english-during-covid-19-and-beyond-143531>, [accessed 20 December 2020].

306 Mullan.

307 Mullan.

308 *Witness Statement of Dr Mariam Tokhi*, para. 27.

309 Aspex Consulting, *Victorian Language Services Procurement Reform Final Project Report*, p. 60.



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Chapter 22

Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction

Recommendation 35:

Improving outcomes for people living with mental illness and substance use or addiction

The Royal Commission recommends that the Victorian Government:

1. by the end of 2022, in addition to ensuring there is at least one highest-level emergency department suitable for mental health and alcohol and other drug treatment in every region (refer to recommendations 3(3) and 8(3)(c)), ensure that all mental health and wellbeing services, across all age-based systems, including crisis services, community-based services and bed-based services:

   a. provide integrated treatment, care and support to people living with mental illness and substance use or addiction; and

   b. do not exclude consumers living with substance use or addiction from accessing treatment, care and support.

Recommendation 36:

A new statewide service for people living with mental illness and substance use or addiction

The Royal Commission recommends that the Victorian Government:

1. establish a new statewide specialist service, built on the foundations established by the Victorian Dual Diagnosis Initiative, to:

   a. undertake dedicated research into mental illness and substance use or addiction;

   b. support education and training initiatives for a broad range of mental health and alcohol and other drug practitioners and clinicians;

   c. provide primary consultation to people living with mental illness and substance use or addiction who have complex support needs; and

   d. provide secondary consultation to mental health and wellbeing and alcohol and other drug practitioners and clinicians across both sectors.

2. as a matter of priority, increase the number of addiction specialists (addiction medicine physicians and addiction psychiatrists) in Victoria.
3. work with the Commonwealth Government to explore opportunities for funded addiction specialist trainee positions in Victoria.

22.1 An integrated approach to improve consumer outcomes

Co-occurring experiences of mental illness and substance use are so common that international experts suggest that services should consider this to be 'an expectation, not an exception'.[1] In Victoria a substantial number of people are living with both mental illness and substance use or addiction, but many are not getting the comprehensive treatment, care and support they need to recover and lead a contributing life.

There is promising evidence that well-delivered integrated care, where both mental illness and substance use or addiction are understood and supported simultaneously by mental health and wellbeing services, delivers better outcomes for consumers.[2] The evidence also suggests that integrated care may be more cost-effective than separate care models.[3] Integrated, comprehensive treatment, care and support is particularly important for people with the most complex support needs, who are often the people living with mental illness and substance use or addiction.[4]

However, most Victorian mental health services are not providing integrated treatment, care and support. Instead, consumers must navigate two distinct systems that often treat their interrelated needs separately. This approach to care is at odds with what many consumers, families, carers and supporters want and reflects a siloed approach to service delivery.[5] Consumers have told the Commission that the lack of integrated care offerings in Victoria is inconsistent with their needs. For example, one consumer explained that:

> you can get set up with a [care] plan, but you have to chase it all down ... you have to go from here, to here, to here and not all the workers are working together ... there's no cohesion.[6]

Ms Catherine White, a witness before the Commission, with lived experience of alcohol use and mental illness, told the Commission that when she sought help, the connection between her use of alcohol and her mental health was not well understood and did not inform the model of care she was offered:

> not a lot of people got the connection between trauma, mental health and addiction. For example, even the psychologist who diagnosed me with PTSD ... ignored the fact that I was still drinking. I obviously didn't have the necessary coping skills. I kept getting triggered and drinking ... he minimised the distress of my alcohol abuse, virtually dismissed it which made me feel like it wasn't a big issue. However, it was affecting all areas of my life and I needed a professional to view it as the problem it was for me. I felt embarrassed, ashamed and invalidated.[7]

Families, carers and supporters of people living with mental illness and substance use or addiction have also told the Commission about how a lack of integrated care had adversely affected people they cared for.

For example, Mr Michael Silva, witness before the Commission and carer, stated that:

> I am a carer for my brother Alan. Alan has a dual diagnosis of bipolar disorder (with psychotic episodes) and addiction to alcohol and drugs ... We have never had an experience in the public mental health system of Alan being treated in an integrated way with respect to his dual diagnosis ... The psychiatrists will only see you for your mental health issues ... [they] may [tell you] that you should not take the drugs or smoke marijuana, but that is about the extent of the integration.[8]

Treatment, care and support delivered separately by different services is not delivering good health and wellbeing outcomes for many consumers.[9] A common experience is that consumers are 'bounced' between different services, forced to retell their story over and over.[10] Too many consumers living with mental illness and substance use or addiction are missing out on treatment, care and support, unable to access support from alcohol and other drug services because they are 'too unwell' but are 'not unwell enough' to access a mental health service.[11] Associate Professor Dean Stevenson, Clinical Services Director of Mercy Mental Health, told the Commission that the current approach does not work from the perspective of a mental health service:

> We are certainly seeing a high concurrence of major mental illness and substance use disorders, and the substance use disorders are addressed by services outside of mental health programs ... it's not an effective model. We would much prefer to see drug and alcohol services embedded within mental health services.[12]

Decades of separate service systems have resulted in many mental health services seeing substance use or addiction as outside of their core business.[13] This has increased the burden on Victoria's alcohol and other drug services, which currently care for many consumers with complex mental health support needs. A critical shortage of addiction specialists limits the ability of alcohol and other drug services and mental health services to access the expertise needed to support consumers with complex support needs. Associate Professor Simon Stafrace, Program Director of Alfred Mental and Addiction Health at the time of giving evidence, and giving evidence in a personal capacity told the Commission:

> Whilst we aspire to being a mental and addiction health service, I think we have a lot of work to do to ensure that the people [who] come to us with severe mental illnesses and serious substance use disorders are getting as much evidence-based attention for the one as they for do the other.[14]

Consumers who have been able to access integrated treatment, care and support from the relatively small number of services that currently offer this have spoken about the benefits to their mental health and wellbeing. For example, one consumer told the Commission about their experiences of care at First Step, a service in St Kilda that provides integrated care for people with addiction, mental illness and other health or support needs:

> I entered a program at First Step, which is a recovery centre where ... everything is covered ... I was able to get legal advice, I was able to see a psychologist, a counsellor ... and I was ... able to get a diagnosis for a mental health condition that I'd had for a very long time. You know, that's what worked well for me, is having gone to one place and getting help in so many areas ... it's been amazing actually.[15]

The intent of the Commission's reforms is to reorient the treatment, care and support for people with more complex and related support needs to Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, which will offer integrated care as well as wellbeing supports. Ensuring consumers can get the right treatment, care and support at the right time will be achieved through a responsive and integrated system. These reforms are described in detail throughout this report and include the following:

- Regional Mental Health and Wellbeing Boards will promote integration through commissioning, including collaborating with alcohol and other drug services within each region, as described in Chapter 28: *Commissioning for responsive services*
- new community-based mental health and wellbeing services will provide integrated treatment and therapies. This includes treatment, care and support to consumers who have co-occurring challenges with substance use or addiction, as set out in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults* and Chapter 13: *Supporting the mental health and wellbeing of young people*
- bed-based services will provide holistic and integrated treatment, care and support to consumers who need it for substance use or addiction and are described in Chapter 10: *Adult bed-based services and alternatives*
- crisis and emergency services will provide integrated care for people with co-occurring mental illness and substance use or addiction. In addition, each region will establish at least one emergency department that provides intensive treatment, care and support through a behavioural assessment unit and are set out in Chapter 9: *Crisis and emergency responses*.

These reforms align with those recommended by the Productivity Commission in its *Mental Health Inquiry Report*. The report recommended that all governments 'should require mental health services, including hospitals and clinical and community health services, to ensure treatment is provided for both substance use' and mental illness for consumers with both.[16] This recommendation was based on the findings that mental illness and substance use or addiction are interrelated and that integrated care has numerous recognised benefits.[17]

The reforms described in this chapter outline a shift to integrated treatment, care and support for consumers living with mental illness and substance use or addiction. A new statewide service with a mandate to increase the capability of services to deliver integrated care, and an increased number of addiction specialists to support those with the most complex support needs, will aid this important shift.

The Commission recognises the importance of Victoria's alcohol and other drug services and their role in providing treatment, care and support to thousands of Victorians who seek help from them each year, and who benefit from their model of care. Victoria's alcohol and other drug services will continue to form an important part in the continuum of care for consumers but will no longer be expected to provide care for those with the most complex mental health support needs. The capability of the alcohol and drug sector to deliver treatment, care and support to consumers with less complex support needs will be enhanced through the work of the new statewide service.

22.2 The Commission's approach to mental illness and substance use or addiction

The Commission's letters patent define the scope of its inquiry. In undertaking its work, the Commission has considered the language preferred by people with lived experience of mental illness and substance use or addiction.

22.2.1 The scope of the Commission's inquiry

The Commission's letters patent include the requirement to 'inquire into and report on … [h]ow to best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches'.[18] The Commission has undertaken that inquiry.

The Commission's letters patent explicitly directed it to focus on reforms that respond to the needs of consumers living with *both* mental illness and 'problematic alcohol or drug use'.[19] Accordingly, the Commission has focused its inquiry into how Victoria's future mental health and wellbeing system and the alcohol and other drug sector can better meet the needs of these consumers.

The Commission did not inquire more broadly into the entirety of Victoria's alcohol and other drug sector as it relates to matters other than the treatment, care and support offered to consumers who experience mental illness and substance use or addiction.

The letters patent also require the Commission to consider the role of evidence-based harm minimisation strategies to support consumers living with mental illness and substance use or addiction.[20] Harm minimisation means a health policy approach that recognises that there are complex and interrelated health, social and economic consequences of substance use or addiction that affect individuals, families, carers, supporters and the community.[21] A harm minimisation approach recognises that a person's drug use is individual and can range from occasional use to dependency or addiction.[22] The approach does not condone drug use, but recognises that a variety of strategies are required to support a progressive reduction in substance-related harm.[23]

A harm minimisation approach is based around three pillars.[24] The first is harm reduction, which aims to reduce risky behaviours associated with substance use or addiction and provide safer environments such as smoke-free areas or free water at music festivals.[25] The second pillar is supply reduction, which is about controlling the supply and availability of substances.[26]

The third pillar is demand reduction, which aims to prevent the uptake of substances. Demand reduction also involves helping people who use substances to recover through a range of evidence-based treatment, care and support options.[27]

Australia's National Drug Strategy highlights that:

> It is critical that Australia's strategy enhances and maintains access to quality evidence-informed treatment. Integrated care is critical to Australia's response and this includes approaches that allow individuals to connect to services which will address barriers to recovery, which might lead to issues such as physical and mental health needs, social, economic, legal or accommodation considerations. It is important that these services are accessible and tailored to the diverse needs of individuals ...[28]

The Commission's recommended approach to integrated care in Victoria's future mental health and wellbeing system aligns with a harm minimisation approach. Specifically, it is consistent with the demand reduction element of harm minimisation that gives priority to services that can assist people experiencing substance use or addiction to recover.[29]

22.2.2 The language used in the Commission's letters patent

The Commission has inquired into '[h]ow to best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use'.[30] This included considering the experiences of people living with 'both mental illness and problematic alcohol and drug use' in Victoria's mental health system, in Victoria's alcohol and other drug sector, and across the community more broadly.[31]

In preparing this report and considering the design of Victoria's mental health and wellbeing system, the Commission considered the preferred prospective language to be used in describing this group of people and their experiences. The Commission's letters patent use the language of 'problematic alcohol and drug use' to describe substance use that is harmful to a person's health and wellbeing or other aspects of their lives. As noted in the Commission's interim report and this report, '[l]anguage is powerful, and words have different meanings for different people.'[32] The language used to describe people's experiences can either 'empower or embolden' or, conversely, can 'be divisive when used to dispossess and divide, and to stigmatise and label'.[33]

'Problematic alcohol and drug use' or 'problematic substance use' were terms commonly used by the former Victorian Department of Health and Human Services.[34] In the course of its inquiry, witnesses have told the Commission that pejorative terms to describe a person's substance use (including adjectives such as 'problematic') place a moral value judgement on substance use, which can contribute to stigmatising attitudes or beliefs. Dr Enrico Cementon, Consultant Psychiatrist at NorthWestern Mental Health, explained that:

> stigma is also driven by the terminology we use in relation to addiction and substance use. For example, we frequently refer to urine samples as being 'clean' or 'dirty'. When a drug-dependent person has been sober or abstinent, we use the term 'clean' or 'good'. We need to remove these pejorative and value-laden terms from our practice ... As a result of this language and stigma ... patients are often very reticent to talk about their substance [use] ... Stigma discourages consumers from openly seeking help and support. Stigma also discourages and prevents clinicians from choosing to engage or specialise in [alcohol and other drug] and addiction health.[35]

Professor Dan Lubman, Executive Clinical Director of Turning Point, Eastern Health and Professor of Addiction Study and Services, Monash University, providing evidence in a personal capacity, also critiqued the term 'problematic alcohol and drug use' as prejudicial.[36] Professor Lubman also explained that the term does not adequately convey that a 'substance use disorder' is a 'mental disorder':

> **The term 'problematic drug and alcohol use' is reflective of how the current health system typically views and addresses substance use disorders—not as legitimate health conditions, or even mental disorders, but something that is self-inflicted and trivialised. It is akin to dismissing depression as a genuine health disorder by saying that people have a 'problematic mood', a term that minimises the suffering experienced and insinuates a level of blame, weakness or poor self-control. The failure to address substance use disorders by their proper name enables them to be dismissed as a health issue by both the health system, including mental health providers, and the community.**[37]

A 'substance use disorder' is recognised as a 'mental disorder' and is contained in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ('DSM-5'), which is the most widely used diagnostic handbook by psychiatrists and other clinicians around the world. The clinical description of a substance use disorder is substance use that is harmful to one's health or where the person has a substance dependence.[38] Dr Cementon similarly remarked that the failure to recognise a 'substance use disorder' as a mental illness means that some mental health services view it as something that 'must be treated elsewhere' rather than within mental health services themselves.[39]

A recent publication, *Power of Words*, which was produced by peak bodies in Victoria and the then Department of Health and Human Services, suggested that the terms 'substance use' or 'addiction' are the terms preferred by consumers, noting that 'person experiencing addiction' is best practice when describing an individual.[40] Addiction to substances means compulsive substance use that is outside a person's control, even when it has adverse effects on that person or families, carers and supporters. It is sometimes referred to as drug or alcohol dependence. The guide highlights that 'substance use disorder' is a clinically appropriate term to describe a diagnosis.[41]

In light of this evidence, the Commission has chosen to use the language of 'substance use or addiction' and 'substance use disorders' in this report. This reflects the commitment to using language that empowers and does not stigmatise or label. Not all consumers will meet a diagnostic threshold for a 'substance use disorder' but may nonetheless wish to seek assistance to reduce or cease their use of substances.[42] For this reason, the Commission has defined substance use more broadly than a 'substance use disorder' but uses this term when appropriate—for example, to describe the findings of data about people with this diagnosis.

The Commission also notes that the term 'dual diagnosis service' has historically been used to describe services in Victoria that provide treatment, care and support to consumers living with mental illness and substance use or addiction. However, the Commission understands that this terminology is being reconsidered by some services that provide integrated treatment, care and support.[43] For example, Mr Gary Croton, Clinical Nurse Consultant, Hume Border Victorian Dual Diagnosis Initiative, Albury Wodonga Health, said that the language used by the Victorian Dual Diagnosis Initiative has evolved to 'people with dual diagnosis and other complex needs' because 'it's seldom dual diagnosis'.[44]

DOH.0003.0001.0745

Mr Patrick Lawrence, CEO, First Step, also stated that:

> It is wrong to think that these two factors are inherently more important than psychosocial indicators such as poverty, social isolation, dysfunctional relationships, emotional under-development or homelessness. It is important to diagnose 'dual' mental illness and addiction, but a good service goes much further. We sometimes refer to this as 'dual diagnosis plus plus' at First Step. The term 'dual diagnosis' is almost never used at First Step because almost all of our clients have multiple treatment needs ...[45]

In light of this, the Commission does not use the language of 'dual diagnosis' except where it describes an existing service of that name, or where evidence before the Commission uses this language.

22.3 Mental illness and substance use or addiction

Integrated treatment, care and support acknowledges the interrelated nature, and the estimated prevalence of, co-occurring mental illness and substance use or addiction.

22.3.1 The relationship between mental illness and substance use or addiction

The relationship between mental illness and substance use or addiction is complex, and each can contribute to the other.[46] Once mental illness and co-occurring substance use or addiction are established, they can be difficult to disentangle.[47] While there appears to be insufficient evidence to conclude that substance use *causes* mental illness in a general sense, substance use appears to be a factor that can increase the risk of a person experiencing poor mental health, or exacerbate the symptoms of mental illness.[48] Some studies indicate that a complex range of factors, including environmental stressors (such as violence in the home environment or encounters with the justice system) or even genetic factors, are likely to play a role in the onset of both substance use or addiction and poor mental health, but more research is needed to understand the links between these factors, particularly for developing brains in young people.[49]

People use substances for many different reasons, including to avoid symptoms of withdrawal or to counter the effects of other substances.[50] Substance use can also be a way for people to manage the distress caused by poor mental health, trauma or other complex life stressors.[51] Particularly when consumers cannot get the treatment, care and support they need, substance use can be a coping strategy or form of self-medication.[52] Addiction experts have informed the Commission that consumers with complex and enduring addiction to substances have frequently experienced trauma early in their lives, such as childhood family violence, sexual abuse, interpersonal violence, neglect, poverty or experiences of out-of-home care or the youth justice system.[53] As Professor Lubman told the Commission at a 2020 hearing panel on how to support people living with mental illness and substance use or addiction:

> Nearly everyone that we see in the alcohol and drugs space are using drugs to solve a problem, to help with ... distress or issues in their lives ... the alcohol and drugs are emotional analgesics that are helping them deal with underlying mental health, stress, life, a whole range of life complexity.[54]

As discussed in Chapter 20: *Supporting Aboriginal social and emotional wellbeing*, poor mental health and substance use disorders are estimated to account for up to 14 per cent of the health gap between Aboriginal and Torres Strait Islander Australians and non-Aboriginal and Torres Strait Islander Australians.[55] Research indicates that trauma, including adverse childhood events, is also associated with poor mental health outcomes, including increased likelihood of substance use disorders.[56] For Aboriginal children and young people, experiences of trauma can also relate to intergenerational trauma.[57]

Research on patterns of substance use for Australians with 'mental health conditions', based on the 2019 National Drug Strategy Household Survey, indicates that of those surveyed, the most common substances used were tobacco, alcohol and cannabis.[58] Of those surveyed and identified as having a diagnosed 'mental health condition', 2.6 per cent of these people reported recent use of methamphetamines, 6.2 per cent reported recent use of cocaine and 4.9 per cent reported use of pain relievers or opioids.[59] The research also suggests that use of some substances (methamphetamine, opioids and cigarettes) has decreased slightly compared with previous years for those aged over 14 years old.[60]

Mental illness and co-occurring substance use or addiction are likely to vary over time for each person.[61] This can include how and when someone uses substances and also reflects the fact that people who experience a mental illness or use substances often have periods of stable health and wellbeing and periods of ill health or increased substance use.[62] People with a long-term substance use or addiction may experience a longer journey to recovery, including periods of relapse.[63] This can be because:

> Recovery from a severe substance use disorder is usually a long-term process where there is substantial internal emotional and psychological change that occurs ... Although this is also relevant to recovery from other mental health issues, it is essential in recovery from addiction. Consumers with addiction are very aware of this need, however their capacity and motivation to engage in this difficult process varies with time and circumstance, thereby affecting their engagement in treatment and mutual help.[64]

Australian research suggests that people living with both mental illness and substance use or addiction frequently have more complex health and other support needs than people with mental illness or substance use issues only, including poorer physical and mental health and more severe drug use.[65] Research by the Centre of Research Excellence in Mental Health and Substance Use indicates that people living with both mental illness and substance use or addiction 'present to treatment with a more complex and severe clinical profile'.[66] This includes:

- poorer mental and physical health
- more severe drug use
- poorer social and occupational functioning
- increased risk of self-harm and suicide
- increased likelihood of homelessness and increased risk of violence
- increased risk of stressed relationships, including with family and friends.[67]

People living with both mental illness and substance use or addiction often face additional barriers to improved wellbeing and recovery compared with those without substance use or addiction. This includes increased rates of relapse, admissions to hospital, attendances at emergency departments, interactions with the justice system, unemployment and homelessness.[68]

Treatment for co-occurring mental illness and substance use or addiction can be more challenging because it can be difficult to identify which condition is causing particular symptoms, or can involve a more complex approach to treatment, care and support.[69] This can be because substance use or addiction can interfere with certain medications and can also interfere with other therapeutic treatments such as counselling.[70] Substance use or addiction can complicate mental health assessments, making it difficult to identify the most appropriate approach to treatment, care and support.[71] In some cases, treatment, care and support is also made more complex where a consumer is discharged from a mental health service due to substance use or addiction.[72]

22.3.2 Estimated prevalence of co-occurring mental illness and substance use or addiction

Estimating the population prevalence of co-occurring mental illness and substance use or addiction in Victoria is difficult. The reasons for this include a lack of consistent data across service systems, different definitions of mental illness and substance use or addiction, and differences in the demographics of populations across Australian states and territories.[73]

Large-scale population studies suggest that co-occurring mental illness and substance use or addiction is relatively common, although there are different estimated prevalence rates for different groups. For example, the 2007 National Survey of Mental Health and Wellbeing indicated that 63 per cent of Australians aged between 16–85 who reported misusing drugs nearly every day also experienced symptoms of a 'mental disorder', including 'substance use disorders', in the previous 12 months.[74] The survey also estimated that the rates of a co-occurring 'substance use disorder' were 12 per cent for people with 'anxiety disorders' and 18 per cent for those with an 'affective disorder'.[75]

A systematic review by the Centre of Research Excellence in Mental Health and Substance Use of a range of Australian studies on co-occurring mental illness and substance use suggested that 31 per cent of men and 44 per cent of women living with a 'substance use disorder' live with at least one other diagnosable mental illness.[76]

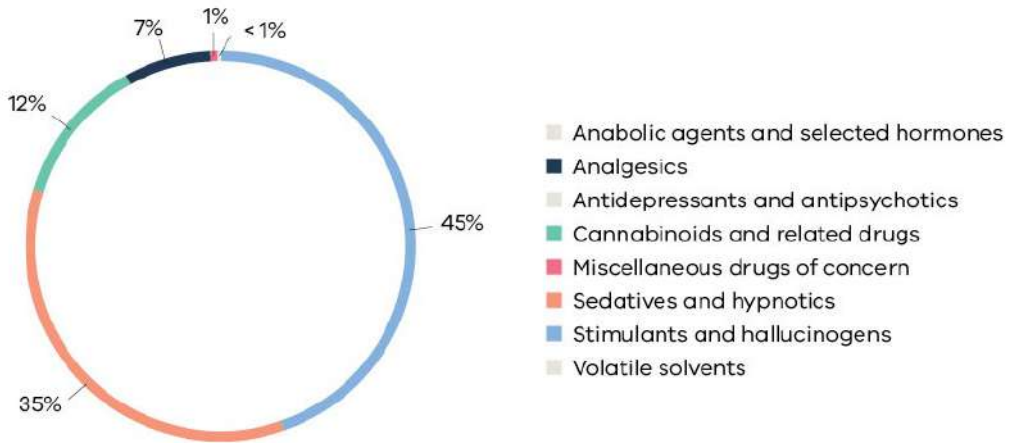
Research suggests that people who seek help from alcohol and other drug services have higher rates of mental illness. For example, research indicates that 50–76 per cent of Australians who use these services meet the diagnostic criteria for at least one co-occurring 'mental disorder'.[77] The research in this area has resulted in some international experts arguing that mental health services should consider co-occurring mental illness and substance use or addiction as 'an expectation, not an exception'.[78]

Alcohol was the largest primary drug type for people accessing emergency departments in Victoria for alcohol- or drug-related reasons in 2019–20, as set out in Figure 22.2. The 'stimulants' category includes methamphetamine and accounts for a relatively small proportion of all drug-related emergency department presentations.

22.3.3 Methamphetamine use and its effects on individuals, communities and health services

The estimated use of methamphetamine in Australia has steadily declined over the past 20 years and makes up a relatively small proportion of drug use overall (an estimated 1.3 per cent of Australians used methamphetamines in 2019 compared with 3.4 per cent of Australians in 2001).[79] However, as the Commission acknowledged in its interim report, methamphetamine use has disproportionately harmful effects for many individuals, families, carers, supporters and communities in Victoria compared with other drugs.[80] Data analysed by the Commission suggests that methamphetamines are in the top three 'main drug of concern' for consumers who seek help from Victoria's alcohol and other drug services. Around 25 per cent of consumers who accessed alcohol and other drug services in 2018–19 nominated methamphetamines as their major drug of concern (the category of stimulants and hallucinogens in Figure 22.1 includes methamphetamines).[81] Although the use of prescription pain killers and opioids has slightly decreased in the last three years (from 3.6 per cent of Australians to 2.7 per cent) it is still a concern due to the risk of overdose.[82]

Figure 22.1: Estimated percentage of consumers of alcohol and other drug services, by broad drug of concern, Victoria, 2018–19



Source: Department of Health and Human Services, Victorian Alcohol and Drug Collection 2018–19.

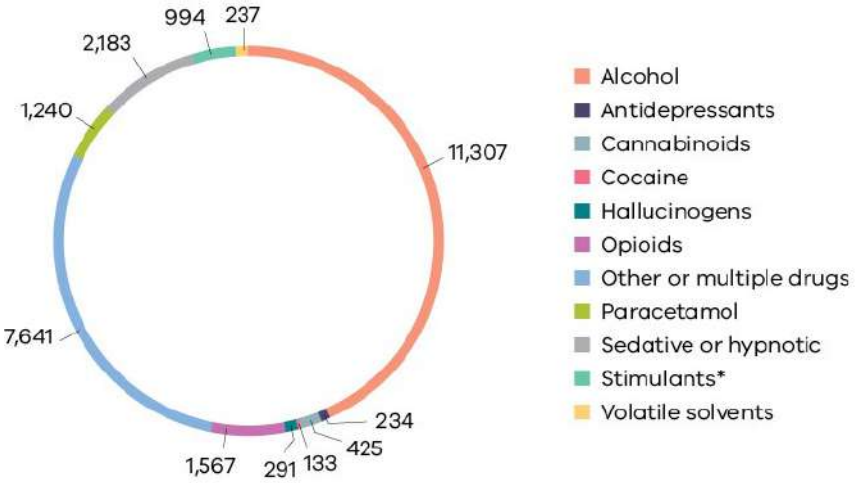
Note: The broad drug of concern is irrespective of whether the drug is the principal drug of concern or not. Percentages may not total 100 due to rounding.

Noting this, data analysed by the Commission and shown in Figure 22.3 from Victoria's emergency departments indicates that methamphetamine- and cocaine-related presentations to emergency departments have both increased substantially since 2008–09.

A recent systematic review and meta-analysis of 59 global studies of the relationship between methamphetamines and mental health suggested that methamphetamine use was associated with increased risk of mental health and 'behavioural issues'.[83] It indicated that any use, compared with no use, was associated with a 4.4 times greater likelihood of experiencing suicidal ideation and a 1.6 times greater likelihood of experiencing depression.[84]

People using methamphetamines can require treatment, care and support in emergency or crisis services, sometimes because of acute intoxication or related health needs such as physical injuries.[85] There is evidence to suggest that some people using methamphetamines are presenting to emergency departments or are being admitted to inpatient units in Victoria. In some cases, these presentations cause health and safety challenges to these services.

Figure 22.2: Number of mental health–related emergency department presentations with an alcohol or other drug-related diagnoses, by primary drug type, Victoria, 2019–20



Source: Department of Health and Human Services, Victorian Emergency Minimum Dataset 2019–20.

Notes: Mental health-related emergency department presentation defined as (a) the presentation resulted in an admission to a mental health bed (inpatient or residential), or (b) the presentation received a mental health related diagnosis ('F' codes, or selected 'R' & 'Z' codes R410, R418, R443, R455, R4581, Z046, Z590, Z609, Z630, Z658, Z765), or (c) the presentation was defined to be 'Intentional self-harm', or (d) the presentation involved interaction with a mental health practitioner.

*Stimulants category includes methamphetamine.

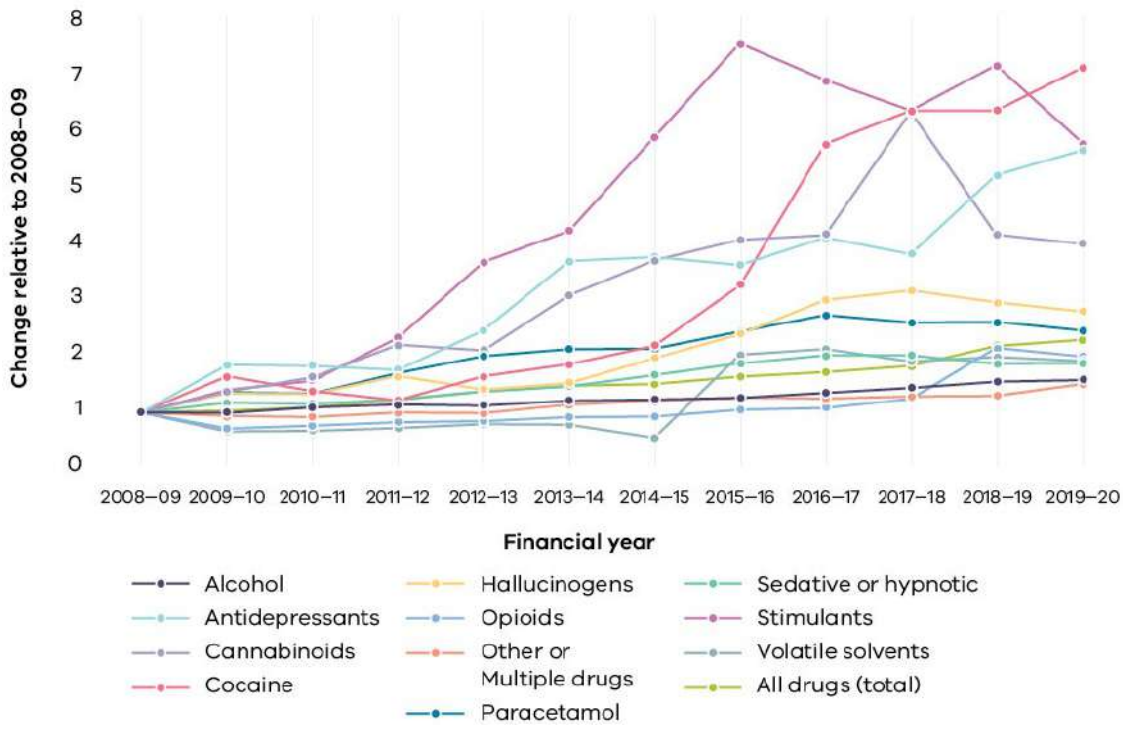
For example, one study comprising a sample of 229 emergency department attendees found that 40.2 per cent (92 people) returned a positive result for any drug, and of that group, 85 people returned a positive test for methamphetamines.[86] Another study, involving 232 'patients' admitted to a mental health inpatient unit over a three-month period, indicated that 30.6 per cent (71 people) of that sample either self-reported or tested positive (or both) to methamphetamine.[87] However, these results should be treated with caution because of the very small samples sizes and the limitations of study methodologies.

Methamphetamine intoxication can create challenges for health and emergency services and those who work in them.[88] This includes increased risk of exposure to occupational violence.[89] This is because methamphetamine use is associated with an increased risk of acute psychosis, agitation, aggression and violence.[90] For example, a recent systematic review indicates that any use of methamphetamines is associated with twice the likelihood of a person experiencing psychosis and 2.2 times the possibility of experiencing violence.[91]

Behaviours of concern resulting from substance intoxication are often referred to as 'acute behavioural disturbance' and can result in health workers or other consumers experiencing violence in the form of verbal abuse, threats, physical harm or bodily fluid assaults.[92]

A challenge for emergency departments is that their physical environments are often busy and brightly lit. This makes them highly stimulating environments, and this can exacerbate the distress that a person who is intoxicated feels.[93] It can also be very challenging for clinicians in an emergency department to know whether a person is intoxicated only, or if they also have an underlying mental illness.[94]

Figure 22.3: Change in the number of mental health–related emergency department presentations with an alcohol or other drug-related diagnoses, by primary drug type, Victoria, 2008–09 to 2019–20



Sources: Department of Health and Human Services, Integrated Data Resource, Victorian Emergency Minimum Dataset 2008–09 to 2018–19; Department of Health and Human Services, Victorian Emergency Minimum Dataset 2019–20.

Notes: Mental health–related emergency department presentation defined as (a) the presentation resulted in an admission to a mental health bed (inpatient or residential), or (b) the presentation received a mental health related diagnosis ('F' codes, or selected 'R' & 'Z' codes R410, R418, R443, R455, R4581, Z046, Z590, Z609, Z630, Z658, Z765), or (c) the presentation was defined to be 'Intentional self-harm', or (d) the presentation involved interaction with a mental health practitioner.

The Commission's definition of mental health-related emergency department presentation may differ slightly from the definition used by the Department of Health and Human Services. Stimulants category includes methamphetamine.

Data excludes the Albury campus of Albury Wodonga Health.

Change expressed relative to the reported number of relevant emergency department presentations in 2008–09. For example, a change of three represents a tripling of presentations.

The Commission notes the findings of the Special Commission of Inquiry into Crystal Methamphetamine and other Amphetamine-type Substances (The Special Commission of Inquiry), conducted in New South Wales. The Special Commission of Inquiry identified that people who seek care in emergency departments, and who are experiencing acute behavioural disturbance, require therapeutic care in a low-stimulus setting away from

emergency departments.[95] The Special Commission of Inquiry highlighted the practice of Victoria's behavioural assessment units at the Royal Melbourne Hospital as exemplars of the care that should be provided to people experiencing acute behavioural disturbance.[96]

The Commission's reforms will see these specialised behavioural assessment units refined and established in every region as a component of the highest-level emergency department suitable for mental health and alcohol and other drug treatment outlined in Chapter 9: *Crisis and emergency responses*. These facilities are major responses and changes to the way that care is delivered in Victoria and will provide the necessary intensive care support options to consumers who need this. This reform will also ensure that there is a specialised response, including multidisciplinary teams, providing integrated treatment, care and support.

People who frequently use methamphetamines are likely to have other complex support needs, including for mental illness, and so can often require holistic and intensive treatment, care and support.[97] However, in Victoria's current approach to care, a major barrier to successful treatment, care and support for people who experience methamphetamine addiction is the 'disjointed transition between assessment, withdrawal and treatment … Given that key characteristics of this cohort include mental health comorbidity and other complexities … quality coordination of care' is needed.[98] The future system will provide integrated care to those consumers with complex care and support needs, including from addiction specialists.

The Special Commission of Inquiry examined the challenges of methamphetamine from different angles, including health, and made a number of recommendations. While Victoria conducted a parliamentary inquiry on the issue of methamphetamine in 2013, the Commission has received evidence that methamphetamine use remains a persistent and troubling issue for many Victorians.[99] Methamphetamine use is a complex health, social and justice issue, and reforms to the mental health system alone cannot deal with the entirety of the issue.

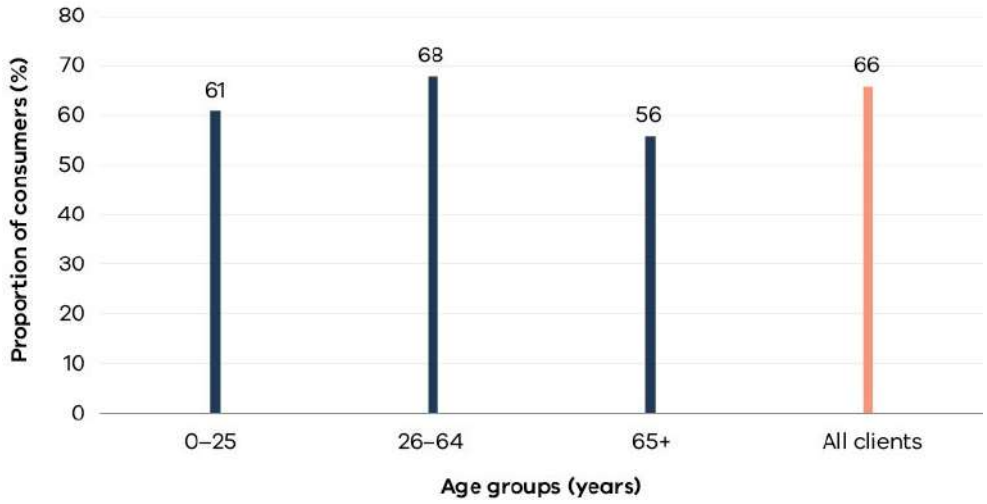
22.3.4 Gaining access to treatment, care and support

Data from Victoria's mental health and alcohol and other drug services helps to estimate the number of people in Victoria who use both services over a specific period of time. It can also identify how many consumers with co-occurring mental illness and substance use or addiction are accessing either a mental health or an alcohol and other drug service (consumers who use one but not the other). As noted in its interim report, the Commission has taken care to distinguish between data about registered consumers of Victoria's mental health system and data that can provide estimations of population prevalence.[100]

A relatively small number of consumers in Victoria are getting treatment, care and support from *both* a public specialist mental health service and an alcohol or drug service. In 2018–19, approximately 7,147 consumers accessed care from both. This represents 19 per cent of the total number of consumers who accessed an alcohol and other drug service (36,735 consumers) and 9 per cent of the total number of consumers who accessed public clinical mental health services (75,379 consumers) in that period.[101] This data is in the context of the difficulties many people have accessing Victoria's mental health system, as outlined in the Commission's interim report.[102]

However, analysis of the data suggests that a far larger cohort of consumers who use Victoria's alcohol and other drug services also have poor mental health or a diagnosed mental illness. Across all age cohorts, approximately 66 per cent of consumers who accessed alcohol and other drug services in 2018–19 indicated that they had received a mental health diagnosis from a mental health practitioner (refer to Figure 22.4).[103]

Figure 22.4: Estimated proportion of Victorian alcohol and other drug service consumers where mental health diagnosis status is known, Victoria, 2018–19



Source: Department of Health and Human Services, Integrated Data Resource, Victorian Alcohol and Drug Collection 2018–19.

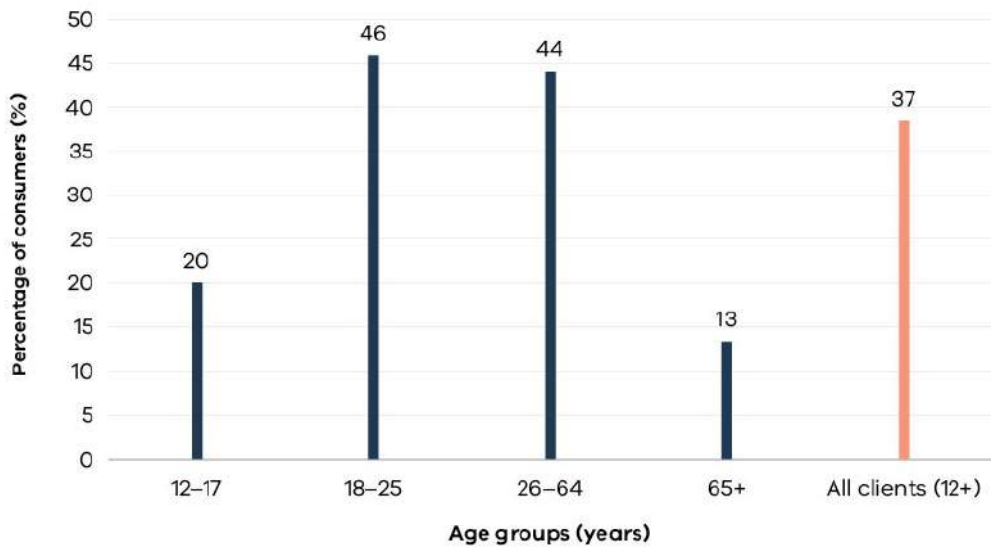
Notes: Data includes diagnosis groups such as conditions of psychological development. 16,091 consumers in 2018–19 did not have a diagnosis recorded or it was inadequately described.

When analysing data recorded by Victoria's mental health services, the Commission observed that approximately 27 per cent of consumers in the five-year period from 2014–15 to 2018–19 were recorded as having a substance use disorder diagnosis.[104]

Other data analysed by the Commission regarding the percentage of consumers who accessed public specialist mental health services who were assessed using an age appropriate Health of the Nation Outcome Scale as having a substance use issue is shown in Figure 22.5 and indicates the following:

- of those consumers aged 12–17 years old, 20 per cent had a substance use issue
- of those consumers aged 18–25 years old, 46 per cent had a substance use issue
- of those consumers aged 26–64 years old, 44 per cent had a substance use issue
- of those consumers 65 years and older, 13 per cent had a substance use issue.

Figure 22.5: Estimated proportion of public clinical mental health service consumers with a substance use issue, Victoria 2019–20



Source: Department of Health and Human Services, Client Management Information/Operational Data Store 2019–20.

Notes: Estimation is based on consumers who have a completed Health of the Nation Outcome Scale (HoNOS), Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) or Health of the Nation Outcome Scale 65+ (HoNOS 65+) assessment and were rated 2, 3 or 4 on those scales in the questions relating to problem drinking or drug-taking, or problems with alcohol, substance or solvent misuse. 68.3 per cent of clients aged 12–17 had a completed questionnaire; 61.7 per cent of clients aged 18–25 had a completed questionnaire; 59.7 per cent of clients aged 26–64 had a completed questionnaire and 64.3 per cent of clients aged 65+ had a completed questionnaire.

22.3.5 Co-occurring mental illness and substance use or addiction at different ages and in different service settings

Anyone can experience mental illness and substance use or addiction. However, there are different patterns of mental illness and substance use or addiction at particular ages and life stages. This is particularly the case for young people and older adults. Further, the acuity or severity of distress for different consumers (including the other complex support needs they have) differs, meaning that different service settings see consumers with different levels of need.

Young people

Service use data analysed by the Commission suggests that in 2018–19 approximately 9,455 consumers aged 12–25 years old accessed a Victorian alcohol and other drug service.[105] The Commission estimates, based on analysing the linked administrative datasets, that 24 per cent of those consumers (2,269 consumers) also used a public specialist mental health service in that period. However, a larger number of young people—61 per cent (6,001 young people)—who used an alcohol and other drug service indicated that they had received a mental health diagnosis from a mental health practitioner.[106]

Figure 22.6: Estimated proportion of youth alcohol and other drug service consumers who also used public mental health services, 12–25, Victoria, 2018–19

Source: Department of Health and Human Services, Integrated Data Resource, Client Management Information/ Operational Data Store, Victorian Alcohol and Drug Collection 2018–19

Note: In this instance, mental health consumers includes consumers who accessed mental health services in the public specialist system, private hospitals and emergency departments.

In Chapter 13: *Supporting the mental health and wellbeing of young people*, the time of early adolescence or young adulthood is described as a time of substantial development and often a time where a young person's substance use or addiction and mental health issues emerge.[107] Research suggests that young people's patterns of substance use differ from those of adults; for example, they may be more experimental or more likely to engage in 'binge' drinking.[108]

Responding to co-occurring mental illness and substance use or addiction experienced by young people requires a response that considers factors relevant to young people's stage of life and development, including:

- the young person's family, and any substance use issues or addiction within their family or relational context
- the influence of social relationships, including peers
- factors that may increase a young person's risk of substance use or addiction, including abuse, neglect or trauma.[109]

Several previous reviews have identified a need for integrated care for young people living with mental illness and substance use or addiction.[110] This includes a review in 2000 that recommended that '[t]he model of care for young people with problematic substance use should be integrated with other youth focussed services and systems such as … mental health'.[111]

A 2015 review by Victoria's largest youth alcohol and other drug service, the Youth Support and Advocacy Service, recommended that alcohol and other drug services should '[f]urther integrate with other youth focussed service systems capable of addressing complex psychosocial issues' and that Victoria should '[e]nsure youth [alcohol and other drug] services are fully integrated with other youth and health service systems'.[112] In particular, integrated care is recommended for young people considered to be at greater risk of developing co-occurring mental illness and substance use or addiction, particularly young people in out-of-home care or who interact with the youth justice system.[113]

Two submissions to the Commission raised the issue of young people with severe substance use or addiction who interact with the youth system and who may struggle to complete residential rehabilitation programs.[114] It was suggested that young people in this situation could be assisted through a residential therapeutic treatment program that would be court-ordered, and therefore compulsory.[115] The Commission's reforms aim to reduce compulsory treatment, so that it 'must only be used as a last resort', and are discussed in detail in Chapter 32: *Reducing compulsory treatment*. The Commission's expectation is that the engagement strategies used by reformed mental health and wellbeing services for young people will benefit young consumers with severe substance use or addiction needs and mental illness. Young people with the most complex support needs relating to mental illness and substance use or addiction will be able to access integrated care in the service stream of youth mental health and wellbeing services, including addiction specialist support.

Older adults

In Chapter 14: *Supporting the mental health and wellbeing of older people*, the Commission outlines that older adults require different mental health support based on their stage of life. Research on the patterns of alcohol and other drug use of older Australians (aged 65 years or older) by the National Drug Research Institute suggested that, in 2016, 25 per cent of men and 8 per cent of women were drinking more than two standard drinks per day (or more than 14 drinks per week, which is more than the healthy recommended amount).[116] The research suggested that alcohol use could occur as a result of distress caused by loss or grief, chronic pain or loneliness or homelessness experienced by older people.[117] Older adults may also use drugs to combat chronic pain, to cope with the symptoms of depression or anxiety, to manage the distress of social isolation or because they have a long-term substance use disorder for which they have not received appropriate treatment, care and support.[118]

People who access emergency departments and other crisis services

As described in Chapter 9: *Crisis and emergency responses*, people who experience a mental health or substance use crisis frequently require an immediate health response. This can be due to a range of reasons including intoxication, physical injuries, suicidal ideation or self-harm.

Data analysed by the Commission suggests that consumers who use both mental health and alcohol and other drug services are 25 times more likely than the Victorian population overall to use an ambulance for a mental health-related reason.[119] Consumers accessing both mental health services and alcohol and other drug services are 48 times more likely to go to Victoria's emergency departments for reasons relating to suicidal ideation and 40 times more likely to go to them for reasons relating to self-harm than other consumers (refer to Figure 22.7).

Figure 22.7: Estimated number of people who used mental health-related services and alcohol and other drug services who also accessed ambulance services and emergency department services, Victoria, 2014–15 to 2018–19

Sources: Department of Health and Human Services, Integrated Data Resource, Client Management Information/ Operational Data Store, Victoria Emergency Minimum Dataset, Victorian Ambulance Minimum Dataset, Victorian Alcohol and Drug Collection 2014–15 to 2018–19; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra.

Note: In this instance, mental health consumers includes consumers who accessed mental health services in the public specialist system, private hospitals and emergency departments.

In response to the growing number of people with both mental health and substance use or addiction issues visiting emergency departments, the Victorian Government has committed to build six mental health and alcohol and other drug crisis hubs.[120] These six hubs are to be built at locations including Monash Medical Centre Clayton, Peninsula Health Frankston, Western Health in Sunshine and Barwon Health at University Hospital Geelong, and will include a total of 24–36 short-stay beds, which will enable consumers to spend 'up to 24 hours, or longer as clinically appropriate'.[121] These hubs are designed to be separate from the emergency department, in a low-stimulus environment and staffed by clinicians and practitioners with expertise in mental health and substance use or addiction, and are described in detail in Chapter 9: *Crisis and emergency responses*.[122]

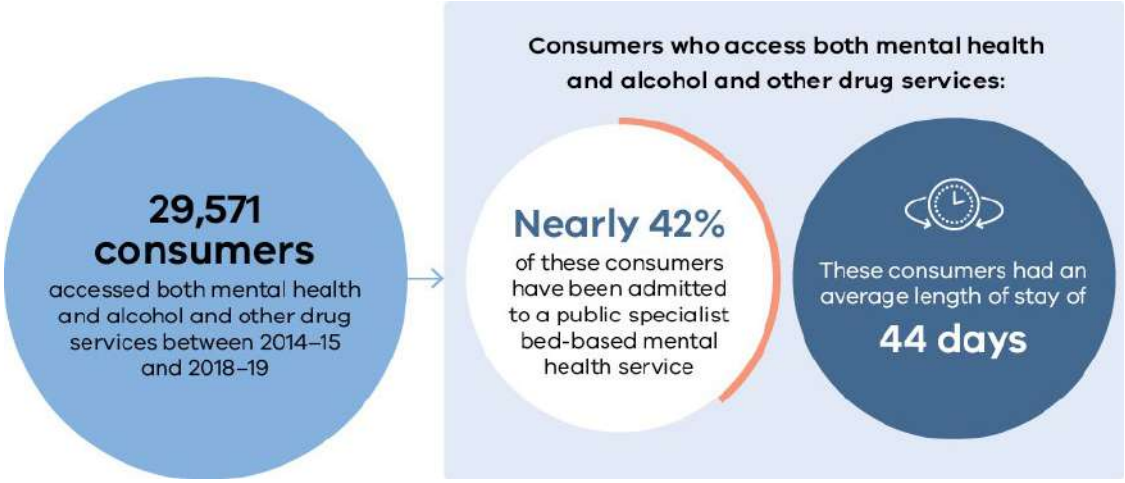
Emergency departments can be traumatic or stressful for people living with mental illness and co-occurring substance use or addiction, or they can be settings where people experience stigma and discrimination because of their use of alcohol and other drugs.[123] These hubs will respond to the needs of people with mental health and substance use or addiction who seek crisis services.

Consumers who use bed-based services

As described in Chapter 10: *Adult bed-based services and alternatives*, Victoria's bed-based services are in various residential settings, including hospitals and subacute facilities, where mental health treatment, care and support is delivered. In the future, bed-based services will make up a relatively small part of Victoria's mental health and wellbeing system and will be reserved for those consumers with complex and higher intensity support needs. Data analysed by the Commission suggests that a substantial proportion of mental health consumers who use bed-based services are also living with substance use or addiction or have a diagnosed 'substance use disorder'.[124]

Analysis of health service data suggests that in the five years from 2014–15 to 2018–19 approximately 29,571 consumers accessed both mental health and alcohol and other drug services.[125] Of this group, nearly 42 per cent (12,419 consumers) had been admitted to a public specialist bed-based mental health service an average of three times and had an average stay of 44 days (refer to Figure 22.8).

Figure 22.8: Estimated number of people who used mental health services and alcohol and other drug services, Victoria, 2014–15 to 2018–19



Sources: Department of Health and Human Services, Integrated Data Resource, Client Management Information/ Operational Data Store, Victorian Admitted Episodes Dataset, Victorian Emergency Minimum Dataset, Victorian Alcohol and Drug Collection 2014–15 to 2018–19.

Note: In this instance, mental health consumers includes consumers who accessed mental health services in the public specialist system, private hospitals and emergency departments.

Consumers who have complex support needs

As described earlier, research indicates that people with co-occurring mental illness and substance use or addiction can also have other complex support needs. These can include supports relating to housing and employment, physical health, family, interpersonal or sexual violence and the justice system.[126]

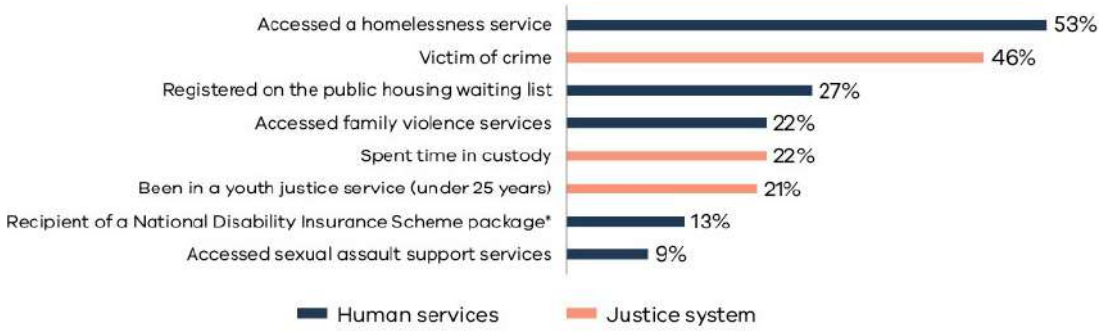
For example, First Step told the Commission that a snapshot of 100 consumers at first presentation to the service indicated that:

- 65 per cent were unemployed or not studying
- 15 per cent were homeless or were at risk of homelessness in the previous month
- 11 per cent had been arrested in the previous month
- 11 per cent had experienced sexual abuse in the previous month
- 7 per cent had attempted suicide in the previous month.[127]

Similarly, Turning Point, a national addiction treatment, education and research service based in Melbourne, submitted that 25 per cent of people seeking treatment from its services were consumers with what it defined as the 'most intensive support needs' due to experiencing multiple health and other life complexities.[128] This means that the consumer is experiencing drug or alcohol dependency, as well as other complex support needs related to mental and physical health or has previously experienced drug, alcohol or mental health treatment.[129] Further, 45 per cent of its consumers were assessed as having needs consistent with the second-highest tier of complex support needs, which includes having moderate mental health issues.[130]

This is consistent with data about the use of different government human services (for example, housing or homelessness services) and the justice system for people who made use of both specialist mental health and drug services over a five-year period, set out in Figure 22.9.

Figure 22.9: Proportion of consumers who accessed both mental health and alcohol and other drug treatment services, by interaction with human services and the justice system, Victoria, 2014–15 to 2018–19



Sources: Department of Health and Human Services, Integrated Data Resource, Client Management Interface/ Operational Data Store, Victorian Admitted Episodes Dataset, Victorian Emergency Minimum Dataset, Victorian Alcohol and Drug Collection, E-justice, Law Enforcement Assistance Program Extract, Specialist Homelessness Services Collection, Victorian Housing Register, Family Violence Support Services Data Collection, Sexual Assault Services, Disability—individual support packages 2014–15 to 2018–19.

Notes: Sample size n = 29,571 people. Includes consumers who accessed mental health services in the public specialist system, private hospitals and emergency departments. *Only includes people that were supported by the Victorian Government disability services that transitioned to the National Disability Insurance Scheme and does not include new consumers.

Mr Croton explained that this is why the Victorian Dual Diagnosis Initiative prefers the term 'complexity capability' over 'dual diagnosis capability'.[131] This is also the terminology used by integrated care experts Christie Cline and Kenneth Minkoff:

> Individuals and families not only have substance use and mental health issues, they frequently have medical issues, legal issues, trauma issues, housing issues, parenting issues, educational issues, vocational issues and cognitive/learning issues ... we need to engage in a process of organizing everything we do, at every level ... to be about all the complex needs of the people and families seeking help.[132]

22.4 Current services for mental illness and substance use or addiction in Victoria

In Victoria the mental health system and the alcohol and other drug sector are, with some exceptions, separate. The separation of mental health and substance use or addiction services occurred in the years after the deinstitutionalisation of Victoria's former mental health services in the 1990s. Prior to this, certain public hospitals provided both mental health and substance use or addiction treatment, care and support.[133] Mr Terry Symonds, the then Deputy Secretary, Health and Wellbeing, Department of Health and Human Services, explained that 'siloed research and clinical domains' have remained the norm in Australia.[134] In addition, '[w]orkforce shortages, problematic siloing of the two sectors and historical culture and practice approaches have led to limited opportunities for integrated care.'[135]

Victoria's alcohol and other drug services are largely delivered by non-government organisations and community health organisations and hospitals, and some services are commissioned by Primary Health Networks.[136] Alcohol and other drug services offer a range of different treatment, care and support options. They provide intake and assessment, counselling, residential and non-residential withdrawal services, residential and day rehabilitation services, care and recovery supports and pharmacotherapy such as opioid replacement therapy. They also offer harm-minimisation programs such as syringe exchange and safe injecting rooms and harm-minimisation education.[137] There are specific alcohol and other drug services for Aboriginal consumers, for young people and for people in forensic mental health care and correctional settings.[138] Services for Aboriginal consumers include healing centres for young people, which are described further in Chapter 20: *Supporting Aboriginal social and emotional wellbeing*.

22.4.1 Victoria's current statewide services for consumers living with mental illness and substance use or addiction

Victoria also has specific services in some health services for people living with mental illness and substance use or addiction who have more intensive needs. These include 28 'dual diagnosis' rehabilitation beds located in Bendigo (eight beds) and Sunshine (20 beds), which provide treatment, care and support for up to 12 weeks.[139] Another service is a statewide Addiction Medicine Unit, consisting of eight beds located at Box Hill Hospital, delivered by Turning Point. This service offers crisis support and withdrawal management, as well as treatment for co-occurring mental or physical health issues. The alcohol and other drug sector also provides beds for withdrawal and rehabilitation for people living with mental illness or psychological distress, including some that are specifically for young people.

Turning Point also has a Statewide Specialist Clinical Service, which is based at Eastern Health. Turning Point provides direct services to anyone in Victoria who meets relevant eligibility criteria. The services include addiction medicine, psychology, neuropsychology and other treatment services. Turning Point's services include a trial of an eight-bed subacute drug withdrawal and intensive rehabilitation service for people with addiction issues and complex mental and physical health needs, which commenced in 2018.[140]

Turning Point also has an important role as a research institution, auspiced by Eastern Health and affiliated with Monash University. Its activities include research, workforce and community training and education programs, providing population-level data through its research, policy advice to governments and expert comment.[141]

Victoria's 'dual diagnosis' rehabilitation beds are limited in the services they provide, including their small scale and an inability to provide withdrawal or non-residential options. They are also unsuitable for people with intensive support needs, such as those who have a substantial risk of suicide. Mr Symonds told the Commission that these 28 beds are 'not enough, and it is my view that the Royal Commission should consider a comprehensive approach to dual diagnosis'.[142] It is also clear that dual-diagnosis bed-based services are not equitably distributed across the state.

The Victorian Dual Diagnosis Initiative (VDDI) works with the alcohol and drug, mental health community support and clinical mental health sectors. It was established in 2002 by the then Department of Health. It aims to increase the capacity of clinicians, practitioners and services to recognise and respond effectively to people with co-occurring mental illness and substance use issues or addiction. The VDDI operates in metropolitan, regional and rural Victoria and is coordinated by the VDDI Leadership Group and the VDDI Rural Forum. Metropolitan health services are funded for a range of positions, including psychiatrists and youth practitioners who provide support to regional and rural VDDI workers. A 2011 evaluation of the initiative indicated that it had had some success, including in building awareness of co-occurring mental illness and substance use or addiction across sectors.[143] However, some stakeholders have informed the Commission that, due to insufficient support, the VDDI has been challenged to expand its remit across Victoria. For example, Mr Symonds stated that:

> the Victorian Dual Diagnosis Initiative made significant gains in the further development of mental health and [alcohol and other drug] workers, agencies and sectors' capacity to recognise and respond effectively to people experiencing co-occurring mental health and substance use concerns and related issues. However, this program has lost momentum and, as outlined in their submission to the Royal Commission, would require updating and refinement, co-design and implementation support were it to continue.[144]

22.4.2 Strengths of current approaches to treatment, care and support

The Victorian alcohol and other drug sector approach to providing treatment, care and support for consumers has several strengths. To some extent, the separation of mental health and alcohol and other drug services in Victoria has enabled the latter to offer treatment, care and support that often:

- puts consumers at the heart of decision making, with the tools, approaches and models of care in the alcohol and other drug sector, based on staff walking alongside people, hearing what their issues are, and developing interventions that work for them
- has a peer workforce that includes many people with a lived experience of substance use or addiction and recovery
- recognises the need to respond to the needs of consumers in a holistic way that understands the complexities of their support needs and their life circumstances
- acknowledges the relationship of trauma and distress and substance use or addiction
- offers therapeutic alternatives to medication and care and recovery coordination
- offers treatment, care and support that is compassionate and non-judgemental
- is proficient in partnerships with other systems and organisations.[145]

These strengths are entirely consistent with the Commission's aims for the future of mental health and wellbeing system in Victoria. Indeed, a recurring theme in the evidence received by the Commission is that the approaches of the mental health and alcohol and other drug sectors are not that different. Both aim to provide a person-centred approach to recovery and both sectors can learn from, and share knowledge with one another.[146]

Peer workers are central to the work of Victoria's alcohol and other drug services, which utilise peer supports when providing treatment, care and support more consistently than mental health services.[147] For example the Self Help Addiction Resource Centre, which has a model of practice grounded in peer support, started in 1986. It was formed when a group of people with lived experience decided to form a new organisation to support other people who needed help with substance use or addiction.[148] Self Help Addiction Resource Centre informed the Commission that:

> Much of the strength of [Self Help Addiction Resource Centre]'s approach is based on the spirit or ethos of self-help culture: Empowering ourselves to make those decisions that directly affect our lives, taking responsibility for ourselves, leading the development of models of support with professional champions and embracing the extraordinary value of mutual support, hope and moving towards recovery as defined by the individual.[149]

Dr Stefan Gruenert, CEO of Odyssey House Victoria, which offers alcohol and other drug treatment, training and support, explained that:

> We know that in sustainable recovery from both drug and alcohol and mental health issues ... positive, strong relationships and relationship skills are one of the key predictors of long-term success ... this is also why so many peer support programs work particularly well, because they can ... go on that journey together with other people that have had similar experiences, at least as part of their treatment.[150]

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A consumer at a focus group for people with lived experience of mental illness or substance use or addiction explained why peer workers are so important during the time of first seeking help from a service:

> Particularly in early recovery … it's a real rollercoaster ride mentally and emotionally, on any given day … having a place to touch base with basically on a daily basis for people who are going through the same thing as you or have been through … and are now in a more stable part of their lives … I just think it's invaluable … It can cause you to feel much less like an alien through a process, which at times feels very alien … just being able to touch base in that confidential space, where there is no agenda, where it's supported … that everybody there understands, without you even needing to say … no matter what state you're in.[151]

In addition, there are many strengths to Victoria's current mental health services that complement those of Victoria's alcohol and other drug sector. In particular, in comparison with Victoria's alcohol and other drug sector, Victoria's mental health services tend to have higher levels of specialisation of workforce in order to provide particularly high intensity supports for consumers with complex support needs. Noting the discussion in Chapter 36: *Research, innovation and system learning*, Victoria's mental health services also tend to have closer connections to research and the development of evidence-based approaches to treatment, care and support.

22.5 Challenges for people living with mental illness and substance use or addiction, and for Victoria's alcohol and other drug services

Despite the large number of people in Victoria living with co-occurring mental illness and substance use or addiction, too many consumers are currently unable to access sufficiently comprehensive and integrated care. This is largely because of the current separation of mental health and alcohol and other drug services, the limited capacity of alcohol and other drug services to provide treatment, care and support to people living with mental illness and related complex support needs, and a range of barriers to accessing integrated services that arise as a result of this.

22.5.1 Challenges in accessing integrated care and experiences of service exclusion

The Commission has heard that many consumers are not receiving sufficiently comprehensive treatment, care and support when they seek help because some mental health services currently do not provide this.[152] This situation is not unique to Victoria. The Productivity Commission's *Mental Health Inquiry Report* concluded that 'there was strong evidence' that integrated care is rare in Australia and that many Australians are not getting the treatment, care and support they need.[153] It is the current system, not consumers, that frequently approaches or treats mental illness and substance use or addiction as separate issues. Consumers identified this approach as inconsistent with the model of care they preferred:

> There are definite problems in the current system in dual diagnosis. So many people living with mental illness use alcohol and drugs to cope with the symptoms. They are not separate issues.[154]
>
> I became homeless, I had a couple of psych unit admissions ... What I found during that time was there was a real disconnect between health services for ... the alcohol and drug stuff, and ... mental health and I require support in both those areas.[155]

In Victoria, as in other Australian states and territories, historic separations of mental health and the alcohol and other drug sector have resulted in separate service responses for issues that are interrelated. While there have been efforts to increase coordination between these separate services, it is clear that consumers experience multiple challenges to getting integrated care. These include limited access and long wait times for integrated care options, being shuttled between multiple services or being excluded from either mental health or alcohol or other drug services.

Being unable to get integrated care can impede recovery. In its submission, the Alcohol and Drug Foundation described how this approach affects consumers:

> A person with the co-occurring conditions of an anxiety disorder and an alcohol or other drug dependency can be locked in a 'catch-22' like state where a resolution seems impossible: consequently the treatment of both disorders is required or the one condition will undermine attempts to treat the second condition. This underlines the need for treatment for both conditions to be integrated rather than taking place in 'silos' independent of each other.[156]

Service fragmentation means that consumers can frequently find themselves triaged or 'shuttling back and forth' to different services.[157] They are then treated by separate workforces for interrelated and co-occurring issues.[158] This is consistent with the experiences of consumers described in a consumer focus group held in July 2020:

> [There is a] silo effect of mental health and [alcohol and other drugs] ... I watched the crossover of people struggling with mental health and being told No, they don't fit into the [alcohol and other drug] service. So, they've [had] to go to the mental health [service] ... the lack of combination between the two is something that I feel really passionately needs to be addressed.[159]

Consumers have told the Commission that this can mean they need to tell and then retell their story multiple times to practitioners at different services:

> Everyone ends up with their sort of own focus of where they think you should be. And how they think things should be handled ... it might make things really difficult, when everything is so siloed ... if we can start to integrate more services together ... we need to be getting everyone working together on the one page.[160]

One mental health professional who participated in the mental health workforce survey, conducted by ORIMA Research on behalf of the Commission, explained that:

> There needs to be acknowledgement in the mental health system that mental illness and addiction happen concurrently, that it is difficult to separate, and the consumer should be treated for both their mental illness and addiction issues in one place, by the same clinician. There should be a 'no wrong door approach', and the consumer should not have to seek out separate services to address each issue, nor should they have to repeat their story to multiple services, especially if that story is traumatic and likely to cause the consumer more distress by repeating it.[161]

Submissions from peak addiction services emphasised that the barriers to getting integrated care can result in substantially poorer health and wellbeing outcomes for some people, particularly consumers with more complex treatment, care and support needs.[162] The VDDI stated that:

> There are several problems with the current systems approach to [people living with mental illness and substance use or addiction] ... Integrated treatment can be difficult (e.g. the person with [mental illness and substance use or addiction] might be treated through disparate systems, which can impede treatment and diagnosis) ... and the number of workers trained in [mental health and substance use or addiction] is limited.[163]

Personal story:

Kit

Kit lives in Melbourne but grew up in regional Victoria. They have experienced long-term mental health issues and dependence on methamphetamines. Kit said they were heavily dependent on drugs and not interested in engaging in treatment until they became homeless and had to find crisis accommodation. It was then that Kit started engaging with a non-residential withdrawal service. Kit said this service was very empathetic and helpful and assisted with a care plan.

The withdrawal service worked with Kit to get a psychological assessment, which recommended that a residential rehabilitation service would provide Kit with the extra support they needed to recover. Kit went to information sessions and found out about several different service options. During the process of referral and interviews with services, Kit recalls being told by an alcohol and other drug residential rehabilitation service not to disclose their history of mental illness, including previous admissions to mental health inpatient units.

> I'd been told to do that by counsellors, like, 'Do you really need to put that down? Because if you don't, it'll be easier for you to access treatment'. Essentially, because of my mental health, they believed that was going to be an impediment to access the service.

Kit was upfront during the interviews about their mental health issues and was subsequently referred for a psychiatric assessment, which recommended 'dual diagnosis' residential rehabilitation.

> I also felt that it would be the best option, but it meant that other rehabilitation services effectively turned me down.

There are a limited numbers of residential rehabilitation beds in Victoria that can treat people for both mental health issues and problems with substance use. After waiting about six months, Kit entered and completed a three-month 'dual diagnosis' residential rehabilitation program, which was able to treat both their mental health and substance use issues.

> This was the turning point for me, the beginning of my current life.
>
> I was also very sad to leave [my crisis accommodation]—the night before and the morning that I left I remember crying. I became very attached; it was a place I identified as saving my life. In the end I loved [the rehabilitation program] and cried a lot when I left there three months later. I experienced quite radical change in that time, and learnt that I had the capacity to change.

Kit explained what was different about the care provided in the residential rehabilitation service compared with other services and what had a positive impact for them.

> The nurse-to-patient ratio there was much better, with a high level of support, and there was a large multidisciplinary team. There was a real community feeling in the environment. I think the fact that it was built that way from the beginning made it really cool too. At no point did I feel like I was on a ward. It's a separate building to the hospital.

This program offered Kit their first regular contact with a psychiatrist. Before this, they had not had regular mental health treatment because they had not been considered eligible to access services like an adult mental health service. The psychiatrist also had a specialisation in addiction, which Kit said was very therapeutic in assisting their recovery in both mental health and substance use issues. The psychiatrist continued to provide treatment, care and support after discharge from the rehabilitation program.

> It was a pure fluke that I was able to continue to see this same psychiatrist after the rehabilitation, and I think this is something that should be embedded in the system.

Leaving a residential rehabilitation program can be a difficult transition, and this was particularly challenging for Kit. Having support as well as having stable housing after their discharge was really important.

> I've got a reasonably good support structure and a reasonably good routine. I'm living in transitional housing independently, with some support.

Source: Kit, *Correspondence to the RCVMHS*, 2020.

Personal story:

Michael Silva

Michael* and his family have been providing care and support to Michael's 55-year-old brother, Alan,* for more than 30 years. Alan has a diagnosis of bipolar disorder, including psychotic episodes, and experiences addiction to alcohol and other drugs.

Michael reflected that in his role as a carer he has not been able to find integrated treatment, care and support for Alan in the mental health system.

> We have never had an experience in the public mental health system of Alan being treated in an integrated way with respect to his dual diagnosis. Alan has eventually moved over to the private health sector, but even in the private health sector it's still only mental health and not integrated treatment.

Michael said he thought the mental health system was not equipped to respond to Alan's needs and found it 'rigid and inconsistent'.

> Alan's dual diagnosis meant that it was difficult for him to receive support. For example, we were once trying to give an explanation of Alan's dual diagnosis to a CAT [Crisis, Assessment and Treatment] Team. Their response was, 'We're not concerned about what the cause is. We just deal with the symptoms'.

Michael speaks of a stigma in the mental health system that Alan experienced because of his addiction and felt that he had to justify the need for Alan to be given mental health support.

> We felt that the mention of his use of illicit substances affected how people responded to the crisis. It was a situation of, 'Well, this is not really our domain. This is a drug and alcohol issue'.

The lack of integrated support for Alan has been an ongoing issue for Michael and his family. Michael said this has affected their own mental health.

> There is a lot of responsibility on the carers. My mother was not coping herself. For her, Alan's situation was a tragedy.
>
> There was a domino effect. It would start with Alan, and then my mother would become unwell herself, due to the stresses that she had. Then it would come through to me.

Michael believes access to a system providing integrated treatment, care and support would have been of great benefit to Alan and in turn help Michael and his family in their role as carers. Michael would like to see mental health and alcohol and other drug services more closely aligned.

> I think integrated treatment would give the family, us, something that we could work within ... I feel that someone in a clinical role with training in dual diagnosis may have resonated with Alan.
>
> In the ideal world, there would be the one person, who understands both sides of the coin, working with a dual-diagnosis client.

Source: *Witness statement of Michael Silva*, 22 June 2020.

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

Dr Cementon stated that, in certain cases, a failure to provide integrated care may lead to tragic outcomes for consumers:

> In the worst case scenario, there can be disputes over who takes clinical responsibility for patients with co-occurring mental illness and [alcohol and other drug] use, patients fall through these service 'gaps', and I've witnessed outcomes such as death as a consequence.[164]

Consumers and peak bodies described the experience of being 'bounced' between mental health and alcohol and other drug services, which can be detrimental to consumer wellbeing and mental health.[165] 'Bouncing' may occur because either a mental health service or an alcohol and other drug service has an exclusion policy affecting consumers.[166] One example of refusal of service is a consumer who wishes to go into alcohol and other drug rehabilitation but cannot do so because they take antipsychotic medication and the rehabilitation service has a strict no substances policy.[167] One submission summarised a common experience for consumers with co-occurring mental illness and substance use or addiction:

> A person assessed by mental health services receives feedback that before receiving any mental health service they first need to address their substance use—only then to be told by [alcohol and other drug] services that [they] first need to address their mental health concerns ... thus falling through the gaps receiving no treatment from either service.[168]

Exclusion from treatment, care and support in Victoria's mental health services can occur for a range of reasons.[169] As a result of the separate service systems, mental health services tend to focus narrowly on a consumer's mental health needs and refer a consumer with substance use or addiction needs to an alcohol or drug service, particularly if they are actively using substances.[170] Dr John Reilly, Queensland's Chief Psychiatrist, said such referrals occur, not because providing integrated care is challenging, but because there is a perception that treatment, care and support for substance use or addiction is not the responsibility of mental health services.[171]

Dr Cementon explained that a narrow understanding of service delivery also acted as a barrier to people living with mental illness or psychological distress accessing support in alcohol or other drug services:

> Dual diagnosis is traditionally not considered to be 'core business', in either mental health or [alcohol and other drug] services, and it is often seen as a reason for exclusion from treatment programmes. This may lead to patients being referred to other services, or ultimately falling through service 'gaps'.[172]

Consumers, families, carers and supporters who participated in the Commission's community consultations shared their experiences of being excluded from services. For example, one person told the Commission:

> The assessment found that he had used marijuana and therefore he could not be admitted. He was denied access due to substance use.[173]

Mr Lawrence described how excluding consumers from services creates a barrier to recovery:

> [E]ven some tertiary outreach programs to homeless people with a mental illness will not see that person if they are drug affected. The question to ask here is 'How many homeless people with a mental illness are not illicit drug users?' Not many.[174]

The alcohol and other drug sector can also experience difficulties caused by a lack of access to mental health clinical support and services for consumers with acute needs. Mr Lawrence similarly stated that:

> Many specialist mental health services will not provide support to consumers if they have [alcohol and other drug] issues. In my view, a lot of specialist psychiatric services that could offer positive change through treatment will not see a person if they are drug affected or if there is an addiction component to their presentation.[175]

The Commission heard about experiences such as these from Kit, a consumer who experienced challenges accessing integrated care, before finding an integrated service that worked for them.

Families, carers and supporters told the Commission that they also felt excluded or unseen by services and that there was often a lack of care and compassion about their needs.[176] For example, during a focus group with families, carers and supporters of people who were living, or had lived with, substance use or addiction and mental illness, participants explained that families, carers and supporters can also experience feeling excluded from services:

> My son was wanting help and [was] looking [for it] everywhere, but we were not able to get it ... alcohol [services] couldn't deal with his mental health. So we kept falling through the gaps ... we lost count of the amount of ED [emergency department] presentations, where he's been labelled as a drug addict ... but he actually wanted mental health help, because that was what was driving the drug use and the mental health, and we just couldn't get it.[177]

22.5.2 Experiences of stigma and discrimination

As described in Chapter 25: *Addressing stigma and discrimination*, people living with mental illness or psychological distress may experience stigma, where people are labelled, shamed or devalued because of negative and prejudiced stereotypes about their mental illness. They may also experience discrimination, which is unfavourable treatment on the basis of someone's personal attributes, including their mental health. People living with mental illness and substance use or addiction can be subjected to a compounded form of stigma because of pervasive negative stereotypes about people who use drugs.

Systematic reviews of Australian and international research indicate that stigma and negative attitudes about people who use substances is a well-recognised phenomenon.[178] Stigma and negative attitudes are held by society generally, and also among health professionals.[179] Common negative attitudes include that people who use substances are dangerous, unable to make decisions about their care or are to blame for experiencing addiction.[180]

As Turning Point stated in its submission to the Commission:

> the prevailing community thinking about addiction is that it is a moral condition that is self-induced, and this damaging paradigm is also applied to consumers with mental illness and co-occurring alcohol and other drug use.[181]

Stigma and shame are powerful barriers that can discourage people from seeking the treatment, care and support they need.[182] Australian research that analysed data from the National Survey of Mental Health and Wellbeing suggests that stigma is a major contributor to the delays of up to 20 years in seeking help for people with 'substance use disorders' compared with other diagnoses.[183]

Even when people do seek help and support from health services, some may experience discriminatory treatment by health professionals, undermining the treatment, care and support they receive.[184] Several witnesses described to the Commission the existence of stigma in Victoria's mental health workforce. For example, Dr Gruenert, said:

> There is particular stigma in the mental health workforce in relation to people who have problematic issues with [alcohol and other drugs]. This is depicted through the language that is often used to describe people with problematic [alcohol and other drug] issues (negative words such as 'addicts' or 'junkies' and reinforcing rare behaviour or incidences of violence).[185]

Negative stereotypes and moral judgements about substance use or addiction can undermine and influence the treatment, care and support that consumers receive in Victoria's mental health system.[186] For example, consumers described experiences of stigma and discrimination in Victoria's emergency departments:

> People say that, when they're in ED [an emergency department] ... and they see that they're there for some kind of substance abuse issue, that their energy and their approach towards the patient changes ... a lot of people feel very judged in those kind of settings ... I think just having that integrated care and support that is specific to [alcohol and other drugs] in the ED, in that entry point, might really help just to educate people who don't work in the sector ... for people who walk through the door to feel more understood and supported from the get-go, when they're in their most vulnerable state.[187]

Stigma and discrimination can no longer have any place in mental health and wellbeing services that provide integrated care. The future mental health and wellbeing system has the ability to change the way consumers access and receive mental health and alcohol and other drug services, to make it a positive experience and not one where they feel judged or ostracised for having a concurrent mental illness and addiction challenge.

The Commission's reforms relating to discrimination and stigma have a particular focus on the cultural and behavioural changes needed to eliminate such experiences in mental health services, including those that relate to people who are living with substance use or addiction.

22.5.3 Victoria's alcohol and other drug services provide treatment, care and support for consumers with complex support needs

Submissions to the Commission highlighted that severely limited access to mental health services and a lack of integrated care is placing pressure on Victoria's alcohol and other drug sector to provide treatment, care and support for consumers living with complex support needs and mental illness.[188]

Victoria's alcohol and other drug sector sees an increasing number of consumers who have complex support needs, including those relating to mental illness and psychological distress.[189] Submissions from Victoria's alcohol and other drug services have identified a range of challenges to providing treatment, care and support for people living with mental illness of psychological distress. This can cause challenges for the mental health system and other services:

> There remains a cohort of people living with [mental illness and substance use or addiction] who do not fit into either service system. These people are often too unwell to be supported in an AOD setting and not unwell enough to get access to acute or community mental health services, often leading to greater demand on emergency services, police (and corrections) or the coronial system.[190]

Submissions from Victoria's alcohol and other drug sector have stated that the sector is not resourced to provide treatment, care and support to people with complex mental health needs. Further, the alcohol and other drug sector finds it particularly challenging to gain access to specialist mental health or medical expertise such as addiction specialists or psychiatrists.[191] As a result, some services must rely on care provided by private GPs or emergency departments for consumers with complex mental health needs.[192] Windana, a drug and alcohol recovery service, identified in their submissions that:

> The [alcohol and other drug] sector would greatly benefit from more ready access to [a]ddiction [m]edicine [s]pecialists and [a]ddiction [m]edicine [p]sychiatrists.[193]
>
> [Alcohol and other drug] funding models are insufficient to support multidisciplinary teams that include more highly skilled and credentialled staff.[194]

Highlighting the challenge facing the alcohol and other drug sector to provide integrated care for consumers with complex support needs, Turning Point stated that:

> Currently, there is overwhelming demand for provision of assessment and treatment in areas of medical and psychiatric complexity, such as co-occurring pain, anxiety and addiction, heroin and depression, prescription opioid and other pharmaceutical misuse, complex trauma, alcohol and liver disease, methamphetamine and psychosis … The relative absence of a tertiary [alcohol and other drug] sector, and associated multidisciplinary team management, has a critical impact on recovery and outcomes for individuals with complex alcohol and other drug use and co-occurring mental illness.[195]

In 2018–19 the Victorian Government spent $260 million on alcohol and other drug services, compared with almost $1.6 billion on mental health services.[196] The then Department of Health and Human Services acknowledged that the current funding and service model in Victoria does not enable alcohol and other drug services to provide this integrated care unless the service is specifically designed to do so.[197] It acknowledges that this challenge is exacerbated by the barriers that consumers face when trying to access Victoria's mental health system.[198]

22.5.4 Barriers to mental health workforce capability relating to substance use or addiction

A consequence of separating alcohol and other drug services in Victoria has been reduced capability of the mental health workforce to provide treatment, care and support for people living with co-occurring substance use or addiction.[199] For example, Dr Reilly explained that Victoria's separation of mental health and alcohol and other drug services has meant that the mental health practitioners within them have not maintained the requisite skill set to offer integrated care.[200] This 'knowledge gap' means that practitioners and clinicians may not have the skills and knowledge to comprehensively deliver treatment, care and support to people with co-occurring substance use or addiction within mental health services.[201]

Professor Lubman stated that this skill deficit extends to a broad range of practitioners and clinicians, including GPs, and is due to the limited number of opportunities for the broader mental health workforce to undertake training in substance use or addiction:

> Since the 1990s across Victoria, there has been a generation of medical, nursing and allied health practitioners who have not had the opportunity to train in addiction settings or interact with Victorians in recovery, and as such, do not have the skills or knowledge to provide evidence-based care to this population, irrespective of setting. This gap in knowledge and experience has led to health practitioners having little confidence in [alcohol and other drug] interventions or the treatment system and being pessimistic, even nihilistic, in their views around treatment and recovery.[202]

Mental health services are challenged both by the capability of mental health practitioners and limited capacity to create multidisciplinary teams including alcohol and other drug or addiction-trained staff. For example, Ms Gail Bradley, Interim Operations Director of the NorthWestern Mental Health Service, stated:

> in relation to alcohol and other drugs, probably about 40 per cent of people who have a severe mental illness also have a substance misuse or dependence problem ... helping them with that problem if they want the help is a really ... important thing to be able to do, but we don't really have the capability amongst our mental health workforce ... [we] employ alcohol and other drug clinicians .... [but] in the other area mental health services within NorthWestern Mental Health [there is only] access to a 0.3 position ... It's simply not adequate.[203]

A particular challenge is the current under-supply of addiction specialists in Victoria. It is estimated that, in 2020, Victoria's fulltime-equivalent addiction specialist capability is only 16 fulltime-equivalent staff across five health services (Western Health, Turning Point at Eastern Health, St Vincent's, the Alfred, Monash Health and Ballarat).[204] Addiction specialists are medical doctors (both physicians and psychiatrists) who have advanced training in addiction, including drug and alcohol addiction. By comparison, as at June 2019, the estimated number of addiction specialists in New South Wales was 81.75 fulltime-equivalent positions, comprising 7 per cent of total alcohol and other drug workforce fulltime-equivalent roles.[205] While New South Wales has many more addiction specialists than Victoria, it is noteworthy that the Special Commission of Inquiry into Crystal Methamphetamine found that even the current levels of addiction specialists were not sufficient to meet demand for these services in that state.[206]

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22.6 The case for integrated treatment, care and support for mental illness and substance use or addiction

There are many benefits to offering integrated treatment, care and support for people living with mental illness and substance use or addiction.

22.6.1 Removing the barriers to comprehensive mental health care

One of the Commission's guiding principles is that Victoria's future mental health and wellbeing system will ensure that:

> Comprehensive mental health treatment, care and support services are provided on an equitable basis to those who need them.[207]

Equitable access to health care is recognised as a human right that allows people to enjoy the best health possible.[208] Realising this right requires continuous work from governments to ensure barriers to care for certain groups of consumers are identified and dealt with.[209] This is particularly important where people with lived experience of mental illness or psychological distress are marginalised or excluded—for example, due to discrimination—from accessing health care. Barriers to accessing health care also include services that do not provide integrated care for people with more complex support needs.

In the future, Victorians who experience both mental illness and substance use or addiction will receive integrated and comprehensive treatment, care and support. Substance use or addiction will not be a barrier to getting mental health treatment, care and support. Mental illness will not be a barrier to getting treatment, care and support for substance use or addiction. This will help to realise the right to health for this group of consumers and will be necessary to fulfill the Commission's vision for Victoria's mental health and wellbeing system.

Case study:

Te Wairua (Odyssey New Zealand)

Odyssey New Zealand runs residential and community services that offer supportive peer environments for adults, young people and extended families to build on their existing strengths and learn new skills that enable long-term recovery from drug, alcohol and other addiction challenges.

Odyssey operates Te Wairua, a residential service for adults seeking support with mental health and addiction issues. There are three Te Wairua services, two in Auckland and one in Whangarei, and each offers a hopeful, compassionate environment in a small residential setting accommodating 11–19 people. During their stay, residents are supported to develop skills and strategies to manage their emotional, spiritual, physical and social wellbeing to help with their recovery.

Jenny Boyle, General Manager of Operations at Odyssey, said Te Wairua provides services to people who require specialised mental health support in addition to general alcohol and other drug services.

> Te Wairua offers an option for people who may be living with moderate to severe mental health issues, who would benefit from a residential stay to support them with their addiction challenges.

Ms Boyle said the program is based on a treatment approach called a therapeutic community, with the service provided in a home-like environment in a residential area.

> Everyone who lives or works in our therapeutic community lives by a set of shared values, known as our pillars. These are trust, honesty, responsibility, concern and love. Learning occurs in the way everyone lives and works together as residents and staff, and in the roles and responsibilities shared across the community. It's all about helping people gain skills to be more in control of their life, free from drug, alcohol or other addiction challenges.

Ms Boyle said routine is critical to the success of the program. Each house follows a timetable of scheduled jobs, activities and group sessions, as well as time for recreation or relaxation.

> We offer a range of supportive, evidence-based interventions, as well as creative, social, cultural and outdoor activities, such as kapa haka [traditional Māori performance] or other tikanga Māori [customary practices or behaviours] study and practice. There are also work training programs available.

DOH.0003.0001.0777

Photo credit: Odyssey New Zealand

Residents are able to stay in the program for a number of months and Odyssey works in partnership with other community agencies to ensure they are supported before, during and after their stay.

Residents have noted the program has helped them recover and to change their behaviour. One resident said:

> All the connections I need in my life to have a healthy lifestyle are back in my life and I'm starting to see the person I used to be, but an even better version. I'm a better mother, a better person. I've found that love and acceptance of myself. I like that.

Source: Odyssey, 'Te Wairua' <www.odyssey.org.nz/our-services/pakeke/te-wairua> [accessed 19 October 2020]; *Visit to Odyssey House with Commissioner Armytage*, 17 September 2019.

Case study:

ReGen (Uniting)

Uniting's ReGen service aims to reduce the harm from problematic alcohol and other drug (AOD) use and promote health and wellbeing. ReGen has grown from being a specific AOD service into an integrated AOD and mental health service.

Laurence Alvis, Uniting's General Manager, Alcohol and Other Drug and Mental Health, spoke of the importance of integrating both services:

> We previously were an AOD specific service which found it very frustrating not to have integrated mental health services. There is a strong interaction of our clients, around 70 per cent would have both mental health and AOD issues.

The integration of support services at both service delivery and governance levels is an area that continues to be a focus for Uniting more broadly. Mr Alvis said:

> The exciting part of Uniting merging AOD and mental health, is that in solving AOD issues, you can address the co-existing issues for clients. That is where we see the key opportunities going forward.

ReGen determined that without joint treatment, care and support people would pass through the treatment for AOD but would return repeatedly. Mr Alvis said the integration breaks down siloed approaches to services, and when they started working with everyone together, 'normal stresses under normal life circumstances didn't push people into addiction again'.

The provision of an integrated AOD and mental health service also supports a good relationship with local clinical mental health services, again supporting a more holistic service for consumers.

A psychiatric registrar comes into ReGen's youth and adult residential withdrawal programs to support consumers and staff and for secondary consultation. Mr Alvis notes the importance of leadership in both organisations recognising the links between AOD and mental health services:

> This partnership is based on a strong relationship with Northern and NorthWestern Mental Health services. It has been great having leaders who recognise that AOD is a critical part of mental health and see there is a benefit to the clientele of continued collaboration.

DOH.0003.0001.0779

ReGen also offers a long-term non-residential program that is targeted at those with severe AOD, mental health and homelessness issues. This supports consistency of clinicians throughout a person's rehabilitation journey. According to Mr Alvis, this builds trust, reduces the risk of dropping out and enables ReGen to comprehensively address a range of issues over a longer period of time.

In addition, ReGen is a registered training organisation that offers training opportunities for AOD workers and provides free courses for consumers and carers, including court and drink drive referrals.

To support ReGen's integrated approach, staff are trained across both AOD and mental health sectors. All AOD workers complete three mental health competencies, as well as forensic and family violence competencies, in order to provide holistic support.

Source: Uniting ReGen meeting with Commissioners Armytage, Cockram and Fels, 16 April 2020.

22.6.2 Integrated care for better mental health and wellbeing outcomes

Several witnesses who gave evidence stated that, in their professional experience, integrated approaches to treatment, care and support are internationally recognised as delivering the best consumer outcomes, including increased likelihood of recovery and improved mental health.[210] The Commission has heard that:

> People should expect to receive treatment that reflects their needs, rather than conceptualising them as an assortment of conditions that need to be compartmentalised and referred off to multiple providers for treatment.[211]

Consumers who engaged with the Commission also expressed a preference for integrated care.[212] Consumers, families, carers and supporters commonly expressed a preference for compassionate, empowering and stigma-free service delivery that is welcoming, recognises co-occurring needs, is person-centred and has a strong focus on peer and lived experience support.[213]

For many consumers, integrated treatment, care and support is likely to support better health and wellbeing outcomes.[214] Mr Symonds told the Commission that integrated care can:

> ensure internally consistent treatment with common objectives, which can explore the complex relationship between conditions. This single point of contact reduces the burden on the individual, along with potential communication problems and discordant treatment philosophies, reducing the chance of clients falling through treatment gaps.[215]

In addition to being a recommendation of the Productivity Commission *Mental Health Inquiry Report*, integrated treatment, care and support is also recommended by Australia's Fifth National Mental Health and Suicide Prevention Plan.[216] The National Drug Strategy has also emphasised the importance of service collaboration and coordination to ensure that the most appropriate treatment and support is offered to consumers.[217]

Integrated care for mental health and substance use or addiction is an approach widely adopted in other countries (such as Canada) as well as certain services in Queensland, a state where mental health and alcohol and other drug services are integrated at the policy and governance levels.[218]

One such service, profiled in a case study in this chapter, is New Zealand's Te Wairua (Odyssey House), which offers integrated care for people with addiction and mental illness.

Another international example of integrated service delivery is a new centre for mental health, addiction treatment and research that will open in 2021 in British Columbia, Canada, to treat people who live with the most severe, complex mental illness and substance use or addiction. The service, which is called the Red Fish Healing Centre, is in part a response to British Columbia's opioid crisis. The 105-bed facility will offer a therapeutic, trauma-informed space and healthcare model to respond to the many needs of a person's recovery journey. It is envisaged that people will usually stay in the centre for six to nine months. The new service will help people learn how they can live a life that is meaningful to them and help with their eventual transition to care in their home communities.[219]

The therapeutic design of the centre features private single rooms with bathrooms, adjustable lighting to help people who don't have standard sleep cycles, and a considered use of textures and colours to support a calm, healing environment. The facility will also feature dedicated spaces for research and education, as well as virtual technologies to provide specialised services. The entire centre will be virtually enabled, including a multipurpose room for community events, allowing patients, families, caregivers and educators across the province to connect.[220]

Trauma-informed practice has been integrated at every level of the centre's design so the multidisciplinary teams of physicians, clinical and support staff are all sensitive to the effects of trauma, and work to avoid re-traumatisation. The centre was developed in close consultation with staff, clients and their families.[221]

In the United States, the influential work of Christie Cline and Kenneth Minkoff has emphasised the need for health services to provide a 'welcoming, accessible, integrated, continuous and comprehensive system of care that can support an array of evidence-based and consensus-based best practices for individuals'.[222]

Several systematic reviews have indicated that integrated care offered in different settings is associated with better outcomes for consumers in certain situations, including:

- better participation in care and treatment programs and interactions with services[223]
- less substance use and improvements in mental health symptoms[224]
- other indicators of wellbeing, including improved quality of life and decreased risk of homelessness or interaction with the justice system.[225]

22.6.3 Integrated services in Victoria

The Commission has observed that a number of services in Victoria currently provide integrated treatment, care and support. In addition, some area mental health services employ clinicians and other practitioners who provide 'dual diagnosis services' or other coordination roles.[226] There are also partnerships between alcohol and other drug and mental health services, services that employ multidisciplinary teams, or services that have merged their mental health and alcohol and other drug units.[227] Often, these services are in the community health or non-government sectors. One such service is Uniting ReGen (refer to Uniting ReGen case study).

22.7 The future system: providing integrated treatment, care and support for mental illness and substance use or addiction

Victoria's future mental health and wellbeing system will be a responsive and integrated system that focuses on providing treatment, care and support through new models of care in the community. Integrated care for substance use or addiction will be a core function of mental health and wellbeing services for young people, adults and older adults. It will also be an expectation of Victoria's emergency departments, including the new Mental Health and Wellbeing Crisis Hubs located in each region. For consumers who need to find community or hospital bed-based care, integrated care for co-occurring substance use or addiction will be provided alongside mental health treatments and therapeutic interventions.

Stakeholders from a broad range of sectors have recommended that the Commission create the necessary reforms to provide consumers with integrated treatment, care and support.[228] However, the Commission acknowledges that different stakeholders have different perspectives about *how* integration should be achieved. Broadly, these perspectives are:

- **full system integration**—integration of mental health services and the entire alcohol and other drug sector in Victoria, including shared governance and funding[229]
- **service integration**—integration of treatment, care and support offered in mental health services while retaining a separate alcohol and other drug sector in Victoria[230]
- **increased service linkage**—enabling increased coordination and collaboration between mental health and alcohol and other drug services, such as stronger referral pathways.[231]

These differences were also apparent in a public hearing panel on how to support people living with mental illness and substance use or addiction, where expert participants advocated for different approaches to achieving greater integration of care.[232] Although there are diverse views about how this should be achieved, the Commission notes that, overall, there is agreement that a greater degree of integration of care is critical for people living with mental illness and substance use or addiction.

The Commission has therefore chosen to focus on which reforms can deliver an experience of integrated care for consumers in Victoria's mental health and wellbeing system. This approach to integration focuses on how services can best respond to the needs of consumers and aligns with the approach recommended by global experts on mental illness and substance use or addiction:

> Any process by which mental health, and alcohol and other drug services are appropriately integrated or combined at either the level of direct contact with the individual client with [co-occurring needs] or between providers or programs serving these individuals ... Integrated services can be provided by an individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or an organised program in which all clinicians or teams provide appropriately integrated services to all clients.[233]

As set out in Figure 22.10, in the future system consumers will access treatment, care and support across a variety of settings, in accordance with the intensity of their needs and preferences. The figure shows that the future system retains an important role for the standalone alcohol and other drug sector, separate to the mental health and wellbeing system. However, the future system would not expect alcohol and other drug providers to be supporting people with high-intensity mental health support needs generally, and certainly not without support from mental health and wellbeing services. Instead people requiring high-intensity mental health treatment, care and support (who are sometimes described as having 'severe' mental illness) will have their comprehensive needs met by Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services. Specifically, the Commission expects that Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will offer integrated treatment, care and support that includes support for substance use or addiction.

This approach aligns with the thinking in the 'quadrant of care approach' used by Queensland Health.[234] It is also used by the United States Department of Health and Human Services in planning its services for people living with mental illness and substance use or addiction.[235] It is designed to assist different services across an entire health system by providing 'guidance for the level of service coordination (defined as consultation, collaboration, or integration) needed to improve consumer outcomes' and to 'facilitate improvements in coordinated care across the mental health and alcohol and other drug treatment sectors'.[236] Although they have limitations, such models can help in planning a system that can respond to the different needs of people living with mental illness and substance use or addiction.[237] In Queensland, which integrates mental health and substance use or addiction care at the system-wide level, the model has been accompanied by an expectation that the mental health system offers treatment, care and support for people living with substance use or addiction.[238]

The approach also shows that at several points in the system, secondary consultation should be used to support people to continue to get treatment, care and support without them having to be referred or 'handed over' to a different provider. This includes Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services providing support to alcohol and other drug providers and the new statewide service for mental health, substance use or addiction (described in this chapter) providing support to Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services.

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Figure 22.10: Continuum of care for people living with mental illness and substance use or addiction in the responsive and integrated care system

22.7.1 Approaches to implementing integrated treatment, care and support

Victoria has existing mental health and alcohol and other drug services across the state. These services have developed to meet the needs of local communities over time. With this in mind, the Commission has determined not to prescribe a single model of integrated care. This choice also recognises that in Victoria there are already existing integrated services of the kinds described in Table 22.1, currently offering integrated treatment, care and support.

Different models can successfully deliver integrated care through configurations that respond to the needs of local communities. Adapting services to the local context is essential when designing and implementing responsive mental health and wellbeing services.[239]

The Commission's expectation is for integrated care to be provided by all Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, for people of all ages. This includes young people who access Youth Local Mental Health and Wellbeing Services and the service stream of Youth Area Mental Health and Wellbeing Services, which is a substantial shift in the current model of mental health treatment, care and support for young people and is described in Chapter 13: *Supporting the mental health and wellbeing of young people*. To decide the approach taken by each Local Mental Health and Wellbeing Service and Area Mental Health and Wellbeing Service, services will be assisted by Regional Mental Health and Wellbeing Boards, described in detail in Chapter 5: *A responsive and integrated system*. Regional Mental Health and Wellbeing Boards will commission the providers of those services using set criteria, which will allow local providers to assess the best of the above integration approaches for their community and service context.

The Commission expects that regardless of the model of integration adopted by each service, each will deliver integrated treatment, care and support that comprehensively meets the needs of consumers in those services specifically. This will be care that is simultaneous, empathetic and matched to the level of need of the consumer and delivered in a timely and coordinated way.

This includes the expectation that Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will provide culturally appropriate treatment, care and support that is responsive to the needs of diverse consumers, and is described in further detail in Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population*. In particular, these services will provide integrated treatment, care and support that is appropriate to the needs and preferences of Aboriginal consumers. This may include models of integrated care formed through partnerships with Aboriginal controlled community health organisations, or alcohol and other drug services for Aboriginal Victorians.

In order to implement the delivery of integrated treatment, care and support, the Commission expects that Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will achieve integration through one or more of the three models outlined in Table 22.1. Importantly, consumers should not be 'bounced' between different services or practitioners.[240] As the World Health Organization states, '[t]ruly integrated care involves more than co-locating health workers with diverse specialties into the same building.'[241] Therefore, across all three approaches, care coordination will play a vital role in delivering integrated care. While Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will have the flexibility to decide which implementation model best meets the needs of their local communities, mental health and wellbeing services will be accountable for delivering integrated treatment, care and support for substance use or addiction.

Table 22.1: Models for implementing integrated treatment, care and support in Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services

Model 1: Multidisciplinary teams Practitioners and clinicians, as well as peer workers, provide integrated care in a single service setting. There is a high degree of collaboration and coordination to deliver consumer care.	For example, in an acute bed-based service, multidisciplinary teams such as mental health nurses, addiction medicine specialists, psychiatrists, lived experience workers, social workers and other allied health workers work together in an integrated way to deliver treatment, care and support. An example of care provided by multidisciplinary teams is that delivered by First Step (mentioned throughout this chapter). First Step's model of care involves multidisciplinary practitioners and clinicians working together to deliver care in a single setting. The team includes GPs, an addiction specialist physician, nurses (including mental health nurses), lawyers, clinical and counselling psychologists and a psychiatrist.[242]
Model 2: Co-location and care coordination partnerships Different services physically co-locate and deliver coordinated care.	For example, in a community mental health service, a mental health service and a non-government provider of alcohol and other drug services physically co-locate. Through care coordination and single care planning, they deliver the integrated services needed to meet the consumer's needs. Regular case conferencing and shared consumer records and information enable seamless and coordinated care, where all care providers work towards joint care goals. Care coordination and shared information systems are critical components in this model.
Model 3: Service delivery partnerships A mental health service partners with another care provider, such as a non-government organisation, to deliver some aspects of the consumer's care within the mental health service.	For example, in a community bed-based service, the mental health service could partner with a non-government organisation to provide peer-support workers or counselling for consumers with substance use issues or addiction, delivered in the mental health service. An example of this is community health organisation cohealth's Homeless Outreach Mental Health Service. This service is located at cohealth's Melbourne CBD site and involves a range of partner organisations (Inner West area mental health service, Launch Housing and McAuley Services for Women) that work together to deliver integrated care to people experiencing homelessness, mental health and other complex support needs.[243] Cohealth itself offers a range of services for people who use substances: health care, drug and alcohol counselling, needle exchange and non-residential withdrawal nursing services.

The Commission also acknowledges that some contributors, particularly those representing Victoria's alcohol and other drug sector, have cautioned that where mental health and alcohol and other drug services are integrated 'mental health becomes the dominant approach and services become more clinical. This does not work for [alcohol and other drug] services'.[244]

It will be critical to ensure that the strengths of Victoria's alcohol and other drug sector are retained in any future integration, including within individual services. Integration should not come at the expense of the consumer-centred model of care that Victoria's alcohol and other drug sector has been able to develop over many years. This will require the leaders of mental health services to recognise and support integrated care as core business:

> The first thing that is required in order to achieve integrated care is clinical leadership to drive cultural change. Responding to people with dual diagnosis with integrated care must be recognised as 'core business'.[245]

The Commission intends that the strengths of the alcohol and other drug sector be retained and suggests that integration through partnerships and consortiums be considered as ways to enable this.

22.8 Supporting the system to provide integrated treatment, care and support for mental illness and substance use or addiction

Achieving integrated care for consumers in some mental health services will be relatively straightforward because integrated care is already provided. Other services will deliver integrated care through newly created partnerships with alcohol and other drug service providers, while others will choose to expand their workforce to create multidisciplinary teams. Each of these approaches to integrated care is valid, provided that all Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services:

- comprehensively meet the needs of consumers living with mental illness and substance use or addiction at that service by offering integrated care to consumers of all ages by the end of 2022
- ensure no consumers are excluded from getting mental health treatment, care and support on the basis that they also need support for substance use or addiction
- have the right practitioners and clinicians to provide integrated care, which can be achieved through multidisciplinary teams, partnerships between services or co-location of services.

The transition of Victoria's mental health services to providing integrated care to consumers will require support, including:

- establishing, funding and supporting a new statewide service for mental health, substance use or addiction to provide expert support to mental health services and alcohol and other drug services—this should be built on the foundations established by the Victorian Dual Diagnosis Initiative
- ensuring the strengths of the Victorian alcohol and other drug sector's approach to care are adopted and retained in mental health services that provide integrated care, including the role of peer workers
- responding to the under-supply of addiction specialists in Victoria, including by increasing the number of addiction specialists and exploring joint Commonwealth–state opportunities for funded addiction specialist trainee positions in Victoria.

22.8.1 A new statewide service for mental health and substance use or addiction

Victoria currently has two statewide services for co-occurring mental illness and substance use or addiction, as well as a statewide service that provides 'dual diagnosis' support to both mental health and alcohol and other drug services (described earlier).

However, the Commission considers that it is necessary for the Victorian Government to establish a new statewide service to support the future responsive and integrated system.

It is the Commission's view that this service be built on the foundations established by the Victorian Dual Diagnosis Initiative.

This statewide service will work closely with the Collaborative Centre for Mental Health and Wellbeing, in particular in relation to translational research and workforce training and education. The main functions of this service are to support Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services across age-based systems to deliver integrated treatment, care and support. It will also provide secondary consultation to alcohol and other drug services, who will continue to play an important role in supporting some consumers with less complex mental health support needs. However, it is also expected that for a very small number of consumers with the most intensive and complex support needs, the statewide service will provide direct treatment, care and support through primary consultation.

This new statewide service will provide the necessary support to mental health and wellbeing services and play an important role in increasing Victoria's capability to support people with mental illness and substance use or addiction. Chapter 5: *A responsive and integrated system*, outlines the Commission's approach to statewide services in the future. In line with the service delivery models outlined in that chapter, the new statewide service will adopt a combination of 'capability uplift', 'direct service provision' and 'hub-and-spoke' models, in order to perform the following functions:

- **research**—this will ensure continuous improvement and best practice. It is expected that the new statewide service will lead research into substance use or addiction and mental health, as well as research into optimal ways of delivering integrated care in Victoria for people who have mental health needs and substance use or addiction needs
- **training and education**—this will increase the substance use or addiction and mental health capability of practitioners and clinicians across Victoria's mental health and alcohol and other drug services. It is expected that a broad range of practitioners and clinicians will be able to take training in substance use or addiction and mental health, with a focus on optimal delivery of integrated care
- **supporting consumers with the most complex support needs**—the service will provide primary consultation to consumers with the most complex support needs in Area Mental Health and Wellbeing Services. Primary consultation can be done in person, or virtually if appropriate.
- **supporting practitioners and clinicians**—the service will provide secondary consultation to mental health and wellbeing practitioners and clinicians working in Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services, as well as in alcohol and other drug services. This can be in person or virtually, particularly when considering the needs of rural or regional services.

The Commission highlights the role that the Victorian Dual Diagnosis Initiative has played over many years in increasing coordination and collaboration between mental health and alcohol and other drug services.[246] This initiative was designed to create links with related agencies including primary care, family violence and homelessness services.[247] The initiative has been central to building 'dual diagnosis capability' across services in Victoria.[248]

The Commission considers that the expertise of practitioners and clinicians who deliver the initiative will be invaluable to supporting the transition to integrated care delivered in mental health services and suggests that the expertise of those involved in the initiative continue to be a feature in the new statewide service.

22.8.2 Increasing the number of addiction specialists in Victoria

Victoria's 2015 *Ice Action Plan* identified a need to strengthen Victoria's addiction medicine capability.[249] Since 2016, Turning Point has undertaken work to increase the number of addiction specialists.[250] This work has included a review of Victoria's addiction specialist workforce and its sustainability, as well as analysing workforce models that may assist this process, such as that used in the Hunter New England region of New South Wales.

Addiction specialists are medical doctors (both physicians and psychiatrists) who have advanced training in addiction, including drug and alcohol addiction. For physicians, this is Advanced Training in Addiction Medicine and for psychiatrists, this is Advanced Training in Addiction Psychiatry. Addiction specialists provide care to consumers with complex needs, such as alcohol or opioid dependence. They also play an important role in training, mentoring and advising other health professionals, such as general practitioners or other physicians and psychiatrists about addiction medicine, including through secondary consultation.[251] Addiction specialists also provide consultation liaison services in hospitals, where they provide advice on care and best clinical management for people with substance use issues, such as in emergency departments, and enhance the knowledge of general hospital staff in addiction and substance use.[252]

The Commission has heard that to increase the number of addiction medicine specialists, more trainees are needed. Several submissions noted that Victoria has more limited addiction medicine training opportunities than any other state:

> The numbers of trainees and qualified addiction specialists are particularly low in Victoria due to a chronic lack of investment in training and specialist positions: New South Wales, by way of contrast, has almost six times the numbers of addiction doctors in training as Victoria, as well as funded addiction specialist positions within each health service.[253]

The project run by Turning Point has resulted in an increase in the number of addiction specialists and trainees. Turning Point has estimated that due to an increase in the number of addiction medicine trainees, by 2021 Victoria's capability will increase to 18 trainees.[254] Turning Point's project has also increased the number of accredited training sites for addiction medicine trainees from four to 11 hospital sites.[255]

The Commission acknowledges the outcomes of this project, which have demonstrably increased both the number of training sites and the number of trainees in addiction medicine. Victoria's new approach to providing integrated care requires that there are enough addiction specialists in its public health system. In light of this, and Victoria's current under-supply of addiction specialists, the Commission recommends that the Victorian Government, as a priority, increases the number of addiction specialists in Victoria.

The Victorian Government should also work with the Commonwealth to explore options for funding trainee positions, as well as funded opportunities for GPs to increase their addiction knowledge and skills through training. The importance of collaboration between the Victorian Government and the Commonwealth to secure the appropriate workforce supply, including of addiction specialists, is explored in Chapter 33: *A sustainable workforce for the future*.

1 Kenneth Minkoff and Christie A. Cline, Developing Welcoming Systems for Individuals with Co-Occurring Disorders: The Role of the Comprehensive Continuous Integrated System of Care Model, *Journal of Dual Diagnosis*, 1.1 (2005), 65–89 (p. 71).

2 Minkoff and Cline, p. 67; Robert E Drake and others, Implementing Dual Diagnosis Services for Clients With Severe Mental Illness, *Psychiatric Services*, 52.4 (2001), 469–476 (p. 471); Christina Marel and others, *Guidelines on the Management of Co-Occurring Alcohol and Other Drug and Mental Health Conditions in Alcohol and Other Drug Treatment Settings*, 2016, p. 98.

3 Orygen, The National Centre of Excellence in Youth Mental Health, *Two At A Time: Alcohol and Other Drug Use by Young People with a Mental Illness*, 2016, p. 24–25.

4 Marel and others, p. 14; Alcohol and Drug Foundation, *Submission to the RCVMHS: SUB.0002.0029.0412*, 2019, p. 9.

5 Self Help Addiction Resource Centre, *Submission to the RCVMHS: SUB.0002.0027.0003*, 2019, p. 6.

6 RCVMHS, *Consumer Human-Centred Design Focus Group—Alcohol and Other Drugs: Record of Proceedings*, 2020.

7 *Witness Statement of Catherine White*, 2 July 2020, para. 9.

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

9 Alcohol and Drug Foundation, p. 9.

10 New South Wales Department of Health, *NSW Clinical Guidelines for the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings*, 2009, p. 18.

11 Windana Drug and Alcohol Recovery, *Submission to the RCVMHS: SUB.0002.0029.0393*, 2019, p. 6–7.

12 *Evidence of Associate Professor Dean Stevenson*, 10 July 2019, p. 606.

13 *Witness Statement of Dr Enrico Cementon*, 25 May 2020, para. 61.

14 *Evidence of Associate Professor Simon Stafrace*, 8 July 2019, pp. 399–400.

15 RCVMHS, *Consumer Human Centred Design Focus Group—Alcohol and Other Drugs: Record of Proceedings*.

16 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, 2020, p. 655.

17 Productivity Commission, p. 653.

18 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, 2019, para. I(5).

19 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, para. I(5).

20 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, para. I(5).

21 Commonwealth Department of Health, *National Drug Strategy 2017–2026*, 2017, p. 4–5.

22 Commonwealth Department of Health, p. 6.

23 Commonwealth Department of Health, p. 6.

24 Commonwealth Department of Health, p. 6–7.

25 Commonwealth Department of Health, p. 13.

26 Commonwealth Department of Health, p. 11–12.

27 Commonwealth Department of Health, p. 9.

28 Commonwealth Department of Health, p. 9.

29 Commonwealth Department of Health, p. 9.

30 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, para. I(5).

31 Victorian Government, Royal Commission into Victoria's Mental Health System—Letters Patent, para. I(5).

32 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 5.

33 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 5.

34 Department of Health and Human Services, Dual Diagnosis Residential Rehabilitation: Information about This New Specialist Treatment Option, 2018, p. 2; Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, 2019, p. 8.

35 *Witness Statement of Dr Enrico Cementon*, paras. 53–56.

36 *Witness Statement of Professor Dan Lubman*, 28 May 2020, para. 13.

37 *Witness Statement of Professor Dan Lubman*, para. 14.

38 Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results 2007*, p. 11.

39 *Witness Statement of Dr Enrico Cementon*, para. 63.

40 Alcohol and Drug Foundation, Association of Participating Service Users, Harm Reduction Victoria, Penington Institute and Department of Health and Human Services, *The Power of Words: Having Alcohol and Other Drug Conversations: A Practical Guide*, 2020, p. 4.

41 Alcohol and Drug Foundation, Association of Participating Service Users, Harm Reduction Victoria, Penington Institute and Department of Health and Human Services, p. 4.

42 *Evidence of Dr Stefan Gruenert*, 18 June 2020, p. 16.

43 Gary Croton, *Submission to the RCVMHS: SUB.2000.0001.0799*, 2019, p. 17; *Witness Statement of Gary Croton*, 21 May 2020, para. 71(b).

44 Croton, p. 17.

45 *Witness Statement of Patrick Lawrence*, 28 May 2020, para. 42.

46 Marel and others, p. 6; Turning Point, *Submission to the RCVMHS: SUB.0002.0028.0533*, 2019, p. 8.

47 Turning Point, *Submission to the RCVMHS: SUB.0002.0028.0533*, p. 8; Marel and others, p. 9.

48 L.M. Squeglia, J. Jacobus and S.F. Tapert, The Influence of Substance Use on Adolescent Brain Development, *Clinical EEG and Neuroscience*, 40.1 (2009), 1–16 (p. 10); Rebecca Kuepper and others, Continued Cannabis Use and Risk of Incidence and Persistence of Psychotic Symptoms: 10 Year Follow-up Cohort Study, *BMJ*, 342:d738 (2011), 1–8 (p. 7); Gabriella Gobbi and others, Association of Cannabis Use in Adolescence and Risk of Depression, Anxiety, and Suicidality in Young Adulthood: A Systematic Review and Meta-Analysis, *JAMA Psychiatry*, 76.4 (2019), 426–434 (p. 431).

49 Paola Pedrelli and others, Alcohol Use and Depression During Adolescence and Young Adulthood: A Summary and Interpretation of Mixed Findings, *Current Addiction Reports*, 3.1 (2016), 91–97 (p. 96); Yasmin L. Hurd and others, Cannabis and the Developing Brain: Insights into Its Long-Lasting Effects, *The Journal of Neuroscience*, 39.42 (2019), 8250–8258 (p. 8255).

50 Turning Point and Rethink Severe Mental Illness, London, *Dual Diagnosis Toolkit, Mental Health and Substance Misuse: A Practical Guide for Professionals and Practitioners*, 2004, p. 10.

51 Marel and others, p. 70.

52 Marel and others, p. 70; *Evidence of Dr Ravi Bhat*, 15 July 2019, p. 970; Alcohol and Drug Foundation, p. 5.

53 *Witness Statement of Patrick Lawrence*, para. 41; *Witness Statement of Dr Enrico Cementon*, para. 40; *Witness Statement of Professor Dan Lubman*, para. 107.

54 *Evidence of Professor Dan Lubman*, 18 June 2020, p. 8.

55 Australian Institute of Health and Welfare, *Australian Burden of Disease Study: Impact and Causes of Illness and Death in Aboriginal and Torres Strait Islander People 2011*, 2016, p. 98.

56 Ariane Marie-Mitchell and Rashel Kostolansky, A Systematic Review of Trials to Improve Child Outcomes Associated With Adverse Childhood Experiences, *American Journal of Preventive Medicine*, 56.5 (2019), 756–764 (pp. 756–757).

57 Commission for Children and Young People Victoria, *Submission to the RCVMHS: SUB.1000.0002.0002*, 2019, p. 6.

58 Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed Findings*, Drug Statistics Series No.31. Cat No. PHE 214 (Australian Institute of Health and Welfare, 2017), pp. 111-113.

59 Australian Institute of Health and Welfare, Alcohol, Tobacco and Other Drugs in Australia: People with Mental Health Conditions, 2020, p. 1.

60 Australian Institute of Health and Welfare, Alcohol, Tobacco and Other Drugs in Australia: People with Mental Health Conditions, p. 1.

61 Turning Point and Rethink Severe Mental Illness, London, p. 3.

62 Turning Point and Rethink Severe Mental Illness, London, p. 3.

63 *Witness Statement of Dr Enrico Cementon*, para. 79.

64 *Witness Statement of Dr Enrico Cementon*, para. 79.

65 Katherine Mills and others, *Submission to the Productivity Commission Inquiry into Mental Health: Lessening the Burden of Comorbid Substance Use and Mental Disorders Through Evidence-Based Care: The Case for a National Minimum Qualifications Strategy*, 2019, p. 8.

66 Mills and others, p. 7.

67 Marel and others, p. 14.

68 Alcohol and Drug Foundation, p. 5.

69 Commonwealth Department of Health, *National Drug Strategy 2017–2026*, p. 27; National Institute on Drug Abuse, *Common Comorbidities with Substance Use Disorders Research Report*, 2020, p. 12.

70 Jasmin Grigg and others, *Methamphetamine Treatment Guidelines: Practice Guidelines for Health Professionals (Second Edition)*, 2018, pp. 43 and 68–69.

71 *Witness Statement of Dr Enrico Cementon*, para. 32.

72 *Witness Statement of Dr Enrico Cementon*, para. 32.

73 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 26.

74 Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results 2007: Tables 1–15*, 2008, Table 8.

75 Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results 2007: Tables 1–15*, 2008, Table 10.

76 Marel and others, pp. 11–12.

77 Marel and others, pp. 11–12.

78 Minkoff and Cline, p. 71.

79 Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2019: Illicit Use of Drugs*, 2020, p. 1.

80 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 176.

81 Department of Health and Human Services, Integrated Data Resource, Victorian Alcohol and Drug Collection 2018–19. Note that 'sedatives' includes alcohol, which accounts for approximately 33 per cent of all consumers.

82 Penington Institute, *Submission to the RCVMHS: SUB.0002.0028.0019*, 2019, p. 44; Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2019: Illicit Use of Drugs*, p. 2.

83 Rebecca McKetin and others, Mental Health Outcomes Associated with the Use of Amphetamines: A Systematic Review and Meta-Analysis, *EClinicalMedicine*, 16 (2019), 81–97 (pp. 83–93).

84 McKetin and others, p. 93.

85 The Commission, *Special Commission of Inquiry into Crystal Methamphetamine and Other Amphetamine-Type Stimulants Report, Volume 1A*, 2020, p. 37.

86 Marie Gerdtz and others, Prevalence of Illicit Substance Use among Patients Presenting to the Emergency Department with Acute Behavioural Disturbance: Rapid Point-of-care Saliva Screening, *Emergency Medicine Australasia*, 32.3 (2020), 473–480 (pp. 475-478).

87 Brian McKenna and others, Association of Methamphetamine Use and Restrictive Interventions in an Acute Adult Inpatient Mental Health Unit: A Retrospective Cohort Study, *International Journal of Mental Health Nursing*, 26.1 (2017), 49–55 (p. 51).

88 *Evidence of Associate Professor Ruth Vine*, 8 July 2019, p. 416.

89 *Witness Statement of Professor David Castle*, 29 May 2020, p. 39; *Evidence of Professor Dan Lubman*, p. 43.

90 The Commission, *Special Commission of Inquiry into Crystal Methamphetamine and Other Amphetamine-Type Stimulants Report, Volume 1A*, p. 497.

91 McKetin and others, p. 91.

92 The Commission, *Special Commission of Inquiry into Crystal Methamphetamine and Other Amphetamine-Type Stimulants Report, Volume 1A*, p. 37.

93 The Commission, *Special Commission of Inquiry into Crystal Methamphetamine and Other Amphetamine-Type Stimulants Report, Volume 1A*, p. 506.

94 The Commission, *Special Commission of Inquiry into Crystal Methamphetamine and Other Amphetamine-Type Stimulants Report, Volume 1A*, p. 506.

95 The Commission, *Special Commission of Inquiry into Crystal Methamphetamine and Other Amphetamine-Type Stimulants Report, Volume 1A*, pp. 509–510.

96 The Commission, *Special Commission of Inquiry into Crystal Methamphetamine and Other Amphetamine-Type Stimulants Report, Volume 1A*, pp. 508–509; for further information about these units refer to George Braitberg and others, Behavioural Assessment Unit Improves Outcomes for Patients with Complex Psychosocial Needs, *Emergency Medicine Australasia*, 30.3 (2018), pp. 353–358.

97 Grigg and others, p. 93.

98 Grigg and others, p. 98.

99 Law Reform, Drugs and Crime Prevention Committee, *Inquiry into the Supply and Use of Methamphetamines, Particularly Ice, in Victoria: Ballarat*, 2013.

100 Royal Commission into Victoria's Mental Health System, *Interim Report,* pp. 26–27 and 32.

101 Department of Health and Human Services, Integrated Data Resource, Client Management Interface/Operational Data Store, Victorian Alcohol and other Drug Collection 2018–19.

102 Royal Commission into Victoria's Mental Health System, *Interim Report,* pp. 159–164.

103 Department of Health and Human Services, Integrated Data Resource, Victorian Alcohol and other Drug Collection 2018–19. Note: Data includes diagnosis groups such as conditions of psychological development; 16,091 consumers in 2018–19 did not state their diagnosis, or it was inadequately described.

104 Department of Health and Human Services, Integrated Data Resource, Client Management Interface/Operational Data Store, Victorian Admitted Episodes Dataset, Victorian Emergency Minimum Dataset 2014–15 to 2018–19. In this instance, mental health consumers includes consumers who accessed mental health services in the public specialist system, private hospitals and emergency departments.

105 Department of Health and Human Services, Integrated Data Resource, Victorian Alcohol and other Drug Collection 2018–19.

106 Department of Health and Human Services, Integrated Data Resource, Victorian Alcohol and other Drug Collection, Client Management Interface/Operational Data Store 2018–19.

107 *Witness Statement of Dr Enrico Cementon*, para. 87.

108 Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed Findings*, p. 11.

109 *Witness Statement of Dr Enrico Cementon*, paras. 87–88.

110 Youth Support + Advocacy Service, *The Victorian Youth Alcohol and Other Drug Service System: A Vision Realised*, 2015, pp. 12–13 citing Best and others, Youth Cohort Study: Young people's pathways through AOD treatment services, Turning Point, 2012.

111 Youth Support + Advocacy Service, *The Victorian Youth Alcohol and Other Drug Service System: A Vision Realised*, p. 11 citing Drug Policy Expert Committee, Drugs: Meeting the Challenge Stage Two Report, November 2000.

112 Youth Support + Advocacy Service, *The Victorian Youth Alcohol and Other Drug Service System: A Vision Realised*, pp. 18–19.

113 Youth Support + Advocacy Service, *The Victorian Youth Alcohol and Other Drug Service System: A Vision Realised*, p. 18.

114 What Can Be Done Steering Committee, *Submission to the RCVMHS: SUB.0002.0028.0190*, 2019, pp. 6–7; Magistrate Jennifer Bowles, *What Can Be Done? Residential Therapeutic Treatment Options for Young People Suffering Substance Abuse / Mental Illness*, 2014, p. 6.

115 Bowles, p. 40; What Can Be Done Steering Committee, p. 7.

116 Celia Wilkinson, *Older Australians: Trends and Impacts of Alcohol and Other Drug Use*, 2018, p. 8.

117 Wilkinson, pp. 7–8.

118 Wilkinson, pp. 43–44.

119 Department of Health and Human Services, Integrated Data Resource, Client Management Information/ Operational Data Store, Victoria Emergency Minimum Dataset, Victorian Admitted Episodes Dataset, Victorian Ambulance Minimum Dataset, Victorian Alcohol and Drug Collection 2014–15 to 2018–19. In this instance, mental health consumers includes consumers who accessed mental health services in the public specialist system, private hospitals and emergency departments.

120 Department of Health and Human Services, *DHHS Guidelines for Emergency Department Mental Health and Alcohol and Other Drug Hubs*, 2019, pp. 1–4.

121 Department of Health and Human Services, *DHHS Guidelines for Emergency Department Mental Health and Alcohol and Other Drug Hubs*, p. 7.

122 Department of Health and Human Services, *DHHS Guidelines for Emergency Department Mental Health and Alcohol and Other Drug Hubs*, pp. 1–4.

123 Department of Health and Human Services, *DHHS Guidelines for Emergency Department Mental Health and Alcohol and Other Drug Hubs*, pp. 1–4.

124 Department of Health and Human Services, Client Management Interface/Operational Data Store 2014–15 to 2018–19.

125 Department of Health and Human Services, Integrated Data Resource, Client Management Interface/Operational Data Store, Victoria Emergency Minimum Dataset, Victorian Admitted Episodes Dataset, Victorian Alcohol and Drug Collection 2014–15 to 2018–19. In this instance, mental health consumers includes consumers who used mental health services in the public specialist system, private hospitals and emergency departments.

126 *Witness Statement of Gary Croton*, paras. 20–21.

127 First Step, *Submission to the RCVMHS: SUB.0002.0029.0310*, 2019, p. 6.

128 Turning Point, *Submission to the RCVMHS: SUB.0002.0028.0533*, p. 13.

129 Professor Dan Lubman, Dr Victoria Manning and Dr Ali Cheetham, *Informing Alcohol and Other Drug Service Planning in Victoria: Final Report* (Turning Point, 2017), p. 58.

130 Lubman, Manning and Cheetham, p. 54.

131 *Witness Statement of Gary Croton*, p. 145.

132 Christie Cline and Kenneth Minkoff, Creating Welcoming, Recovery-Oriented, Co-Occurring Capable Services for Adults, Children and Families with Complex Needs (Zia Partners, 2009), p. ii.

133 Turning Point, *Submission to the RCVMHS: SUB.0002.0028.0533*, p. 7.

134 *Witness Statement of Terry Symonds*, 2 November 2020, para. 97.

135 *Witness Statement of Terry Symonds*, para. 98.

136 *Witness Statement of Sam Biondo*, 7 July 2020, para. 10.

137 *Witness Statement of Sam Biondo*, para. 16; Youth Support + Advocacy Service, *The Victorian Youth Alcohol and Other Drug Service System: A Vision Realised*, p. 4.

138 *Witness Statement of Sam Biondo*, para. 17.

139 Department of Health and Human Services, Dual Diagnosis Residential Rehabilitation: Information about This New Specialist Treatment Option, p. 1.

140 Turning Point, *Annual Report 2018*, p. 4.

141 Turning Point, *Annual Report 2018*, pp. 4–5.

142 *Witness Statement of Terry Symonds*, para. 102.

143 Australian Healthcare Associates, *Evaluation of the Victorian Dual Diagnosis Initiative*, 2011, p. 3.

144 *Witness Statement of Terry Symonds*, para. 100.

145 Youth Support + Advocacy Service, *The Victorian Youth Alcohol and Other Drug Service System: A Vision Realised*, p. 12; *Witness Statement of Sam Biondo*, para. 34.

146 *Evidence of Professor Dan Lubman*, pp. 8–11; *Evidence of Dr Stefan Gruenert*, pp. 8–11; *Evidence of Dr John Reilly*, 18 June 2020, pp. 11–12; *Witness Statement of Sam Biondo*, para. 40.

147 *Evidence of Dr Stefan Gruenert*, p. 27.

148 Self Help Addiction Resource Centre, *Information to the RCVMHS: CSP.0001.0120.0001, SHARC History/Family Drug Help History*, 2020, p. 1.

149 Self Help Addiction Resource Centre, p. 1.

150 *Evidence of Dr Stefan Gruenert*, p. 27.

151 RCVMHS, *Consumer Human-Centred Design Focus Group—Alcohol and Other Drugs: Record of Proceedings*.

152 *Witness Statement of Sam Biondo*, para. 46(b).

153 Productivity Commission, pp. 644–645.

154 RCVMHS, *Melbourne Community Consultation—May 2019*.

155 RCVMHS, *Consumer Human-Centred Design Focus Group—Alcohol and Other Drugs: Record of Proceedings*.

156 Alcohol and Drug Foundation, p. 7.

157 Penington Institute, p. 35.

158 Turning Point, *Submission to the RCVMHS: SUB.0002.0028.0533*, pp. 6–7 referencing Lubman, Hides and Elkins.

159 RCVMHS, *Consumer Human-Centred Design Focus Group—Alcohol and Other Drugs: Record of Proceedings*.

160 RCVMHS, *Consumer Human-Centred Design Focus Group—Alcohol and Other Drugs: Record of Proceedings*.

161 ORIMA Research, *Quotes from Mental Health Workforce Survey*, 2020.

162 Turning Point, p. 16.

163 Victorian Dual Diagnosis Initiative, *Submission to the RCVMHS: SUB.0002.0029.0044*, 2019, p. 2.

164 *Witness Statement of Dr Enrico Cementon*, para. 60.

165 *Witness Statement of Sam Biondo*, para. 46(i).

166 E.L. Barrett and others, Lived Experiences of Australians with Mental Health and AOD Comorbidity and Their Perspectives on Integrated Treatment, *New Paradigm*, Summer, 2018, pp. 38–44.

167 Croton, p. 10.

168 Croton, p. 10.

169 *Witness Statement of Patrick Lawrence*, para. 46; Self Help Addiction Resource Centre, *Submission to the RCVMHS: SUB.0002.0027.0003*, p. 9; *Witness Statement of Dr Enrico Cementon*, paras. 58 and 60.

170 *Evidence of Dr John Reilly*, p. 38.

171 *Witness Statement of Dr John Reilly*, 29 May 2020, para. 38.

172 *Witness Statement of Dr Enrico Cementon*, para. 58.

173 RCVMHS, *Seymour Community Consultation—May 2019*.

174 *Witness Statement of Patrick Lawrence*, para. 46.

175 *Witness Statement of Patrick Lawrence*, para. 46.

176 RCVMHS, *Carer Human-Centred Design Focus Group—Alcohol and Other Drugs: Record of Proceedings*, 2020.

177 RCVMHS, *Carer Human-Centred Design Focus Group—Alcohol and Other Drugs: Record of Proceedings*.

178 Lawrence H. Yang and others, Stigma and Substance Use Disorders: An International Phenomenon, *Current Opinion in Psychiatry*, 30.5 (2017), 378–388 (p. 384); Leonieke C. van Boekel and others, Stigma among Health Professionals towards Patients with Substance Use Disorders and Its Consequences for Healthcare Delivery: Systematic Review, *Drug and Alcohol Dependence*, 131.1–2 (2013), 23–35 (p. 26).

179 Yang and others, p. 6; van Boekel and others, p. 26.

180 Yang and others, p. 6.

181 Turning Point, *Submission to the RCVMHS: SUB.0002.0028.0533*, p. 5.

182 *Witness Statement of Dr Enrico Cementon*, para. 55; Croton, p. 38.

183 Cath Chapman and others, Delay to First Treatment Contact for Alcohol Use Disorder, *Drug and Alcohol Dependence*, 147 (2015), 116–121 (p. 117).

184 Turning Point, p. 5; Yang and others, p. 6.

185 *Witness Statement of Dr Stefan Gruenert*, 28 May 2020, para. 24.

186 Turning Point, *Submission to the RCVMHS: SUB.0002.0028.0533*, p. 5.

187 RCVMHS, *Consumer Human-Centred Design Focus Group—Alcohol and Other Drugs: Record of Proceedings*.

188 Turning Point, pp. 6 and 12; Youth Support + Advocacy Service, *Submission to the RCVMHS: SUB.0002.0028.0682*, 2019, p. 16; Penington Institute, p. 3; Caraniche, *Submission to the RCVMHS: SUB.0002.0028.0676*, 2019, pp. 2 and 4; Odyssey House Victoria, *Submission to the RCVMHS: SUB.0002.0030.0047*, 2019, p. 6; First Step, pp. 3–6.

189 Victorian Alcohol and Other Drug Association, *Submission to the RCVMHS: SUB.0002.0029.0452*, 2019, p. 19.

190 Windana Drug and Alcohol Recovery, pp. 6–7.

191 Victorian Alcohol and Drug Association, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, p. 19.

192 Turning Point, p. 16.

193 Windana Drug and Alcohol Recovery, p. 7.

194 Windana Drug and Alcohol Recovery, p. 6.

195 Turning Point, p. 16.

196 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, p. 6.

197 Department of Health and Human Services, Mental Health and AOD Workforce Joint Working Group: Priority Issues Discussion Paper, 2019, p. 4.

198 Department of Health and Human Services, p. 4.

199 Penington Institute, p. 34.

200 *Witness Statement of Dr John Reilly*, para. 39.

201 Turning Point, p. 7; *Witness Statement of Dr Enrico Cementon*, para. 63.

202 *Witness Statement of Professor Dan Lubman*, para. 27.

203 *Evidence of Gail Bradley*, 9 July 2019, p. 539.

204 Healthcare Management Advisors, Development of an Addiction Specialist Workforce Model: Second Workforce Committee Meeting, 2019, p. 11.

205 The Commission, *Special Commission of Inquiry into Crystal Methamphetamine and Other Amphetamine-Type Stimulants Report, Volume 2*, p. 473.

206 The Commission, *Special Commission of Inquiry into Crystal Methamphetamine and Other Amphetamine-Type Stimulants Report, Volume 2*, p. 482.

207 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 13.

208 General Assembly, United Nations, *International Covenant on Economic, Social and Cultural Rights, Entry into Force: 3 January 1976, in Accordance with Article 27*, 16 December 1966 Article 12.1; General Assembly, United Nations, *International Convention on the Elimination of All Forms of Racial Discrimination, Entry into Force: 4 January 1969, in Accordance with Article 19*, 21 December 1965 Article 5 (e) (iv). Committee on the Elimination of Discrimination Against Women, United Nations, *Convention on the Elimination of All Forms of Discrimination Against Women: General Recommendation No. 35 on Gender-Based Violence Against Women, Updating General Recommendation No. 19*, 26 July 2017 Articles 11 (1), 12 and 14 (2)(b); General Assembly, United Nations, *Convention on the Rights of Persons with Disabilities, Entry into Force: 3 May 2008, in Accordance with Article 45(1)*, 13 December 2006 Article 25.

209 Office of the United Nations High Commissioner for Human Rights, *The Right to Health*, 2008, p. 1.

210 *Witness Statement of Dr John Reilly*, para. 34.

211 *Witness Statement of Professor Dan Lubman*, para. 20.

212 RCVMHS, *Consumer Human-Centred Design Focus Group—Alcohol and Other Drugs: Record of Proceedings*; RCVMHS, *Carer Human-Centred Design Focus Group—Alcohol and Other Drugs: Record of Proceedings*.

213 RCVMHS, *Consumer Human-Centred Design Focus Group— Alcohol and Other Drugs: Record of Proceedings*.

214 *Evidence of Associate Professor Dean Stevenson*, p. 606; Alcohol and Drug Foundation, p. 9.

215 *Witness Statement of Terry Symonds*, para. 99.

216 Commonwealth Department of Health, *The Fifth National Mental Health and Suicide Prevention Plan*, 2017, p. 8.

217 Commonwealth Department of Health, *National Drug Strategy 2017–2026*, pp. 2, 5, 9 and 16.

218 Queensland Mental Health Commission, *Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023*, 2018, pp. 32–35.

219 The Red Fish Healing Centre, B.C.'s New Provincial Centre for Mental Health and Addiction, <www.youtube.com/watch?v=1IP5NXlYM80&feature=emb_logo>, [accessed 5 November 2020].

220 The Red Fish Healing Centre.

221 The Red Fish Healing Centre.

222 Minkoff and Cline, p. 69.

223 Maria Donald, Jo Dower and David Kavanagh, Integrated versus Non-Integrated Management and Care for Clients with Co-Occurring Mental Health and Substance Use Disorders: A Qualitative Systematic Review of Randomised Controlled Trials, *Social Science and Medicine*, 60.6 (2005), 1371–1383 (p. 1381).

224 Michelle Cleary and others, Psychosocial Treatments for People with Co-Occurring Severe Mental Illness and Substance Misuse: Systematic Review, *Journal of Advanced Nursing*, 65.2 (2009), 238–258 (p. 253).

225 Drake and others, p. 471.

226 *Witness Statement of Gary Croton,* p. 240.

227 *Witness Statement of Sam Biondo*, para. 82.

228 Alcohol and Drug Foundation, p. 3; NorthWestern Mental Health (A Division of Melbourne Health), *Submission to the RCVMHS: SUB.0002.0030.0061*, 2019, pp. 4–6; Australasian College for Emergency Medicine, *Submission to the RCVMHS: SUB.1000.0001.0051*, 2019, p. 2; Victorian Alcohol and Drug Association, p. 7; Yarra Mental Health Alliance, *Submission to the RCVMHS: SUB.0002.0030.0063*, 2019, p. 5.

229 *Witness Statement of Dr John Reilly*, paras. 14–16.; *Evidence of Dr John Reilly*, pp. 13–14.

230 Alcohol and Drug Foundation, pp. 8–9; Turning Point, *Submission to the RCVMHS: SUB.0002.0028.0533*, pp. 14–16; *Witness Statement of Professor Dan Lubman*, para. 22.

231 *Witness Statement of Sam Biondo*, paras. 84–85; Uniting, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, pp. 11–13; Odyssey House Victoria, p. 2.

232 *Evidence of Dr Stefan Gruenert*, pp. 16–18; *Evidence of Dr John Reilly*, pp. 13–14; *Evidence of Professor Dan Lubman*, pp. 15–16.

233 Kenneth Minkoff and Nancy H. Covell, *Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What's Now?* (National Association of State Mental Health Program Directors, 2019), p. 8.

234 Queensland Health, *Dual Diagnosis Clinical Guidelines: Co-Occurring Mental Health and Alcohol and Other Drug Problems*, 2010, p. 15.

235 U.S. Department of Health and Human Services, *Substance Abuse Treatment for Persons with Co-Occurring Disorders: A Treatment Improvement Protocol TIP 42*, 2005, pp. 28–30.

236 Queensland Health, p. 15.

237 *Witness Statement of Dr John Reilly*, paras. 28–29.

238 *Witness Statement of Dr John Reilly*, para. 30.

239 Bianca Albers, Mary Abdo and Robyn Mildon, *Implementing the Commission's Recommendations: Prepared by the Centre for Evidence and Implementation for the Royal Commission into Victoria's Mental Health System*, 2020, p. 10.

240 New South Wales Department of Health, p. 18.

241 World Health Organization, *Integrating the Response to Mental Disorders and Other Chronic Diseases in Health Care Systems*, 2014, p. 11.

242 First Step, pp. 3–4.

243 CoHealth, *Submission to the RCVMHS: SUB.0002.0029.0410*, 2019, pp. 35–36.

244 *Evidence of Dr Stefan Gruenert*, p. 84.

245 *Witness Statement of Dr Enrico Cementon*, para. 119.

246 Croton, p. 29.

247 *Witness Statement of Gary Croton*, para. 19.

248 Croton, pp. 30–31.

249 Turning Point, *Interim Report: Strengthening Addiction Specialist Capability in the Victorian Public System*, 2019, p. 5.

250 Turning Point, *Interim Report: Strengthening Addiction Specialist Capability in the Victorian Public System*, p. 5.

251 Lubman, Manning, and Cheetham, pp. 32–33.

252 Lubman, Manning, and Cheetham, p. 33.

253 Turning Point, *Submission to the RCVMHS: SUB.0002.0028.0533*, p. 16.

254 Turning Point, *Interim Report: Strengthening Addiction Specialist Capability in the Victorian Public System*, p. 14.

255 Turning Point, *Interim Report: Strengthening Addiction Specialist Capability in the Victorian Public System*, p. 15.

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Chapter 23

Improving mental health outcomes across the criminal justice, forensic mental health and youth justice systems

Recommendation 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

The Royal Commission recommends that the Victorian Government:

1. expand the Assessment and Referral Court to each of the 12 headquarter Magistrates' Courts to meet demand at both existing and new locations.
2. expand the existing forensic community model to:
   - **a.** enable Adult and Older Adult Area Mental Health and Wellbeing Services and Infant, Child and Youth Area Mental and Wellbeing Services (refer to recommendation 3(2)(c)) to provide consistency in treatment, care and support to people in contact with, or at risk of coming into contact with, the criminal justice system; and
   - **b.** establish the specialist behaviour response team described by the Royal Commission in its final report.
3. establish a program of supports for people in prison living with mental illness who require ongoing intensive treatment, care and support to transition the delivery from correctional settings to the mainstream mental health and wellbeing system upon their release.
4. expand specialist youth forensic mental health programs to a statewide model, including across the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services (refer to recommendation 3(2)(b) and (c)), to provide consistent and appropriately specialised treatment, care and support to children and young people in contact with, or at risk of coming into contact with, the youth justice system.

Recommendation 38:

Providing safe and appropriate mental health treatment, care and support at Thomas Embling Hospital

The Royal Commission recommends that the Victorian Government:

1. in line with master planning for Thomas Embling Hospital and the proposal of the Victorian Health and Human Services Building Authority:

   a. refurbish the existing 136 beds; and

   b. by the end of 2026, provide an additional 107 beds, a small number of which should be allocated for people living with mental illness whose treatment, care and support requirements cannot be safely and appropriately met in acute inpatient settings or through the forensic community model (refer to recommendation 37(2)).

2. provide up to 20 beds, in addition to the 107 beds referred to in recommendation 38(1)(b) and the additional beds in recommendation 11(3), to support people living with mental illness whose treatment, care and support requirements cannot be, or are unlikely to be, safely and effectively met in other extended rehabilitation settings.

23.1 Improving mental health outcomes across the criminal justice system

The Royal Commission has been tasked with inquiring into and reporting on how to improve mental health outcomes for people in contact, or at greater risk of contact, with the criminal justice, forensic mental health and youth justice systems. These three systems comprise:

- the adult criminal justice system—including police, courts, prison and community-based management of offenders
- the forensic mental health system—including community and inpatient services for people living with mental illness who have offended or are at risk of offending
- the youth justice system—including police, the Children's Court, youth justice centres and community-based management of young people.

These three systems present unique opportunities to improve mental health outcomes. People living with mental illness are over-represented throughout the criminal justice system, including in prisons. For some people, interactions with the criminal justice system may be the first time they can access mental health treatment, care and support. In a well-functioning system, this access can be facilitated through police, courts, prisons and in community-based services. The Commission has a unique opportunity to improve service access for people living with mental illness who are often excluded from mainstream service delivery.

In examining this issue, the Commission has considered evidence about best practice treatment and current research and has listened to the experiences and views of people with lived experience of the justice system.

Like other members of the community, those in contact with the criminal justice system need continuity and consistency in mental health treatment, care and support. As Dr Emma Cassar, Commissioner of Corrections Victoria at the Department of Justice and Community Safety, articulated:

> The mental health care of those in contact with the justice system, or at risk of contact, should be a part of a lifetime continuum of care responsive to their health needs. Access to and quality of mental health care should not change based on a person's legal status.[1]

This is currently not the case in Victoria. Evidence received by the Commission paints a picture of a mental health system under strain, which is in turn placing pressure on police, courts and prisons. While there are pockets of progress, these systems and services are not structured and resourced to adequately support people living with mental illness.

Ms Peta McCammon, Associate Secretary at the Department of Justice and Community Safety, described the interface between the justice system and the mental health system as fragmented, poorly coordinated and impeded by capacity constraints.[2] Specifically, Ms McCammon highlighted:

- poor coordination between justice and community services
- capacity constraints in community-based mental health services that result in the justice system becoming mental health treatment providers of last resort
- lack of continuity in how people transition out of the criminal justice system and back into the community.[3]

The Commission has made recommendations directed at improving outcomes for people living with mental illness who are involved in the criminal justice system. Specifically, these recommendations seek to:

- improve coordination between justice and mental health and wellbeing services through increased access to problem-solving courts
- ensure that community-based Area Mental Health and Wellbeing Services have capacity to offer forensic mental health services to people who need it
- improve transitions out of the criminal justice system for people living with mental illness.

23.1.1 Rates of imprisonment and community-based supervision orders

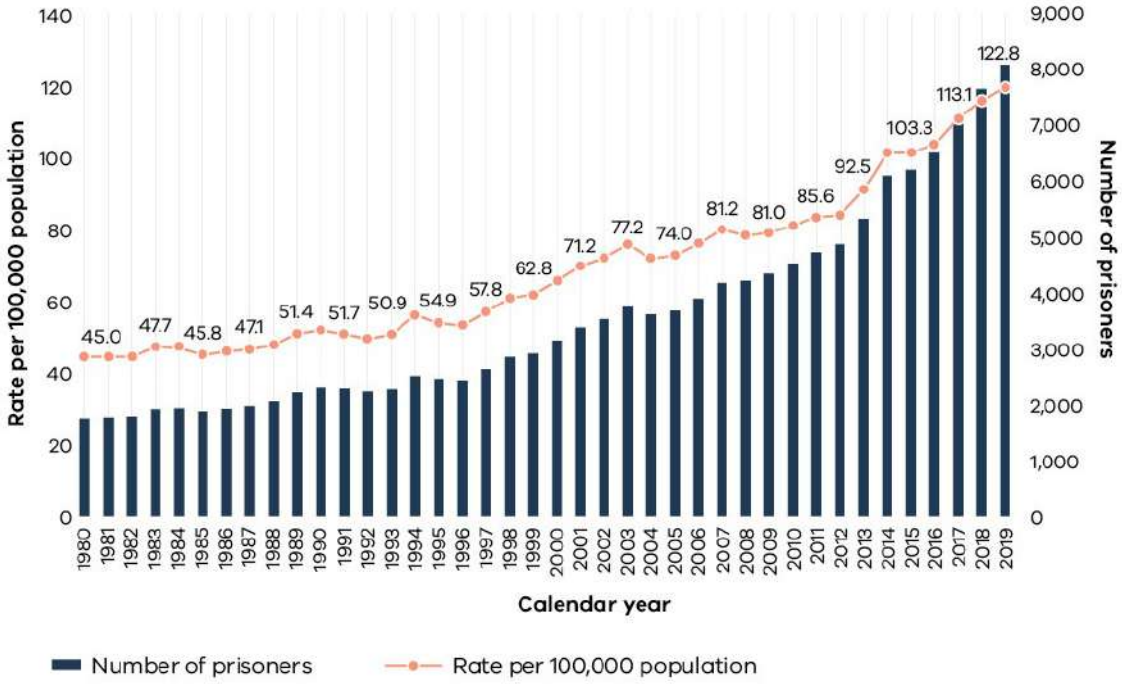
For the past 20 years there has been a consistent upward trend within Victoria in the proportion of the adult population in prison.

In Victoria the imprisonment rate has almost doubled over the past 20 years. In 2019 the rate was 123 prisoners per 100,000 people compared with 62 per 100,000 in 1998 (and 38 per 100,000 people in 1977).[4] The Aboriginal imprisonment rate more than doubled between 2009 and 2019, from 839.4 to 2,267.7 per 100,000 adults.[5] The increase in the number and rate of Victorian prisoners since 1980 is shown in Figure 23.1.

This increase is not explained by increasing crime rates, which have mostly declined over the same period.[6] Rather, it is primarily explained by reporting rates, policing practices, sentencing laws and bail laws.[7]

As the Commission delivers its report it is not entirely clear what the ongoing impact of the COVID-19 pandemic will be on prisoner numbers. Between 31 January 2020 and 30 November 2020 there was a 13 per cent decrease in the sentenced prisoner population (from 5,017 to 4,381) and a 13 per cent decrease in the remand population (from 3,143 to 2,728).[8] Remand is when an accused person does not get bail and is held in custody in the lead-up to finalising their charges. For all sentenced and unsentenced prisoners, there has been a 12 per cent decrease for male prisoners and a 19 per cent decrease for female prisoners.[9] The Commission does not have access to data to explain this decrease, but it may be attributable to the increased access to—and size of—Commonwealth benefits and support, programs to reduce rough sleeping and homelessness by the Victorian Government, and a reluctance of judicial officers (judges and magistrates) to place more accused people on remand due to current delays in the criminal justice process and the increased health risks of closed environments.

Figure 23.1: Number of prisoners and rate of prisoners per 100,000 population, Victoria, 1980 to 2019



Source: Sentencing Advisory Council, 'Victoria's Imprisonment Rates' <www.sentencingcouncil.vic.gov.au/statistics/sentencing-trends/victoria-imprisonment-rates> [accessed 6 November 2019].

Similar growth patterns are evident in people subject to Community Correctional Services supervision. Community Correctional Services oversees delivery of community corrections in Victoria. Community corrections involves managing and supervising people who have offended and are serving court-imposed orders either as part of a sentence or as a condition of their release from prison. This includes people subject to supervision in the community through court, administrative and parole orders. This group of people increased by 50 per cent between 2009 and 2019, following a period of sustained growth between 2014 and 2017.[10] Since 2017 the number of people subject to supervision has decreased slightly. This was primarily driven by a 39 per cent decrease in the number of people on a reparation order.[11] Offenders with reparation orders must only undertake unpaid community work.

Between 2009 and 2019 the number of people:

- on a supervised court order increased from 55 to 80 per cent of the total population of people subject to Community Correctional Services supervision
- on reparation orders decreased by 28 per cent
- on parole decreased by 43 per cent, from 17 to 7 per cent of the total population of people subject to Community Correctional Services supervision
- aged under 25 years decreased from 23 to 14 per cent of the total population of people subject to Community Correctional Services supervision.[12]

Similar to the trends in imprisonment evident during the COVID-19 pandemic, on 30 November 2020 there were 8,531 Victorians under Community Correctional Services supervision, which is a 30 per cent decrease since 31 January 2020 when 12,197 Victorians were under supervision.[13]

23.1.2 Over-representation of people living with mental illness in the criminal justice system

Imprisonment

Increasing rates of imprisonment disproportionately affect people living with mental illness. In its interim report, the Commission referenced the most recent survey of prisoner health, which reported that 61 per cent of people entering Victorian prisons had a diagnosed mental illness and 35 per cent of Victorian prisoners were referred to a prison mental health service.[14] Prisoners are also two to three times more likely to have a mental illness and 10 to 15 times more likely to have a 'psychotic disorder' than someone in the community.[15]

The Australian Institute of Health and Welfare reported that around 40 per cent of prison entrants and 37 per cent of people released from prison, sometimes referred to as 'dischargees', reported a previous diagnosis of a mental illness, including alcohol and other substance use disorders.[16] This report also stated that 65 per cent of female prison entrants reported a history of a mental illness in comparison with 35 per cent of male prison entrants.[17] An investigation conducted by the Victorian Ombudsman found that, in 2015, 54 per cent of people in prison had a history of suicide attempts or self-harm.[18]

Dr Cassar reported that of the 8,156 prisoners in Victorian prisons (public and private) on 1 March 2020, there were 2,351 prisoners (29 per cent) with a mental health diagnosis.[19] Depression, substance use disorders and 'anxiety disorders' accounted for 72.8 per cent of all diagnoses for this cohort.[20]

Community Correction Orders

It is estimated that a high proportion of people subject to Community Correction Orders are living with mental illness.[21] This conclusion is drawn from looking at the percentage of people on Community Correction Orders who have a mental health treatment rehabilitation condition.[22] Mental health treatment rehabilitation conditions may require people subject to a Community Correction Order to get psychological, neuropsychological, or psychiatric treatment, or other treatment a court considers necessary including, for example, personal development programs (*Sentencing Act 1991* (Vic), section 48D). Dr Cassar reported that as 'at 30 June 2019, 10,063 offenders were subject to a [Community Correction Order] with a supervision condition, and of those, 56 per cent (5,625) had a [mental health treatment rehabilitation] condition'.[23] This proportion has remained fairly consistent over time—in 2015–16, 51.4 per cent of Community Correction Orders had a mental health treatment rehabilitation requirement.[24]

The imposition of a mental health treatment rehabilitation condition does not necessarily mean treatment is received. Ms McCammon observed that the lack of services in the community may make it difficult for people to comply with Community Correction Orders.[25] For example, some offenders may not be eligible for referral to specialists, may not be able to afford the costs of complying with their orders, or bulk-billed services available through a GP may not be sufficient.[26] Dr Cassar observed that before implementation of the Forensic Mental Health in Community Health Initiative, which connects people to treatment when they have a mental health treatment requirement on their Community Correction Order:

> the majority of offenders in the community had significant difficulties accessing and completing treatment to fulfil their [mental health treatment requirement] condition. This was because their mental health needs were not sufficiently severe or acute to engage an [area mental health service]; or Commonwealth funded psychological counselling as part of a GP referral was not intensive enough, or suitable.[27]

With specific reference to mental health programs, the Victorian Auditor-General's Office concluded:

> Lack of access to services to enable offenders to fulfil the conditions of their [Community Correction Orders] is a significant concern. Further steps are needed to develop a permanent and viable solution to meet this gap in service provision.[28]

The Victorian Auditor-General's Office identified the Neighbourhood Justice Centre's integrated model as an effective model for supporting compliance with Community Correction Orders.[29] The elements of the centre's model that were found to be beneficial include 'collocation of a range of services at court including [Community Correctional Services], active judicial monitoring and effective integration of all support and services'.[30] The Neighbourhood Justice Centre is Australia's first community justice centre and is based in Collingwood. It is only available to people who live in the City of Yarra, or who are homeless or Aboriginal and if the offence occurred in the City of Yarra.[31]

Box 23.1 examines the over-representation of Aboriginal people in Victoria's criminal justice system.

Box 23.1: Over-representation of Aboriginal people

Aboriginal people are significantly over-represented in Victoria's criminal justice system. Between 2009 and 2019, the imprisonment rate for Aboriginal people was significantly higher than the imprisonment rate for the total Victorian population. In 2019 the imprisonment rate for Aboriginal Victorians was 2,267.7 per 100,000 adults compared with 157.1 per 100,000 adults for all Victorians.[32] The Victorian Aboriginal Legal Service stated that as of May 2019, the Victorian imprisonment rate for Aboriginal people was higher than in any other Australian state or territory, with 10 per cent of the total prison population (812 people) identifying as Aboriginal.[33] The Victorian Aboriginal Legal Service also reported that in 2017–18, 32 per cent of their criminal law matters involved clients who reported mental health concerns.[34]

For Aboriginal prisoners, over-representation is 'inextricably linked to the intergenerational consequences of dispossession, disruption of culture and kinship systems and high rates of socioeconomic disadvantage'.[35] Aboriginal-led research from New South Wales and the Northern Territory discussed how over-policing and high rates of imprisonment can have a further negative impact on Aboriginal people's mental health.[36] This research indicated that 'institutionalised racism, the taking of land, forcible removal of children, poor education, over-crowded housing, a lack of appropriate health care, early loss of family and community members, over-policing and high rates of incarceration' all have a negative impact on the mental health of Aboriginal people and contribute to their over-representation in the criminal justice system.[37]

23.1.3 Mental illness, victimisation and perpetration

High-profile incidents involving people diagnosed with mental illness have contributed to a public perception that there may be a causal relationship between mental illness and offending. The true relationship between mental illness and offending is complex and multifaceted, and a mental illness diagnosis is not an accurate predictor of potential offending. As highlighted in the evidence below, 'some relationship appears to exist between certain severe mental health conditions and offending behaviours, but the nature and extent of the association remains in doubt'.[38] The existing body of research on mental illness and offending can be summarised in this way: 'most people with mental illnesses are not violent, most violent offenders are not mentally ill, and the strongest risk factors for violence (e.g. past violence) are shared by those with and without mental illnesses'.[39]

People living with mental illness are more likely to be a victim of crime than a perpetrator[40] and are more likely to be a victim of crime than people without a mental illness.[41] Research based on the American National Crime Victimization Survey found that people living with severe mental illness were about 11 times more likely to be a victim of violent crime compared with the general population.[42] In Victoria a 2013 study of people diagnosed with 'schizophrenic-spectrum disorders' found a significantly higher likelihood of being the victim of violence, including sexual violence, compared with the general population.[43] Distinguished Professor James Ogloff AM, Executive Director at Forensicare, Distinguished Professor at the Centre for Forensic Behavioural Sciences at Swinburne University and Expert Advisory Council member for the Commission, noted in his statement to the Commission that, '[t]he risks of victimisation were greatest among people living with schizophrenia who have criminal offending histories themselves, and who experience substance misuse.' [44]

In relation to the perpetration of violence, several systematic reviews have shown a modest association between violence and schizophrenia and other psychoses.[45] One study of 130 male offenders who had contact with Forensicare, Victoria's statewide specialist provider of forensic mental health services, found that co-occurring mental illness and 'substance use disorders' had a greater association with offending than mental illness alone.[46]

A recent review, conducted in Norway, suggests that the major factor linking schizophrenia and violence is substance use.[47] Another study that looked at common assumptions and misconceptions regarding the association between mental illness and violence acknowledged that research has consistently shown substance use is a strong predictor of violence and that it reduces the association between schizophrenia and violence.[48] The authors concluded that 'there is limited evidence that mental health problems are independent predictors of violence when accounting for other factors, such as substance use or previous violence'.[49]

Predicting the risk that people living with mental illness may commit violent offences is extremely difficult. A study on schizophrenia risk categorisation found that 'in order to prevent one homicide of a stranger, 35,000 high-risk patients with schizophrenia would require completely successful individual risk management'.[50] This research found that 'proper consideration of the patient's situation, symptoms, strengths, and disabilities'[51] would be better for consumers than focusing on risk assessment and predicting future behaviour.

A study published in 2020 concluded that receiving psychiatric treatment is associated with a decrease in the likelihood of offending.[52] There was, however, a three-fold increase in the likelihood of offending for people who became disengaged from treatment post-imprisonment or hospitalisation compared with those who did not.[53] Of those who did reoffend, two-thirds committed another offence within one year of leaving treatment.

This body of research indicates that dealing with mental illness alone will not reduce rates of offending or increase community safety. Distinguished Professor Ogloff told the Commission:

> Although necessary, however, psychiatric treatment is not sufficient in reducing the risk of offending. Rather, interventions must also address the factors that relate to offending in order to significantly decrease the likelihood of offending, while increasing community safety. Indeed, the same ... risk factors exist in people with mental illnesses who offend, and those who offend but do not have a mental illness.[54]

23.1.4 Investment in corrections, police and custodial mental health services

The Victorian Government has made significant recent investments in corrections, police and custodial mental health services. The 2018–19 Victorian Budget included $1.8 billion funding for 1,600 new prison beds, including a new prison in Geelong and adding beds to existing prisons (for example, Ravenhall Correctional Centre).[55] This budget also included $6 million to plan a new custody and courts complex in light of increasing remand numbers.[56]

In 2016 the Victorian Government announced 'the biggest ever investment in law and order in our state's history'.[57] This included funding for an additional 3,135 police officers and, more recently, has also included 100 additional protective services officers to work across the public transport network.[58]

There has also been an increased focus on building specialist mental health units within prisons, rather than providing mental health treatment, care and support in secure hospital settings.[59] Recent investments include:

- Ravenhall Correctional Centre, a medium security prison for sentenced and remanded male prisoners, opened in 2017. As of 30 June 2019, Ravenhall had capacity for 1,300 prisoners, as well as 75 dedicated forensic mental health beds across four units.
- The Marrmak and Rosewood units at the Dame Phyllis Frost Centre were refurbished and expanded in 2018. Dame Phyllis Frost Centre is a maximum security prison for women. As of 30 June 2019, the prison had capacity for 604 prisoners. Marrmak Unit is a 20-bed mental health residential program, intensive outreach program and a therapeutic day program for women.
- The Acute Assessment Unit at the Melbourne Assessment Prison was refurbished in 2019.[60] This is 'a 16-bed short stay unit for patients thought to be mentally ill and requiring psychiatric assessment and a range of recovery-oriented short-term interventions and support. The assessments determine future treatment needs both in and out of custody. The Acute Assessment Unit also accommodates patients requiring compulsory treatment and awaiting admission to Thomas Embling Hospital.'[61]

There has also been increased spending on primary and specialist mental health services in prisons to meet demand.[62] The Commission has been told that there are no publicly available data on demand for mental health services in Victorian prisons.[63] Dr Cassar explained that a range of factors are taken into account to ensure services meet demand, with growth in prisoner population not necessarily being the driving factor.[64] As an illustration, the total annual expenditure on specialist mental health services across public prisons doubled from $6.9 million in 2012–13 to $13.9 million in 2018–19. And while the prison population increased over this period, it was at roughly half the rate of the funding increase.[65]

Forensicare provides specialist mental health services at the following prisons:

- Melbourne Assessment Prison (Acute Assessment Unit)
- Dame Phyllis Frost Centre (Marrmak Unit)
- Ravenhall Correctional Centre (Ballerrt Yeram-boo-ee Forensic Mental Health Service)

- Metropolitan Remand Centre (a Mobile Forensic Mental Health Service that also provides outreach to other prisons and incorporates satellite psychology services at Barwon Prison and Marngoneet Correctional Centre)
- Port Phillip Prison (St Paul's Unit)
- visiting consultant psychiatric and nurse practitioner sessions at the larger state-managed regional prisons.[66]

Figure 23.2 provides a summary of services provided by Forensicare across the prison system in 2018–19.

Figure 23.2: Activity at Forensicare's prison services, 2018–2019

	Reception assessments	Average length of stay	Admissions	Mobile Forensic Mental Health Service
Melbourne Assessment Prison	9,063 reception assessments	7.50 days in the Acute Assessment Unit	16 admissions to the Acute Assessment Unit	-
Dame Phyllis Frost Centre (Marrmak Unit)	-	43.74 days	142 admissions	-
Metropolitan Remand Centre	1,214 reception assessments	-	-	3,748 occasions of service 782 clients seen by the service
Ravenhall Correctional Centre	915 reception assessments	45.14 days in the Aire Unit 66.37 days in the Erskine Unit 119.69 days in the Moroka Unit 151.50 days in the Tambo Unit	375 admissions to Ballerrt Yeram-boo-ee Forensic Mental Health Service	-
Port Phillip Prison (St Paul's Unit)	-	204.67 days	37 admissions	-

Source: Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, 2020, p.27.

There have not been similar funding trends for community-based mental health services or diversion, rehabilitation and reintegration programs. In the budget that allocated $1.8 billion for new prison accommodation, $42.7 million was allocated to services focused on keeping people out of the justice system and $22.7 million to diversion, rehabilitation and reintegration programs.[67] This total allocation to diversion programs is equivalent to 3.6 per cent of the investment in prisons.

Mr Grant Todd, a witness, described his experience of community and forensic mental health services. Mr Todd noted the difference between community and inpatient services, and the need for increased funding of community services:

> There needs to be more funding for mental health services. In my view, there is a vast difference between community services and the forensic system. I understand that community workers have caseloads of between 30 and 40 people. It must be hard for them to stay on top of all their patients, and I'm sure their appointments aren't frequent enough. There needs to be more funding for case managers, and infrastructure and mental health services in the community.[68]

Victoria Police and Dr Cassar highlighted the impact of inadequate investment in community-based mental health services on police and the corrections system. Victoria Police stated:

> patterns of investment over the past twenty years (an almost exclusive focus on numbers of police and police stations) will not meet the challenges faced by police and the community's expectations.
>
> Police increasingly deal with the consequences of a variety of social ills, such as family violence, abuse of alcohol or illicit drugs, mental illness or underemployment. They depend on the effectiveness of other services to resolve a situation fully, and they are expected to work with other agencies to find ways to deal with the causes of harmful behaviours.[69]

Dr Cassar said 'there are too many people coming into the corrections system who have not received adequate treatment and support in public specialist mental health services'[70] and that 'the corrections system is too often acting as a mental health provider of last resort because people are unable to access mental health services in the community'.[71]

Prisons as the 'catchall solution to social problems'

Limited investment in mental health services has meant that some people are unable to get mental health services until they enter the criminal justice system. Forensicare commented that, '[s]adly, it is not uncommon for some people to have the first opportunity to access mental health assessment and services when they enter the justice system'.[72] The Magistrates' Court of Victoria similarly concluded that 'prisons have in some circumstances become front line mental health care providers by default'.[73] At the Commission's community consultation in Box Hill, a participant spoke about her experience trying to find support for her son:

> There is no treatment, the doors have all closed, [my son is] self-medicating – not a single private hospital will take him and the last public hospital had him arrested. I have been told by a clinician that 'the best thing for your son is the criminal justice system'.[74]

In their submission, Caraniche, a specialist provider of psychological services, discussed the impact of differences in access to care in custody and the community. Some Caraniche clients experience a cycle of arrest and placement in supervision (either through a Community Correction Order or in custody), stabilisation due to consistent access to treatment, release to the community, disconnection from care and subsequent relapse and rearrest.[75]

Ms Mary Pershall, a witness before the Commission, reiterated Caraniche's observation that prison mental health services can achieve stabilisation and positive mental health outcomes. Ms Pershall told Commission that as a result of the routine, structure and community within prison, as well as the access to mental health care, her daughter's 'mental health is better than it has been since she started school'.[76]

The Commission also heard that prison can have detrimental impacts on a person's mental health. Mental Health Victoria and the Mental Health Legal Centre told the Commission that '[f]or many people living with mental illness prison is a challengingly restrictive environment and incarceration can have a debilitating impact on their mental health and well-being'.[77] The Human Rights Law Centre stated that prisons fail 'to provide adequate health care to people denied community-based interventions and supports. Prisons are increasingly being used as the 'catchall solutions to social problems'.[78]

While prison mental health services achieve positive outcomes for some people, it is not appropriate that some Victorians are excluded from receiving mental health treatment until they enter the criminal justice system. It is anticipated that the Commission's suite of reforms across crisis and emergency responses, Area Mental Health and Wellbeing Services and community mental health will go some way to ameliorate the demand pressures currently facing the prison system. The recommendations of this chapter will build on these reform areas by improving service delivery across the criminal justice system.

23.1.5 The net of the criminal justice system

The Senate Select Committee on mental health identified a number of causes for the over-representation of people living with mental illness in the criminal justice system.[79] This included homelessness, substance use or addiction, a lack of early intervention and limited mental health services in the community. The Commission has made recommendations to respond to these issues for all Victorians living with a mental illness, not only those engaged with the criminal justice system, which are outlined in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*, Chapter 16: *Supported housing for adults and young people* and Chapter 22: *Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction*.

A lack of mental health services in the community combined with a criminal justice system that is not sufficiently resourced to support recovery is a key cause of current over-representation in Victoria.

Dr Cassar said a significant number of prisoners with acute needs had not received the treatment, care and support they required in the community:

> prisoners with acute needs requiring compulsory treatment while in custody have generally been clients of one [area mental health service] or more previously, but have been disconnected from the service for a period before they entered custody. In my opinion, this indicates that the public specialist mental health service system appears to be identifying but not meeting the needs of people at risk of offending.[80]

Mr Dan Nicholson, Executive Director of Criminal Law at Victoria Legal Aid, agreed that inadequate community-based supports may lead to engagement with police and subsequent entry into the criminal justice system:

> Because of a lack of other services, Victoria Police are too often first responders when people are experiencing mental health issues. Once contact is made, our current settings mean that people are too often caught in the net of the criminal justice system. These settings include: police practices including in respect of charging, cautioning, bail and remand; ongoing criminalisation of minor offending such as begging and drug use; and the consequences of bail laws.[81]

Mr Nicholson went on to describe the impact of being caught in the 'net of the criminal justice system':

> the net is cast too wide, then once people experiencing mental health issues are propelled into the criminal justice system, it is not sufficiently therapeutically oriented and resourced to support them to recover and return to stable lives. They find themselves unable to get out of the system which is often harmful for their mental health and hinders recovery.[82]

The Magistrates' Court of Victoria reiterated the flow-on effect identified by Dr Cassar and Mr Nicholson. Regarding the over-representation of people living with mental illness within the justice system, the Magistrates' Court recognised 'it as a critical problem caused by, in part, community-based services and responses being limited and under-resourced'.[83] The Magistrates' Court went on to say that limited access to community-based services can increase:

> the likelihood of Victoria Police being called out to respond to people with mental health symptoms manifesting in difficult behaviours. Police contact increases the probability of criminal charges. When mental health behaviours are criminalised, clients are likely to remain in custody where they do not have access to services that address their health and wellbeing needs.[84]

The Commission has identified three key elements of the criminal justice system that have contributed to the net widening and subsequent over-representation of people living with mental illness:

- minor offences that disproportionately affect people living with mental illness
- use of police as first responders when a health response is required
- use of remand as a 'method of safe management and containment'[85] for people living with mental illness.

Minor offences and infringements

People living with mental illness are more likely to be charged with minor offences and infringements than people without mental illness. Submissions to the Commission have variously pointed to the potential of reforming minor offences in reducing the disproportionate impact on people living with mental illness including begging, public space offences (like obstruction of footpaths or relating to directions to move on), offensive language and some drug offences including possession.[86] The 1993 *Burdekin Report* also found that 'mentally ill people are especially likely to fall foul of laws concerning drunkenness, offensive behaviour, disorderly conduct, loitering or vagrancy (which commonly coincides with homelessness)'.[87]

More recent evidence received by the Commission shows these trends are still evident. Inner Melbourne Community Legal told the Commission they have 'assisted many clients charged with low-level offences which are a direct consequence of a mental health episode'.[88] Springvale Monash Legal Service reported that 'certain kinds of behaviour can be deemed 'anti social' and can cause people with a mental illness to be an easy target for policing practices'.[89]

In his statement to the Commission, Mr Nicholson called for minor offences reform:

> Offences that penalise poverty and addiction should be repealed or decriminalised to reduce the overcriminalisation of people with complex needs, such as the offences of begging and low-level possession of drugs of dependence for personal use. Enforcement of minor offences does not address the underlying circumstances of mental health, disability, homelessness and social marginalisation, and can further entrench these issues.[90]

This is a view held consistently across organisations and agencies that work with people living with mental illness who have come into contact with the criminal justice system.[91]

Receiving fines—for example, public transport, parking or toll road fines—also disproportionately affects people experiencing homelessness, living with mental illness or who are on low incomes.[92] Springvale Monash Legal Service stated that these groups may be 'more vulnerable to receiving fines, [and] … more likely to accumulate larger debts through multiple fines and additional penalties'.[93]

Illustrating the impact of infringements on people living with mental illness, data analysis conducted by the Commission indicates that registered clients of area mental health services are 10 times more likely to be charged with fare evasion than the general Victorian population.[94] The Northern Community Legal Centre stated that of the 568 people it assisted in 2018–19 who identified as having a 'diagnosed mental illness', 20 per cent (115 people) were assisted with infringements issues.[95] WEstjustice told the Commission that when they assist clients with mental illness to deal with fines, they are routinely withdrawn and the corresponding debts and penalties waived.[96]

The Fines Reform Advisory Board was established in September 2019 to review the fines system following reforms made under the *Fines Reform Act 2014* (Vic) which came into force in early 2018). The board submitted its report to the Attorney-General in April 2020, and in December 2020 it, along with the Victorian Government's response, was published.

Relevant to the work of this Commission, the board found that '[s]ocial justice initiatives delivered under Fines Reform are providing more support for vulnerable fine recipients'.[97] The board went on to recommend improvements to the way the fines system treats vulnerable people:

> the Advisory Board recommends that the eligibility test for persons who shouldn't pay their fine ('the special circumstances or nexus test') should be reformulated in two ways to make it fairer: the threshold to meet the existing test should be reduced and a second, narrow limb, requiring no causal link between the infringement offences and a person's condition or circumstances, should be available to those with a substantially diminished capacity to pay or otherwise manage a fine for the foreseeable future.[98]

The board goes on to note that one such example of diminished capacity to pay would include 'a person subject to long-term involuntary treatment under the Mental Health Act 2014.'[99] The Victorian Government has indicated it accepts in principle the board's recommendation.[100] The Commission notes the wealth of evidence it has received in relation to the impact of infringements on people living with mental illness that may be of assistance to the government in the implementation of the recommendations of the board.

Health justice partnerships

In addition to advocating for reform to minor offences, submissions to the Commission highlighted the potential benefits of health justice partnerships as a way to respond to the impact of minor offences and fines on people living with mental illness.[101] There are a number of health justice partnerships currently or recently operating in Victoria, including:

- Melbourne Legal Care—a partnership between the Royal Melbourne Hospital and Inner Melbourne Community Legal
- Rumbalara Therapeutic Justice Practice—a partnership between the Goulburn Valley Community Legal Centre and Rumbalara Aboriginal Cooperative Limited
- St Vincent's Hospital Melbourne health justice partnership—a partnership with Justice Connect, Seniors Law
- Sunshine Hospital Family Violence Project, Sunshine—a partnership between Brimbank Melton Community Legal Centre and Western Hospital
- First Step Legal—embedded and co-located within First Step, an addiction and mental health services clinic.

The health justice partnerships case study provides an overview of the health justice partnership between WEstjustice and Werribee Mercy Hospital.

Police engagement with people living with mental illness

The Victorian Government told the Commission that a lack of mental health services is leading to an increased reliance on police to be first responders for people experiencing mental illness.[102] The Commission's interim report stated that between 2014 and 2018, mental health transfers, where police transfer a person experiencing a mental health crisis to hospital, increased by 13 per cent annually, and 'psychiatric crisis' or 'suicide attempt or threat' computer-aided dispatch events increased by 10.9 per cent annually.[103] In comparison, non-mental health computer-aided dispatch events increased by 3.6 per cent each year.[104]

Case study:

Health justice partnerships

Health justice partnerships are collaborations embedding legal assistance within health care services. They support people who are at risk of poor health and unmet legal need. They can identify and address people's legal problems that may otherwise not be addressed and would have a continuing impact on a person's health, including their mental health. There are more than 60 health justice partnerships in Australia, with more than 30 operating in Victoria.

WEstjustice and Mercy Mental Health

In 2016, WEstjustice and Mercy Mental Health (MMH) established a Fines and Debt Clinic, Victoria's first health justice partnership focusing on people with a disability that may arise from mental ill-health. The clinic operated until 2020, but is currently on hold while the service model is being evaluated and future funding is confirmed.

The Fines and Debt Clinic supports people living with mental ill-health by providing legal services to inpatients of MMH's adult inpatient unit, as well as clients of MMH's community care unit. Social workers identify people with legal issues and refer them to the clinic's lawyer, who sees clients in the hospital while they are inpatients or in MMH's community care services.

Shifrah Blustein, Program Manager of the health justice partnership, said it has assisted 242 clients since 2016.

> Working with clients in the Mercy Mental Health setting provided many valuable insights into the complexities of clients facing significant mental health issues. It afforded us the opportunity to forge client relationships with a cohort that were very much in need of legal assistance but would likely not find their way to our centre if it were not for our health-justice partnership with the hospital.

Ms Blustein said a recent evaluation of the program showed that some staff believed that the assistance greatly reduced stress for clients and reduced readmissions to hospital.

> Clients surveyed attested to the sometimes life-changing nature of the assistance provided, aiding them to rein in financial problems and reduce stress and poor health outcomes.

Source: Health Justice Australia <www.healthjustice.org.au> [accessed 16 November 2020]; WEstjustice, *Diverting vulnerable offenders away from the traditional criminal justice system, Submission to the RCVMHS: SUB.1000.0001.5694*, 2019; WEstjustice, *Health Agency to Court, Tackling the Fines System Evaluation Report*, September 2020.

In 2017–18 Victoria Police attended 43,000 events relating to a psychiatric crisis or suicide attempt or threat and conducted 14,000 transfers to an emergency department or designated health facility for an urgent mental health response.[105] Police responded to mental health callouts on average once every 12 minutes in that year.[106]

Victoria Police observed that 'for many of these callouts, a health based intervention, rather than a law enforcement one, would have likely been the most beneficial response'.[107] In his evidence to the Commission, Assistant Commissioner Glenn Weir, Victoria Police, noted that 'unnecessary contact between police and people experiencing mental health issues should be minimised as this can compound stigma and add to the person's trauma, leading to suboptimal outcomes'.[108] Fitzroy Legal Service described the current approach of sending police as first responders as failing to 'meaningfully engage people with appropriate community services' and that it causes harm through the 'trauma and stigma of a public, at times violent arrest, further criminalisation, and potentially imprisonment'.[109]

The Productivity Commission's *Mental Health Inquiry Report* recommended changes to how police respond to mental health incidents in line with a co-responder model:

> State and Territory Governments should implement a systematic approach for responding to mental health related incidents to support all parties involved. Mental health professionals should be embedded in police communication centres and police, mental health professionals and/or ambulance services should be able to co respond to mental health related incidents.[110]

The demands placed on Victoria Police to support people living with mental illness are considerable. The need for health-based interventions in many of these circumstances is clear. Chapter 9: *Crisis and emergency responses*, sets out the Commission's findings in relation to Victoria Police's role as first responder. This includes the recommendation that, wherever possible, emergency services' response to people experiencing mental health crises is led by health professionals rather than police.

Police response to minor offences

In addition to the role of police as first responders, another area of significant interaction between police and people living with mental illness is through minor offences. Submissions to the Commission discussed how these interactions could be improved to ensure people receive health-based interventions where required.

Police decision making is pivotal in determining whether or not a person enters the justice system.[111] For some offences, police have the ability to recommend diversion or issue a caution as an alternative to charging an individual 'where it would not be in the public interest to proceed with criminal charges'.[112]

Despite this capacity, the Commission heard that the use of diversion has declined in Victoria in recent years. Emeritus Professor Arie Freiberg AM, Chair of the Sentencing Advisory Council, observed in his personal capacity that:

> One notable trend is what seems to be an overall decline in the use of diversion in Victoria in recent years. The Council is generally supportive of diversion. This is largely due to a decline in the use of police-ordered diversion; however, there has been a significant increase in the use of court-ordered diversion.[113]

Fitzroy Legal Service reiterated this observation and stated that for their clients, 'arrest and criminal charge is the predominant police response' and that this decision means 'a health issue is transformed into a criminal justice issue'.[114] The Magistrates' Court of Victoria advised that 'providing a law and order response to an episode of mental illness that requires medical intervention is not appropriate'.[115] Fitzroy Legal Service recommended that Victoria Police policy be updated to expand the circumstances in which a 'pre-charge' diversion could be granted. Fitzroy Legal Service advised:

> This could allow police officers to redirect a person into therapeutic and rehabilitative services instead of prosecuting them for low-level offences attributable to drug addiction and/or mental health issues.[116]

There are examples of cautioning and pre-charge diversion programs currently operating in Victoria. The Aboriginal Youth Cautioning Program, funded through the Victorian Government's Community Safety Statement, seeks to respond to the over-representation of Aboriginal young people in the criminal justice system through greater use of cautioning and diversion options.[117] There is also the Koori Women's and Adult Pre-Charge Diversion Programs that operate in Mildura and Latrobe.[118] Ms Marion Hansen, Co-Chair of the Aboriginal Justice Caucus, said the Koori Women's Diversion program was developed with extensive Aboriginal involvement,[119] providing 'practical support to ensure women are connected to the services they need, supported to get to appointments, and reconnected to culture as a source of therapeutic strength, healing and self-esteem'.[120]

Ms Hansen noted the benefits of diversion programs developed in close consultation with Aboriginal communities:

> Diversion schemes or services, including mentoring, that are facilitated by Aboriginal community controlled organisations, community members or Elders are more positive for strengthening cultural connection, re-establishing broken relationships and community building.[121]

The fourth Aboriginal Justice Agreement recommended expanding these programs. The Aboriginal Justice Agreement was developed in response to recommendations from the 1991 Royal Commission into Aboriginal Deaths in Custody.[122] The agreement is now in its fourth phase and aims to improve Aboriginal justice outcomes and reduce over-representation in criminal justice settings. It is yet to be completed.[123]

In one of the Commission's roundtables, Assistant Commissioner Luke Cornelius at Victoria Police reflected on the capacity of cautioning and pre-charge diversion programs to achieve positive outcomes for young people: 'we know the evidence is very clear, that effective cautioning, effective diversion, with appropriate supports in place actually is the best way of supporting young people in changing behaviour'.[124] Assistant Commissioner Cornelius highlighted the Aboriginal Youth Cautioning Program as a positive example of police and community services working closely together.[125]

Jesuit Social Services supports the broader use of cautioning models that involve police and support services working together:

> Jesuit Social Services would like to see a youth social worker working alongside police because we consider a caution issued by police to a young person could trigger an opportunity for a social worker to engage with a young person and refer the young person to necessary supports—without further engagement in the criminal justice system.[126]

At the Commission's roundtable, Assistant Commissioner Cornelius added the caveat that the success of these models relies on the quality of services that young people are referred to:

> one of the particular challenges we face, is many of the services out there are not fit for purpose when it comes to being able to deal with particularly complex cases. And so the standard suite of offerings from service providers oftentimes fall short, in terms of being able to address some of the particular complexities that come with some of the mental health issues that young people ... are living with.[127]

It is anticipated that the Commission's recommendations to significantly expand community-based mental health services, as outlined in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*, will enable cautioning and pre-charge diversion programs to refer people to services that have the resources and capacity to provide appropriate supports.

Use of remand and its impact on people living with mental illness

Recent bail reforms are likely to have had a significant impact on people living with mental illness due to their over-representation in the prison system. In 2013 there were significant reforms to bail legislation in Victoria. These included creating offences for contravening a condition of bail and committing an indictable offence (a more serious offence) while on bail. In 2017, in the aftermath of the Bourke Street tragedy, the Honourable Paul Coghlan QC reviewed the bail laws. Following this review, further legislative changes were implemented, which made it more difficult for people to obtain bail.

Since these reforms, the number of people held on remand in the adult prison system has increased. On 30 June 2013, prior to the bail reforms, 18 per cent of all prisoners were remandees (954 from a total of 5,340 prisoners).[128] By 31 July 2016 this proportion had increased to 30 per cent of all prisoners and has remained above 30 per cent since then.[129] On 30 November 2020, 38 per cent of all prisoners were remandees (2,728 from a total of 7,109 prisoners).[130] This increase can also be seen in the numbers of prisoners who are remanded but do not receive a sentence of imprisonment when their matter is finalised by a court. On 30 June 2013, 144 prisoners on remand (29 per cent of all prisoners on remand) were discharged without being sentenced.[131] On 30 November 2020 this had increased to 455 prisoners, or 45 per cent of all prisoners on remand.[132]

Mr Nicholson discussed how increasing remand rates have particularly affected people living with mental illness. Bail laws may require people to prove there are strong reasons or exceptional circumstances for not remaining in custody (even for minor offending), and this has been particularly challenging for people living with mental illness 'who may have difficulty complying with bail conditions or desisting from minor offending'.[133] Mr Nicholson further proposed that remand rates may be contributing to the recidivism (subsequent interactions with the criminal justice system) rate among people living with mental illness because 'time in custody is criminogenic—people are much more likely to go back to prison once they have been there, even for short periods'.[134]

The Commission heard about the use of 'therapeutic remand'—'where a person is denied bail in order to ensure they receive treatment in prison'.[135] Dr Cassar reported that she is 'anecdotally aware that "therapeutic" remand continues to occur'.[136] In her witness statement, Ms McCammon cited data to support this. Among prisoners with a 'serious or significant mental health condition' in custody on 30 June 2019, almost two-thirds (63 per cent) were on remand (324 of 515 prisoners).[137] Ms McCammon concluded that '[w]hile not conclusive, this data aligns with various submissions to the Royal Commission indicating the continued use of 'therapeutic remand''.[138]

Mr Coghlan also made recommendations for bail reform that were not implemented. These recommendations were directed towards removing some lower-level offences from the bail and remand system and establishing a 'Notice of Charge' to allow people to be charged with these lower-level offences without entering the bail and remand system.[139] Mr Coghlan noted:

> The use of bail in cases of minor offending causes broader problems for the criminal justice system. It can lead to accused persons who pose a low risk to the community being remanded in custody for offences for which they would be unlikely to receive a sentence involving imprisonment. This creates pressure on the remand system, which requires places to be available for people charged with more serious offences and those who pose a greater risk to the community. Even a remand overnight puts pressure on the system. Resource pressures on the police and the courts are exacerbated when warrants are issued for accused who fail to appear, rather than cases being determined in the accused's absence.[140]

The impact of the bail reforms on people living with mental illness can be reduced through the Commission's recommendations to improve diversion, rehabilitation and reintegration programs. This will enable people living with mental illness to avoid appearing before the courts, and if they do appear, they will have the supports in place to assist them to comply with their bail conditions. These recommendations include the police and ambulance co-responder model referred to in Chapter 9: *Crisis and emergency responses*, expansion of problem-solving courts, significant investment in community mental health and wellbeing services and reforms to community-based forensic mental health services.

23.1.6 Problem-solving courts

Problem-solving courts have been developed to deal with the underlying causes of crime.[141] By responding to the factors that contributed to an offence, it is hoped that the person will be less likely to reoffend. Through this mechanism these courts aim to deal with patterns of repeated involvement with the justice system. Problem-solving courts are, to some extent, based on the principles of therapeutic jurisprudence.[142] Those principles emphasise that better outcomes can be achieved by having a positive impact on the psychological wellbeing of the accused. These courts aim to address issues related to offending (such as mental illness or substance use or addiction) through service referrals, treatment provisions or supervision requirements.[143]

The history of problem-solving courts at the Magistrates' Court of Victoria is outlined in Box 23.2.

Box 23.2: Problem-solving courts at the Magistrates' Court of Victoria

The Magistrates' Court of Victoria sits at 51 locations around Victoria. There are 12 headquarter courts (Geelong, Broadmeadows, Dandenong, Frankston, Latrobe Valley, Ballarat, Heidelberg, Shepparton, Bendigo, Melbourne, Ringwood and Sunshine). The remaining 39 courts are satellite courts.

The Magistrates' Court has developed a range of problem-solving courts and related services. Problem-solving approaches were introduced in Victoria in 1994 with the Mental Health Court Liaison Service in the Magistrates' Court.[144] The interest in problem-solving approaches grew in the early 2000s with an increased policy focus on reducing offending. In 2005 the Victorian Government published *A Fairer Victoria*, which committed to reducing offending and reoffending by tackling the underlying causes of crime and improving access to justice for targeted disadvantaged groups.[145] In 2006 the Senate Select Committee on mental health recommended:

> That there be a significant expansion of mental health courts and diversion programs, focussed on keeping people with mental illness out of prison and supporting them with health, housing and employment services that will reduce offending behaviour and assist with recovery.[146]

In 2008 Mr Rob Hulls, the then Victorian Attorney-General, published his second 'justice statement'—a Ministerial Statement that outlined the government's plans for the Victorian criminal justice system. This statement endorsed the use of problem-solving approaches to respond to the underlying causes of offending behaviour.[147] One of the 25 initiatives of the statement was:

> Develop and implement a framework for problem-solving approaches in the Magistrates' Court to consistently address the underlying causes of offending behaviour by people from groups who are over-represented in the criminal justice system. The Koori Court program will be extended to Mildura and Gippsland and a Koori Children's Court will be established.[148]

Around this time, a number of problem-solving courts and related services began, including the Drug Court, the Neighbourhood Justice Centre, the Court Integrated Services Program and the Assessment and Referral Court. The Koori Court was also established around this time. There is also a Koori Court in the County Court of Victoria jurisdiction.

Established in 2010, the Assessment and Referral Court (ARC) is a problem-solving court that operates as part of the Magistrates' Court. The ARC focuses on clients living with 'a mental illness or cognitive impairment due to intellectual disability, acquired brain injury, autism spectrum disorder and/or neurological impairment'.[149] It is a specialist therapeutic court that shifts 'the focus of the court from determining a legal contest between opposing sides to being actively engaged in addressing the underlying causes of offending and the therapeutic needs of the individual'.[150]

The Magistrates' Court summarises the functions of the court this way:

> The ARC List combines active court supervision or judicial monitoring with clinical case management. A team of advanced, clinically-trained and court-based case managers, including social workers and psychologists, develop and support clients to engage with tailored treatment and support plans. The primary focus of the program is to scaffold and support clients to engage with appropriate treatment and services to ensure they manage their functional and/or social disabilities (including mental illness, intellectual disability, acquired brain injury, autism spectrum disorder and neurological impairment).[151]

The court aims 'to address the needs and circumstances of the individual to bring about recovery and stabilisation'.[152] This can include assisting a person to get mental health, disability, drug treatment, housing, physical health and other services as required.[153]

The ARC is currently available at three headquarter courts (Frankston, Melbourne and Latrobe Valley) and two satellite courts (Moorabbin and Korumburra). Given the limited geographic coverage of the ARC, many Victorians do not have access to the court.[154]

ARC participants are people who have been charged with one or more criminal offences within the jurisdiction of the Magistrates' Court for either summary (minor) or indictable (more serious) offences that are capable of being heard as summary offences.[155] Offenders who have been charged with a serious, sexual or violent offence (as defined in section 6B (1) of the Sentencing Act) are not eligible for participation in the ARC list.[156]

To be eligible for the ARC, offenders must remain out of custody, consent to participate in the ARC, and meet diagnostic, functional and needs criteria including:[157]

- having a mental illness, intellectual disability, acquired brain injury, 'autism spectrum disorder' and/or neurological impairment, including (but not limited to) dementia—the diagnostic criterion
- having substantially reduced capacity in self-care, self-management, social interaction or communication due to the condition—the functional criterion
- being likely to benefit from receiving coordinated services and participating in a problem-solving court process—the needs criterion.[158]

These criteria ensure the 'ARC provides a dedicated justice pathway for a small number of people with mental health conditions and cognitive or neurological impairments'.[159]

On acceptance into the ARC, participants receive supervision, assessment and case management for up to 12 months.[160] Ensuring each participant encounters the same court staff is a core component of the program. The same magistrate, case manager and police officer are involved throughout the program and interact with the participant in a less formal setting than is usual in the Magistrates' Court.[161] The Magistrates' Court observed that:

> the presence of a sworn police member creates a relationship between the offender and Victoria Police, which can change perceptions, and assist in the client's rehabilitation, further reducing engagement or contact with the Victoria Police in the community.[162]

Personal story:

Whitney Dwyer

Whitney has had numerous contacts with the mental health and criminal justice systems. When she heard about the Assessment and Referral Court (ARC), she asked her lawyer if she would be suitable.

> my lawyer got me to see a professional psychologist ... [who] diagnosed me with borderline personality disorder and severe depression, among other things, which got me into the program.

Whitney says her experience with ARC was very positive and she does not think she would be where she is today if she had not had this experience.

> I was skating on thin ice but the Judge kept giving me chances. She saw a lot more than I saw in myself, and she believed in me.
>
> ARC offered me a second chance at life. They were very patient—I wouldn't even be that patient with me! They don't look down on you, they sit at your level.

Whitney said it is critical that services care about their clients.

> You need someone who is not going to give up on you.
>
> when I got out of prison, even though I went straight back down the same old road, my housing worker really cared about me. ... Usually if you don't engage with workers, they close your case, but she didn't even though she didn't hear from me for ages. The next minute she was rocking up at my shared accommodation door with a bag and she was like 'I just wanted to check how you are'. I honestly started crying and I gave her a hug and I felt like 'wow, she actually cares'.

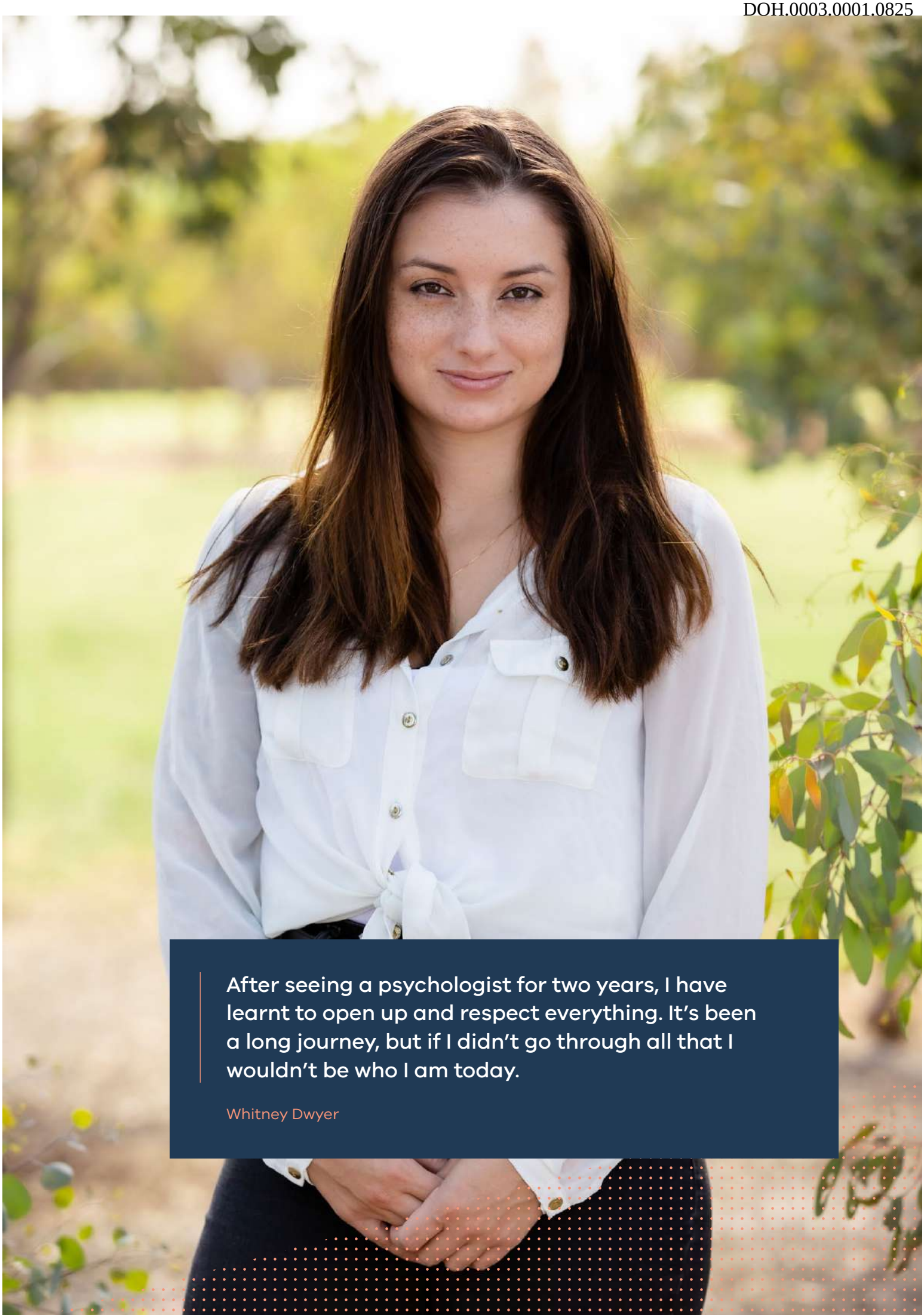
It has taken time for Whitney to find the mental health services and practitioners that work well for her.

At her current mental health service, Whitney is able to decide which services to access at her own pace. With these supports, she is now positive about the future.

> After seeing a psychologist for two years, I have learnt to open up and respect everything. It's been a long journey, but if I didn't go through all that I wouldn't be who I am today.

Whitney said the most important factor for a successful future mental health and wellbeing system is a passionate and caring workforce.

Source: *Witness Statement of Whitney Dwyer*, 12 June 2020; Whitney Dwyer meeting with Commissioner Cockram,, July 2020.



After seeing a psychologist for two years, I have learnt to open up and respect everything. It's been a long journey, but if I didn't go through all that I wouldn't be who I am today.

Whitney Dwyer

Positive outcomes for participants

The ARC is achieving positive outcomes for participants and is well regarded by police, participants and the legal system. Victoria Police highlighted the ARC as evidence that a health-based approach can respond to the factors that lead to offending and 'can often be more beneficial than a traditional criminal justice pathway'.[163] Victoria Legal Aid reported that such courts 'can have strong therapeutic benefits for participants' and that it has 'assisted many clients in ARC and has seen a number of people transform their lives over the time they have been participating in the program'.[164]

A 2016 study sought to determine whether the ARC had reduced the number of offenders with a 'mental impairment' received into custody.[165] The study concluded that 'successful program completion was the most significant predictor of non-reoffending or a longer time to reoffending'.[166] This research also indicated there was a significant difference in the 'time to reoffending' between those who completed the program and those who did not. The average time to the first proven offence post-program for program completers was 21.87 months, and for non-completers this was 4.87 months.[167] For those who did reoffend, their offences after they had completed the program were less severe than those committed before entering the program. Severity of offending during the program was also significantly lower than post-program severity of offending.[168]

Support across the justice sector and from participants

The ARC has received support from across the justice sector and from participants. Whitney Dwyer, a witness before the Commission, said:

> I can't think of many improvements for ARC, I think they are doing an excellent job. I don't think anything needs to be changed with the program itself. It might be good if they could give the program more workers because I think last time I was there, they only had two main support workers. They could also try to promote more caring work and how to help people with mental health issues so it carries less stigma.[169]

Inner Melbourne Community Legal reported that while therapeutic courts such as the ARC 'provide welcome alternatives for people in mental health crisis', access to these lists is currently limited.[170] This service regularly has clients who are unable to access the ARC because the court in which their charges are to be heard does not have an ARC.[171] Inner Melbourne Community Legal recommended an increase in funding for the ARC and related programs 'to ensure that all suitable matters can be heard in the therapeutic system and that this is not determined by whether the court where a person's matter is listed has ARC'.[172] Support for the expansion of problem-solving courts, and specifically for the expansion of the ARC, was also expressed by participants in the Commission's panel hearings.[173] Youthlaw recommended that funding for the ARC list should 'be made available in all major courts'.[174]

In 2015 the Victorian Ombudsman made a recommendation to expand the:

> successful models of the Drug Court of Victoria, the Court Integrated Services Program, the Neighbourhood Justice Centre, the Assessment and Referral Court List, the Criminal Justice Diversion Program and the CREDIT/Bail Support Program and the Koori Court.[175]

The Ombudsman defined success as reducing reoffending. This report stated that the ARC provided an estimated benefit of between $2 and $5 for every dollar spent.[176] Ms McCammon referenced an evaluation of the ARC that forecast that, over five years, the 'ARC List would generate savings of $2.24 for every $1 invested in it'.[177] These savings were attributed to reduced reoffending as well as fewer days in prison or under community correction supervision.[178]

The Ombudsman concluded that expanding diversion, rehabilitation and reintegration programs requires a 'whole-of-government' approach to improve accessibility:

> Although there is some good practice across the justice system in diversion, rehabilitation and reintegration, these are often uncoordinated, as well as demographically, geographically and financially constrained. A whole-of-government approach is needed to shift the focus: to reduce offending and recidivism and to promote the rehabilitation of offenders. This requires a common intent and set of shared objectives across justice agencies, health, education and housing, and stronger links to community service organisations.[179]

The Productivity Commission's *Mental Health Inquiry Report* made four recommendations regarding diversion, rehabilitation and reintegration services for people living with mental illness who are engaged with the criminal justice system (refer to Box 23.3).

Box 23.3: Productivity Commission recommendations for diversion, rehabilitation and reintegration services for people living with mental illness who are engaged with the criminal justice system

1. 'An early intervention approach should be introduced to identify people with mental illness at high risk of contact with the criminal justice system, and provide supports to reduce the risks of them offending.'
2. 'State and Territory Governments should work to ensure that people with mental illness who would benefit from mental health court diversion programs, are able to access them.'
3. 'State and Territory Governments should develop disability justice strategies and work towards integrating legal and health services (including through health justice partnerships) so that people with mental illness are better supported to resolve legal matters and participate in the justice system.'
4. 'Supported decision making by and for people with mental illness should be promoted through improved access to individual non-legal advocacy services … and mental health advance directives.'[180]

23.1.7 Expanding the Assessment and Referral Court

The Commission recommends expanding the ARC to improve opportunities for directing people living with mental illness away from the criminal justice system. This reform will contribute to addressing the over-representation of people living with mental illness in Victorian prisons and increase access to support services. It is anticipated that these benefits will contribute to improved mental health outcomes for people living with mental illness who are in contact with the criminal justice system. It is expected that this reform will also contribute to improved cohesion between the mental health, justice and broader support service systems. This recommendation is aligned with the findings of the Productivity Commission's inquiry into mental health.

Regarding the ARC, Victoria Police told the Commission that a health-based approach 'can often be more beneficial than a traditional criminal justice pathway'[181] and that 'the existence of the ARC is positive … as it works to more effectively support the needs of … individuals'.[182] However, Victoria Police also noted that the success of the ARC depends on capacity across referral services.[183] That is, if the court refers a participant to a drug treatment service, but this service has no capacity to take on new clients, the effectiveness of the ARC approach may be compromised. Victoria Police reported that 'due to the increasing demand on the mental health service system there can be difficulty for individuals to access the support services they need'.[184] The proposed expansion of the ARC into new geographic areas must consider the accessibility of mental health, disability, drug treatment, housing, physical health and other services. It is anticipated that the new community model recommended by the Commission and described in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*, will improve access to mental health and other services throughout Victoria.

The Commission does not have access to data on how many applicants are expected to apply for the ARC in the coming years. Analysis of this expected demand will be required to inform the scale of expansion. Given the recent investment to expand the ARC, there should be a strong basis available to government on which to model the expansion as recommended by the Commission.

23.2 Improving mental health outcomes across the adult forensic mental health system

Forensic mental health services provide treatment, care and support to people living with mental illness who have come into contact with the criminal justice system. In Victoria these services are primarily delivered by Forensicare in three settings:

- community-based mental health services
- inpatient care at Thomas Embling Hospital, the state's forensic mental health hospital
- prison-based specialist mental health services (refer to section 23.1.4).

23.2.1 Community forensic mental health services

The adult community-based forensic mental health system aims to meet the needs of people with a mental illness who have committed a criminal offence or are at risk of doing so. Consumers may have had repeated involvement with police, a matter before the court, been sentenced to a community-based order, or been recently released from custody. The system includes any forensic mental health service that is provided outside of a hospital or prison setting.

Forensicare's Community Forensic Mental Health Service is a small suite of community-based programs for people living with mental illness who have offended or are at high risk of offending. These programs provide clinical advice and consultation services. Forensicare's service plan provided an overview of current programs:

- The **Court Reports Service** provides psychiatric and psychological pre-sentence reports to courts at the request of magistrates and judges.
- The **Community Integration Program** provides short-term support and linkage assistance to people with severe mental illness who require ongoing treatment when they leave prison. This program has 3.5 fulltime-equivalent positions and has the capacity to support 35 people at any one time.[185]
- The **Community Transition and Treatment Program** oversees the treatment, care and supervision for forensic and civil consumers transitioning from Thomas Embling Hospital to the community.
- The **Forensic Clinical Specialist Program** builds forensic mental health expertise and capacity in Victoria's mental health services. Forensicare provides central coordination of the program, which is delivered in partnership with local specialist mental health service providers. There are currently 23 forensic clinical specialists employed across area mental health services.[186]
- The **Forensicare Serious Offender Consultation Service** aims to support Community Correctional Services and mental health services to manage people who have a severe mental illness and a history of serious violent and/or sexual offending. In 2018–19 this program had 1,420 contacts with Community Correctional Services.[187]

- The **Mental Health Advice and Response Service (MHARS)** provides clinical mental health advice within the court to reduce delays in proceedings and remands and to improve the appropriateness of mental health interventions and referrals for people appearing before the court. In 2018–19 this program provided 4,232 court liaison assessments.[188]
- The **Non-Custodial Supervision Order Consultation and Liaison Program** supervises the monitoring and direct treatment of people placed on a Non-Custodial Supervision Order. A Non-Custodial Supervision Order is an order made by a court following a finding that a person is permanently unfit to plead or not guilty by reason of mental impairment. The order allows the person to live in the community subject to conditions such as restrictions on where they can live or travel and that they obtain medical, psychiatric or psychological treatment. In 2018–19 this program supported 68 consumers.[189]
- The **Problem Behaviour Program** provides psychiatric and psychological consultation and treatment for adults aged 18 years or older with a range of behaviours associated with offending. In 2018–19 this program supported 323 consumers.[190]
- The **Victorian Fixated Threat Assessment Centre** 'provides a structured and coordinated approach to serious threats of violence posed by people with complex needs'.[191] This program is a significant recent investment in community-based forensic mental health care—in 2017–18 the program was established with $31.6 million in funding.[192] It is a partnership between specialist police and Forensicare that aims to 'identify high-risk people who may pose a serious threat to the community, including terrorists and lone actors who have made ongoing threats to others'.[193] In 2018–19 this program received 60 referrals.[194]

Figure 23.3 provides a summary of consumer pathways into these services.

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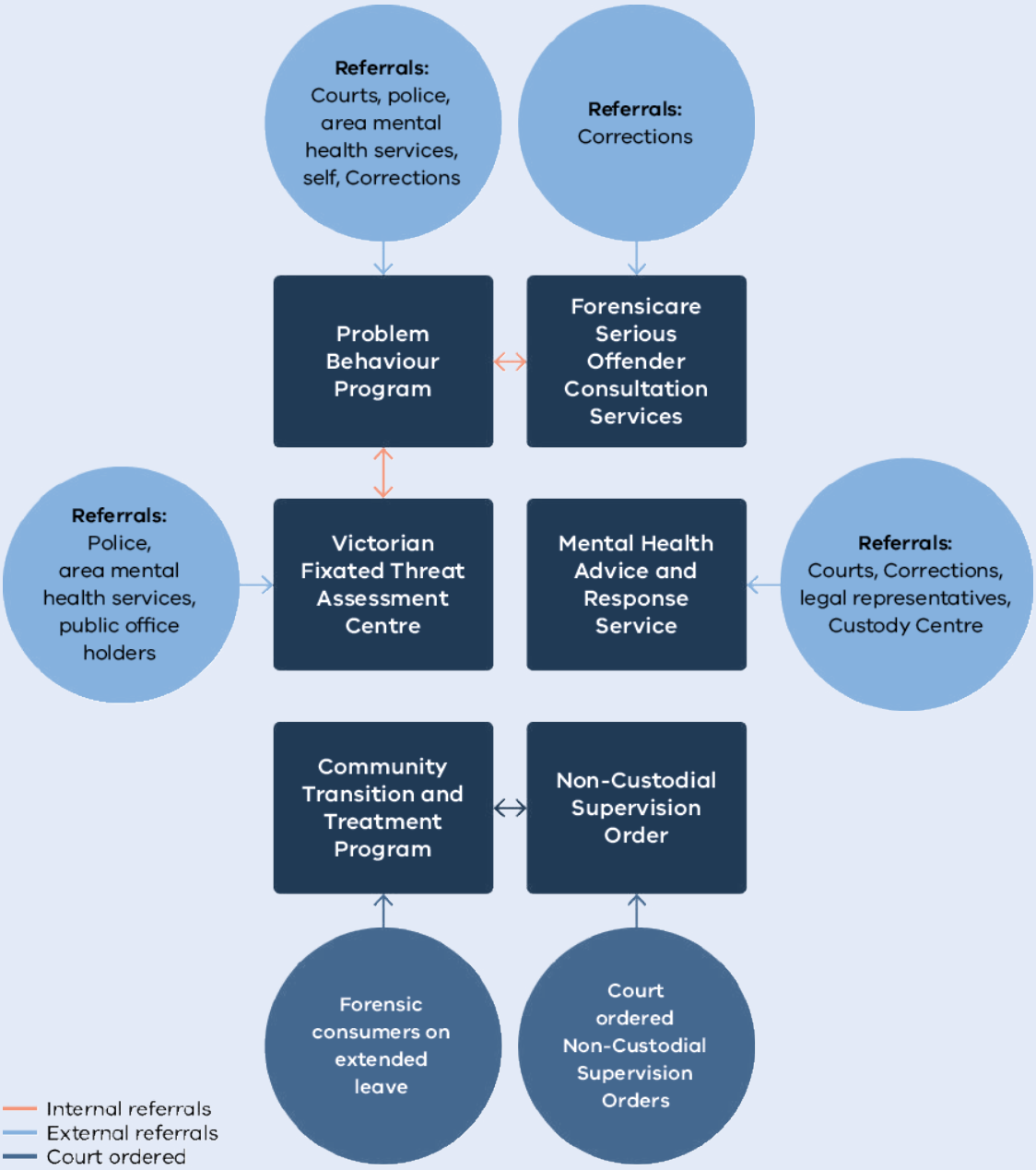
Figure 23.3: Community Forensic Mental Health Service consumer pathways (internal and external referrals)



Source: *Forensicare, Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, 2020, p.33.

Further detail as to the current state of some of these programs is set out in the following sections, as the Commission ultimately recommends their expansion.

Forensic Clinical Specialist Program

Currently, the Forensic Clinical Specialist Program provides specialist forensic services to area mental health services. Dedicated forensic clinicians are embedded within area mental health services to provide specialist clinical, training and service development functions. Through this program, forensic clinical specialists are employed by local area mental health services to 'improve the expertise and capacity of the workforce in [these] services to optimally assess and manage offending and problem behaviours'.[195] Specifically, forensic clinical specialists aim to:

- improve clinical outcomes for consumers
- reduce consumer contact with the justice system
- improve management of offence-related risk
- improve worker safety and reduce violence and aggression in the workplace
- improve coordination and referral pathways between specialist mental health services and correctional services
- focus on people released from custody in need of mental health follow-up
- improve oversight of people subject to Non-Custodial Supervision Orders.[196]

When the program began in 2010, there were between six and eight forensic clinical specialists; there are now 23.[197] Despite this increase, the program is not responding effectively to high levels of demand and the increasing complexity of consumers.[198] Dr Margaret Grigg, CEO of Forensicare, identified 'workload and the limited support currently available to [forensic clinical specialists] from Forensicare' as the major barriers to the effectiveness of the program.[199] The significant workload means that forensic clinical specialists are currently only able to focus on primary and secondary consultation, and 'there is limited opportunity … to work directly with complex clients.'[200] Distinguished Professor Ogloff told the Commission that a crucial challenge to the program's effectiveness was that 'there is largely only one forensic clinical specialist for an entire area mental health service'.[201] Similarly, Mr Peter Kelly, Director of Operations at NorthWestern Mental Health, reported that 'forensic clinical specialists are spread very thinly across services' and that this creates 'a situation whereby recommendations may be made but which staff may or may not be able to implement'.[202] Distinguished Professor Ogloff observed that the program cannot currently meet sector demand for forensic expertise:

> From my experience interacting with and teaching the Forensic Clinical Specialists since their inception, many become highly experienced but all typically lament the inability to meaningfully address all of the needs in their home services. Although the current model has begun to bridge a gap in services, it has not filled that gap. Only with expanded services, can the broader needs of the area mental health service and their consumers with forensic histories and contact be met.[203]

Despite these barriers, an evaluation of the program found statistically 'significant improvements in the competency, confidence and skill of the clinical workforce' in area mental health services to work with the target client group between August 2010 and April 2013.[204] This evaluation also found that area mental health service staff were 'working together and communicating more effectively around risk as a result' of the program.[205]

There is support for the expansion of the Forensic Clinical Specialist Program. Dr Shaymaa Elkadi, Executive Director of Strategy, Planning and Performance at Forensicare, told the Commission that 'expansion of [the forensic clinical specialist] role is much needed to enable area mental health services to cope with the growing acuity [severity of illness] and risk complexity of presenting cases'.[206]

Distinguished Professor Ogloff recommended that the Forensic Clinical Specialist Program be expanded 'such that it can be a conduit between Forensicare and the area mental health services'.[207]

Dr Elkadi further identified the need for more integration between Forensicare and the area mental health services, particularly to support people living in rural and regional areas:

> There is significant merit in supporting Forensicare to provide regional outreach and to operate satellite clinics across metropolitan and regional areas by collocating with area mental health services to provide shared care (particularly for high risk clients). This would support the regional model of Community Corrections, creating a stronger interface between justice and forensic mental health. [208]
>
> there is also need for a shared care model with area mental health services. This may require Forensicare to co-locate with area mental health services and have satellite clinics in regional areas. It would assist Forensicare to proactively build relationships with stakeholders and provide assertive outreach.[209]

Dr Grigg identified a shared care model as an important opportunity to improve community-based forensic mental health care:

> I do think that the issue of having regional forensic mental health community teams is important, really intensive treatment to a small number of consumers potentially through a shared care model, where Forensicare doesn't just provide advice to area mental health services, on what the risk is, but potentially helps work with them and hold that risk with them ...[210]

Area mental health services are not currently adequately supported, and the workforce does not always have the skills to respond to consumers' behaviour symptoms when they are 'experiencing an acute mental health episode'.[211] This may include consumers who are extremely agitated, distressed and placing the safety of themselves, other consumers and staff at risk. Queensland Health's *Violence Risk Assessment and Management Framework—Mental Health Services* provides a pathway for mental health services to get forensic expertise and advice on consumer care (refer to Box 23.4). The Commission has considered this when contemplating the expansion of the current system.

Box 23.4: Queensland's Violence Risk Assessment and Management Framework—Mental Health Services

Queensland's Violence Risk Assessment and Management Framework—Mental Health Services sets out guidance on how to identify, assess and manage service consumers who may pose a risk of violence towards others. This framework was recommended by the 2016 report *When Mental Health Care Meets Risk: A Queensland Sentinel Events Review into Homicide and Public Sector Mental Health Services*.[212] This review was initiated in response to a number of high-profile fatal events involving people with a known or suspected mental illness in Queensland. In reviewing these fatal ('sentinel') events, the review aimed to provide recommendations for improving the delivery of public and forensic mental health care.

The review found that risk of violence was not well understood or managed in mental health services in Queensland. Specifically, risk assessments and management plans did not consider a consumer's previous history of violence. There was limited 'senior staff involvement in the provision of treatment, management and supervision of high risk consumers', and this resulted in an unclear escalation process for assessing and managing risk.[213] The review also found there had been limited access to specialist forensic mental health advice and support for 'generalist clinicians [who are] managing forensic consumers or other consumers who pose a high risk of violence'.[214]

In response to these findings, the sentinel events review recommended developing a violence risk assessment framework. This framework aimed to improve access to specialist forensic mental health advice for the highest risk consumers.

The framework provides a pathway for mental health services to access forensic expertise and advice on consumer care. It uses a structured three-tiered approach to risk assessment and management. Each tier represents an escalation in the risk of violence and an associated increase in the service response. The tiers are:

- **Tier 1—screening** focuses on 'all people receiving mental health services'
- **Tier 2—assessment and response** focuses on people 'identified through the Tier 1 screening process as having an elevated risk profile' (this is conducted by 'senior clinicians and consultant psychiatrists with training and experience in violence risk assessment')
- **Tier 3—specialist assessment and response** focuses on people 'identified through the Tier 2 risk assessment and response process as having a significantly elevated risk profile that is unable to be managed without specialist forensic input and meets specialist forensic mental health services referral criteria'. This process is undertaken by specialist forensic mental health services.[215]

Community Integration Program

Forensicare's existing Community Integration Program provides assertive case management before and after release for prisoners with severe mental illness and complex needs who are at high risk of discontinuing treatment in the community.[216] It 'provides short term support and linkage assistance for people with serious mental illness who need ongoing treatment when they leave prison'.[217] This program involves discharge planning six to eight weeks before discharge and assertive community outreach immediately following release. During the outreach stage, clinicians facilitate linkages to area mental health services or community health services.[218]

This program is very small. Currently, there are 3.5 fulltime-equivalent clinicians in the Community Integration Program. Given the current cap of one fulltime-equivalent clinician per 10 consumers, the program 'only has capacity to service 35 clients at any given time'.[219] Forensicare estimates that this is less than 0.5 per cent of all Victorian prisoners.[220]

Community Integration Program clinicians therefore have limited capacity to support consumers with other needs beyond connecting them with mental health treatment in the community. Forensicare reported that clinicians are often asked to assist in 'non–mental health, yet essential, needs such as accessing legal advice, assistance with accommodation, guidance and access to financial assistance, obtaining essential items, supporting reconnection with family and physical health care needs'.[221] The inability of the program to deal with these broader factors due to resourcing limitations is an impediment to achieving positive outcomes for consumers.

23.2.2 Transitions from custody to the community

The importance of continuity of care

The Commission recognises the importance of continuity of care when people move between custody and the community. 'Continuity of care' means:

> health services in the community being integrated and closely aligned with the health services provided in prisons such that there is no gap or interruption in the services and support a person receives as they transition from prison to the community.[222]

A Victorian Alcohol and Drug Association report to the Commission goes on to note that '[e]nhanced continuity of care reduces the risk of poor [mental] health outcomes, the need for expensive emergency healthcare contact after release from prison'.[223] Forensicare advised that many people 'quickly lose any health gains made in prison within a few months of release' in part through their disengagement from treatment with poor outcomes for, 'not only the individual, but the entire community'.[224] Lack of access to consistent mental health treatment can also lead to reoffending and ongoing involvement in the justice system.[225] Distinguished Professor Ogloff informed the Commission that there is particularly poor continuity of care for people living with mental illness who are leaving prison.[226] He concluded that this cohort is 'more likely to deteriorate very rapidly in their mental state and re-offend before they get mental health care if not engaged with mental health services'.[227]

The Victorian Alcohol and Drug Association argues that:

> continuity of care between the criminal justice, mental health and [alcohol and drug] systems is essential before, during and after release from prison to redress inequality and build on any health gains made during incarceration. ... Ideally, planning for reintegration into the community should begin as soon as someone enters prison, with service provision continuing seamlessly after they return to the community.[228]

These sentiments about the importance of continuity of care have been echoed to the Commission by multiple experts.[229]

Lack of integration between prison and community services

The health care experienced by 'people released from prison in Victoria is neither well integrated nor continuous with community services.'[230] Forensicare's service plan identified 'limited community transition planning for people leaving prison' as a key challenge for the community-based forensic mental health system.[231] The service plan stated:

> Transition to community from prison is a time of great complexity, anxiety, and risk for the individual and community. Currently post release support for prisoners is limited. ... This cohort often experiences multiple assessments, misdiagnosis, lack of tailored support and continuity of care, and episodic service engagement, leading to relapse or increased substance use.[232]

Forensicare said that 'due to a lack of comprehensive assessment and discharge planning, many prisoners without family or community support leave prison without any post-release support'.[233] Forensicare also described communication systems between prisons and community services as 'prohibitive, exacerbating the tyranny of distance experienced by them; increasing risk and subsequent stress on practitioners'.[234] Dr Danny Sullivan, Executive Director of Clinical Services at Forensicare told the Commission that:

> the coordination of care as justice-involved persons enter the community provides a sharp disjunction between previous care in prison and the availability and access of subsequent care in the community.[235]

Many prisoners held on remand are bailed and released directly into the community, most often with very little notice and planning. For these prisoners there are no formal pathways into community forensic mental health services.[236] This is also the case for straight release prisoners (prisoners who are not released on parole), who do not have obligations to start or continue forensic mental health treatment but who do in contrast to the above have a known planned release date.

In her witness statement, Ms Julie Edwards, CEO of Jesuit Social Services, highlighted the importance of continuity of care to ensure people do not 'fall through the gaps when they transition between services'.[237] Ms Edwards stated that a case or 'key' worker can be integral to supporting continuity of care,[238] along with information sharing[239] and embedding mental health services within other services.[240] Forensicare highlighted the importance of discharge planning in ensuring effective continuity of care.[241] Effective planning is required to ensure people have access to housing, support resources and general mental health and health services once they leave prison.[242]

Dr Sullivan supported creating 'integrated care in prison that then follows people back into the community'.[243] Ms McCammon advised that people in custody would:

> benefit from in-reach services which allow them to commence treatment with community mental health providers prior to release, to deliver continuity of care and build connections with the mental health provider they will use in the community.[244]

Dr Cassar recommended creating an 'assertive in-reach model where dedicated clinicians work with the prisoner and [area mental health service] prior to their release to ensure a suitable discharge plan is in place'.[245]

Release from custody straight into emergency departments

Some prisoners reach the end of their term of imprisonment 'but [continue] to experience acute mental illness'.[246] This is typically due to a prisoner refusing treatment, as is their right, while in custody. Due to prolonged wait times or other factors, these prisoners have not been transferred to Thomas Embling Hospital to receive compulsory treatment before the end of their sentence. In such cases, at the time of discharge prison health services may seek an Assessment Order under the *Mental Health Act 2014* (Vic).[247] An Assessment Order authorises the compulsory assessment of a person to determine whether the person requires compulsory mental health treatment. It is the required precursor to any order which authorises compulsory treatment. Once an Assessment Order is made, a prisoner is transported via ambulance to the nearest designated mental health service.

Mr Kelly expressed concern that Assessment Orders are being used as a 'mechanism of convenience' to transfer care from the justice system to the mental health system. Mr Kelly stated, '[w]hat we find most commonly is that the released person is homeless and has no funds, and under these circumstances the mental health service is left to sort out these issues'.[248] Mr Kelly estimated that 50 per cent of Assessment Orders do not result in a recommendation for compulsory treatment from the attending psychiatrist.[249]

For prisoners who are acutely unwell, and an Assessment Order is therefore appropriate, Mr Kelly says there is poor communication between prisons and emergency departments:

> We often have very little warning that these people are going to be released and consumers often arrive at the emergency department in a state that is unmanageable, for example a consumer who is floridly psychotic and in restraints.[250]

Eastern Health and NorthWestern Health similarly reported that there have been some instances of aggression and violence in inpatient units from this cohort.[251]

The Commission's recommendation to increase forensic bed capacity will ensure many more prisoners receive the treatment they need before their release. This change should reduce the role of emergency departments in treating recently released prisoners. The Commission's recommendation to improve transitional supports when leaving custody will ensure there is appropriate communication and planning between prisons and hospitals when an Assessment Order is required. It should be noted that Assessment Orders and transfer to emergency departments may still be needed when a person is released on bail at short notice, or released directly from court.

23.2.3 Inpatient care at Thomas Embling Hospital

Thomas Embling Hospital provides specialist mental health treatment for consumers transferred from prison or ordered by courts to be detained for psychiatric assessment and treatment. Treatment is provided under the *Mental Health Act 2014* (Vic), the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) (CMIA) or the *Sentencing Act 1991* (Vic) for the following cohorts:

- security consumers, who are people transferred from the criminal justice system for psychiatric assessment, treatment and care under the Mental Health Act
- civil consumers, who are admitted under the Mental Health Act (sections 45 and 52), including consumers transferred from other area mental health services for treatment
- forensic consumers, who are people who have been found not guilty by reason of mental impairment and are admitted under the CMIA.

If a person is found not guilty because of mental impairment they may be placed on a supervision order (custodial or non-custodial) or may be unconditionally discharged. Forensic consumers at Thomas Embling Hospital have been placed on a Custodial Supervision Order. Both Custodial and Non-Custodial Supervision Orders are of indefinite length, but the court must set a nominal term for the order that is set out under the CMIA. The orders can be very long-lasting depending on the person's response to treatment.

Figure 23.4 provides a summary of the consumer pathways for each of these cohorts.

Thomas Embling Hospital has 136 beds across seven units contained within a high-secure precinct, and one low-secure unit.[252] Since opening in 2000, Thomas Embling Hospital inpatient infrastructure has expanded very slowly despite the concurrent very significant expansion of the Victorian population and the prison population. Thomas Embling Hospital opened with 65 beds, before becoming fully operational with 100 beds by the end of 2002. Over the past 18 years an additional 36 beds have been created. The eight-bed Apsley Unit opened in March 2019 to provide acute treatment to consumers transferred from prison under the Mental Health Act, particularly those with challenging behaviours.

In a roundtable with representatives from the Forensicare Consumer Advocacy Group, the Commission heard about both positive and negative experiences at Thomas Embling Hospital. One consumer stated:

> The service was brilliant. It took a long time. But I think with a lot of people with mental illness, it does take time to sort things out. So, having been afforded the time to get well again yes, I do approve of the service and I think it's been very helpful for not just me but for all that use it.[253]

Another roundtable participant discussed limited bed numbers and the impact this had on consumer flows: 'the biggest concern is beds available because it's very slow moving'.[254]

Another consumer said: 'They look after me, they want the best for me, they don't want you to be upset and I find that very welcoming environment'.[255]

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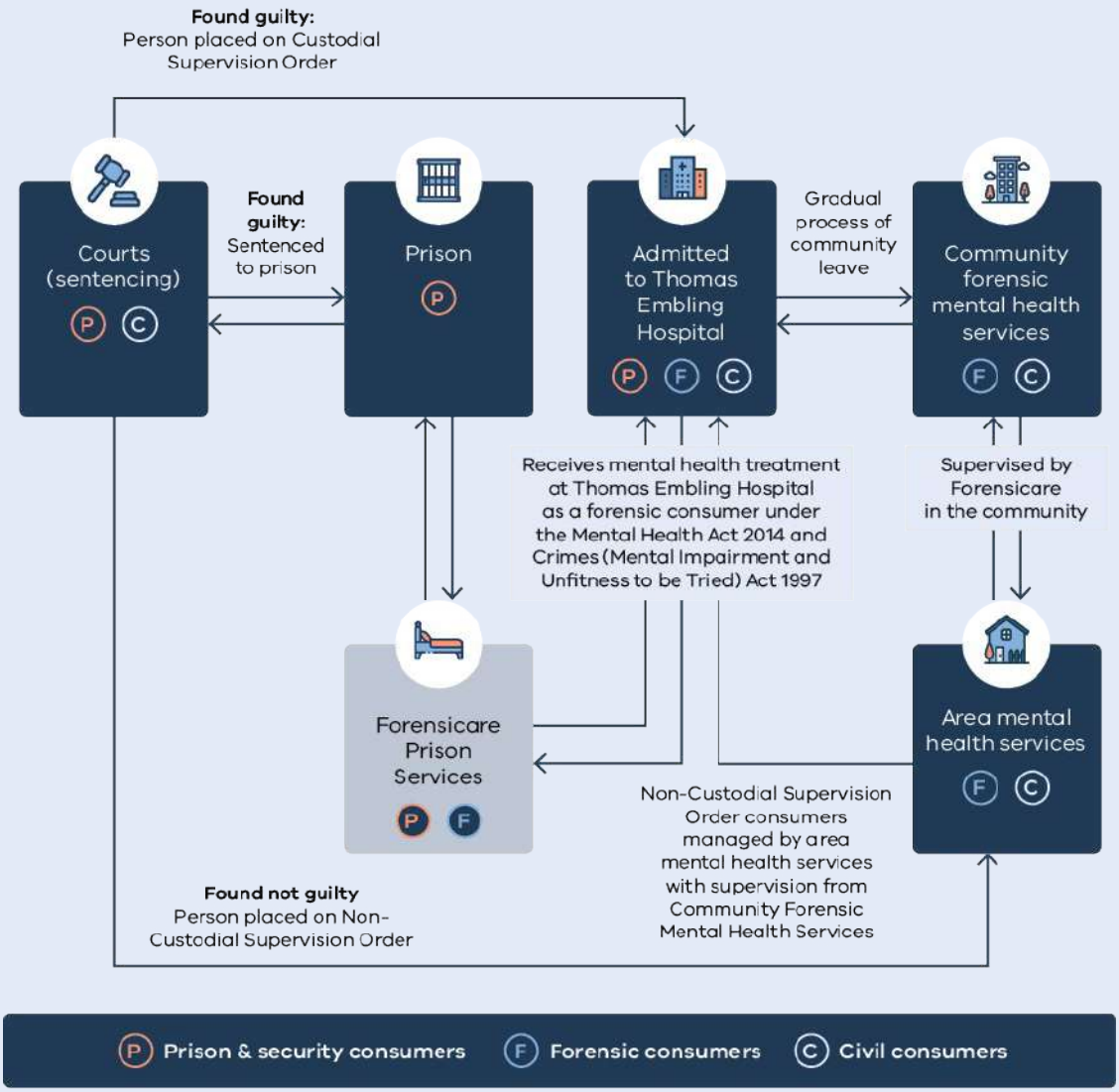
Figure 23.4: Summary of consumer pathways



Source: Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, 2020, p.33.

Note: In some cases, forensic and security consumers may be on remand.

Personal story:

Tommy

Tommy* had multiple hospital admissions for mental illness starting from the age of 19. He was admitted to Thomas Embling Hospital when he was 30, where he stayed until recently.

> I have been in and out of hospital many times. I must have had over 20 admissions to public units. For about 10 years, until I came to Thomas Embling, I was never really well. I was never what I'd call stable or recovered or anything like that.

Tommy said his experience of stays in mental health inpatient units were always too short to allow him to fully recover and that the system needs places where people can stay for longer.

> I've been on clozapine for about 12 years now. And even then, it's probably only the last four or five years that I've really become stable. Which is incredible, because you think of the public system where you are in and out in three or four weeks. That's not nearly enough time to get someone stable and well, and to the point where they don't have to come back to the hospital anymore. It's important to not just patch someone up but actually get them stable—it's a thing that only time can really do.

Tommy said it took a long time with stable medication and other supports for him to recover.

> It was only when I got to Thomas Embling that with time and consistent medication taking and all the therapy and all that sort of thing, that I started to get well again. I think now I am fully recovered and managing a very good mental state. It took about 15 years in Thomas Embling to get my head right.

When Tommy was younger, he said it was hard to understand the help he needed. He was put on a compulsory treatment order when he was 20.

> I had difficulties with taking medication consistently. I think I never really took it seriously enough and drug use was another problem.
>
> The [community treatment order] was a bit of a kick in the guts. I never really understood the gravity of the situation. I never thought anything was wrong. The hard part is identifying that there's something wrong when you don't think there is.

'Insight' is a big word for Tommy—he said he did not have insight into his mental illness and the impact of his offending until he got to Thomas Embling.

> I wish I had access to Thomas Embling without committing an offence. If there were a Thomas Embling in the community, for the public before you commit an offence, I think that would be a real positive. If that existed, then I might have gotten back the 20 years that I've lost.
>
> I've lost a good 20 years of my life because of poorly managed mental health. The frustration was crushing. I just couldn't shake it. I couldn't shake the illness. I tried, and there were no quick fixes. When you've got a headache you take Panadol and then an hour later it's gone. But mental illness isn't like that. It's a war of attrition.

Tommy found peer support and the group sessions at Thomas Embling helpful. He said this was not something he had access to in other hospital settings.

> For me, one of the best things I did was talking to my peers about similar things that have put us here, how mental illness has affected us. When I was in the acute units in the public system, they had art therapy and music groups which were more distracting people from their illness. I don't remember having a room full of peers talk about their illness and how that affects them, and that would have been a really big help.
>
> If I could tell my story to someone who's just starting to get unwell, point out the things that work and what helps and what doesn't, maybe that might help them. I wish I could say that to young people—listen, if you don't fix this now, you're gonna lose all that time. It's going to cost you time off your life. If you don't address it and do it well, do it right early, it's just gonna consume your life.

Source: *Personal Story of 'Tommy' (pseudonym), Collected by Victoria Legal Aid.*

Note: *Name has been changed to protect privacy.

One representative discussed the need for improved services for women:

> the women need more facilities where they can actually have some space to get well instead of all being put in a corridor where you're all on top of each other ... there's really not much there for women at all and it's actually quite disappointing when you look at the facts because there's a lot of women waiting in jail and this was my experience when I went through this system and you know, you can just get lost in it and it's really not fair actually.[256]

Forensicare observed:

> Despite recognition of the specific needs of women across the spectrum of forensic mental health services, they do not have the same options as men for a staged transition through security levels to support recovery and community integration.[257]

The Commission did, however, hear of the positive experience of recovery and integration of witness, Leona Coleman.

As discussed in the Commission's interim report, the demand for beds at Thomas Embling Hospital has increased for several reasons, including the growing prison population, recent changes to bail laws that have increased the number of people held on remand, and the introduction of the CMIA.[258] Since the Act's introduction, many more people have received supervision orders than before, and this has added to the demand for beds at Thomas Embling Hospital.[259] This increase in demand has not been met with increased investment to expand service capacity, with consequent restrictions on access and poorer quality of care.[260] A number of reviews have highlighted the service capacity challenges at Thomas Embling Hospital and the risks of not providing enough mental health services to acutely unwell prisoners.[261]

Growing proportion of forensic consumers

In 2002, 31 of the 100 beds at Thomas Embling Hospital were occupied by forensic consumers and the remainder by security and civil consumers.[262] Since 2002 the proportion of forensic consumers at Thomas Embling Hospital has increased. The hospital now has 136 beds, of which approximately 90 beds (66 per cent) are occupied by forensic consumers.[263] Figure 23.5 has been reproduced from the Commission's interim report and shows the change in the proportion of total occupied bed days by each consumer cohort, from 2002–03 through to 2019–20.

Despite this focus on forensic consumers, this cohort still commonly long wait times to be admitted to Thomas Embling Hospital from prison.[264] That is, these consumers—found not guilty by reason of impairment—are on average being kept in prison for more than a year before a bed at Thomas Embling Hospital becomes available. In 2019–20 this was an average of 392 days for men and 88 days for women.[265] This delay in receiving mental health treatment, care and support often results in a severe deterioration in mental health. This delay and subsequent deterioration may constitute a violation of a person's human right to humane treatment when deprived of liberty. Figure 23.6, reproduced and updated from the Commission's interim report, shows the increase in the average wait time for forensic consumers to be admitted to Thomas Embling Hospital over time.

Personal story:

Leona Coleman

After experiencing mental health and addiction issues for some time, Leona* committed a serious offence. She was found not guilty due to mental impairment and placed on a custodial supervision order at Thomas Embling Hospital.

Prior to the commission of the offence, Leona had been admitted to a mental health facility four times, including a two-month stay in the year the offence was committed. Despite trying a range of medications, Leona had been quite unwell in the lead-up to the offence.

> When I think about my offence I feel like I had hit rock bottom, like the light inside me went out. It felt like I had charcoal in my chest and I lived like that for years and years. It was not me that night. It was a different person. I know I have to live with what I did and that really hurts.

During her time at Thomas Embling Hospital she was put on a combination of medications which she said have 'kept me well for a number of years now'. At Thomas Embling Hospital, Leona was able to access a range of treatments including a psychologist, group therapy, and a drug and alcohol group, which she said was very helpful.

Leona was able to transition slowly back into the community and now lives independently with the help of some community-based supports. Leona lives in stable accommodation, which has also been a great way for her to maintain her health and wellbeing.

> I still receive treatment and support in the community. I am on medication and see a counsellor who is really great ... I also see my local area mental health service who have worked with me to help me identify my early warning signs. It is my responsibility to keep myself well. I have a good National Disability Insurance Scheme package. I do singing lessons and art classes once a week. I have a cleaner and a gardener that helps me with my plants out in the courtyard. I also have a kitten which has changed my life. I am hoping to start a family soon.

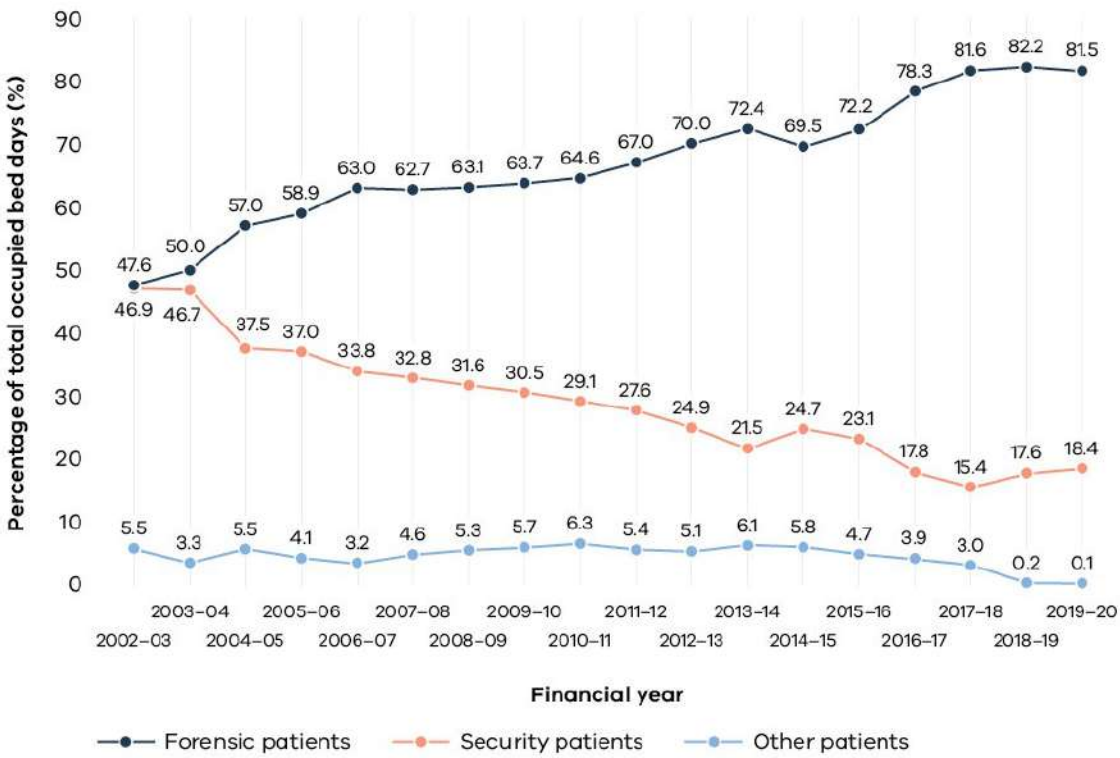
Leona advocates for more facilities to support people to stay well in the long term.

> There should be a Thomas Embling in the community. A facility where you can check in and constantly get support, medication, group therapy, workshops and courses. All these things help you learn more about yourself and what you are feeling.

Source: *Witness Statement of 'Leona Coleman' (pseudonym)*, 4 May 2020.

Note: *Name has been changed in accordance with an order made by the Commission.

Figure 23.5: Proportion of total occupied bed days by consumer type, Thomas Embling Hospital, Victoria, 2002–03 to 2019–20



Source: Department of Health and Human Services, Client Management Interface/Operational Data Store 2002–03 to 2019–20.

Notes: Classification of consumer legal status for the purposes of calculating the percentage of total occupied bed days by consumer legal status is as follows:

- Forensic consumer included anyone on a forensic order at any time during their episode.
- Security consumers included anyone who was not on a forensic order, but on a security order at any time during their episode.
- Other consumers included all other consumers not listed above.

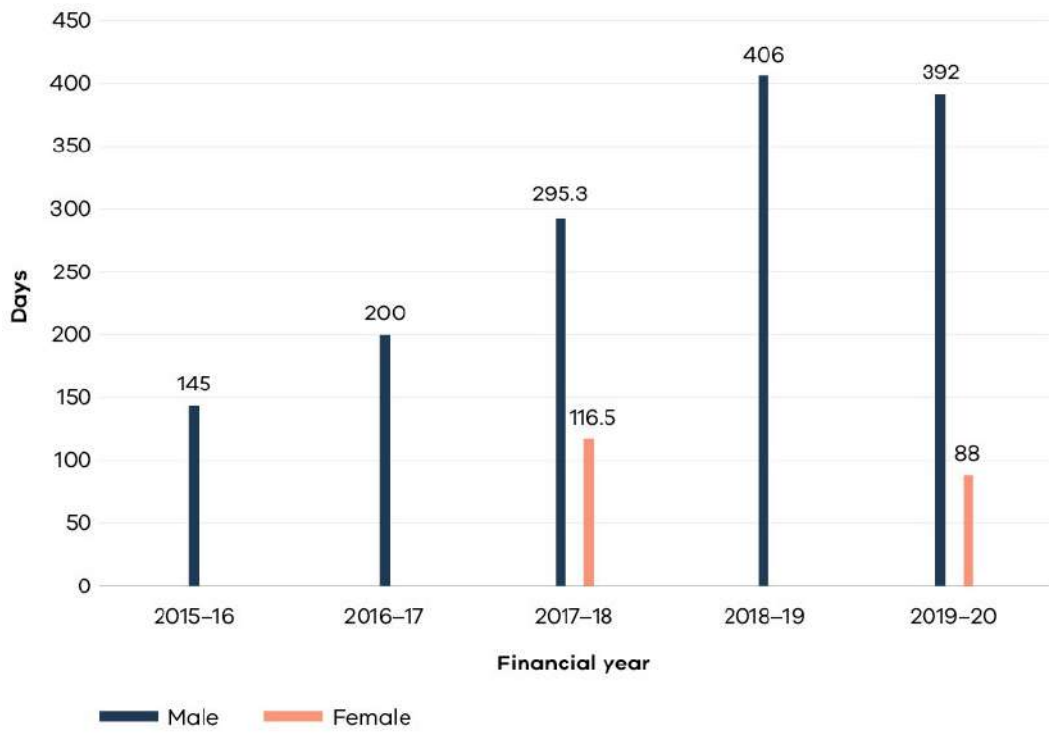
Limited capacity to treat civil consumers

The target population of Thomas Embling Hospital includes 'people with a serious mental health disorder in mainstream mental health services who are … a danger to their carers or the community'.[266] This means that Thomas Embling Hospital can provide inpatient services for civil consumers. These consumers are involuntary consumers who are not subject to forensic or sentencing orders—that is, who have not committed an offence or been placed under an order issued under the CMIA.[267]

In practice, Thomas Embling Hospital has rarely been able to provide treatment, care and support to these consumers. Distinguished Professor Ogloff said 'the capacity to assist the broader area mental health services by admitting complex and challenging patients for assessment and intervention has been lost'.[268]

Dr Neil Coventry, Victoria's Chief Psychiatrist, observed that civil consumers requiring high-intensity support in a higher security, safe environment at Thomas Embling Hospital cannot be admitted because of bed constraints.[269]

Figure 23.6: Average wait time (days) for forensic consumers in prison to be admitted to Thomas Embling Hospital following a recommendation to the court for a custodial supervision order, 2015–16 to 2019–20



Sources: Forensicare, *Yanith Bilang Quality Account 2017–18,* p.49; Forensicare, *Annual Report 2018–19,* p.39; Forensicare, information provided to the Royal Commission, 1 December 2020.

Notes: Wait time on average is for forensic consumers in prison to be admitted to a bed at Thomas Embling Hospital. There were no female prisoners in 2015–16, 2016–17 and 2018–19 who had to wait for a bed at Thomas Embling Hospital on a Custodial Supervision Order.

In some cases these consumers may instead access treatment, care and support in secure extended care units, which provide extended bed-based rehabilitation in the current system.[270] As the Mental Health Tribunal has suggested, changes over time, and a growth in the number of people who may present in secure extended care units with aggressive behaviours, has altered 'the milieu of a [secure extended care unit], arguably requiring it to provide a service it was not intended to provide'.[271] One outcome of this change is a reduced therapeutic environment for other consumers accessing treatment, care and support in secure extended care units, for example, because of heightened security requirements that may be applied to all rather than only for those who may need it.

The need for additional civil capacity was identified by Distinguished Professor Ogloff in his witness statement to the Commission, and in research undertaken by the University of Melbourne for the Commission. Distinguished Professor Ogloff stated:

> consistent with the principle of least restriction under the [Mental Health Act], consumers currently at [secure extended care units] may benefit if they are in a [secure extended care unit] in [Thomas Embling Hospital] instead.[272]

The University of Melbourne research also concluded:

> We suggest that a statewide system of secure units could be developed and linked with Forensicare, separate to the afore-mentioned inpatient rehabilitation units. These would operate similarly to the Forensicare rehabilitation model but in community locations and/or within Thomas Embling Hospital (TEH) itself. They would effectively serve a step-up/step-down function within a high level of security and assist consumers unable to leave Forensicare without a high level of support to transition to the community. They would also re-create a statewide capacity to assess and treat consumers with very complex needs from area mental health services, including those not subject to forensic or sentencing orders but who are likely to be subject to compulsory orders.[273]

Figure 23.7 provides a summary of Thomas Embling Hospital consumers as of July 2020.

Compulsory treatment for people in custodial settings

Currently in Victoria, people living with mental illness in prison cannot receive compulsory mental health treatment under section 67 of the Mental Health Act. Compulsory treatment means that a person may receive treatment and medication without their consent, though their treatment must adhere to a legislative framework. In order to receive compulsory treatment, a prisoner must first be transferred to a designated mental health service. For adults, the designated mental health service is Thomas Embling Hospital, while young people are transferred to an intensive care area of the Orygen Specialist Program. This program provides specialist mental health services for young people aged 15–25 years who live in the western and north-western regions of Melbourne.

This approach is consistent with 'a long-established principle in Victoria that compulsory mental health treatment must not be provided in correctional settings'[274] and with the *National Statement of Principles for Forensic Mental Health*.[275] The expected outcome of a course of compulsory treatment is that the person's illness is stabilised, enabling them to return to the prison environment for voluntary treatment.

The shortage of beds at Thomas Embling Hospital means that prisoners who may need compulsory treatment are waiting for long periods in prison before they can be admitted.[276] In 2018–19 female security consumers waited an average of nine days before admission and male security consumers waited 38.8 days on average.[277] This delay in care may have serious consequences for the health of consumers as well as safety risks for staff. To address these wait times, some have suggested that Victoria introduces compulsory treatment in custodial settings.

Figure 23.7: Current activity at Thomas Embling Hospital

		Security		Forensic		Civil	
Overall Thomas Embling Hospital occupancy (as at end of July 2020)		22%		76%		2%	
Gender mix based (as at end of July 2020)		**Male** 88%	**Female** 12%	**Male** 85%	**Female** 15%	**Male** 100%	**Female** 0%
Average length of stay	**Acute**	2.4 months	3.5 months	3.5 months	-	2.1 years	-
	Subacute	-	-	2.0 years	-	8.6 years	-
	Rehab	-	-	4.1 years	6.5 years	-	-
Discharges (per year)		146	27	19	1	5	-

Source: Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, 2020, p.22.

Note: Data above is for the period 1 July 2017 to 30 June 2019 inclusive.

Associate Professor Ruth Vine, Director at Forensicare, supports introducing compulsory treatment in prisons, given long wait times associated with bed shortages at Thomas Embling Hospital. Associate Professor Vine argued:

> until there is sufficient capacity in the forensic mental health system, there needs to be a way to provide more intensive mental health care (including the use of compulsory treatment) in prisons; it is untenable that we provide 19th century treatment to people living with mental illness in prisons in the 21st century. Ideally, there should be greater investment in the amenities and capacity of the forensic mental health system, so that there is a reduced number of prisoners living with untreated mental illness.[278]

The Commission heard opposition to compulsory treatment in custodial settings from multiple witnesses.[279] In a position statement, the Royal Australian and New Zealand College of Psychiatrists opposed compulsory treatment in custodial settings, '[i]nvoluntary mental health treatment in custodial settings compromises clinical care, encourages inappropriate management of prisoners, and breaches human rights'.[280]

The Commission heard that compulsory treatment in custody compromises the 'principle of reciprocity', as set out in the United Nations *Standard Minimum Rules for the Treatment of Prisoners*.[281] Dr Coventry explained:

> This principle holds that society has no right to remove civil liberties from individuals for the purpose of treatment if resources for that treatment are inadequate. If a prisoner experiences psychiatric symptoms that are so acute that compulsory treatment is needed, they should receive it from a specialist multidisciplinary team at a hospital; the care available in prison is not an adequate substitute, particularly in situations where prisoners require treatments with the potential for serious side effects.[282]

Despite this interpretation of the principle of reciprocity, New South Wales and South Australia do provide compulsory treatment in custodial settings.[283] In New South Wales, this is the result of mental health facilities within correctional centres being declared as designated health services under the *Mental Health Act 2007* (NSW) for the purposes of providing involuntary treatment.[284] In South Australia, this is expressly enabled under legislation.[285]

The weight of evidence before the Commission indicates that compulsory treatment should not be provided in Victorian correctional settings. It is anticipated that the recommended increase in bed numbers at Thomas Embling Hospital will provide enough capacity for prisoners to gain timely access to compulsory treatment.

23.2.4 Expanding the existing community forensic model

Multiple witnesses have highlighted the need for forensic mental health experts to better support area mental health services.[286] The Commission recommends improving supports for Area Mental Health and Wellbeing Services to care for consumers who have either:

- committed or are at risk of committing an offence, or
- engaged in threatening or violent behaviours towards others.

This will occur in two ways:

- increase the workforce of the Forensic Clinical Specialist Program—in line with current arrangements, these specialists will be employed by and based at Area Mental Health and Wellbeing Services
- establish a specialist behaviour response team to support Area Mental Health and Wellbeing Services in responding to the needs of consumers in mainstream adult inpatient services.

The Commission further recommends that the Department of Health conducts a review of forensic community-based services two years after implementation. This review will focus on the interaction between the Forensic Clinical Specialist Program, the specialist behaviour response team and other community-based programs. This review will identify and respond to any opportunities to further improve community-based forensic service delivery in Victoria's new mental health and wellbeing system.

Expand the Forensic Clinical Specialist Program

The Forensic Clinical Specialist Program will receive funding to increase the workforce across Area Mental Health and Wellbeing Services. The program will employ people with expertise in social work, psychology, occupational therapy and psychiatry to provide the area mental health and wellbeing workforce with training, clinical advice and co-case management as required.

The new specialist behaviour response team will provide the forensic clinical specialists with support from Forensicare, increasing their capacity to work directly with complex consumers.

The implementation of this recommendation will be informed by data analysis of demand for the service based on consultation with Forensicare, Area Mental Health and Wellbeing Services and the existing forensic clinical specialist workforce.

The Commission has recommended improving the forensic capacity of the Area Mental Health and Wellbeing Services by expanding existing programs and creating a new service that focuses on consumers who act in threatening or violent ways. In implementing these recommendations, the relationship between these programs and service providers should be informed by some aspects of Queensland's Violence Risk Assessment and Management Framework—Mental Health Services (as detailed in Box 23.4).

Create a specialist behaviour response team

In addition to the Forensic Specialist Clinical Program, Forensicare will provide a specialist behaviour response team to support Area Mental Health and Wellbeing Services strengthen their capacity to respond to consumers who are extremely agitated, distressed and placing the safety of themselves, other consumers or staff at risk. The specialist behaviour response team will help ensure consumers receive highly specialised care responses in the least restrictive way and build on other initiatives to improve inpatient settings.

The explanation and rationale for creating a specialist behaviour response team, along with the description of its functions and purpose, is contained in Chapter 10: *Adult bed-based services and alternatives*.

23.2.5 Supporting transitions between prisons and mental health services

The Commission recommends that the Victorian Government establishes a program to transfer the supports people living with mental illness receive in prison to mainstream mental health services on their release. Targeted to people who need ongoing intensive treatment, care and support the program will be based on the Community Integration Program and will support people leaving prison to begin or continue their treatment with Area Mental Health and Wellbeing Services.

Between December 2019 and November 2020, 13,103 people were discharged from Victorian prisons.[287] This includes people who may have had multiple short stays in prison during this period. Almost half of these (46 per cent), or 6,009 people, were not sentenced during their episode of imprisonment.[288] The high proportion of prisoners released while on remand reflects the need to enable remandees to be referred to this program. *The Health of Australia's Prisoners* report found that, in 2018, 18 per cent of Victorian prison dischargees reported experiencing a high or very high level of psychological distress, as measured by the Kessler 10 scale (a simple measure of psychological distress).[289] The very small sample size for this study should be noted—only 83 prison dischargees from Victoria were included in the study.[290] This proportion is equivalent to 2,359 prisoners released between December 2019 and November 2020. Additionally, 26 per cent prison dischargees reported being distressed about mental health issues.[291] Applied to the number of people discharged between December 2019 and November 2020, this is 3,407 prisoners.

The recommended transition program will provide three key services:

- discharge planning six to eight weeks before discharge from prison
- facilitate connections to Area Mental Health and Wellbeing Services
- facilitate access, whether through the pre-release planning conducted by the Department of Justice and Community Safety, or directly to community support services such as housing, legal assistance, physical health care, the National Disability Insurance Scheme and Commonwealth benefits.

Remandees and sentenced prisoners living with mental illness may be referred to the program by Forensicare staff providing specialist forensic mental health services in prisons.

The following prisoners should be referred to the program:

- prisoners leaving prison from a custodial unit dedicated to mental health service requiring referral to an Area Mental Health and Wellbeing Service
- prisoners leaving prison from a Forensicare outpatient service requiring referral to an Area Mental Health and Wellbeing Service
- prisoners leaving prison from a primary mental health care outpatient service requiring referral to an Area Mental Health and Wellbeing Service.

Referrals from Forensicare will be provided to the Sentence Management Unit within each prison so the program can begin in line with expected release dates.

It is recommended that the program be initially rolled out in the major prisons where Forensicare currently provides specialist mental health services. These are Dame Phyllis Frost Centre, Ravenhall Correctional Centre and Melbourne Assessment Prison. Following an evaluation of the effectiveness of the program, it could be expanded to other prisons if appropriate.

The Commission estimates that when implemented across all locations, the expanded transition program will support around 500 prisoners each year. The implementation of this recommendation should include robust data analysis on expected demand for the service.

This program will be developed in partnership with Aboriginal community-controlled organisations to ensure culturally appropriate transitional support is provided to Aboriginal prisoners.[292] The Aboriginal Social and Emotional Wellbeing Centre, a recommendation of the Commission's interim report,[293] is well placed to facilitate the required connections between prisoners and community-based Aboriginal health providers.

The expanded program will require a multidisciplinary workforce that can provide prisoners with: mental health treatment, care and support; appropriate wellbeing supports; supervision in the community adapted to a person's presentation and needs; and assertive outreach visits where staff visit consumers.

Proposed model of care

As discussed above, there is strong evidence that continuity of care is required to ensure good outcomes during the transition from prison to the community. However, evidence about the specific components of transition support programs is less clear.[294] The implementation of this recommendation will require careful consideration of the specific elements of this transition support program, in consultation with experts and consumers.

In many instances people living with mental illness who transition out of prisons have ongoing, intensive mental health treatment, care and support needs. The Commission's recommendation that people living with this high-intensity level of need will be supported through Assertive Community Treatment is described in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services* and in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults*. Assertive Community Treatment involves care delivered where a person needs it by multidisciplinary teams with low caseloads and is a model of care that may be adapted to best support people who have been involved with the justice system.[295]

23.2.6 Expanding the capacity of Thomas Embling Hospital

The Commission recommends expanding the bed capacity at Thomas Embling Hospital. An expansion of bed numbers will enable consumers to receive appropriate care throughout their recovery.

The expanded capacity of Thomas Embling Hospital is also intended to support the extended rehabilitation needs of people who cannot safely and appropriately be provided with treatment, care and support in secure extended care settings and other extended rehabilitation settings. As well as being briefly described in section 23.2.3, the impact of the expanded capacity of Thomas Embling Hospital to support the extended rehabilitation needs of civil consumers is described in Chapter 10: *Adult bed-based services and alternatives*.

This recommendation seeks to:

- increase capacity for civil consumers—this will ensure these consumers receive the specialist forensic support they need and relieve pressure on community-based inpatient services
- decrease the wait time for compulsory treatment among prisoners—this will ensure prisoners receive compulsory treatment in a timely manner in line with service delivery in the community
- improve consumer streaming—being able to organise the hospital based on security needs, gender and level of need will improve consumer care as well as safety for consumers and staff
- improve services for women—currently women do not have the same options as men for a staged transition through security levels to support recovery and community integration.[296]

Mr Robert Fiske, CEO of the Victorian Health and Human Services Building Authority, submitted to the Commission a statement on service planning for Thomas Embling Hospital. This statement provided secure forensic bed demand projections until 2036 informed by Forensicare's bed-based service plan. The current modelling was completed in November 2019 and is based on population forecasts from Census data and prisoner number forecasts.[297] Table 23.1 and Table 23.2 summarise Mr Fiske's projected forensic bed requirements until 2036 by consumer cohort.

Stage 1A of expansion works includes a 48-bed men's medium security building and 34-bed women's precinct.[298] The Victorian Health and Human Services Building Authority has advised the Commission that this stage has an estimated program timeframe of four years once funding is secured. The exact timeframe depends on when government gives final approval and on the need to modify any planning to meet the final recommendations of the Commission.[299]

The Commission recommends that the Victorian Government commits to meeting required capacity until 2026. The Commission expects that further expansion of Thomas Embling Hospital will occur in line with demand following 2026, noting the Commission's recommendation that the Victorian Government establishes a process for assessing the Victorian population's need for mental health and wellbeing services, including forensic mental health and wellbeing services discussed further in Chapter 28: *Commissioning for responsive services*. It is anticipated that prevention elements, in particular a better resourced and targeted community mental health and wellbeing system, will affect demand for forensic beds. The precise level of impact is unknown, and the Building Authority's projections may need to change to reflect this. The need to adjust projections following the introduction of the reformed system is discussed in Chapter 5: *A responsive and integrated system*.

Table 23.1: Secure forensic bed demand projections and shortfall 2018–2036

	Current capacity	Required capacity 2018	Required capacity 2021	Required capacity 2026	Required capacity 2031	Required capacity 2036
Total beds	136	189	213	239	257	275
Bed shortfall		53	77	103	121	139

Source: RCVMHS calculation of *Witness Statement of Robert Fiske*, 15 October 2020, para 14; Forensicare, Review of Forensic Bed numbers (based on the bed forecast model) endorsed by the VHHSBA/Forensicare Steering Committee in 2019.

Table 23.2: Secure forensic bed demand projections and shortfall by consumer cohort, Victoria 2018–2036

Consumer cohort	Current capacity	Required capacity 2018	Required capacity 2021	Required capacity 2026	Required capacity 2031	Required capacity 2036
Security consumers	27	77	99	116	125	134
Forensic consumers	107	101	102	109	117	125
Civil consumers	2	11	12	14	15	16
Total	136	189	213	239	257	275

Source: *Witness Statement of Robert Fiske*, 15 October 2020, para 14; Forensicare, Review of Forensic Bed numbers (based on the bed forecast model) endorsed by the VHHSBA/Forensicare Steering Committee in 2019.

23.3 Improving mental health outcomes across the youth justice system

Victoria's youth justice system is composed of a community supervision system and a detention system.

The detention system consists of two centres—Parkville Youth Justice Precinct and Malmsbury Youth Justice Precinct. Parkville 'accommodates:

- 10–14-year-old males (remanded or sentenced)
- 15–18-year-old young men (remanded or sentenced)
- 10–17-year-old females (remanded or sentenced)
- 18–21-year-old women sentenced to a Youth Justice Centre Order by the Magistrates', County and Supreme Courts'.[300]

Malmsbury 'accommodates young men aged 15–20 years when remanded or sentenced to a Youth Justice Centre Order in a mixture of low and high security residential units.'[301]

On an average day in 2018–19 there were 191 young people held in youth justice detention in Victoria.[302] A further 766 were subject to community-based orders.[303]

Community supervision means the supervision of children and young people who are on community-based orders including probation, Youth Supervision Orders, Youth Attendance Orders and parole orders. This supervision is undertaken by youth justice units staffed by youth justice workers who support the children and young people to comply with their orders, along with providing referrals to other parts of the social services system, including health, education, employment and housing.

Aboriginal young people are significantly over-represented in Victoria's criminal justice system. Ms Hansen reported that '[o]n an average day in 2018–19 in Victoria, Aboriginal young people were 11 times as likely to be under youth justice supervision than non-Aboriginal young people'.[304]

Young people in the youth justice system experience high rates of mental illness. This has been acknowledged by the Victorian Government in the master planning of the new youth justice centre currently being built at Cherry Creek, west of Werribee, which was intended to have a 12-bed mental health unit.[305] The 2019 youth justice survey reported that of the 185 young people under youth justice custodial supervision on 31 December 2019, 68 per cent presented with mental health issues.[306] The Youth Parole Board reported that 'around two out of three young people on parole will present with mental health issues'.[307]

Ms McCammon told the Commission that 367 (45 per cent) of young people in custody between July 2019 and May 2020 had a mental health 'diagnosis recorded, including a substance use-related disorder'.[308] These numbers reflect the short sentences and high churn associated with the youth justice system.

For example, the Victorian Auditor-General in 2018 described that:

> In 2017–18, 961 young people received a total of 1332 sentences and 460 young people received 777 remand orders. Between 1 November 2017 and 31 January 2018, young people on remand spent an average of 25 days and young people sentenced spent an average of 58 days in youth detention.[309]

Between July 2019 and May 2020, the top four diagnoses among young people under youth justice supervision in Victoria (excluding substance use-related diagnoses) were:

- reaction to stress and adjustment disorders (including post-traumatic stress disorder, acute stress reaction and adjustment disorder)
- attention deficit hyperactivity disorder and other hyperkinetic (frenetic energy or activity) 'disorders'
- depressive 'disorders'
- schizophrenia, schizotypal and delusional 'disorders'.[310]

The over-representation of young people living with mental illness in the youth justice system is not unique to Victoria.[311] The 2016 *Review of the Youth Justice System in England and Wales* found that more than a third of young people in the youth justice system in England and Wales have a 'diagnosed mental health disorder'.[312] This review recommended that:

> Health commissioners and providers in England and Wales should ... rethink the way that mental health support is provided to children who are at risk and who currently do not get the access they need or deserve.[313]

Mental illness among young people in the justice system is correlated with experiences of neglect, trauma and abuse. For example, among young people in the American juvenile justice system, the vast majority have experienced trauma as a child and 90 per cent have experienced at least one traumatic event during their lifetime.[314] Dr Adam Deacon, Child and Adolescent Consultant Psychiatrist at Alfred Health, told the Commission in a personal capacity that a cycle of childhood trauma, mental illness and substance use is common among the youth justice cohort in Victoria. Dr Deacon observed that children in the Victorian youth justice system have often been neglected, abused and traumatised.[315] The impact of these experiences can include the onset of 'mood disorders' and 'anxiety disorders', as well as having a negative impact on neurological development, cognitive development and the capacity to regulate behaviour.[316] In turn, substance use to manage these psychological challenges is common. Dr Deacon concludes that '[e]xtensive drug use, particularly cannabis and methamphetamine, can contribute to the development of psychotic symptoms, and potentially enduring psychotic disorders such as schizophrenia.'[317]

These experiences may also contribute to cycles of recidivism among young people. Dr Claire Gaskin, Forensic Adolescent Psychiatrist at the University of New South Wales, referenced, in a personal capacity, the findings of a study of young people in youth justice custody in New South Wales:

> Another factor that increased recidivism was exposure to significant psychosocial issues when returning home—for example, if they had parents with mental illness, with substance use issues, or who are abusive. Additionally, homelessness and lack of support were key factors in determining the likelihood of recidivism.[318]

Young people in contact with the youth justice system often have difficulty obtaining access to mainstream youth mental health services. For example, the Youth Parole Board acknowledges the difficulties faced by young people in custody with significant mental health needs in getting parole because of the limited availability of community-based mental health services.[319]

Echoing the failure of mainstream services to support young people in contact with the youth justice system, Ms McCammon described the results of the 2018 Annual Survey of Young People in Youth Justice in Victoria, which showed that 'as of 31 December 2018, of the 361 children and young people on community orders who presented with mental health issues, only 144 were accessing mental health supports or services'.[320] Ms McCammon acknowledged that this limited access to services 'may be due to their challenging behavioural presentations resulting in access issues. That is, they may be turned away from mental health supports and services in the community because their behavioural presentations are often too challenging or complex.'[321]

Dr Cassar similarly noted that young people often have greater difficulty in obtaining access to forensic mental health services than adults, particularly those living in rural and regional areas:

> In regional areas, waitlists for forensic mental health services are long or offenders must travel to the city to engage appropriately qualified professionals. This is particularly true for young people under twenty five in Children and Youth/Adolescent Mental Health Service catchments, where there is even more restricted access to forensic mental health services.[322]

Professor Stuart Kinner, Head of the Justice Health Unit in the Centre for Health Equity at the Melbourne School of Population and Global Health, University of Melbourne, emphasised the significant health needs of young people in contact with the justice system who are living in the community:

> People who have contact with the criminal justice system but do not experience incarceration also typically have significant unmet health needs. For example, our work in Victoria has shown that the burden of mental health and substance use problems among young people under youth justice supervision is concentrated among those under community supervision—this is because only a minority of justice-involved young people are in detention at any one time.[323]

Gaps in service delivery are reflected in current funding arrangements. Orygen, the National Centre of Excellence in Youth Mental Health, told the Commission that while mental illness is evident long before a young person reaches custody, 'funding for mental health intervention is currently aimed toward the population of young people in custodial settings'.[324]

23.3.1 The state of Victoria's youth forensic mental health services

The following programs comprise the current suite of youth forensic mental health services in Victoria:

- Children's Court Mental Health Advice and Response Service, provided by the Orygen Specialist Program
- Community Forensic Youth Mental Health Service, operated by Alfred Health and the Orygen Specialist Program
- Youth Justice Mental Health Initiative, coordinated by Forensicare
- Custodial Forensic Youth Mental Health Service, provided by the Orygen Specialist Program (including a secure unit in the Orygen Inpatient Unit at Footscray Hospital).

Table 23.3: Existing youth forensic services

What is the service?	Who delivers the service?	Who is it for?	Where is it delivered?
Children's Court Mental Health Advice and Response Service	Orygen Specialist Program	Children and young people appearing before the Children's Court	Melbourne Children's Court
Community Forensic Youth Mental Health Service	Alfred Health and the Orygen Specialist Program	Children and young people engaged or at risk of becoming engaged with youth justice who are referred by child and youth mental health services and child and adolescent mental health services	North, West and Southern Metropolitan Regions of Melbourne
Youth Justice Mental Health Initiative	Coordinated by Forensicare, delivered by clinicians in child and youth mental health services and child and adolescent mental health services	Children and young people under the community-based supervision of Youth Justice	Child and youth mental health services and child and adolescent mental health services
Custodial Forensic Youth Mental Health Service	Orygen Specialist Program	Children and young people in custody	Youth justice centres (including the secure unit in the Orygen Inpatient Unit at Footscray Hospital)

In addition to these components, the new youth justice centre at Cherry Creek will provide bed-based mental health treatment, care and support to young men living with mental illness aged between 15 and 18 years.[325] This centre is expected to be open by 2022.[326]

The **Children's Court Mental Health Advice and Response Service** provides mental health assessments for young people appearing before the Children's Court.[327] The service may also advise the Children's Court if a young person's offending was affected by mental illness, as well as facilitate access to mental health support services.[328] The program is being trialled in the Melbourne Children's Court with a single clinician available. The Children's Court submitted to the Commission that there is a view for the service to be expanded across all Children's Courts in Victoria, but there is currently no timetable for its expansion.[329] This service is provided through the Orygen Specialist Program.

The **Community Forensic Youth Mental Health Service** started operating in mid-2019 and 'provides mental health support to youth who are experiencing mental illness and who are at risk of offending or have offended'.[330] Specifically, it is a consultation service that provides forensic expertise to child and adolescent mental health services and child and youth mental health services with 'complex clients presenting with forensic issues'.[331] The service currently provides assessments of 'young people presenting with problem behaviours, including interpersonal aggression and violence, threats, stalking, sexualised behaviour, arson, animal cruelty and other complex behaviour disturbance.'[332] The program currently does not provide case management and treatment.[333] The program is operated by Alfred Health in the Southern Metropolitan Region and Melbourne Health (Orygen Specialist Program) in the North West Metropolitan Region.[334]

The program was initially developed to support the 'missing middle' of youth justice consumers who may be excluded from community-based mental health services. Dr Deacon, the lead psychiatrist of the program operated by Alfred Health, stated that:

> Once police become involved or youth justice intervention has occurred, Child and Adolescent Mental Health Services (CAMHS) and Child and Youth Mental Health Services (CYMHS) may not consider the adolescent to be a suitable candidate for their service.[335]
>
> Likewise, many clinicians do not have the confidence, or do not perceive that it is within their clinical remit, to treat children and adolescents with complex needs that includes offending behaviour.[336]

Dr Paul Denborough, the Clinical Director of Alfred Child and Youth Mental Health Services and headspace at Alfred Health, in a personal capacity, described the impetus of the program as:

> The [Community Forensic Youth Mental Health Service] program was implemented to address the lack of forensic mental health services available for youth within Victoria. Forensicare provides support to all adults with mental health issues and there was no comparable support for youth experiencing similar mental health and juvenile justice issues.[337]

Dr Denborough told the Commission that beyond the assessment provided through the Forensic Youth Mental Health Service:

> No further treatment or follow up service is able to currently be provided. Forensic work generally requires specific expertise that generic mental health services struggle to manage. A treatment arm to the forensic youth services is critical and would match equivalent Forensicare adult services.[338]

Dr Denborough said the biggest impediment to the service is a lack of resources and staff members.[339] Dr Deacon reiterated this need for more resources:

> Ideally we would be better resourced with more expert staff and have the capability to provide a case management model akin to that provided at Forensicare with their community programs, including the Problem Behaviour Program.[340]

The **Youth Justice Mental Health Initiative**, coordinated through Forensicare, was established in 2010 and aims:

> to improve access of young people (those aged 18–24 years) to mental health services, and to support the capacity of youth justice staff and mental health staff to effectively meet the needs of young people with mental health issues.[341]

The program has six forensic clinicians, five of whom are based in child and youth mental health services or child and adolescent mental health services across Victoria.[342] The sixth clinician is based at Forensicare, providing direct services to Parkville, as well as coordinating the initiative overall and supervising the other five clinicians.[343] The initiative has four core functions. As described by Ms McCammon, these are to:

> - build the capacity of the youth justice program
> - provide mental health assessments in the community
> - facilitate referral pathways and advocate for appropriate service provision
> - engage mental health community support services and clinical mental health services before a young person's mental health concerns escalate.[344]

Dr Grigg advised the Commission that:

> In redesigning Victoria's mental health system, the Youth Justice Mental Health [Initiative] could be repositioned to take on a more active leadership role that better supports the capability of youth justice staff to understand and respond to the mental health needs of young people. ... there is an opportunity to better embed forensic mental health youth expertise across youth mental health services.[345]

The Custodial Forensic Youth Mental Health Service is a specialist mental health service operated by Melbourne Health (Orygen Specialist Program) at Parkville and Malmsbury, which provides evidence-based specialist assessment and treatment for young people in detention. In November 2020 three secure beds opened at the Orygen Inpatient Unit at Footscray Hospital. These beds are for providing 'compulsory treatment for children and young people in custody'.[346]

An evaluation of the program is expected to be completed in early 2021.

Case study:

Custodial Forensic Youth Mental Health Service

The Custodial Forensic Youth Mental Health Service is a specialist mental health service located in both Parkville and Malmsbury Youth Justice Centres. It provides clinical mental health services for children and young people on remand or sentenced in the centres. It began in February 2019.

The service is operated by Royal Melbourne Hospital (Orygen Youth Health) and works closely with Correct Care Australasia, which provides the primary health service to the children and young people in detention. It is funded through the Department of Health, which manages the program in consultation with Justice Health.

Ms Emma Burke, a clinical psychologist at Royal Melbourne Hospital, said the service was designed to provide tertiary mental health care through a multidisciplinary team made up of medical staff, including a neuro-psychologist, psychiatric registrar and consultant psychiatrist, as well as other allied health clinicians (including psychiatric nurses, social workers, occupational therapists and psychologists).

> Prior to this service, young people in custody were provided with a mental health service that was primarily focused on a psychiatric response. The Custodial Forensic Youth Mental Health Service is an attempt to start to make specialist mental health services that young people require in custody more equitable to what young people receive from a community youth mental health service.

Ms Burke said the service provides assessment, case management and therapeutic work, as well as discharge planning at both detention centres. Young people in custody present with a range of complex mental health illnesses, as well as conditions that are difficult to diagnose.

> We often see young people in custody through this service who you wouldn't typically see get into a tertiary mental health service. This is particularly the case in the under 15 cohort who may present with a lot of things going wrong but nothing that you can easily diagnose, but they clearly need specialist input.

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Ms Burke said young people can be discharged to other tertiary specialist mental health services, or services such as headspace or to GPs, but it is catchment-based, which can limit the type of care they receive and whether Orygen can provide continuity of care into the community.

> If the young people are in Orygen's catchment area, then we will refer them to other community teams. That's where we actually find that this works, when we can all liaise together. For example, when someone in the court role can communicate that someone is coming into custody, or when the custodial team can let the justice mental health workers know when someone is being discharged we can work together to provide care.

Source: RCVMHS, *Interview with Ms Emma Burke*, November 2020.

The Commission has heard that this service is not meeting demand, and that the effectiveness of service delivery is being compromised by the quality of youth justice centre facilities.

Mr Kelly stated that the program is currently not keeping up with demand and requires a significant increase in funding.[347] Orygen said the 'funding is not adequate to reach the demand of young people experiencing mental ill-health in custody'.[348]

The Commission has heard about the significant challenges in the way that specialist mental health services are delivered within youth justice custodial centres. They include:

- inadequate physical infrastructure (including inappropriate facilities to treat the children and young people)
- a youth justice workforce that is not equipped with the appropriate skills, experience or support to manage children and young people living with mental illness who are under their supervision
- unmet need for the services provided in custody—both primary and specialist mental health services
- barriers to information sharing both within custodial settings and at the points of transition into and out of custodial settings
- a lack of oversight, including the lack of clarity of the role of the Chief Psychiatrist in relation to safety and quality
- a lack of clarity about who commissions and manages the service.[349]

Dr James Belshaw, Consultant Psychiatrist for the Custodial Forensic Youth Mental Health Service, also told the Commission that inadequate physical infrastructure in youth justice centres was limiting the capacity for a trauma-informed approach to care. Dr Belshaw told the Commission that the current custodial sites are not 'fit for purpose, in terms of delivering effective mental health care'.[350] He described the areas allocated to interview people as 'the opposite of what a trauma-informed approach would dictate'.[351] The rooms are dimly lit, do not have dual exits and there are often windows whereby peers can observe and communicate with the young person being interviewed.[352] This limits the ability of staff to accurately assess young people and give a valid diagnosis as there are other confounding variables.[353] Dr Belshaw also observed that the lack of facilities such as sensory rooms limits the tools that can be recommended in management plans.[354] It is clear that custodial services in particular are facing difficulties in delivering a trauma-informed approach.

The lack of a trauma-informed approach is particularly concerning given the high rates of mental illness among young people in custody, the negative mental health impact of custody and the subsequent increased likelihood of recidivism. Dr Belshaw said that the Orygen team working within Parkville and Malmsbury:

> find that youth custody makes people with mental health issues, which is perhaps all of them, more unwell. And we often see that they're more likely to offend, especially the clients that we're working with. At the current time, our average client ... sadly and inevitably seems to return to custody within a number of months.[355]

Inadequate custodial mental health service provision has also been identified in reviews of the system. The 2017 *Youth Justice Review and Strategy: Meeting Needs and Reducing Offending* report identified issues affecting the Victorian youth justice system at the community and custodial levels and proposed reforms.[356] Although the mental health of young people engaged with youth justice is not a headline of this review, it was acknowledged as 'central'.[357]

The review found that '[o]nce in contact with Victoria's youth justice system, the life outcomes of young people are poor and there is no change in their offending patterns' and that 'Victoria has the most expensive youth justice system per capita, with little difference in outcomes'.[358] With specific reference to mental health services, the review highlighted:

- the informality of mental health referrals into the system
- the lack of a dedicated and secure adolescent mental health unit
- how ill-equipped custodial facilities were to deal with the mental health needs of young people, with the result that they may be inappropriately held in custody
- limited staff training in mental health.[359]

No fully functioning youth forensic service in Victoria

Victoria currently does not have a fully functioning, adequately resourced forensic youth mental health service that meets the needs of young people. Ms McCammon reported that there are currently 'gaps in mental health infrastructure that restrict the ability for children and young people involved with Youth Justice to have their needs met (secure and non-secure).'[360] Distinguished Professor Ogloff noted, referring to forensic outreach services, that any youth service is 'severely limited' with 'far fewer resources' than those devoted to adult services.[361] And, more directly, he concluded:

> we need a joined-up service system. It's one of the only elements I think the Royal Commission is looking at that simply doesn't exist. That is, we don't have a youth forensic mental health system, in Victoria.[362]

Dr Deacon described the 'disjointed' system currently facing children and young people:

> There are too many disjointed parts. Many children are repeatedly assessed. This is taxing, disrespectful and unhelpful to the child. There is often a lack of clear coordination of information sharing. The reports on the children are often invaluable, but not necessarily readily accessible.[363]

Dr Elkadi summarised the impact of an under-resourced and disconnected mental health system for young people:

> The trajectory into the criminal justice system is too often the cumulative result of a reactive and belated mental health system response to mental ill health in young people. The lack of systematic prevention, early identification and treatment interventions for young people is a key contributor to the decline of mental health in young people which over time manifests in serious mental illness, a cycle of offending and reoffending and inevitable contact with the criminal justice system.[364]

Orygen stated that '[t]here is immense scope for the improvement of the forensic system in order to better support and improve the mental health of young people who are justice-connected'.[365] Orygen provided the Commission with recommendations 'to better respond to the mental health needs of young people who are at risk of offending or who are in contact with the justice system'.[366]

Specifically, Orygen highlighted the need to:

> Develop and deliver a state-wide comprehensive forensic mental health service for young people both in custody and in the community. This should include: a focus on early intervention, integration of specialised mental health treatment with interventions that address offending behaviours; and Youth Forensic Clinical Specialists for youth justice clients (12–21 years).[367]

Box 23.5: Queensland youth forensic mental health system

The Queensland youth forensic mental health system has been presented to the Commission as 'the most comprehensive and effective program' of its kind in Australia.[368]

Queensland's Forensic Child and Youth Mental Health Service has two main components:

- the Brisbane Youth Detention in-service of the Mental Health Alcohol and Other Drugs Service, which operates in custodial settings
- the Child and Youth Forensic Outreach Service, which is delivered in the community.[369]

These two services feature multidisciplinary teams. Staff include child and adolescent forensic psychiatrists, psychiatry registrars, clinical nurses, psychologists, social workers, administrative officers and Aboriginal health workers.[370] Dr Denborough considers the community service 'a great success and a model which could be replicated within Victoria's mental health and justice systems.'[371] This service uses an 'individualised and multi-systemic approach to intervention'.[372] This means the treatment approach differs for each young person depending on their needs and circumstances. This may include a co-therapy arrangement with a primary service provider from the local child and youth and mental health service, providing a block of therapy for a specific period of time, or being the sole therapy provider.[373] The service operates across most of the state[374] and has the fulltime-equivalent staff of 30.[375]

The Commission was told that the most important component of this system is the integration of a mental health team into the youth justice system. As Dr Denborough described it, this 'allows for not only assessments to take place, but also for those individuals to receive initial treatment and further referrals into the mental health system as required'.[376]

The Commission has recommended that aspects of the Queensland system be adapted to the Victorian context and implemented in the youth forensic mental health system.

There is no statewide comprehensive forensic mental health service for young people in Victoria. That is, the equivalent of Forensicare does not exist in the youth system. However, there are some current programs that, if adequately resourced and connected, could form the basis of a well-functioning youth forensic mental health and wellbeing system. Dr Deacon noted that creating an integrated service model would be challenging:

> The major challenges that will be faced by the youth forensic mental health system over the next ten years will be in establishing an integrated service model and developing a workforce with sufficient skills and experience to work with children and adolescents with forensic backgrounds.[377]

Treatment for young people subject to an order under the CMIA

In 2014 the CMIA was amended to enable the Children's Court of Victoria to consider the defence of mental impairment. This followed a recommendation made by the Victorian Law Reform Commission.[378] If a young person's fitness to stand trial is raised the Court requests a psychological report from the Children's Court Clinic.[379] Of the 40 young people referred to the clinic since 2014, 23 have been found to be unfit, mentally impaired, or both.[380] 'Mental impairment' can mean the young person has mental illness, intellectual disability or another cognitive impairment such as a brain injury.[381] The Children's Court noted that most CMIA cases involve children and young people with intellectual disability, autism and attention deficit hyperactivity disorder.[382]

Despite guidance by the Victorian Law Reform Commission to adopt a 'specialised approach' to implementation,[383] the Children's Court of Victoria reported that 'the CMIA legislative framework was extended to the Children's Court without the facilities, programs and services intended by the [Victorian Law Reform Commission] to underpin an effective response for these vulnerable children'.[384] The Commission heard that this is having an impact on the effectiveness of the CMIA process. Her Honour Judge Amanda Chambers, the former President of the Children's Court, noted that she presided over almost all the CMIA matters that came before the Children's Court and, in her view:

> the process under the Act is lengthy and even where a child is ultimately placed on a supervision order, the supports and supervision available in the community to address the problematic behaviour are generally those that would otherwise be available, for instance under the NDIS.[385]

The Victorian Law Reform Commission originally recommended creating a framework for operating the CMIA in the Children's Court but only once a dedicated youth forensic facility was established. Despite the fact the CMIA is currently operating in the Children's Court, no dedicated youth forensic facility has been established.

The urgent need for a youth forensic facility has been highlighted in subsequent reviews of the youth justice system. The 2017 *Youth Justice Review and Strategy* found that 'young people under CMIA orders are not best placed for rehabilitation in youth justice custodial centres; they should be housed in environments that cater to their health needs first'.[386] The review recommended that the responsible department:

> immediately cease to house all young people on a CMIA order in youth justice facilities, and commence a process to determine appropriate alternate accommodation for young people currently on those orders in Youth Justice care.[387]

The 2018 *Inquiry into Youth Justice Centres in Victoria* also recommended establishing a youth forensic mental health precinct.[388] To date, these recommendations have not been acted on.

The Commission heard that this continues to be a priority concern for the sector. Dr Grigg advised:

> The establishment of an appropriate model of care for children and young people under the age of 18 who are under the CMIA should be a priority. The model of care is particularly complex for this group, as the number of people in this group is small, their needs (gender, developmental, educational, criminogenic and mental health) are diverse, and there is a need to safeguard vulnerable children and young people. Currently the only custodial setting available is a Youth Justice correctional facility which does not meet the treatment or therapeutic needs of the child or young person.[389]

Ms McCammon reported that:

> three young people have been detained in Parkville Youth Justice Precinct in the last five years pursuant to a Custodial Supervision Order following a finding of being unfit to stand trial or not guilty by reason of mental impairment.[390]

When a child is placed on a Non-Custodial Supervision Order, there is no coordinated approach for how the child is to receive rehabilitation and care, as required by the CMIA. It falls to the Chief Psychiatrist to negotiate with the relevant community-based services to ensure the young person receives treatment, care and support.[391]

The Commission notes that the failure of the government to provide the appropriate facilities, programs and services to support implementation of the CMIA demonstrates that the human rights of young people with mental impairment are still not being met.[392]

Dr Grigg further stated that:

> Services should be provided within a mental health setting that supports recovery and ensures children and young people have access to the same range and quality of services as their non-CMIA peers living with mental ill health and those in the adult forensic system under CMIA.[393]

There are at least three significant issues in the operation of the CMIA for young people. These include:

- the CMIA process is lengthy[394] and is not achieving good outcomes for young people[395]
- young people subject to a Custodial Supervision Order are placed in a youth justice custodial centre[396]
- young people subject to a Non-Custodial Supervision Order do not receive mental health treatment through an established care pathway.[397]

23.3.2 Establishing a statewide youth forensic mental health service

The Commission recommends expanding existing youth forensic mental health programs across the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services to provide an integrated statewide model and to ensure consistency in treatment, care and support to children and young people in contact with, or at risk of coming into contact with, the youth justice system.

This suite of programs described below will provide Victoria with a statewide comprehensive forensic mental health service for young people both in custody and in the community.

Given that Orygen is currently delivering the bulk of the programs that will need to be subsumed through establishing this service and has the attributes of a statewide service, including strong and established links to academia, it is well positioned to run part or all of this new service. This service will play the equivalent role of Forensicare in the adult system by providing and coordinating service delivery and contributing to research. This service should be run in formal partnership with Forensicare.

This specialist Youth Forensic Mental Health Service will operate in community, inpatient and custodial settings.

In community settings, this includes young people living with mental illness who are:

- at risk of coming in contact with the youth justice system (through referrals from schools, police, parents and social support services)
- under the supervision of youth justice in the community (including those on parole orders, supervised bail and other community-based orders)
- appearing before the Criminal Division of the Children's Court
- subject to a Non-Custodial Supervision Order under the CMIA.

In inpatient settings, this includes young people living with mental illness who are:

- at risk of coming in contact with the youth justice system (through referrals from schools, police, parents and social support services)
- under the supervision of youth justice in the community (including those on parole orders, supervised bail and other community-based orders).

In custodial settings, this includes young people living with mental illness who are:

- under the supervision of youth justice in youth justice centres (including those serving sentences of detention and on remand)
- subject to a Custodial Supervision Order under the CMIA.

Required programs within a statewide youth forensic mental health service

To 'develop and deliver a state-wide comprehensive forensic mental health service for young people both in custody and in the community',[398] the following reforms are required.

The **Community Forensic Youth Mental Health Service** will be expanded to meet current demand. The expanded service will provide assessments, treatment and case management as required. Any young person aged up to 25 years old can be referred to this program. The implementation of this expanded remit will require close consultation with Forensicare to ensure there is no duplication in service delivery for young people aged 18–25 years.

The **Custodial Forensic Youth Mental Health Service** will be expanded to meet current demand. This expansion will require significant collaboration with youth justice to ensure a trauma-informed approach to care is facilitated by youth justice staff and supported by appropriate infrastructure. This expanded service will be available to all young people in youth justice custody.

A **youth forensic clinical specialist program** will be created to build forensic capability within Infant, Child and Youth Area Mental Health and Wellbeing Services. Such a program will be modelled on the forensic clinical specialist program in the adult system and should build on the existing base of the Youth Justice Mental Health Initiative. Implementation of this recommendation should consider how this new service will sit alongside the referral component of the Youth Justice Mental Health Initiative.

There will be at least one forensic clinical specialist in each of the 13 Infant, Child and Youth Area Mental Health and Wellbeing Services. The precise workforce requirements should be based on robust demand projections completed during implementation of this recommendation. Any young person with a forensic history, or those at risk of coming into contact with the justice system, aged up to 25 years old can be referred to this program.

Similar to the adult service, youth forensic clinical specialists will:

- work closely with the Infant, Child and Youth Area Mental Health and Wellbeing Service clinical manager, consultant psychiatrists, psychiatric registrars and other members of the multidisciplinary teams to ensure procedures to reduce risk in clinical settings are closely followed
- proactively identify and refer eligible high-risk, complex or severely unwell young people to the Youth Forensic Mental Health Service
- develop and deliver professional development, education and training activities
- establish and maintain referral pathways to enable young people with mental illness to access other necessary supports (such as general health, housing, employment, education/training and family services)
- evaluate clinical practices and systems against research evidence, identifying areas for improvement
- develop and/or review treatment and crisis plans.

As part of establishing the Youth Forensic Mental Health Service, the Commission recommends that the service leads two changes relating to the operation of the CMIA for young people. First, **creating appropriate accommodation options for young people subject to a Custodial Supervision Order**, noting that the small number of young people subject to these orders means an individually tailored solution could be provided. And second, **developing a care pathway for young people subject to a Non-Custodial Supervision Order**.

Echoing the recommendation made in Chapter 13: *Supporting the mental health and wellbeing of young people,* the Commission recommends that **all child and youth services are available until a person is 26 years old**. The expansion of this age bracket will also apply in the forensic mental health and wellbeing system, to both those in custody and under community supervision. At this point, or where considered appropriate in consultation with the young person, their families and carers, people will transition to receiving care through Adult and Older Adult Area Mental Health and Wellbeing Services.

This requires the **creation of a Youth Forensic Mental Health Service in adult prisons**. It is proposed that Forensicare be funded to operate this service alongside the adult specialist mental health services that it already provides. In the first instance, this service should be provided at the following locations:

- Melbourne Assessment Prison (Acute Assessment Unit)
- Dame Phyllis Frost Centre (Marrmak Unit)
- Ravenhall Correctional Centre (Ballerrt Yeram-boo-ee Forensic Mental Health Service).

Pending a two-year evaluation of the service by the Department of Justice and Community Safety, in partnership with the Department of Health, this function could be expanded to other prison locations.

Supporting elements for the service

In developing this recommendation to establish a statewide specialist Youth Forensic Mental Health Service, the Commission proposes four supporting elements that must be considered in its implementation—a consistent model of care, supporting principles, workforce development and careful demand projections.

A consistent model of care will underpin these services. The Commission recommends that the development of the model of care be informed by the model created for the existing custodial and community services.[399] The core attributes of this model are that services will:

- be culturally and gender safe and sensitive
- promote a focus on early intervention
- provide person-centred care and continuity of care that will reduce the need for consumers to repeat their stories and go through unnecessary transition points
- deliver trauma-informed, recovery-focused treatment, care and support
- deliver age and developmentally appropriate treatment, care and support through a multidisciplinary team
- improve accessibility and effectiveness of the redesigned Infant, Child and Youth Area Mental Health and Wellbeing Services
- establish clear pathways for referral, admission and discharge.[400]

The Youth Forensic Mental Health Service will be underpinned by the *National Statement of Principles for Forensic Mental Health*.[401] The first 11 principles are of particular relevance and have been adapted to form the principles for establishing and operating the statewide specialist Youth Forensic Mental Health Service. These are set out in Box 23.6.

Box 23.6: Principles of Victoria's statewide specialist Youth Forensic Mental Health Service

Principle 1: Equivalence. Young people living with mental illness who are under the supervision of youth justice, whether in the community or a custodial setting, will have the same access to treatment, care and support that has equivalent availability and quality to that which is available to the general population.

Further, young people living with mental illness who are under the supervision of youth justice have equivalence in relation to the legal rights and protection enjoyed by the general population as it relates to their treatment, care and support.

Principle 2: Safe and secure treatment. Treatment, care and support will be provided to young people living with mental illness under the supervision of youth justice in an environment that is appropriate and compatible with their needs while also considering any need of the community for safety.

Principle 3: Responsibilities of the health and justice systems. Providing mental health treatment, care and support for young people is the joint responsibility of the health and justice systems (including police, youth justice and court systems) and will be addressed in partnership. There will be a focus on communication between these systems.

Principle 4: Access and early intervention. A young person, whether on remand, serving a sentence of detention or in police custody, will have timely referral and access to mental health treatment, care and support when appropriate.

Principle 5: Comprehensive forensic mental health services. The Youth Forensic Mental Health Service will be a specialist mental health service providing integrated inpatient services, custodial mental health services, court liaison services and community mental health services in a coordinated clinical and administrative stream. The service will have strong links and partnerships with the redesigned infant, child and youth mental health and wellbeing system, the adult forensic mental health and wellbeing system and with consumer and carer organisations. The service will provide evidence-based, multidisciplinary, continuous care, consistent with those of the redesigned child and youth mental and wellbeing health system. The service will also engage social support services, including providing intervention relating to homelessness, alcohol and substance use.

Principle 6: Integration and linkages. Integration of the above elements of the service will minimise barriers to young people living with mental illness receiving treatment, care and support in the most clinically appropriate setting. There will also be close integration with custodial services and parole bodies.

Principle 7: Ethical standards. The rights of young people living with mental illness subject to supervision under youth justice to be respected for their individual human worth, dignity and privacy is not given up by any circumstance, regardless of the person's history of offending or their status as a forensic mental health client or a young offender. The person's capacity or right to consent is not given up as a result of their history of offending or alleged criminal behaviour.

Principle 8: Staff: knowledge, attitudes and skills. The service's workforce will require a high degree of professionalism and strong clinical leadership. Appropriate training and support will be required to maintain a highly skilled workforce.

Principle 9: Individualised care. The service will meet the changing needs of each person, considering their biological, psychological, social, cultural and spiritual context.

Principle 10: Quality and effectiveness. The service will have in place a quality improvement process that, through performance outcomes, identifies opportunities for improvement in the way services are delivered and includes action to address identified deficiencies. This improvement process will involve carers and consumers.

Principle 11: Transparency and accountability. The service will be subject to processes of accreditation against national standards for mainstream services. It will also be subject to external and peer review. The National Standards for Mental Health Services provide appropriate benchmarks for forensic mental health services.

Given the size of this reform, the workforce requirements are significant. The Commission recommends that the new youth forensic service includes a training and research function to support workforce development. Orygen is well placed to fulfil this function. Chapter 33: *A sustainable workforce for the future*, provides more information on building the capability required across the mental health and wellbeing system.

The specific level of demand for the new service has not been determined. The Commission recommends that during the implementation process a rigorous demand modelling process be undertaken. This should be based on population projections and from data from youth justice, Victoria Police, the Children's Court of Victoria and Infant, Child and Youth Area Mental Health and Wellbeing Services.

1 *Witness Statement of Dr Emma Cassar*, 3 September 2020, para. 13.

2 *Witness Statement of Peta McCammon*, 13 August 2020, para. 13.

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

4 Sentencing Advisory Council, Victoria's Imprisonment Rates, <www.sentencingcouncil.vic.gov.au/statistics/sentencing-trends/victoria-imprisonment-rates>, [accessed 10 November 2020].

5 Sentencing Advisory Council, Victoria's Indigenous Imprisonment Rates, <www.sentencingcouncil.vic.gov.au/statistics/sentencing-trends/victoria-indigenous-imprisonment-rate>, [accessed 16 November 2020].

6 Andrew Leigh, *The Second Convict Age: Explaining the Return of Mass Imprisonment in Australia*, 2020, p. 15.

7 Leigh, p. 17.

8 Corrections Victoria, *Monthly Time Series Prisoner and Offender Data*, 2020, Table 1—Number of Prisoners by Gender and Warrant Status—End of Month, July 1998 to November 2020.

9 Corrections Victoria, *Monthly Time Series Prisoner and Offender Data*, Table 1—Number of Prisoners by Gender and Warrant Status —End of Month July, 1998 to November 2020.

10 Corrections Victoria, Offender Profile—Community Correctional Services (CCS), 2019, p. 1.

11 Corrections Victoria, Offender Profile—Community Correctional Services (CCS), p. 1.

12 Corrections Victoria, Offender Profile—Community Correctional Services (CCS), p. 1.

13 Corrections Victoria, *Monthly Time Series Prisoner and Offender Data*, Table 4—End of Month Offender Numbers by Offender Type and Gender.

14 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 49; Australian Institute of Health and Welfare, *The Health of Australia's Prisoners, Supplementary Tables—States and Territories*, 2019, Tables s169 and s193.

15 James Ogloff, Good Mental Health Care in Prisons Must Begin and End in the Community, *The Conversation*, 24 April 2015, p. 1.

16 Australian Institute of Health and Welfare, *The Health of Australia's Prisoners, Supplementary Tables—States and Territories* Tables s169 and s193.

17 Australian Institute of Health and Welfare, *The Health of Australia's Prisoners 2018*, 2019, p. 27.

18 Victorian Ombudsman, *Investigation into the Rehabilitation and Reintegration of Prisoners in Victoria*, 2015, p. 61.

19 *Witness Statement of Dr Emma Cassar*, para. 68.

20 *Witness Statement of Dr Emma Cassar*, para. 68.

21 *Witness Statement of Dr Emma Cassar*, para. 70.

22 *Witness Statement of Dr Emma Cassar*, para. 70.

23 *Witness Statement of Dr Emma Cassar*, para. 70.

24 Victorian Auditor-General's Office, *Managing Community Correction Orders*, 2017, p. 26.

25 *Witness Statement of Peta McCammon*, para. 290; Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, May 2020, pp. 51–52; Victorian Auditor-General's Office, *Managing Community Correction Orders*, p. 27.

26 Victorian Auditor-General's Office, *Managing Community Correction Orders*, p. 27.

27 *Witness Statement of Dr Emma Cassar*, para. 95.

28 Victorian Auditor-General's Office, *Managing Community Correction Orders*, p. 27.

29 Victorian Auditor-General's Office, *Managing Community Correction Orders*, p. 24.

30 Victorian Auditor-General's Office, *Managing Community Correction Orders*, p. 24.

31 Magistrates' Court of Victoria, *Submission to the RCVMHS: SUB.3000.0001.0672*, 2019, pp. 19–20.

32 Sentencing Advisory Council, Victoria's Indigenous Imprisonment Rates.

33 Victorian Aboriginal Legal Service, *Submission to the RCVMHS: SUB.0002.0030.0226*, 2019, p. 33.

34 Victorian Aboriginal Legal Service, p. 33.

35 *Witness Statement of Dr Emma Cassar*, para. 103.

36 Dr Ruth McClausland, Elizabeth McEntyre and Professor Eileen Baldry, *Indigenous People, Mental Health, Cognitive Disability and the Criminal Justice System, Brief 22*, 2017, p. 3.

37 McClausland, McEntyre and Baldry, p. 1.

38 'Preventing Harm to Others as a Criterion for Compulsory Treatment: An Overview of Criticisms and Current Research', ed. by Bernadette McSherry, *Journal Law and Medicine*, 27 (2020), 570–573 (p. 571).

39 Jennifer Skeem, Jillian Peterson and Eric Silver, 'Chapter 10: Toward Research-Informed Policy for High Risk Offenders with Serious Mental Illness', in *International Perspectives on Forensic Mental Health. Dangerous People: Policy, Predication and Practice* (New York: Routledge/Taylor and Francis Group, 2011), pp. 1–132 (p. 113).

40 Office of Police Integrity, *Policing People Who Appear to Be Mentally Ill*, 2012, p. 26; Gennady N. Baksheev and others, 'Correlates of Criminal Victimisation among Police Cell Detainees in Victoria, Australia', *Police Practice and Research*, 14.6 (2013), 522–534 (p. 522).

41 *Witness Statement of Distinguished Professor James Ogloff AM*, 6 August 2020, para. 48.

42 Linda A Teplin and others, 'Crime Victimization in Adults With Severe Mental Illness', *Arch Gen Psychiatry*, 62.8 (2005), 911–921 (p. 911).

43 Tamsin B R Short and others, 'A Case-Linkage Study of Crime Victimisation in Schizophrenia-Spectrum Disorders over a Period of Deinstitutionalisation', *BMC Psychiatry*, 13:66 (2013), 1–9 (p. 1).

44 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 104.

45 Katrina Witt, Richard van Dorn and Seena Fazel, 'Risk Factors for Violence in Psychosis: Systematic Review and Meta-Regression Analysis of 110 Studies', ed. by Xiang Yang Zhang, *PLoS ONE*, 8.2 (2013), p. 1; Seena Fazel and others, 'Schizophrenia and Violence: Systematic Review and Meta-Analysis', ed. by John McGrath, *PLoS Medicine*, 6.8 (2009), p. 2; Matthew Large, Glen Smith and Olav Nielssen, 'The Relationship between the Rate of Homicide by Those with Schizophrenia and the Overall Homicide Rate: A Systematic Review and Meta-Analysis', *Schizophrenia Research*, 112 (2009), 123–129 (p. 125).

46 James R. P. Ogloff and others, 'Co-Occurring Mental Illness, Substance Use Disorders, and Antisocial Personality Disorder among Clients of Forensic Mental Health Services', *Psychiatric Rehabilitation Journal*, 38.1 (2015), 16–23 (pp. 16, 20 and 21).

47 Bjørn Rishovd Rund, 'A Review of Factors Associated with Severe Violence in Schizophrenia', *Nordic Journal of Psychiatry*, 72.8 (2018), 561–571 (p. 563).

48 Lia Ahonen, Rolf Loeber and David A. Brent, 'The Association Between Serious Mental Health Problems and Violence: Some Common Assumptions and Misconceptions', *Trauma, Violence, and Abuse*, 20.5 (2019), 613–625 (pp. 613, 617–618 and 621).

49 Ahonen, Loeber and Brent, p. 621.

50 Matthew M. Large and others, 'The Predictive Value of Risk Categorization in Schizophrenia', *Harvard Review of Psychiatry*, 19.1 (2011), 25–33 (p. 28).

51 Large and others, p. 31.

52 Ye In Jane Hwang and others, 'Disengagement from Mental Health Treatment and Re-Offending in Those with Psychosis: A Multi-State Model of Linked Data', *Social Psychiatry and Psychiatric Epidemiology*, 2020, p. 6.

53 Hwang and others, p. 6.

54 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 64.

55 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: Prison Expansion Locks In Jobs And Drives Safer Community, 21 October 2020, <www.premier.vic.gov.au/prison-expansion-locks-jobs-and-drives-safer-community>, [accessed 16 November 2020]; Corrections, Prisons and Parole, Corrections Budget for 2019–20 Released: The Victorian Government Is Investing More Than $1.8 Billion to Ensure That Prisons Are Able to Keep Pace with Demand, <www.corrections.vic.gov.au/corrections-budget-for-2019-20-released>, [accessed 29 November 2020].

56 Corrections, Prisons and Parole.

57 Victorian Government, *Community Safety Statement 2018–19*, 2018, p. 4.

58 Victorian Government, *Community Safety Statement 2018–19, Summary*, 2018, p. 4; Victorian Government, *Community Safety Statement 2019–20*, 2019, p. 20; Victorian Government, *Community Safety Statement 2018–19*, pp. 4, 9 and 25.

59 *Witness Statement of Dr Emma Cassar*, para. 60.

60 *Witness Statement of Dr Emma Cassar*, para. 59.

61 Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, 2020, p. 23.

62 *Witness Statement of Dr Emma Cassar*, 2020, para. 60.

63 *Witness Statement of Professor Stuart Kinner*, 21 July 2020, para. 22.

64 *Witness Statement of Dr Emma Cassar*, para. 60.

65 *Witness Statement of Dr Emma Cassar*, para. 60.

66 Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, p. 27; Forensicare, Prison Services, <www.forensicare.vic.gov.au/our-services/prison-services/>, [accessed 10 December 2020].

67 Human Rights Law Centre, *Submission to the RCVMHS: SUB.0002.0029.0215*, 2019, p. 3.

68 *Witness Statement of 'Grant Todd' (pseudonym)*, 4 May 2020, para. 16.

69 Victoria Police, *Victoria Police Blue Paper: A Vision for Victoria Police in 2025*, 2014, pp. 7–8.

70 *Witness Statement of Dr Emma Cassar*, para. 74.

71 *Witness Statement of Dr Emma Cassar*, para. 16.

72 Forensicare, *Submission to the RCVMHS: SUB.0002.0030.0126*, 2019, p. 3.

73 Magistrates' Court of Victoria, p. 34.

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

75 Caraniche, *Submission to the RCVMHS: SUB.0002.0028.0676*, 2019, p. 7.

76 *Witness Statement of Mary Pershall*, 9 July 2019, para. 71.

77 Mental Health Victoria and Mental Health Legal Centre, *Submission to the RCVMHS: SUB.0002.0029.0006*, 2019, p. 16.

78 Human Rights Law Centre, p. 3.

79 The Senate, Select Committee on Mental Health, Parliament of Australia, *A National Approach to Mental Health: From Crisis to Community: First Report*, 2006, p. 335.

80 *Witness Statement of Dr Emma Cassar*, para. 74.

81 *Witness Statement of Dan Nicholson*, 22 May 2020, para. 13(b).

82 *Witness Statement of Dan Nicholson*, para. 14.

83 Magistrates' Court of Victoria, p. 34.

84 Magistrates' Court of Victoria, p. 34.

85 Magistrates' Court of Victoria, p. 34.

86 Federation of Community Legal Centres Victoria, *Submission to the RCVMHS: SUB.3000.0001.0232*, 2019, p. 21; Fitzroy Legal Service, *Submission to the RCVMHS: SUB.0002.0032.0021*, 2019, pp. 21–22; Women Transforming Justice Women's Leadership Group, *Submission to the RCVMHS: SUB.0002.0028.0690*, 2019, pp. 2–3; Law Institute Victoria, *Submission to the RCVMHS: SUB.1000.0001.2134*, 2019, pp. 5–6; First Step Legal, *Submission to the RCVMHS: SUB.0002.0027.0148*, 2019, p. 6.

87 The Senate, Select Committee on Mental Health, Parliament of Australia, *A National Approach to Mental Health: From Crisis to Community: First Report*, p. 335.

88 Inner Melbourne Community Legal, *Submission to the RCVMHS: SUB.0002.0030.0006*, 2019, p. 12.

89 Springvale Monash Legal Service, *Submission to the RCVMHS: SUB.3000.0001.1249*, 2019, p. 10.

90 *Witness Statement of Dan Nicholson*, para. 21.

91 Inner Melbourne Community Legal, p. 12; Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, 2019, p. 3; Federation of Community Legal Centres Victoria, pp. 64–84; Human Rights Law Centre, p. 20; Springvale Monash Legal Service, pp. 9–14; *Witness Statement of Julie Edwards*, 21 May 2020, para. 103.

92 Springvale Monash Legal Service, p. 9.

93 Springvale Monash Legal Service, p. 9.

94 Department of Health and Human Services, Integrated Data Resource, Client Management Interface/Operational Data Store, Law Enforcement Assistance Program 2014–15 to 2018–19; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat.no. 3101.0, Canberra.

95 Northern Community Legal Centre, *Submission to the RCVMHS: SUB.0002.0030.0065*, 2019, p. 10.

96 WEstjustice, *Submission to the RCVMHS: SUB.1000.0001.5694*, 2019, p. 5.

97 Fines Reform Advisory Board, *Summary Report on the Delivery of Fines Reform*, 2020, p. 8.

98 Fines Reform Advisory Board, p. 9.

99 Fines Reform Advisory Board, p. 14.

100 Engage Victoria, Fines Reform, <engage.vic.gov.au/fines-reform>, [accessed 20 December 2020].

101 *Witness Statement of Julie Edwards*, para. 106; Springvale Monash Legal Service, p. 8.

102 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, 2019, p. 24.

103 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 205.

104 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 205.

105 Victoria Police, *Submission to the RCVMHS: SUB.0002.0029.0370*, 2019, p. 3.

106 Victoria Police, *Submission to the RCVMHS: SUB.0002.0029.0370*, p. 3.

107 Victoria Police, *Submission to the RCVMHS: SUB.0002.0029.0370*, 2019, p. 3.

108 *Witness Statement of Assistant Commissioner Glenn Weir*, 5 July 2019, para. 124.

109 Fitzroy Legal Service, p. 19.

110 Productivity Commission, *Mental Health Inquiry Report, Volume 3*, 2020, p. 1012.

111 *Witness Statement of Peta McCammon*, para. 105.

112 Inner Melbourne Community Legal, p. 13.

113 *Witness Statement of Emeritus Professor Arie Freiberg AM*, 27 April 2020, para. 24.

114 Fitzroy Legal Service, pp. 17–18.

DOH.0003.0001.0876

115 Magistrates' Court of Victoria, p. 34.

116 Fitzroy Legal Service, p. 26.

117 Victorian Aboriginal Legal Service, pp. 52–53; Victorian Aboriginal Justice Agreement, Burra Lotjpa Dunguludja: The Victorian Aboriginal Justice Agreement, <www.aboriginaljustice.vic.gov.au/the-agreement/the-victorian-aboriginal-justice-agreement>, [accessed 27 July 2020].

118 Analysis and Policy Observatory, Burra Lotjpa Dunguludja: Victorian Aboriginal Justice Agreement—Phase 4, <apo.org.au/node/260401>, [accessed 27 July 2020].

119 *Witness Statement of Marion Hansen*, 31 July 2020, para. 28.

120 *Witness Statement of Marion Hansen*, 31 July 2020, para. 28.

121 *Witness Statement of Marion Hansen*, para. 27.

122 Analysis and Policy Observatory, p. 6.

123 Analysis and Policy Observatory, p. 6.

124 RCVMHS, *Mental Health Services for Children and Young People in the Youth Justice System Roundtable: Record of Proceedings*, 2020.

125 RCVMHS, *Mental Health Services for Children and Young People in the Youth Justice System Roundtable: Record of Proceedings*, 2020.

126 *Witness Statement of Julie Edwards*, para. 101.

127 RCVMHS, *Mental Health Services for Children and Young People in the Youth Justice System Roundtable: Record of Proceedings*.

128 Corrections Victoria, *Monthly Time Series Prisoner and Offender Data*, Table 1—End of Month Prisoner Numbers by Gender and Warrant Status.

129 Corrections Victoria, *Monthly Time Series Prisoner and Offender Data*, Table 1—End of Month Prisoner Numbers by Gender and Warrant Status.

130 Corrections Victoria, *Monthly Time Series Prisoner and Offender Data*, Table 1—End of Month Prisoner Numbers by Gender and Warrant Status.

131 Corrections Victoria, *Monthly Time Series Prisoner and Offender Data*, Table 3—Monthly Number of Discharges from Prisons by Gender and Warrant Status of Episode.

132 Corrections Victoria, *Monthly Time Series Prisoner and Offender Data*, Table 3—Monthly Number of Discharges from Prisons by Gender and Warrant Status of Episode.

133 *Witness Statement of Dan Nicholson*, para. 55.

134 *Witness Statement of Dan Nicholson*, para. 55; Dr Marilyn McMahon, *No Bail, More Jail?: Breaking the Nexus Between Community Protection and Escalating Pre-Trial Detention*, 2019, p. 22; Paul Heaton, Sandra Mayson and Megan Stevenson, 'The Downstream Consequences of Misdemeanor Pretrial Detention', *Stanford Law Review*, 69 (2017), 711–794 (pp. 714 and 786–787).

135 *Witness Statement of Peta McCammon*, para. 41.

136 *Witness Statement of Dr Emma Cassar*, para. 81.

137 *Witness Statement of Peta McCammon*, para. 41.

138 *Witness Statement of Peta McCammon*, para. 41.

139 The Hon. Paul Coghlan QC, *Bail Review: Second Advice to the Victorian Government*, 2017, pp. 5–6.

140 Coghlan QC, p. 15.

141 Magistrates' Court of Victoria, pp. 12–13; Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, pp. 33 and 58.

142 Magistrates' Court of Victoria, p. 30; Michael S King, 'Restorative Justice, Therapeutic Jurisprudence and the Rise of Emotionally Intelligent Justice', *Melbourne University Law Review*, 32 (2008), 1096–1126 (pp. 1098 and 1115).

143 Magistrates' Court of Victoria, pp. 11–13 and 30.

144 Victorian Auditor-General's Office, *Problem-Solving Approaches to Justice*, 2011, p. 3.

145 Victorian Auditor-General's Office, *Problem-Solving Approaches to Justice*, p. 2.

146 The Senate, Select Committee on Mental Health, Parliament of Australia, *A National Approach to Mental Health: From Crisis to Community: Final Report*, 2006, p. 20.

147 Law Institute of Victoria, Justice Statement Sketches Victoria's Future, <www.liv.asn.au/LIV-Home/Practice-Resources/Law-Institute-Journal/Archived-Issues/LIJ-July-2004/Justice-Statement-sketches-Victorias-future>, [accessed 29 November 2020].

148 Law Institute of Victoria.

149 Magistrates' Court of Victoria, p. 30.

150 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 33.

151 Magistrates' Court of Victoria, p. 6.

152 Magistrates' Court of Victoria, p. 12; Victoria Police, *Submission to the RCVMHS: SUB.0002.0029.0370*, pp. 14–15.

153 Magistrates' Court of Victoria, p. 12.

154 Victoria Legal Aid, *Correspondence to the RCVMHS: CSP.0001.0001.0151, Paving the Roads to Recovery: Building a Better System for People Experiencing Mental Health Issues in Victoria*, pp. 33 and 61.

155 Brianna Chesser and Kenneth H Smith, 'The Assessment and Referral Court List Program in the Magistrates Court of Victoria: An Australian Study of Recidivism', *International Journal of Law, Crime and Justice*, 45 (2016), 141–151 (p. 144).

156 Chesser and Smith, p. 144.

157 Magistrates' Court of Victoria, p. 11.

158 Magistrates' Court of Victoria, p. 11.

159 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, p. 33.

160 Magistrates' Court of Victoria, p. 11.

161 Magistrates' Court of Victoria, p. 12.

162 Magistrates' Court of Victoria, p. 12.

163 Victoria Police, *Submission to the RCVMHS: SUB.0002.0029.0370*, p. 11.

164 Victoria Legal Aid, *Answers to Questions on Notice in Response to the Productivity Commission Public Hearing into Mental Health: Is There Evidence of Systematically Different Outcomes Before Mental Health Tribunals Depending on Whether There Is Legal Representation?*, 2020, p. 3.

165 Chesser and Smith, p. 149.

166 Chesser and Smith, p. 149.

167 Chesser and Smith, p. 150.

168 Chesser and Smith, p. 149.

169 *Witness Statement of Whitney Dwyer*, 12 June 2020, para. 25.

170 Inner Melbourne Community Legal, p. 14.

171 Inner Melbourne Community Legal, *Submission to the RCVMHS: SUB.0002.0030.0006*, 2019, p. 15.

172 Inner Melbourne Community Legal, *Submission to the RCVMHS: SUB.0002.0030.0006*, 2019, p. 16.

173 *Evidence of Dr Dan Nicholson*, 9 June 2020, pp. 24–25; *Evidence of Julie Edwards*, 9 June 2020, pp. 26–27; *Evidence of Dr Shaymaa Elkadi*, 9 June 2020, pp. 25–26.

174 Young Peoples' Legal Rights Centre (Youthlaw), *Submission to the RCVMHS: SUB.0002.0029.0252*, 2019, p. 7.

175 Victorian Ombudsman, *Investigation into the Rehabilitation and Reintegration of Prisoners in Victoria*, p. 153.

176 Victorian Ombudsman, *Investigation into the Rehabilitation and Reintegration of Prisoners in Victoria*, p. 8.

177 *Witness Statement of Peta McCammon*, Appendix B, para.55.

178 *Witness Statement of Peta McCammon*, Appendix B, para. 55.

179 Victorian Ombudsman, *Investigation into the Rehabilitation and Reintegration of Prisoners in Victoria*, 2015, p. 9.

180 Productivity Commission, p. 1012.

181 Victoria Police, *Submission to the RCVMHS: SUB.0002.0029.0370*, p. 11.

182 Victoria Police, *Submission to the RCVMHS: SUB.0002.0029.0370*, 2019, p. 15.

183 Victoria Police, *Submission to the RCVMHS: SUB.0002.0029.0370*, 2019, p. 15.

184 Victoria Police, *Submission to the RCVMHS: SUB.0002.0029.0370*, 2019, p. 15.

185 Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, p. 73.

186 *Witness Statement of Dr Shaymaa Elkadi*, 25 May 2020, paras. 86–88.

187 Victorian Institute of Forensic Mental Health, *Annual Report 2018–19*, 2019, p. 26.

188 Victorian Institute of Forensic Mental Health, pp. 26–27.

189 Victorian Institute of Forensic Mental Health, p. 26.

190 Victorian Institute of Forensic Mental Health, p. 26.

191 Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, p. 28.

192 Victorian Government, *Community Safety Statement 2018–19*, p. 30.

193 Victorian Government, *Community Safety Statement 2018–19*, p. 30.

194 Victorian Institute of Forensic Mental Health, p. 26.

195 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 163.

196 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 163.

197 *Witness Statement of Dr Shaymaa Elkadi*, 25 May 2020, para. 87.

198 *Witness Statement of Dr Shaymaa Elkadi*, para. 90.

199 *Witness Statement of Dr Margaret Grigg*, 28 May 2020, para. 68.

200 *Witness Statement of Dr Margaret Grigg*, para. 69.

201 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 165.

202 *Witness Statement of Peter Kelly*, 29 May 2020, para. 155.

203 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 164.

204 Department of Health, *Forensic Clinical Specialist Initiative Evaluation: Summative Evaluation*, 2013, p. 5.

205 Department of Health, p. 5.

206 *Witness Statement of Dr Shaymaa Elkadi* (25 May 2020), para. 91.

207 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 165.

208 *Witness Statement of Dr Shaymaa Elkadi*, para. 83.

209 *Witness Statement of Dr Shaymaa Elkadi*, para. 95.

210 RCVMHS, *Forensic Mental Health Roundtable: Record of Proceedings*, 2020.

211 *Witness Statement of Dr Lynne Coulson Barr OAM*, 4 June 2020, para. 174.

212 Queensland Health, *When Mental Health Care Meets Risk: A Queensland Sentinel Events Review into Homicide and Public Sector Mental Health Services: Final Report*, 2016, pp. 7–8.

213 Queensland Health, *When Mental Health Care Meets Risk: A Queensland Sentinel Events Review into Homicide and Public Sector Mental Health Services: Final Report*, pp. 7 and 61.

214 Department of Health, Queensland, *When Mental Health Care Meets Risk: A Queensland Sentinel Events Review into Homicide and Public Sector Mental Health Services: Final Report*, 2016, p. 7.

215 Queensland Health, *Violence Risk Assessment and Management Framework - Mental Health Services*, 2019, pp. 8–12.

216 Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, p. 73.

217 Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, p. 73.

218 Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, p. 73.

219 Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, p. 73.

220 Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, p. 73.

221 Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, p. 73.

222 Victorian Alcohol and Drug Association and Justice Health Unit, Melbourne School of Population and Global Health, The University of Melbourne, *Submission to the RCVMHS: SUB.0002.0029.0453*, 2019, p. 11.

223 Victorian Alcohol and Drug Association and Justice Health Unit, Melbourne School of Population & Global Health, University of Melbourne, *Submission to the RCVMHS: SUB.0002.0029.0453*, 2019, p. 11.

224 Forensicare, *Submission to the RCVMHS: SUB.0002.0030.0126*, p. 26.

225 Hwang and others, p. 6; Caraniche, p. 7.

226 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 109.

227 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 109.

228 Victorian Alcohol and Drug Association and Justice Health Unit, Melbourne School of Population & Global Health, University of Melbourne, *Submission to the RCVMHS: SUB.0002.0029.0453*, 2019, p. 5.

229 *Witness Statement of Dr Emma Cassar*, paras. 124–131 and 176; *Witness Statement of Peta McCammon*, para. 81(e), 163, 165, 262, 403(d), 412, 525 and 548–550.

230 Victorian Alcohol and Drug Association and Justice Health Unit, Melbourne School of Population and Global Health, The University of Melbourne, p. 40.

231 Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, p. 2.

232 Forensicare, *Correspondence to the RCVMHS: CSP.0001.0108.0001, Forensicare Service Plan*, p. 2.

233 Forensicare, *Submission to the RCVMHS: SUB.0002.0030.0126*, p. 14.

234 Forensicare, *Submission to the RCVMHS: SUB.0002.0030.0126*, p. 29.

235 *Witness Statement of Dr Danny Sullivan*, 8 July 2020, para. 84.

236 *Witness Statement of Dr Emma Cassar*, para. 127.

237 *Witness Statement of Julie Edwards*, para. 121.

238 *Witness Statement of Julie Edwards*, para. 121.

239 *Witness Statement of Julie Edwards*, para. 122.

240 *Witness Statement of Julie Edwards*, para. 123.

241 Forensicare, *Submission to the RCVMHS: SUB.0002.0030.0126*, p. 14.

242 Forensicare, *Submission to the RCVMHS: SUB.0002.0030.0126*, p. 14.

243 *Witness Statement of Dr Danny Sullivan*, para. 84.

244 *Witness Statement of Peta McCammon*, para. 262.

245 *Witness Statement of Dr Emma Cassar*, para. 128.

246 *Witness Statement of Peta McCammon*, para. 280.

247 *Witness Statement of Peta McCammon*, para. 280.

248 *Witness Statement of Peter Kelly*, para. 150.

249 *Witness Statement of Peter Kelly*, para. 150.

250 *Witness Statement of Peter Kelly*, para. 151.

251 NorthWestern Mental Health (A Division of Melbourne Health), *Submission to the RCVMHS: SUB.0002.0030.0061*, 2019, p. 23; Eastern Health, *Submission to the RCVMHS: SUB.0002.0028.0585*, 2019, p. 20.

252 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 15.

253 RCVMHS, *Forensicare Consumer Advisory Group Roundtable: Record of Proceedings*, 2020.

254 RCVMHS, *Forensicare Consumer Advisory Group Roundtable: Record of Proceedings*.

255 RCVMHS, *Forensicare Consumer Advisory Group Roundtable: Record of Proceedings*.

256 RCVMHS, *Forensicare Consumer Advisory Group Roundtable: Record of Proceedings*.

257 Forensicare, *Submission to the RCVMHS: SUB.0002.0030.0126*, p. 26.

258 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 144.

259 Victorian Institute of Forensic Mental Health, p. 39.

260 Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care. Report of the Review of Hospital Safety and Quality Assurance in Victoria*, 2016, p. 139.

261 Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care. Report of the Review of Hospital Safety and Quality Assurance in Victoria*, pp. 139–142; Victorian Auditor-General's Office, *Mental Health Strategies for the Justice System*, 2014, p. xiii; Victorian Ombudsman, *Investigation into Deaths and Harm in Custody*, 2014, p. 119.

262 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 143.

263 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 144.

264 Victorian Institute of Forensic Mental Health, *Annual Report 2019–20*, 2020, p. 46.

265 Forensicare, *Information provided to the RCVMHS*, 1 December 2020.

266 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 156.

267 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 156.

268 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 158.

269 *Witness Statement of Dr Neil Coventry*, 29 July 2020, para. 283.

270 Department of Health and Human Services, *Review of Mental Health Subacute Services in Victoria Discussion Paper*, 2019, p. 11.

271 Victorian Mental Health Tribunal, *Submission to the RCVMHS: SUB.1000.0001.0979*, 2019, p. 25.

272 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 161.

273 Carol Harvey and others, *Models of Care for Victorians Living with Severe and Persistent Mental Illness and Complex Multiagency Needs: Literature Review and Key Reform Considerations. Report Prepared for the Royal Commission into Victoria's Mental Health System*, 2020, p. 79.

274 *Witness Statement of Dr Neil Coventry*, 2020, para. 424.

275 Australian Health Ministers' Advisory Council, Mental Health Standing Committee, *National Statement of Principles for Forensic Mental Health*, 2006.

276 Victorian Government, *Submission to the RCVMHS: SUB.5000.0001.0001*, p. 25.

277 Victorian Institute of Forensic Mental Health, p. 22.

278 *Witness Statement of Associate Professor Ruth Vine*, 29 April 2020, para. 45.

279 *Witness Statement of Dr Danny Sullivan*, para. 194; *Witness Statement of Distinguished Professor James Ogloff AM*, para. 177; *Witness Statement of Dr Adam Deacon*, 2 July 2020, para. 88; *Witness Statement of Dr Emma Cassar*, para. 164; *Witness Statement of Peta McCammon*, para. 276; *Witness Statement of Dr Margaret Grigg*, paras. 92–93.

280 The Royal Australian and New Zealand College of Psychiatrists, Involuntary Mental Health Treatment in Custody, <www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/involuntary-mental-health-treatment-in-custody#:~:text=The%20RANZCP%20supports%20legislation%20that,in%20the%20criminal%20justice%20system.>, [accessed 6 September 2020].

281 General Assembly, United Nations, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, 2015, Rule 109.

282 *Witness Statement of Dr Neil Coventry*, 2020, para. 433.

283 Bobbie Clugston and others, *Prison Mental Health Services: A Comparison of Australian Jurisdictions*, 2018, p. 23.

284 Clugston and others, p. 23.

285 Clugston and others, p. 23.

286 *Witness Statement of Dr Margaret Grigg*, paras. 67–70; *Witness Statement of Dr Shaymaa Elkadi*, paras. 63, 75–76, 83 and 90–91. *Witness Statement of Distinguished Professor James Ogloff AM*, para. 166.

287 Corrections Victoria, *Monthly Time Series Prisoner and Offender Data* Table 3—Monthly Number of Discharges from Prisons by Gender and Warrant Status—July 1998 to November 2020.

288 Corrections Victoria, *Monthly Time Series Prisoner and Offender Data* Table 3—Monthly Number of Discharges from Prisons by Gender and Warrant Status—July 1998 to November 2020.

289 Australian Institute of Health and Welfare, *The Health of Australia's Prisoners—Supplementary Tables—States and Territories* Table S173: Prison Dischargees, Levels of Psychological Distress as Measured by the K10 Scale, States and Territories, 2018.

290 Australian Institute of Health and Welfare, *The Health of Australia's Prisoners—Supplementary Tables—States and Territories* Table S173: Prison Dischargees, Levels of Psychological Distress as Measured by the K10 Scale, States and Territories, 2018.

291 Australian Institute of Health and Welfare, *The Health of Australia's Prisoners—Supplementary Tables—States and Territories* Table S185: Prison Dischargees, Distress Related to Mental Health Issues, States and Territories, 2018.

292 *Witness Statement of Dr Emma Cassar*, para. 130.

293 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 465.

294 Fiona G. Kouyoumdjian and others, 'A Systematic Review of Randomized Controlled Trials of Interventions to Improve the Health of Persons During Imprisonment and in the Year After Release', *American Journal of Public Health*, 105.4 (2015), e13–e33 (pp. e13-e14).

295 Harvey and others, p. 26.

296 Forensicare, *Submission to the RCVMHS: SUB.0002.0030.0126*, p. 26.

297 *Witness Statement of Robert Fiske*, 15 October 2020, para. 11.

298 *Witness Statement of Robert Fiske*, para. 38.

299 *Witness Statement of Robert Fiske*, para. 38.

300 Department of Justice and Community Safety, Custody in the Youth Justice System, <www.justice.vic.gov.au/justice-system/youth-justice/custody-in-the-youth-justice-system>, [accessed 10 December 2020].

301 Department of Justice and Community Safety.

302 Australian Institute of Health and Welfare, *Youth Justice in Australia 2018–19*, 2020, p. 5.

303 Australian Institute of Health and Welfare, *Youth Justice in Australia 2018–19*, p. 5.

304 *Witness Statement of Marion Hansen*, para. 6.

305 Victorian Government, *Youth Justice Centre Facility Plan*, 2018, p. 4.

306 Youth Parole Board Victoria, *Correspondence to the RCVMHS: CSP.0001.0117.0001*, 2020, p. 1.

307 Youth Parole Board Victoria, p. 1.

308 *Witness Statement of Associate Secretary Peta McCammon*, para. 43.

309 Victorian Auditor-General's Office, *Managing Rehabilitation Services in Youth Detention*, 2018, p. 7.

310 *Witness Statement of Associate Secretary Peta McCammon*, para. 419.

311 Charlie Taylor, *Review of the Youth Justice System in England and Wales*, 2016, p. 2.

312 Taylor, p. 2.

313 Taylor, p. 50.

314 Matthew Kliethermes, Megan Schacht and Kate Drewry, 'Complex Trauma', *Child and Adolescent Psychiatric Clinics of North America*, 23 (2014), 339–361 (p. 348).

315 *Witness Statement of Dr Adam Deacon*, para. 7.

316 *Witness Statement of Dr Adam Deacon*, para. 25; *Witness Statement of Professor Louise Newman AM*, para. 105.

317 *Witness Statement of Dr Adam Deacon*, para. 34.

318 *Witness Statement of Dr Claire Gaskin*, 1 July 2020, para. 25.

319 Youth Parole Board Victoria, pp. 2–4.

320 *Witness Statement of Peta McCammon*, para. 473.

321 *Witness Statement of Peta McCammon*, para. 473.

322 *Witness Statement of Dr Emma Cassar*, para. 91(b).

323 *Witness Statement of Professor Stuart Kinner*, para. 59.

324 Orygen, The National Centre of Excellence in Youth Mental Health, *Submission to the RCVMHS: SUB.2000.0001.0741*, 2019, p. 34.

325 *Witness Statement of Peta McCammon*, para. 499.

326 The Honourable Daniel Andrews MP, Premier of Victoria, Media Release: New Malmsbury Youth Justice Precinct Expansion Open, 17 November 2020, <www.premier.vic.gov.au/new-malmsbury-youth-justice-precinct-expansion-open>, [accessed 29 November 2020].

327 Children's Court of Victoria, *Submission to the RCVMHS: SUB.0002.0032.0026*, 2019, p. 16.

328 Children's Court of Victoria, p. 17.

329 Children's Court of Victoria, p. 17.

330 *Witness Statement of Dr Paul Denborough*, 11 May 2020, para. 111.

331 *Witness Statement of Dr Paul Denborough*, 2020, para. 111.

332 *Witness Statement of Dr Paul Denborough*, 2020, para. 112.

333 *Witness Statement of Dr Paul Denborough*, 2020, para. 111.

334 *Witness Statement of Peta McCammon*, para. 476.

335 *Witness Statement of Dr Adam Deacon*, para. 38.

336 *Witness Statement of Dr Adam Deacon*, para. 39.

337 *Witness Statement of Dr Paul Denborough*, 2020, para. 123.

338 *Witness Statement of Dr Paul Denborough*, 2020, para. 121.

339 *Witness Statement of Dr Paul Denborough*, 2020, para. 124.

340 *Witness Statement of Dr Adam Deacon*, para. 56.

341 *Witness Statement of Dr Margaret Grigg*, para. 112.

342 *Witness Statement of Dr Margaret Grigg*, para. 112.

343 *Witness Statement of Dr Margaret Grigg*, para. 112.

344 *Witness Statement of Peta McCammon*, para. 238.

345 *Witness Statement of Dr Margaret Grigg*, para. 113.

346 *Witness Statement of Peta McCammon*, para. 497.

347 *Witness Statement of Peter Kelly*, paras. 136–140.

348 Orygen, The National Centre of Excellence in Youth Mental Health, p. 34.

349 RCVMHS, *Mental Health Services for Children and Young People in the Youth Justice System Roundtable: Record of Proceedings*.

350 RCVMHS, *Mental Health Services for Children and Young People in the Youth Justice System Roundtable: Record of Proceedings*.

351 RCVMHS, *Mental Health Services for Children and Young People in the Youth Justice System Roundtable: Record of Proceedings*.

352 RCVMHS, *Mental Health Services for Children and Young People in the Youth Justice System Roundtable: Record of Proceedings*.

353 RCVMHS, *Mental Health Services for Children and Young People in the Youth Justice System Roundtable: Record of Proceedings*.

354 RCVMHS, *Mental Health Services for Children and Young People in the Youth Justice System Roundtable: Record of Proceedings*.

355 RCVMHS, *Mental Health Services for Children and Young People in the Youth Justice System Roundtable: Record of Proceedings*.

356 Penny Armytage and Professor James Ogloff, *Youth Justice Review and Strategy: Meetings Needs and Reducing Offending—Part 1*, 2017.

357 Penny Armytage and Professor James Ogloff AM, *Youth Justice Review and Strategy: Meeting Needs and Reducing Offending Executive Summary*, 2017, p. 11.

358 Armytage and Ogloff AM, *Youth Justice Review and Strategy: Meeting Needs and Reducing Offending Executive Summary*, pp. 7–8.

359 Armytage and Ogloff AM, *Youth Justice Review and Strategy: Meeting Needs and Reducing Offending Executive Summary*, pp. 13–14.

360 *Witness Statement of Peta McCammon*, para. 468.

361 *Witness Statement of Distinguished Professor James Ogloff AM*, para. 171.

362 RCVMHS, *Mental Health Services for Children and Young People in the Youth Justice System Roundtable: Record of Proceedings*.

363 RCVMHS, *Mental Health Services for Children and Young People in the Youth Justice System Roundtable: Record of Proceedings*.

364 *Witness Statement of Dr Shaymaa Elkadi*, para. 10.

365 Orygen, The National Centre of Excellence in Youth Mental Health, *Submission to the RCVMHS: SUB.2000.0001.0741*, 2019, p. 33.

366 Orygen, The National Centre of Excellence in Youth Mental Health, p. 7.

367 Orygen, The National Centre of Excellence in Youth Mental Health, p. 35.

368 *Witness Statement of Dr Paul Denborough*, 2020, para. 125.

369 *Witness Statement of Dr Paul Denborough*, 2020, para. 126.

370 Child and Youth Mental Health Service, Children's Health Queensland Hospital and Health Service Queensland Health, Children's Health Queensland, *Forensic Adolescent Mental Health Alcohol and Other Drugs Program Response to Royal Commission into Institutional Responses to Child Sexual Abuse*, 2015, p. 1.

371 *Witness Statement of Dr Paul Denborough*, 2020, para. 21.

372 Child and Youth Mental Health Service, Children's Health Queensland Hospital and Health Service Queensland Health, p. 2.

373 Child and Youth Mental Health Service, Children's Health Queensland Hospital and Health Service Queensland Health, p. 1.

374 *Witness Statement of Dr Paul Denborough*, 2020, para. 126.

375 *Witness Statement of Dr Paul Denborough*, 2020, para. 127.

376 *Witness Statement of Dr Paul Denborough*, 2020, para. 21.

377 *Witness Statement of Dr Adam Deacon*, para. 65.

378 Children's Court of Victoria, pp. 14–15.

379 Children's Court of Victoria, p. 15.

380 Children's Court of Victoria, p. 15.

381 Children's Court of Victoria, p. 15.

382 Children's Court of Victoria, p. 15.

383 Victorian Law Reform Commission, *Review of the Crimes (Mental Impairment and Unfitness to Be Tried) Act 1997*, 2014, p. 28.

384 Children's Court of Victoria, p. 15.

385 RCVMHS, *Mental Health Services for Children and Young People in the Youth Justice System Roundtable: Record of Proceedings*.

386 Penny Armytage and Professor James Ogloff AM, *Youth Justice Review and Strategy: Meeting Needs and Reducing Offending Part 2*, 2017, p. 308.

387 Armytage and Ogloff AM, *Youth Justice Review and Strategy: Meeting Needs and Reducing Offending Part 2*, p. 308.

388 Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into Youth Justice Centres in Victoria: Final Report*, 2018, p. 96.

389 *Witness Statement of Dr Margaret Grigg*, para. 117.

390 *Witness Statement of Peta McCammon*, para. 71.

391 *Witness Statement of Dr Neil Coventry*, 2020, paras. 588 and 593.

392 Australian Human Rights Commission, *Children's Rights Report 2019—In Their Own Right: Children's Rights in Australia*, 2019, p. 247.

393 *Witness Statement of Dr Margaret Grigg*, para. 117.

394 Katinka Morton, Adam Deacon and Danny Sullivan, 'The Extension of the Crimes (Mental Impairment and Unfitness to Be Tried) Act 1997 to the Children's Court: Opportunities and Shortfalls', *Psychiatry, Psychology and Law*, 2018, 1–10 (pp. 4–5 and 9).

395 Morton, Deacon and Sullivan, p. 8.

396 Morton, Deacon and Sullivan, pp. 2 and 5.

397 Morton, Deacon and Sullivan, pp. 2 and 8.

398 Orygen, The National Centre of Excellence in Youth Mental Health, p. 35.

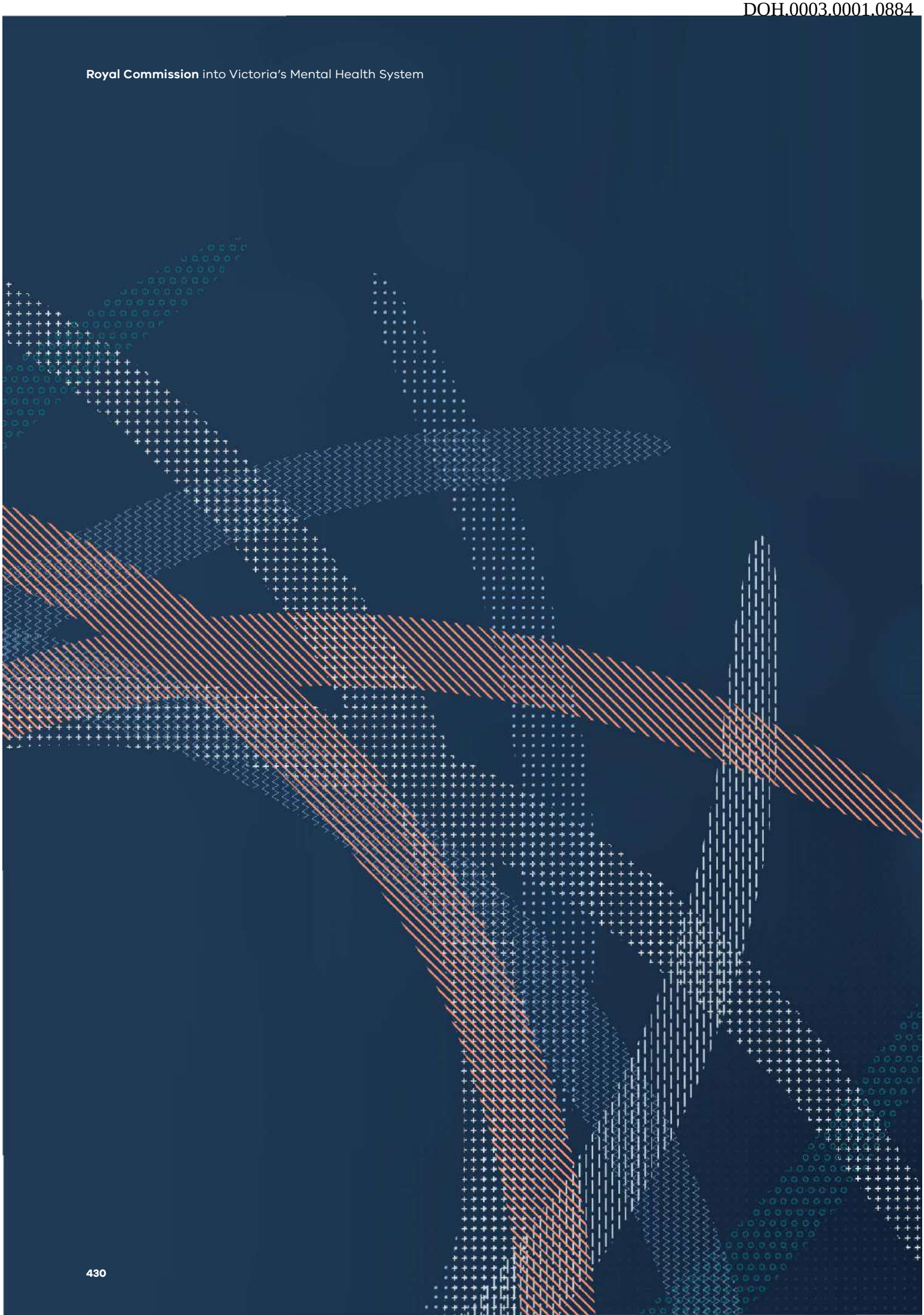
399 Department of Health and Human Services, *Model of Care for Forensic Youth Mental Health Initiatives*, 2018.

400 Department of Health and Human Services, *Model of Care for Forensic Youth Mental Health Initiatives*, pp. 6–7.

401 Australian Health Ministers' Advisory Council, Mental Health Standing Committee.

DOH.0003.0001.0883

DOH.0003.0001.0884



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Chapter 24

Supporting the mental health and wellbeing of people in rural and regional Victoria

Recommendation 39:

Supporting the mental health and wellbeing of people in rural and regional Victoria

The Royal Commission recommends that the Victorian Government:

1. in addition to ensuring rural and regional communities receive the benefits of the Royal Commission's recommended responsive and integrated mental health and wellbeing system:

   a. provide additional resources to enable mental health and wellbeing services operating in regional Victoria to deliver services to small or geographically isolated rural communities; and

   b. by the end of 2022, trial two new digital service delivery initiatives in rural and regional areas that meet the needs of local communities.

Recommendation 40:

Providing incentives for the mental health and wellbeing workforce in rural and regional areas

The Royal Commission recommends that the Victorian Government:

1. address mental health and wellbeing workforce supply needs in rural and regional areas and establish an incentive scheme to:

   a. attract mental health and wellbeing workers to rural and regional mental health and wellbeing services; and

   b. retain mental health and wellbeing workers in such services.

24.1 Responsive and accessible services in rural and regional Victoria

The Commission's recommendations present a vision for a future mental health and wellbeing system that adapts and responds to the needs of all Victorians. This includes a more equitable, high-performing system for people living in rural and regional Victoria.

In its interim report, the Commission stated that wherever possible, people living in these communities should be able to obtain mental health services close to home, and close to their families and loved ones.[1] Regardless of where they live, all Victorians have the right to access mental health treatment, care and support that is responsive to their needs and context.

The new integrated mental health and wellbeing system is designed to respond to the changing composition, needs and choices of rural and regional Victorian populations.

Victorians in rural and regional communities will be able to use a diverse range of face-to-face treatment, care and support. To complement in-person services, digitally enabled mental health and wellbeing services—including digital interventions and services offered through telehealth—will offer consumers, families, carers and supporters service options across the state.

In the future system, Regional Mental Health and Wellbeing Boards will have a critical leadership role in providing rural communities with mental health and wellbeing services. Area Mental Health and Wellbeing Services based in regional centres will have more responsibility for providing inreach services—that is, the delivery of services to people in their own communities—to more geographically isolated or smaller rural communities.

The collective strength and wisdom of rural and regional communities will be harnessed to shape service delivery, partnerships and operating models that work for local communities and their mental health and wellbeing needs.

While the future integrated mental health and wellbeing system is designed to respond to the needs of all communities, the challenges that rural and regional services face will require tailored action. At the Commission's Maryborough hearing on mental health and wellbeing in rural communities, Dr Ravi Bhat, Divisional Clinical Director, Goulburn Valley Area Mental Health Service, Goulburn Valley Health, emphasised this, saying '[o]ne of the things I think we all have to appreciate is that the problems that mental health services face are hugely amplified in rural areas.'[2]

The future system must redress disparities in service access and mental health outcomes that rural and regional communities face, compared with their metropolitan counterparts. This will require:

- a structured, coordinated and appropriately resourced approach to providing services with the right capability to support the needs of people in these communities
- using digital service delivery and innovation to their full potential in rural and regional settings
- responding to workforce availability and distribution in rural and regional Victoria by introducing strategies to attract, develop and retain mental health and wellbeing frontline workers.

24.2 Diverse and growing rural and regional communities

Victoria's rural and regional communities vary in geography, community demographics and experiences of mental health and service delivery. As outlined in Chapter 1: *The reform landscape,* the rural population in Victoria is growing, and people living in rural and regional communities already require additional, and more accessible, mental health and wellbeing services.[3]

Census data indicates a trend over the past decade towards people moving from capital cities to regional areas.[4] Anecdotal evidence in relation to the impacts of the COVID-19 pandemic suggests that more people from metropolitan regions are interested in moving to rural and regional areas for a better quality of life.[5]

As the population grows, there is likely to be increased demand for mental health and wellbeing services, particularly in regional centres. This presents both challenges and opportunities for communities and mental health and wellbeing services, which will greatly affect the design and planning of these services.

There is considerable diversity in the background and experiences of rural and regional communities. Measures of remoteness are often used as an indicator of whether a person can reach necessary supports and services.[6] However, experiences differ between large regional centres, smaller country towns and dispersed rural farming communities. People's experiences of living in large regional centres may be more similar to those of people living in metropolitan cities, while communities on the outskirts of Melbourne may have more in common with smaller regional towns.

Associate Professor Steven Moylan, Clinical Director for Mental Health, Drug and Alcohol Services at Barwon Health, observed that this diversity can occur within a single region, with an impact on the range of services that are required:

> **we have an interesting spread of kind of inner urban plus very rural population needs, and I think that speaks a little bit to the need for localised variation in service delivery.**[7]

The Commission recognises this diversity and acknowledges that each community has its own identity and culture. For the purposes of this report, however, the term 'rural and regional' is used to refer generally to all areas in Victoria outside metropolitan Melbourne (refer to Figure 24.1).[8]

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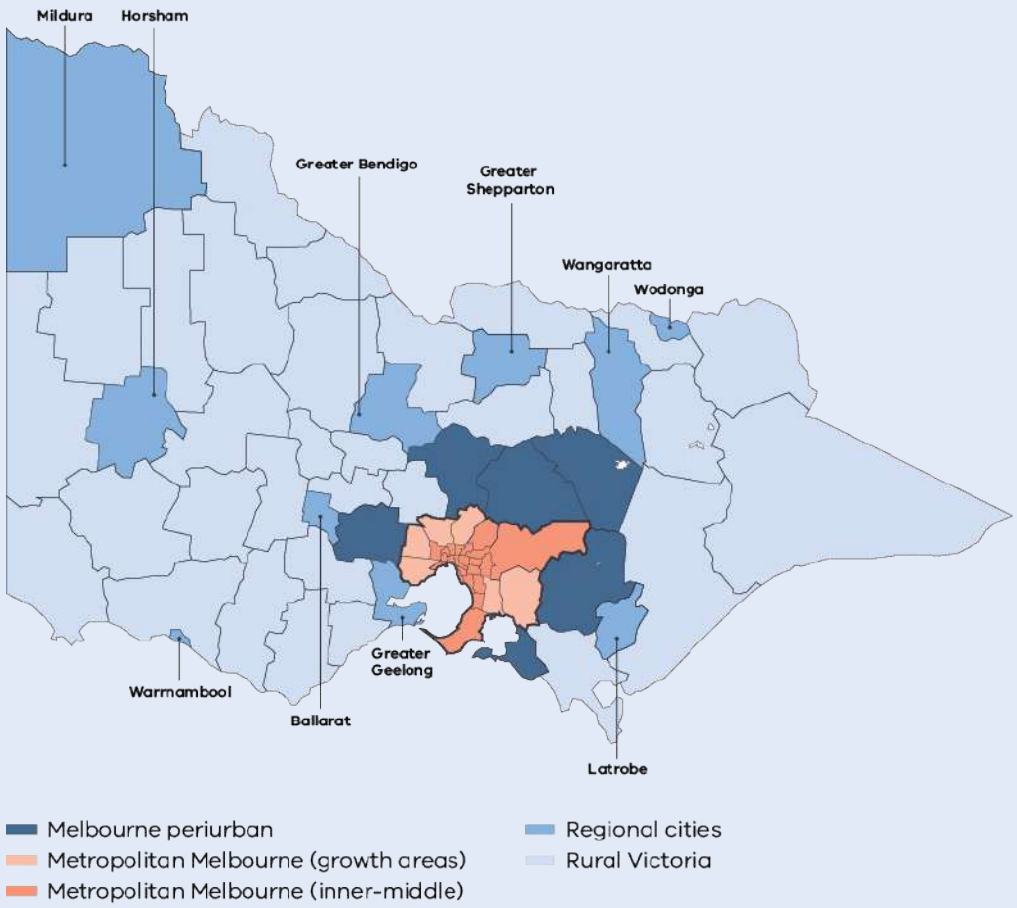
Figure 24.1: Metropolitan, regional and rural areas of Victoria



Source: Regional Development Victoria, Regional Descriptions, <www.rdv.vic.gov.au/information-portal/more-information/region-descriptions-and-geography-structure>, [accessed 25 November 2020].

Notes: Metropolitan Melbourne (inner-Middle) areas include 25 local government areas in and surrounding Melbourne, including Greater Dandenong, the Mornington Peninsula and the Yarra Ranges. Metropolitan Melbourne (growth areas) include six local government areas (Cardinia, Casey, Hume, Melton, Whittlesea and Wyndham).

Melbourne periurban areas surround Metropolitan Melbourne and interface with rural or bush areas – they are neither urban nor rural in the conventional sense. There are six periurban areas in Victoria (Bass Coast, Baw Baw, Mansfield, Mitchell, Moorabool and Murrindindi).

Regional cities refer to the 10 regional city local government areas of Ballarat, Greater Bendigo, Greater Geelong, Greater Shepparton, Horsham, Latrobe, Mildura, Wangaratta, Warrnambool and Wodonga. The remaining 38 local government areas, including six alpine resort areas, are referred to as rural local government areas.

The circumstances and needs of Victorians living in rural and regional locations are diverse, but common experiences affect the mental health and wellbeing of people living in these communities. For example, many communities have experienced profound and devastating natural disasters from which they have, at times, struggled to recover.

The Commission has heard about the commitment of rural and regional towns to community participation and leadership, to overcome the impact of such events through involvement in volunteering, local events, sporting clubs or community groups. These traumatic experiences have provided opportunities for people to come together, but can erode the sense of hope for the future.

As discussed in Chapter 15: *Responding to trauma*, people exposed to repeated traumatic events or prolonged adversity are at increased risk of developing mental illness.[9] This includes people who are commonly exposed to traumatic events or stories of traumatic events. However, protective factors such as social connection increase the likelihood of recovery from trauma.[10]

Nationally, research suggests that more people are moving from cities to regional areas than from regional areas to cities.[11] Between 2011 and 2016, regional Victoria was the third-most-popular destination (behind regional Queensland and regional New South Wales) for those leaving interstate cities of Sydney, Brisbane, Darwin and Canberra.[12]

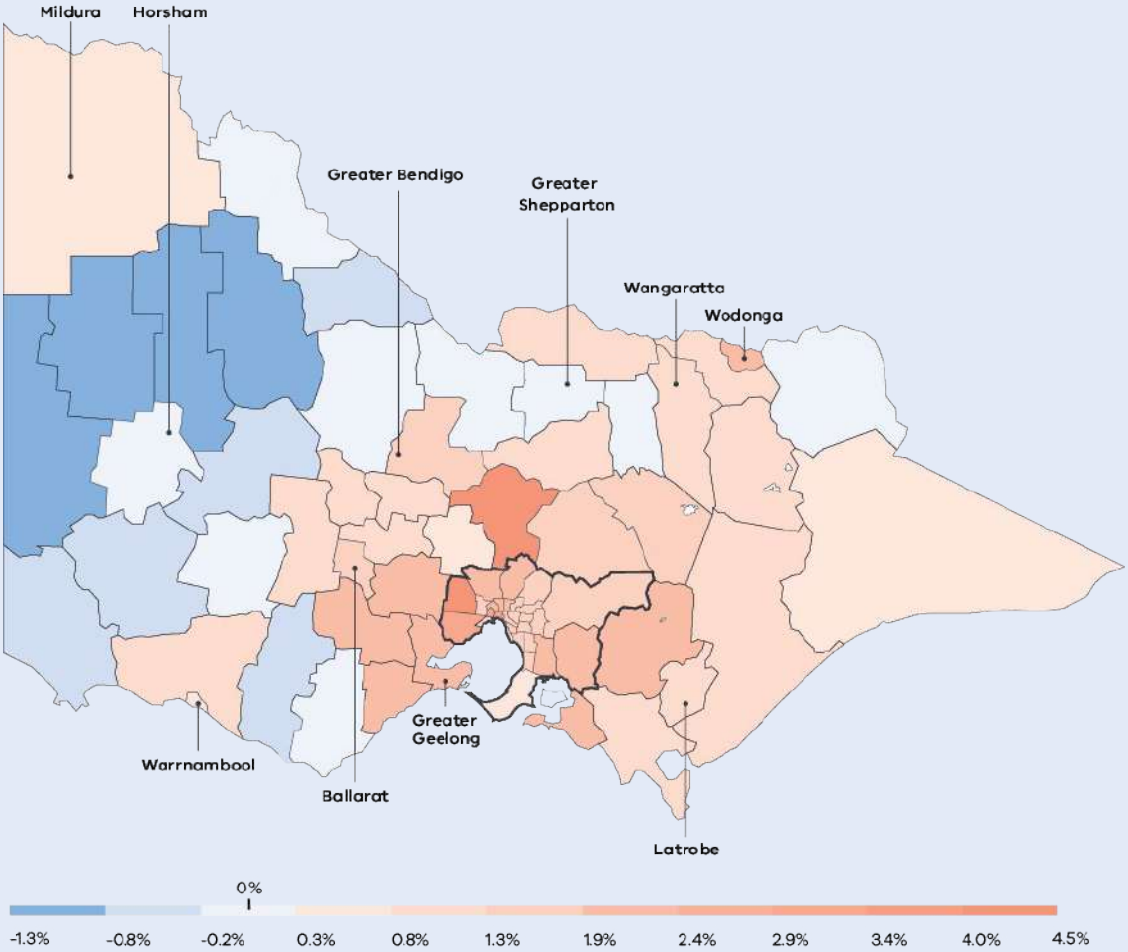
While the population of rural and regional Victoria is forecast to increase from 1.6 million in 2018 to 2.4 million in 2056, there is variation in projected population growth across the state.[13] The largest areas of growth in regional Victoria are expected to occur in major regional cities and regional areas that are close to Melbourne. These areas have the largest numbers of recent apartment construction and projected extra dwellings.[14]

As illustrated in Figure 24.2, the regional and rural local government areas with the highest projected growth rates between 2018 and 2036 include Mitchell, Golden Plains, Greater Geelong and Wodonga.[15] A number of periurban areas—including Moorabool, Baw Baw and Surf Coast—are also expected to grow above the Victorian average growth rate over this period.[16]

In contrast, the size of many rural communities is expected to decline due to population ageing, overseas migrants' preferences for urban areas, and younger people moving to metropolitan areas.[17] This includes the local government areas of Glenelg, Southern Grampians, Buloke, West Wimmera, Gannawarra, Swan Hill, Northern Grampians, Corangamite and Yarriambiack.[18] While the growing populations in regional centres will place increasing demand on mental health and wellbeing services, declining rural populations will require improved inreach service support to maintain equitable access to a diverse range of services.

These population projections do not take into account any potential changes in light of the COVID-19 pandemic. While migration to and from rural and regional areas has varied, evidence suggests the increased acceptability of flexible and working-from-home arrangements may contribute to more regional migration from metropolitan Melbourne.[19]

Figure 24.2: Forecast population growth rate (compound annual growth rate) by local government area, Victoria, 30 June 2018 to 30 June 2036



Source: Department of Environment, Land, Water and Planning, *Victoria in Future 2019*.

Notes: Annual growth represented in this figure is compound annual growth. Compound annual growth is the smoothed annual change over the specified period (as if the growth had happened steadily each year over that time period).

Demand for rural and regional properties is expected to increase,[20] accompanied by calls for government to invest in regional areas to capitalise on 'post pandemic migration'.[21] This will present both opportunities and challenges for rural and regional mental health and wellbeing services. While there will probably be more opportunities to attract new workforces moving into regional Victoria, such migration patterns are likely to favour regional centres. Migration patterns will therefore largely reflect the previous projections of higher regional population growth and decreasing population growth in smaller, more remote rural towns. This will mean larger regional services will need to play a more active role in supporting smaller rural communities.

24.3 Mental health and wellbeing needs in rural and regional communities

There are many social, environmental, cultural and physical factors that influence whether people experience poor or good mental health, and how they seek and receive treatment, care and support. The Commission's interim report found that people in rural and regional Victoria face particular challenges that affect their mental health and wellbeing needs, and their ability to access appropriate services and supports.[22]

24.3.1 Prevalence of psychological distress

Victorian Population Health Survey data indicates that there are varied levels of psychological distress in rural and regional Victoria. As illustrated in Figure 24.3, while many areas in rural and regional Victoria report lower levels than the average Australian rate, most of the local government areas with the highest levels of psychological distress are in rural or regional Victoria (including Mitchell, Mount Alexander and South Gippsland). In 2017, Swan Hill had one of the greatest proportions of adults with high to very high levels of psychological distress, at 23.3 per cent.[23] In contrast, Southern Grampians had one of the lowest, at 8.0 per cent.[24]

There is also a higher prevalence of anxiety and depression in adults in rural and regional areas compared with metropolitan areas, as illustrated in Figure 24.4.

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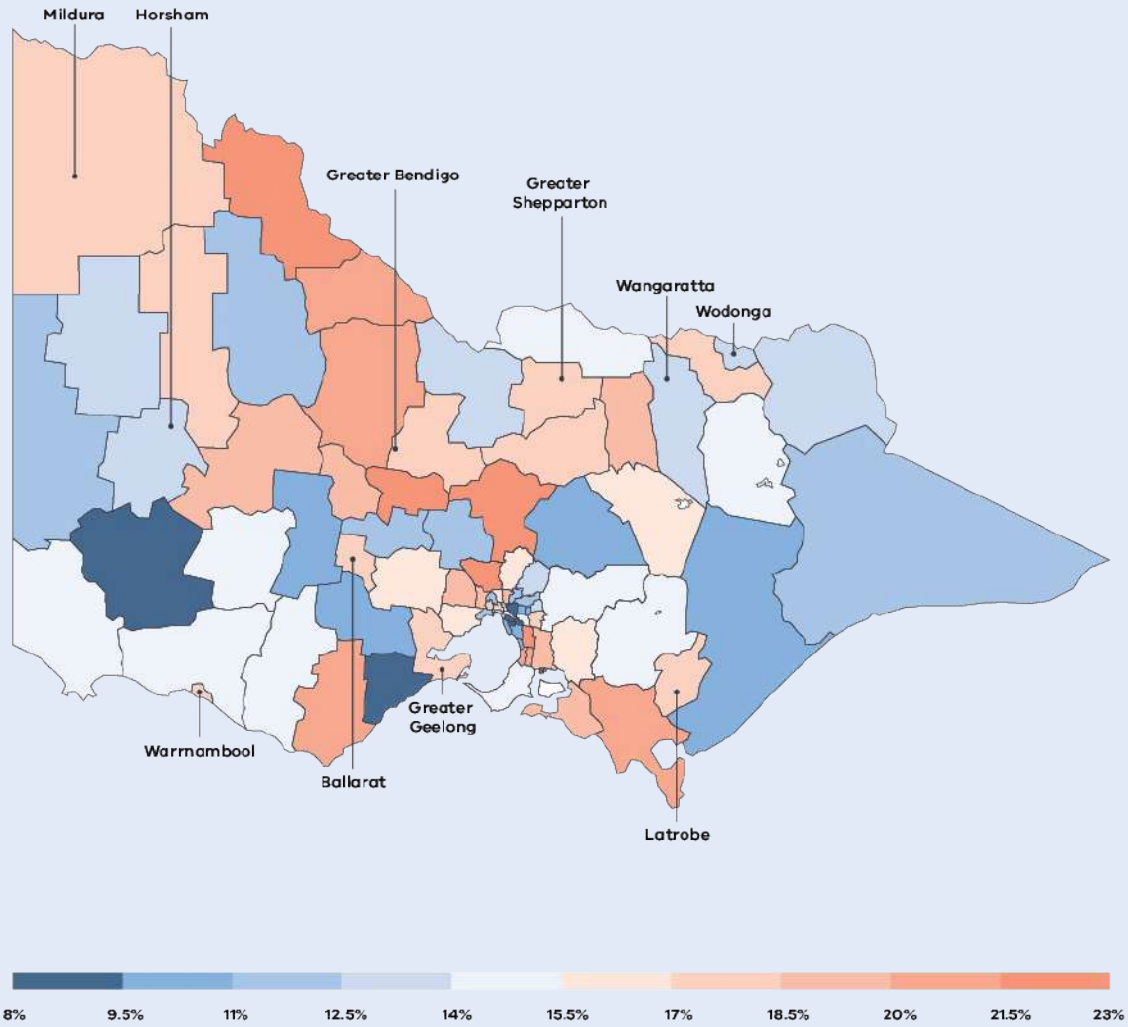
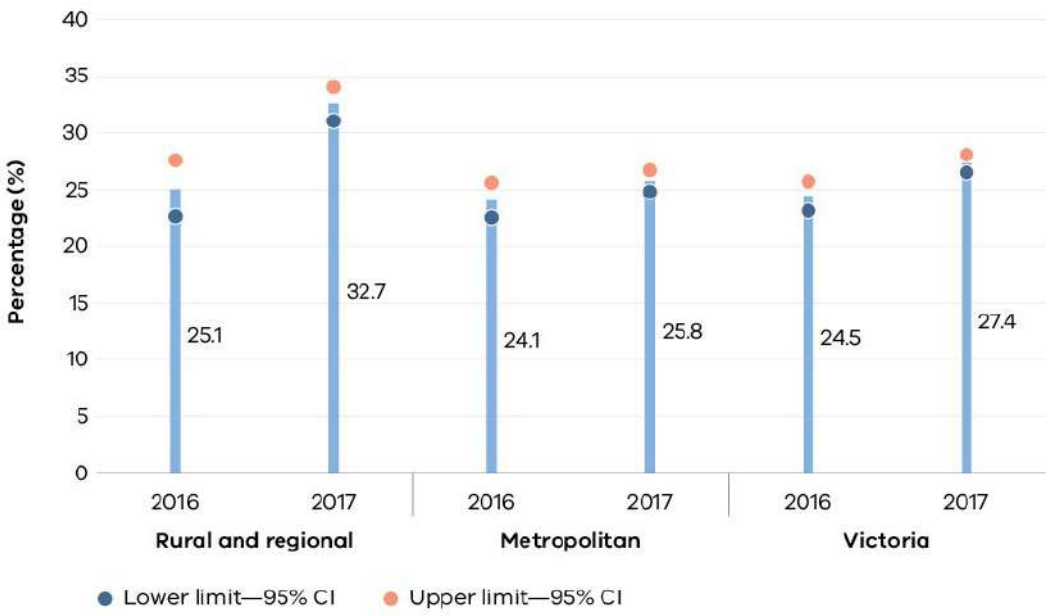
Figure 24.3: Proportion of adult population with high or very high levels of psychological distress, Victoria, 2017



Source: Department of Health and Human Services, *Victorian Population Health Survey 2017.*

Notes: Psychological distress is measured using the Kessler-10 psychological distress scale. People with a score of 22 or greater are defined as having high or very high psychological distress.

Figure 24.4: Proportion of adults ever diagnosed with depression or anxiety, by metropolitan and rural and regional Victoria, 2016 and 2017



Sources: Department of Health and Human Services. Victorian Population Health Survey 2016; Victorian Agency for Health Information. Mental Health and Wellbeing—Victorian Population Health Survey 2017 (preliminary draft and unpublished). For more information, refer to <www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/victorian-population-health-survey>.

Notes: Proportion represented in the graph is 'ever diagnosed' with anxiety or depression.

Data is age standardised to the 2011 Victorian population.

Upper/lower limits are the 95 per cent confidence interval upper and lower limits.

As discussed in section 24.2, there is great community diversity in rural and regional Victoria. Some groups of people in these communities experience high incidences of trauma and psychological distress.

Many Aboriginal people call rural and regional Victoria home.[25] Census data from 2011 shows that approximately 54 per cent of Aboriginal Victorians live in regional areas. The local government areas with the highest Aboriginal population included Shepparton, Mildura, Geelong, Bendigo, East Gippsland, Ballarat and Latrobe.[26]

Aboriginal people can have a range of mental health and wellbeing needs, although there is a significant prevalence of trauma, which is both transgenerational and shared by communities.[27]

A number of rural and regional areas also have significant populations of people from migrant or refugee communities recently arrived in Australia. In 2014, the Victorian Auditor-General reported that there was little reliable data on migration and settlement of refugees and asylum seekers within Victoria. However, at least 10 per cent of the population of Greater Shepparton, Swan Hill and Greater Geelong have backgrounds with languages other than English.[28]

Research indicates that many recent arrivals to Australia may have pre- and post-migration trauma that requires support for effective recovery.[29] For example, refugee families have often been exposed to torture and traumatic pre-migration experiences.[30] Around half the migrant community arrives as children, and may never have known safety and security.[31]

Research also suggests that the physical and psychological stresses many refugees and asylum seekers experience in their countries of origin, during transition, and on arrival in the host country can lead to increased risks of poor mental health.[32] These stresses have variable effects across different refugee and asylum-seeker populations.[33] A 2017 survey study of refugees and asylum-seekers attending a refugee health service in Melbourne reported that 'mental health services in areas with high refugee and asylum-seeker populations need to understand the mental health problems of their local client base' in order to plan appropriate culturally sensitive treatment.[34]

Similarly, many people choose to retire to rural and regional locations, and earlier life trauma or other mental health and wellbeing needs can sometimes emerge later in life.[35]

Data from 2018 indicates that people aged 65 years and over comprise 13.8 per cent of the population of metropolitan Melbourne, but 19.9 per cent in other parts of the state.[36] In 2020, three of the five local government areas that were home to the most Department of Veteran Affairs pensioners and Treatment Card Holders in Victoria were outside metropolitan Melbourne—namely Greater Geelong, Greater Bendigo and Wodonga.[37]

Chapter 14: *Supporting the mental health and wellbeing of older people*, discusses research by the National Drug Research Institute that indicates that many older Australians (aged 65 years or older) drink more alcohol than the healthy recommended amount.[38] The research suggested that alcohol use could occur as a result of distress caused by loss or grief, chronic pain, loneliness or homelessness experienced by older people.[39] Older adults may also use drugs to combat chronic pain, to cope with the symptoms of depression or anxiety, to manage the distress of social isolation, or because they have a long-term substance use disorder for which they have not received appropriate treatment, care and support.[40]

24.3.2 Higher levels of self-harm and suicide

One of the most tragic costs of mental illness is the loss of human life, and rural and regional Victorians are disproportionately affected by suicide and self-harm. While the prevalence of psychological distress is comparable to that of people living in metropolitan areas,[41] the rates of suicide and self-harm are higher among people living in rural and regional Victoria:

- the rate of self-harm-related emergency department presentations between 2013–14 and 2017–18 was about 30 per cent higher in rural and regional areas than in metropolitan areas[42]
- data from the Coroners Court of Victoria indicates that between 2009 and 2018, the annual suicide rate was about 40 per cent higher in rural and regional Victoria than in metropolitan Melbourne[43]
- the rate of suicide among men aged 35–54 years, who lived in rural and regional Victoria, was about 60 per cent higher than in Melbourne between 2009 and 2018.[44]

Headspace states that people in close proximity to suicide, particularly young people—whether by geography, relationship or social connection, or shared experiences—are more at risk of suicide themselves.[45] This may increase the risk for people in small and isolated communities, and among young people. In 2009, concerns about a 'suicide culture' among young people in the Greater Geelong and Barwon South West regions of Victoria initiated a cross-agency, coordinated response to strengthen community suicide prevention.[46]

As emphasised in the Commission's interim report and elsewhere in this report, suicide does not always mean that mental illness is present.[47] Research into farmers who have died by suicide has suggested that farmers' familiarity with risk and pain, the distress of needing to euthanise animals during disaster, and high levels of pressure all contribute to suicide.[48]

One participant in a study exploring the effects of climate and environment on rural mental health explained that financial pressures of 'green drought' can impact farmers' mental health:

> it's a farming community ... there's water, it's green ... but some farmers have been incredibly depressed ... there's just not enough grass to feed the cows ... all the farmers were having to buy hay ... they'd have bills in the tens, if not, hundreds of thousands of dollars.[49]

Greater access to firearms may also be a risk factor. Farmers rely on firearms for tasks on their farms, and fear of firearm removal may stop them from seeking help for mental distress.[50]

The Commission has also heard that people's vulnerability to self-harm and suicidal ideation is increasing as a direct result of compounding traumatic events such as bushfires and COVID-19—this is especially the case for children and young people.[51]

Aboriginal communities from across rural and regional Victoria have shared with the Commission the devastating losses of members of their community to suicide.[52] Intergenerational trauma associated with the Stolen Generation, and loss of family, culture, place and connection all contribute to a suicide crisis for Aboriginal people and the communities they belong to.[53]

This was reflected in community consultations dedicated to mental health and wellbeing in regional areas of Victoria:

> Earlier [in 2020], the Victorian Coroner's office released a report in regards to Aboriginal suicides. Now [2018–2019] was the highest number of Aboriginal suicides in the history of the report. So far ... this calendar year, we're tracking to actually beat that with the number of Aboriginal suicides within Victoria. So [the] big thing for us is not the postvention focus ... it's how do we work with the Aboriginal community to address poor mental health and wellbeing ... and prevent that extreme action and extreme behaviour from occurring. Postvention support is all good and well for those who have left, but for the person who is actually suffering that trauma, it doesn't help, it's too late.[54]

Aboriginal people are around three times more likely to experience high or very high levels of psychological distress than non-Aboriginal Victorians.[55] Self-harm emergency department admissions for Aboriginal people are four times the rate of other Victorians.[56] The national suicide rate for Aboriginal people is estimated to be twice the rate of the general population,[57] and generally occurs at much younger ages.[58]

Aboriginal people should ideally receive social and emotional wellbeing services on country, so they remain connected to family, community and culture, thereby minimising retraumatisation.[59] However, many services lack the resources to provide culturally appropriate, place-based care.[60] This can add to the distress and trauma that Aboriginal people can experience.[61]

In the *Balit Murrup Aboriginal Social and Emotional Wellbeing Framework*, the Victorian Government identified the need to develop Aboriginal culturally informed approaches to treatment, care and support.[62] In its interim report, the Commission considered in some detail the challenges faced by Aboriginal communities, and recommended the expansion of social and emotional wellbeing teams in Aboriginal community-controlled health organisations.[63]

As discussed in Chapter 17: *Collaboration for suicide prevention and response*, the Commission understands that people from LGBTIQ+ communities may be at particular risk of suicidal behaviour. This includes substantially higher rates of suicidal thoughts and self-harm,[64] as well as 10 times higher rates of attempted suicide than that observed in the general population.[65]

A study examining the experience of student suicide for rural high schools in the Gippsland and Loddon Mallee regions of Victoria found that teachers and school counsellors were more likely to have experienced student suicide if they taught Aboriginal and/or LGBTIQ+ students.[66]

National research indicates that Aboriginal LGBTIQ+ Australians, LGBTIQ+ migrants and refugees, LGBTIQ+ young people and LGBTIQ+ people residing in rural and remote areas are likely to be at particularly high risk of suicide.[67]

Dr Louise Flynn, Manager, Support After Suicide, Jesuit Social Services, told the Commission that the insufficiency of services available for Victorians bereaved by suicide is particularly acute in rural and regional areas.[68]

24.3.3 Social determinants of poor mental health

The Commission understands there are many reasons why some rural and regional communities may experience higher rates of psychological distress, suicide or self-harm.

The Commission's interim report recognised that there is a considerable unmet need for mental health and wellbeing services in rural and regional Victoria, which affects people's ability to receive the right treatment, care and support when they most need it.[69] Research indicates that the prevalence of poor mental health, including depression, anxiety, substance use disorders and first-episode psychosis, is higher for young people in rural locations, partly because of barriers to accessing services.[70]

As discussed in Chapter 1: *The reform landscape*, mental health and wellbeing is shaped by the social, economic and physical environments in which people live.[71] For example, unemployment and job insecurity is linked with poor mental health,[72] as are other factors such as housing and access to resources, including water and food.[73]

Individuals, families and communities living in rural and regional Victoria can be disproportionately affected by social determinants of poor mental health. When coupled with a lack of services and supports, people's mental health and wellbeing can suffer.

Rural and regional communities face higher levels of socioeconomic disadvantage compared with metropolitan communities, which can negatively affect mental health and wellbeing. Demographic data indicate that eight of the 10 most disadvantaged local government areas in Victoria are in rural and regional areas.[74]

Many smaller rural towns provide low-cost housing, thereby attracting people who may be migrating due to financial or other stressors.[75] There are also people already living in rural and regional areas under considerable financial stress.[76] The combination of excessive distance from services and limited options for transport has a compounding negative impact on mental health and wellbeing.[77]

24.3.4 Extreme weather events and the impacts of climate change

Rural and regional communities are often affected by extreme weather events and the impacts of climate change.[78] They experience regular and severe natural disasters and weather conditions that occur much less in metropolitan areas, that may affect mental health and wellbeing.[79]

Regional Development Victoria reports that bushfires in Victoria have had devastating and wide-ranging impacts on regional areas of the state.

> Victoria's bushfires in December 2019 and January 2020 resulted in catastrophic impacts to rural and regional communities around the state. Towns in North East Victoria and East Gippsland suffered significant loss. More than 1.4 million hectares were burnt, affecting all aspects of life, including business and tourism, and causing flow-on effects for communities elsewhere in Victoria.[80]

The report highlights that rural and regional communities have struggled with the 'compounding challenges of bushfires, drought, economic transition and coronavirus'.[81] For example, it was identified in the Hume region that bushfires, followed closely by the COVID-19 pandemic, had major impacts on tourism and wine sectors.[82]

People living in rural and regional communities face unique mental health risk factors relating to natural disasters, such as bushfires and drought.[83]

South West Healthcare told the Commission:

> Rural areas often experience environmental issues, natural disasters, and other extreme weather conditions, which can impact upon the mental health experienced by the population.[84]

The Royal Commission into National Natural Disaster Arrangements found 'compelling evidence of the impacts of natural disasters on mental health'. It reported that natural disasters give rise to increased rates of stress, depression, anxiety, post-traumatic stress disorder, alcohol and substance abuse, aggression and violence, suicide and exacerbation of other underlying mental health problems.[85]

As part of the 2008 National Review of Drought Policy, the expert social panel on the social impacts of drought on Australian farm families and communities observed, 'extended dryness has a significant negative impact on the mental health of farm families and others within rural communities'.[86]

An editorial in the *International Journal for Mental Health Nursing* noted that the combination of drought and bushfires had 'a particularly devastating impact on rural agricultural-based communities':

> in addition to the impact experienced by other bushfire-affected individuals in Australia, rural communities have lost farms which represent years of family income, livestock, and buildings essential to run farms effectively. These losses were especially tragic for Australian rural farming communities as they have struggled through many years of severe drought prior to the onset of the bushfires.[87]

The Victorian Farmers Federation submitted:

> There can be many factors that lead to farmers encountering mental hardship; they include natural disasters, season failure, financial difficulty and relationship breakdowns.[88]

Dr Alison Kennedy, Research Fellow at Deakin University in the Faculty of Health and at the National Centre for Farmer Health, told the Commission, '[f]armers often have a strong connection to their land and can draw solace from that connection. Where that connection is threatened it can cause real psychological distress.'[89]

Research suggests that such disasters are associated with long-term mental health and wellbeing effects for both individuals and communities.[90] Ms Christine Morgan, CEO, National Mental Health Commission, told the Commission that successive national crises—such as the prolonged drought and recent catastrophic bushfires—can have cumulative mental health impacts.[91]

The cumulative impact of drought, fires, floods and now COVID-19 have significantly affected the mental health and wellbeing and strength of rural and regional communities.[92] Community members have described services being stretched to capacity prior to bushfires and COVID-19, and say that recent sudden increases in service demand have become unmanageable.[93]

A participant at the Commission's East Gippsland roundtable said that mental health and wellbeing supports were missing among other bushfire responses:

> These bushfires we've seen ... had major impacts with [school] students and families with an increase in trauma, mental health presentations, increasing anxiety, depression, suicidal ideation ... we've definitely seen an increase in complex cases for schools with mental health presentations ... we've all seen the bushfire response, injection of funds and new services coming into the region. But ... we've not really seen an increase in ... extra assistance with mental health support [particularly for primary schools].[94]

Dr Sara Renwick-Lau, General Practitioner at the Mallacoota Medical Centre, giving evidence in a personal capacity, described how bushfires in the holiday town of Mallacoota affected mental health services, where demand already exceeded capacity for mental health services prior to the bushfires:

> Prior to the bushfire event [during the tourist town's busiest week of the year] there were no other visiting or resident mental healthcare providers in Mallacoota, including mental health social workers, relationship counselling services, child and youth counsellors and other counsellors.[95]
>
> the first thing that happened was everyone looked at each other and said 'We're not prepared, how do we deal with other people's distress'.[96]

Dr Renwick-Lau said there have been increased presentations of post-traumatic stress disorder and exacerbations of pre-existing mental illness resulting from the bushfires.[97] She estimated that 95 per cent of children present during the fire threat will develop symptoms and signs of post-traumatic stress disorder,[98] and that mental illness may emerge six to 12 months after the disaster event.[99] Another report on the 2009 Victorian bushfires indicated that five years after the fires, a proportion of the survivors were still experiencing significant mental illness at a rate higher than that of the general population.[100]

Dr Renwick-Lau warned:

> Failure to respond to the current and emerging mental health needs of the Mallacoota and Cann River communities following this major bushfire event will have long term implications on the town's ability to recover. The ramifications of poor mental health outcomes in these small isolated communities, are the degradation of personal and social lives and loss of productivity and ability to work and other social problems.[101]

Research examining wellbeing in drought-affected communities found that the impacts of drought can have traumatic effects on families and children. Wellbeing concerns in these communities include increases in financial stress, household and family tension, spousal stress, domestic violence and abuse, mental health problems (such as anxiety and depression), suicide and reduced help seeking behaviour.[102]

A teacher from one community noted that these can be triggered by small things, due to the build up of trauma from external events, including drought-related stresses:

> you know they might have had so much built up trauma related to external things that have happened with them, and it's just that one seemingly insignificant event that tips them over because of this built up vicarious trauma.[103]

Dr Renwick-Lau also noted that people seeking 'psychological care' prefer that it is with a familiar local service provider.[104] However, the Commission recognises that members of the mental health workforce and their families who live and work in these communities face similar events, losses and distress to those experienced by the people in their care.

Roundtable participants explained that staff need support as members of the community:

> But our staff work in the community, [living] in the community as well, they've been affected by drought, by fire, by COVID, too. So we have [a] number of counsellors that we have going out and seeing people in our communities, we actually need to look after them as well.[105]
>
> We had some of our own staff ... who have lost their properties. They've lost everything and to look after those ... staff members and they keep wanting to work. But you know, people are fragile and now we've got COVID on top of that, it's just adding another stress to the whole community, to the staff, and you wonder where this is all going to end to be honest.[106]

The COVID-19 pandemic has had a devastating impact on communities that rely on tourism (see Box 24.1). In addition, the Australian tourism industry has reportedly suffered around $2 billion in losses, with a further $4.5 billion in projected losses, as a result of bushfires in the 2019–20 season.[107] The Department of Jobs, Precincts and Regions reports that in 2018–19, tourism in Victoria was estimated to be worth $29.4 billion to the Victorian economy and generated approximately 263,300 jobs. However, the dual crises of bushfires and COVID-19 have had 'a devastating impact on the visitor economy', with total tourism expenditure in Victoria showing an 18 per cent decline in the year ending June 2020.[108]

Ms Sue Medson OAM, CEO, Gippsland Lakes Complete Health, described the community and individual trauma experienced and its effects:

> the effects of the drought followed by fire, followed by COVID restrictions, has had an enormous impact on [East Gippsland]. And it'll be ongoing until we're able to safely restore tourism, see rain on the pastures and have gone through at least one other fire season without a repeat of the devastation. And none of us can guarantee that. So they're the sort of trauma events that do trigger a lot of mental health aspects. But it's not just the tragedy, the trauma and the tourism that affects the mental health and people in East Gippsland. We were essentially already in trouble ...[109]

Rural and regional participants have told the Commission that a rapid influx of funding, and external clinicians and services to the regions after a natural disaster can be overwhelming for an already traumatised community.

One participant at the Commission's East Gippsland roundtable explained how external services quickly converging can create confusion for people who are already overwhelmed:

> We have noted that there's been some frustration post the bushfires with an influx of new different service providers coming into some of these remote communities with very good intentions. But in the community kind of feeling like it can be a bit confusing about not knowing which service to access.[110]

Evidence put before the Commission has highlighted the importance of communities and community leaders in trauma-informed disaster recovery. Rural and regional service providers describe feeling displaced and minimised by incoming providers unfamiliar with their regions and communities.

Dr Rob Gordon, Clinical Psychologist, President of the Australasian Confederation of Psychoanalytic Psychotherapies and consultant to the Department of Health and Human Services and the Red Cross, giving evidence in a personal capacity, emphasised the need to support communities to lead recovery:

> There needs to be community organisation with a focus around the formation of community recovery committees, advocacy processes and social organisation so people can let their needs be known and communicated. Outreach programs and programs to help bring the community together should be adopted. Helping the community form their own 'community led recovery process' where community advocates communicate with government has enormous mental health payoffs because it gives people what makes them resilient—confidence, trust, optimism and security.[111]

The Commission has also heard that the state lacks a repository of knowledge gained and lessons learned from natural disasters to draw on when new disasters occur. Professor Alexander McFarlane AO, Professor of Psychiatry in the School of Medicine at the University of Adelaide, giving evidence in a personal capacity, told the Commission:

> one of the great tragedies is that people quickly lose knowledge about how to manage these tragic events ... The way to help individuals is to have a system that maintains knowledge within it in an organized way, which should then be imparted to clinicians and other health workers ... In this way, health workers at all levels in the system would be equipped to get the best results.[112]

The Victorian Bushfires Royal Commission, reporting on the Black Saturday fires of 2009 'urge[d] all involved in developing and implementing bushfire policy to look to the long term'[113] and to anticipate future events:

> This was one of Australia's worst natural disasters. It will be many years before its effects dim. Governments, fire and emergency services agencies and all individuals can learn valuable lessons from those days, so that we might reduce the risk of such destruction occurring again. It would be a mistake to treat Black Saturday as a 'one-off' event. With populations at the rural–urban interface growing and the impact of climate change, the risks associated with bushfire are likely to increase.[114]

The Bureau of Meteorology indicates that the rate of natural disasters, such as flood, drought, cyclones and bushfires, in Australia is increasing. It anticipates conditions that result in more time in drought, but more intense rainfall events, longer fire seasons and an increase in the number of dangerous fire weather days.[115] This has been reinforced by the Department of Environment, Land, Water and Planning, warning that harsher fire weather and longer fire seasons are also expected across the state.[116]

The Australian Psychological Society notes that 'assuming this trend continues there will be higher costs to community resilience with potential to impact on the mental health of Australians'.[117]

Associate Professor Moylan emphasised to the Commission how recent disasters have further revealed the fragility of a system in which people are unable to access services in regional areas:

> What I see is a system that was already broken … especially in the regional areas. And [with] the last disasters of the bushfires and the flood have actually shown how fragile the system actually is … [w]ith people essentially being traumatised and not being able to access the appropriate services all over.[118]

Box 24.1: The impacts of COVID-19 on health and wellbeing in rural and regional Victoria

Rural and regional communities have told the Commission that COVID-19 has had a deeply negative impact on mental health and wellbeing.

Community organisations that support the mental health and wellbeing of the community through shared activities, fundraising and social gatherings have not been able to operate.[119] These services support social contact, exercise and recreation for community members.[120] Sporting groups also provide health promotion and screening in an informal manner for their communities, but this extra safety net has not been in place since the onset of the pandemic.[121] Sporting groups and other similar community groups have lost funding associated with memberships, fundraising and other activities, which places them at financial risk in the future.[122]

Aboriginal communities describe the COVID-19 restrictions generally, and travel restrictions more broadly, as having a distressing effect on their people. Not being able to meet and gather—a practice that promotes healing and recovery for Aboriginal people—has meant that trauma from bushfires and the burning of sacred land remains painful and unaddressed. The inability to travel across borders in communities that extend across states has meant that many families and communities have been separated and isolated from one another. Aboriginal health workers who would ordinarily work across borders to care for their community members have not been able to do so.[123]

Similarly, in rural areas affected by the recent bushfires, there has been a delay in healing and recovery processes, which has compounded trauma within communities. Local events that would ordinarily provide a chance to connect, share experiences and regain a sense of belonging and stability have not happened.[124] Most mental health and community health providers describe a notable increase in demand for help during the COVID-19 pandemic, but services were already at capacity before COVID-19 struck.[125]

There has been a considerable increase in psychological and suicidal distress during the COVID-19 pandemic across age groups, which local providers have done their best to respond to within existing resources. Young people have become increasingly disadvantaged.[126] Older people who were already somewhat isolated before the pandemic have experienced an increase in their isolation. Some health providers continued to provide outreach services to these older people rather than use telehealth, which can be difficult to introduce in times of crisis.[127]

Financial and employment stress resulting from the pandemic has added to the pressure on rural and regional communities that experience high levels of psychological distress, domestic violence, and alcohol and drug use.[128]

Clinical and community support staff and volunteers describe high stress levels within their workforces, as they too have often experienced loss associated with prolonged drought and the recent bushfires.[129]

An important source of employment for rural and regional areas is tourism and hospitality, which has been unable to operate for most of 2020.[130] In turn, this has contributed to compounding disadvantage in rural and regional communities, felt most keenly by those who were already struggling.

Despite these challenges, the pandemic has given rise to some new and innovative ways of working, which have come from necessity and the goodwill of rural and regional people. Telehealth was expanded and largely well received when there was the infrastructure to support its use,[131] and some regional tertiary health providers trialled innovative methods of community-based care, and aimed to keep as many consumers out of hospital as possible.[132]

24.4 Access to mental health and wellbeing services in rural and regional areas

Victorians living in rural and regional areas can face additional challenges in receiving mental health and wellbeing treatment, care and support.

Chapter 5: *A responsive and integrated system*, introduced the Commission's vision of a mental health and wellbeing system that is strongly reoriented towards community-based treatment, care and support. As outlined in Chapter 6: *The pillars of the new service system—community-based mental health and wellbeing services*, this reorientation recognises the benefits of treatment, care and support for people in their own communities and close to their homes, families, carers and supporters.

The responsive and integrated system is designed to improve equity of access to mental health and wellbeing services in the future. People living in rural and regional Victoria face additional barriers to consistent access to service compared with those in metropolitan Melbourne.

The proportion of Victorians accessing Medicare-subsidised mental health services is lower in rural and regional communities than in metropolitan Melbourne, and there are also fewer average services per person in these areas (see section 24.4.3). This indicates that Victorians living in rural and regional areas can face great challenges in getting the mental health treatment, care and support they need.

24.4.1 Stigma can discourage help-seeking

In its interim report, the Commission found that mental health stigma can be felt acutely in rural and regional communities.[133] Many people in rural and regional Victoria have told the Commission that people are reluctant to seek help for fear of judgment or embarrassment, or fear that their circumstances may become public.[134]

At its hearing on rural mental health, Dr Kennedy told the Commission of 'a case in which one person who, despite wanting to seek assistance from a mental health professional, remained silent because he feared that seeking professional advice would lead to the loss of his business'.[135]

The Royal Flying Doctor Service said that stigma acts as a barrier to help seeking:

> In rural and remote communities, stigma, in particular, self-stigma, is a key barrier to progress. There [is] still [a] strong cultural desire for independence and an attitude that aligns asking for help with failure.[136]

Miss Jennifer Rowan, witness before the Commission, explained how stigma can prevent people from asking for help:

> The stigma associated with mental ill-health in rural towns is a massive barrier holding communities back. Young people and in particular men can find it challenging to go to their GP, let alone a mental health professional.[137]

In some communities, mental health workers of local services are well known to the people they support.[138] As noted above, some people prefer to receive 'psychological care' from a familiar local service provider.[139]

A number of community service providers within and outside of the mental health system noted that people in isolated communities were most likely to be open with people they have built up trust with. This means that people in a range of professional and social relationships—including agricultural organisations, financial counsellors, employment services, men's sheds, neighbourhood houses and sporting clubs—are confided in about mental health issues.[140] It was suggested to the Commission that there would be benefit in equipping a range of people working in local communities with the capacity to provide 'Mental Health First Aid' supports, and to be conduits for introducing people to appropriate professional supports and mental health and wellbeing services.[141]

However, proximity can often result in a perceived lack of anonymity or confidentiality when accessing services. Mr Terry Welch, CEO, Maryborough District Health Service, told the Commission:

> In regional towns, one of the challenges is that when a resident presents at the GP (which is the access point); they know the person who is at the reception desk. People are not likely to seek and engage with support in those circumstances.[142]

The Victorian Farmers Federation echoed this sentiment:

> Farmers often get a sense that by having a personal relationship with the GP, or small towns often knowing personal details of residents, that farmers may not visit the GP for fear their circumstances may be public or become gossip.[143]

Evidence indicates that farmers in small towns may also feel ashamed or embarrassed, or find it to hard reach out for help.[144]

Carer groups have also reported high levels of stigma and discrimination in rural and regional areas, leading to increased social isolation and loneliness. Loddon Mallee Mental Health Carers said this particularly affects people in rural towns:

> Small town syndrome (stigma) for carers who live in rural towns is very real; they suffer in silence and eventually become a shadow in their own community.[145]

This was echoed by a business that provides financial counselling and other supports to rural farmers:

> Small rural communities are very supportive. They're resourceful. They band together in emergencies in drought, or when they're organizing community events. But they can also be incredibly distant and closed off when it comes to business, family and personal matters … Hence, people are rarely asked if they're okay, why would you because everything looks fine … if people do enquire the rural culture and the family expectation is to say, well, we're fine, thank you. Or we're having a bit of a tough patch, but everything's under control, which is nowhere near the truth. And then when people can't hide it anymore, they just work harder. They withdraw from the community, so they don't get asked, or [say] that they're too busy to attend the events … by the time they come to [the] notice of friends, neighbours and community groups, they are often very unwell, or they have committed suicide … or are the victim of a farm accident, or vehicle accident with very suspicious circumstances.[146]

The Commission also heard that familiarity in small communities can sometimes mean people experience being 'labelled' as someone living with mental illness or experiencing psychological distress, which can affect their ability to receive other services. It may also result in people assuming a person intends to do themselves harm, even when that is not the case. One person told the Commission how police were called when they were close to a train line because of concerns for their safety, despite there being no risk.[147]

Some people from minority communities reported experiences of stigma from health providers.[148] In addition, specialist services for LGBTIQ+ people in rural and regional areas are limited, despite the evidence that this population is at greater risk of psychological distress, stigma and discrimination, including homophobia, bullying, violence, self-injury and suicide.[149]

A man from rural Victoria who participated in Beyond Blue research reflected on the importance of open and accepting service providers:

> When my GP made the referrals, it was important to her that she find me gay-friendly providers. Having bipolar disorder was/is unrelated to me being gay, but some of the pressures of life as a gay man mean that those stressors need to be examined and put into order to prevent life stresses from contributing to a situation where I could become unwell.[150]

24.4.2 Geography can create barriers

Geographical barriers, such as location of services, extended travel times, increased travel costs and the need to take time off work or other commitments to use mental health and wellbeing services, can contribute to limited help-seeking behaviours in rural and regional communities. Although modest compared to other states, there are many locations in Victoria that have large travel times to major regional centres.

Dr Bhat noted that people in more remote locations may not be able to afford to own or maintain a car, or to pay for petrol to travel long distances. He said this challenge is compounded by the fact that '[t]here is little or no public transport in some or many areas in Regional Victoria to access long distances.'[151]

Ms Emma King, CEO of the Victorian Council of Social Service, also advised that being able to travel to access services can be a significant issue for people experiencing poverty.[152] These factors limit the ability of consumers to use face-to-face services.

Even where a person can access services, families, carers and supporters face multiple challenges in having to deal with long distances, travel time and the added burden of a child, friend or family member being treated away from home.

Mr Welch explained to the Commission:

> We witness regularly, even for life saving treatments, many people will not go to treatment arranged for them because of the cost, for example, of travelling to Ballarat.[153]

For some people, work or caring responsibilities may present a barrier to leaving a town or farm to access mental health and wellbeing services.[154]

People living in rural and regional communities are often forced to make the difficult decision to either stay with their friends and family, and use more limited local services, or travel to get help. The Commission has been told of people being transferred far from their home in order to receive treatment, including people who have been transported long distances to mental health services.

As one carer explained to the Commission:

> The local hospital is not equipped for mental health admissions; my son was sent in a taxi from Shepparton to Kilmore by the hospital because they could not be admitted.[155]

The Commission has also been told about the lack of available transport to transfer people from local health services to regional hospitals. As Mr Welch explained to the Commission:

> There is no dedicated centralised transport service or specific vehicles for transfer of acutely mentally unwell patients. We have other centralised services (for example Adult Retrieval Victoria for medically unwell patients and [Paediatric, Neonatal and Perinatal Emergency Response] for pregnant mothers) but there is no such service for acutely mentally unwell patients.[156]

Dr Gerard Ingham, a General Practitioner working in Daylesford, said that regional clinicians have to rely on larger services to whom they are making inpatient referrals to determine where patients need to go, and to make the appropriate travel arrangements:

> the difficulty with the mental health process, is we have no oversight of bed capacity, bed availability, and I'm sure Bendigo Health are under extreme pressure and then we're contacting them escalating that pressure even further ... With the medical process, with Adult Retrieval Victoria, they have oversight over the system: they know bed capacity, they know resource availability, so they support our clinicians with the care, at the same time arranging transportation and the location for where the patient will go.[157]

Barwon Health told the Commission that accessing out-of-area services can also create 'inefficiencies and risks through handover' between multiple service providers.[158] One participant in a community consultation explained the situation of a consumer who was discharged from a metropolitan hospital:

> We've had people released from hospital three hours away, selling their medication to afford transport home. By the time they get home, they're unwell and we're sending them back again.[159]

Rural and regional services often have no local inpatient beds for children and adolescents who are acutely unwell. They have to be admitted to inappropriate environments, such as emergency departments and paediatric wards, while they wait for an inpatient bed.[160] Inpatient beds for children and young people, if they can be secured, may involve hours of travel, and sometimes multiple ambulance transfers (due to ambulance boundary limitations).[161]

South West Healthcare told the Commission this was necessary for some young people in its catchment needing an inpatient admission:

> The closest adolescent beds to the [South West Healthcare Mental Health Service] catchment are located at the Royal Children's Hospital in Melbourne, which can be up to 500 kilometres away from where consumers live (requiring up to four ambulance transfers/handovers).[162]

Albury Wodonga Health also said this was the case in their catchment:

> When a child or adolescent who resides in the [Albury Wodonga Health] catchment region requires a specialist mental health admission, the current options are to transfer them to Box Hill, Victoria or Orange, New South Wales. The admission catchment for [Albury Wodonga Health North East Border Mental Health Service] extends out past Barham in the west, which is a 7-hour road trip to Box Hill via Albury (or 4-hour trip direct from Barham) or a 7-hour road trip to Orange.[163]

In Chapter 5: *A responsive and integrated system*, the Commission outlines evidence of significant challenges in accessing services—including insufficient capacity, high access thresholds and long waiting lists to get treatment, and inequitable variation in the choice, quality and affordability of services—and the impact these have on consumers, families, carers and supporters.

These challenges are felt most acutely in communities that are a long way from the specialist services they need, particularly for children. Ms Amelia Morris, a witness before the Commission, explained the sense of isolation she felt when having to leave her family and community supports in regional Victoria to access private inpatient care in Melbourne.

Personal story:

Amelia Morris

Amelia's mental health began to deteriorate when she was about 15 years old. Living in a regional area, it was difficult for Amelia to find the support she needed.

> the closest headspace centre was a 45-minute drive away, with no public transport, and it was only open between 9am and 5pm. My mum had to take time off work, pick me up from school, drive me to headspace, wait for my appointment to finish, drive me back to school and then drive herself back to work.

While Amelia sees value in headspace, there came a point where she needed more intensive support.

> While I believe headspace plays a positive role for many young people, it was insufficient to meet my needs. There was nothing for me in between primary care and the emergency department. As someone with more complex needs, I felt abandoned by the mental health system when I needed it most. I also feel that the services I have managed to access are not suitable for me as a young person.

Amelia was moved to an inpatient ward in Melbourne, away from her familiar supports and surroundings.

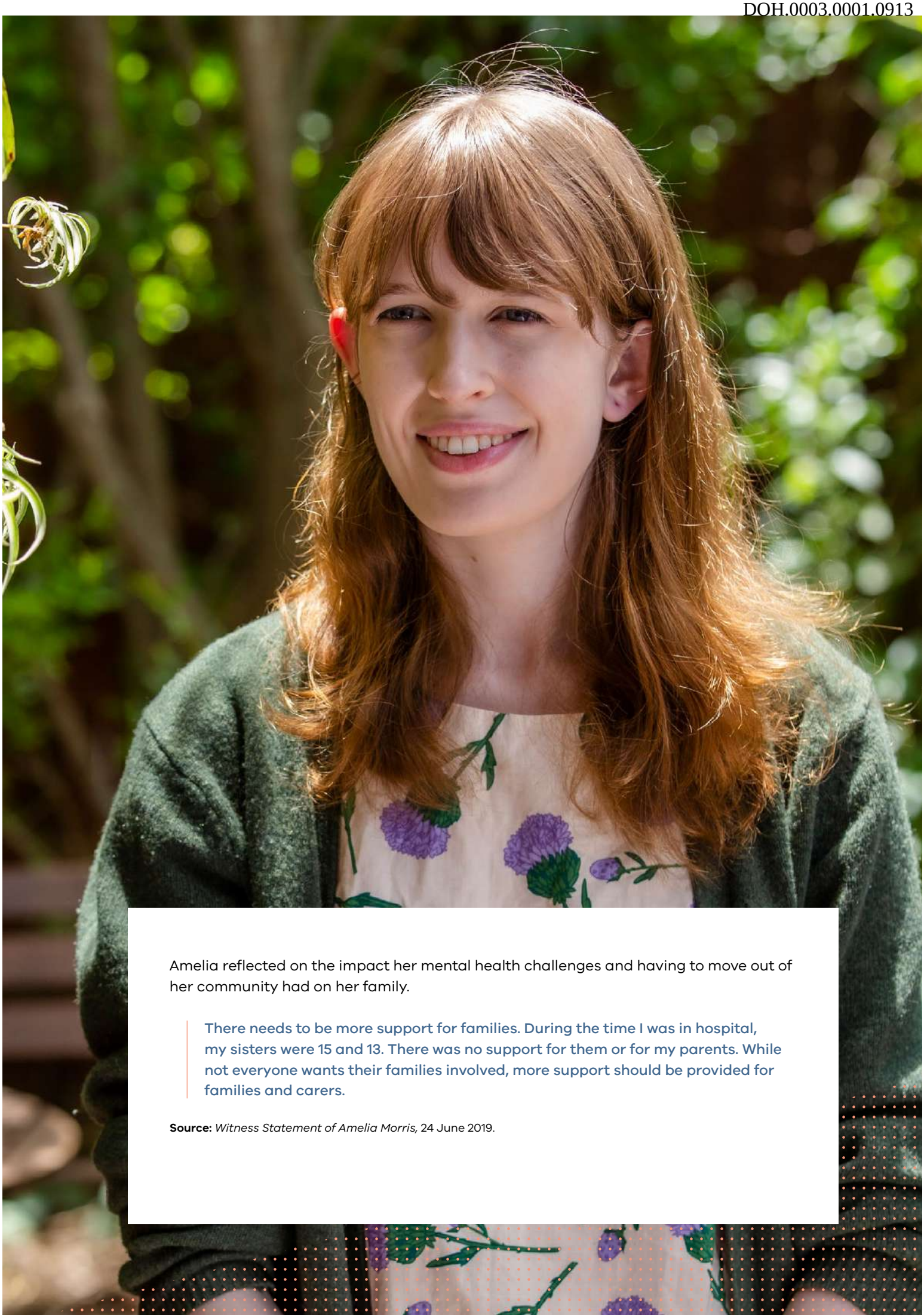
> I spent nearly three months in the psychiatric hospital in Melbourne. I turned 17 just after my arrival there. I was two hours away from my family and friends, who could only visit me on weekends because of school and work ... I had restricted access to my mobile phone, meaning I was not always able to communicate with my support networks. I felt incredibly isolated from the people I loved.

Amelia would like to see better access for consumers in rural and regional areas.

> Access should also be improved for rural and regional communities, especially people within these communities with complex needs. Like me, some people may be forced to go to Melbourne and leave their support network to get help. This was a very isolating experience for me and I believe it impacted upon my recovery.

Amelia felt abandoned by the mental health system.

> when I asked for help, it felt like there was nothing there ... It's so heartbreaking when you finally work up the courage to voice the horrible things that you're experiencing, but there's nothing there to help you.



Amelia reflected on the impact her mental health challenges and having to move out of her community had on her family.

> There needs to be more support for families. During the time I was in hospital, my sisters were 15 and 13. There was no support for them or for my parents. While not everyone wants their families involved, more support should be provided for families and carers.

Source: *Witness Statement of Amelia Morris,* 24 June 2019.

24.4.3 Services can be difficult to access and navigate

The current mental health system can be difficult to navigate for rural and regional consumers, families, carers and supporters, representing another barrier to seeking help.[164]

Ms Karyn Cook, Executive Director of Mental Health Services at South West Healthcare, Warrnambool Community Health, spoke about the lack of community-based support for those living in rural areas of Victoria:

> The further away from larger centres a consumer is, the less options they have for support in the community mental health and primary health sector. In short, it is more challenging for a rural person to have all their needs met in relation to the social determinants of health.[165]

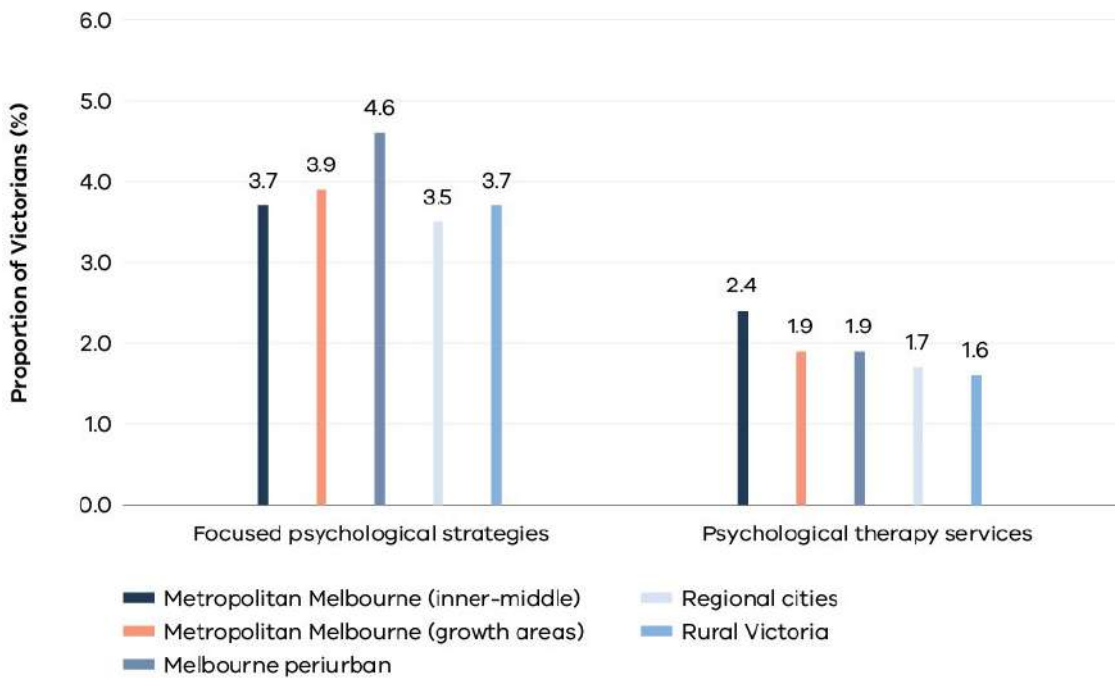
The Department of General Practice at the University of Melbourne stated that there is 'below optimal' access to general primary health services in rural and remote locations across the country:

> This results in patients [presenting] to emergency departments in tertiary hospitals for crisis or first aid mental health care as a result of not receiving proactive [preventive] care in the primary care setting.[166]

Workforce capacity is also an issue. In Victoria, workforce shortages for mental health professions are more pronounced in rural and regional areas.[167] The Commission's analysis indicates that the majority of mental health professionals work in major cities.[168] This limits people's access to expertise and opportunities for early support and intervention. Workforce shortages are discussed in more detail in section 24.6.

The accessibility of private mental health care in rural and regional areas is also limited. A range of mental health services are provided in the private sector and are eligible for financial subsidy through the Medicare Benefits Schedule. Analysis of service use in different residential locations has identified that a lower number of people per capita use Medicare Benefits Schedule services in rural and regional areas of Victoria.[169] As illustrated in Figure 24.5, the Commission's analysis indicates that for psychological therapies, roughly 2.4 per cent of people in inner metropolitan Melbourne areas received at least one session in a year, compared with 1.7 per cent in regional cities and 1.6 per cent in rural areas.[170]

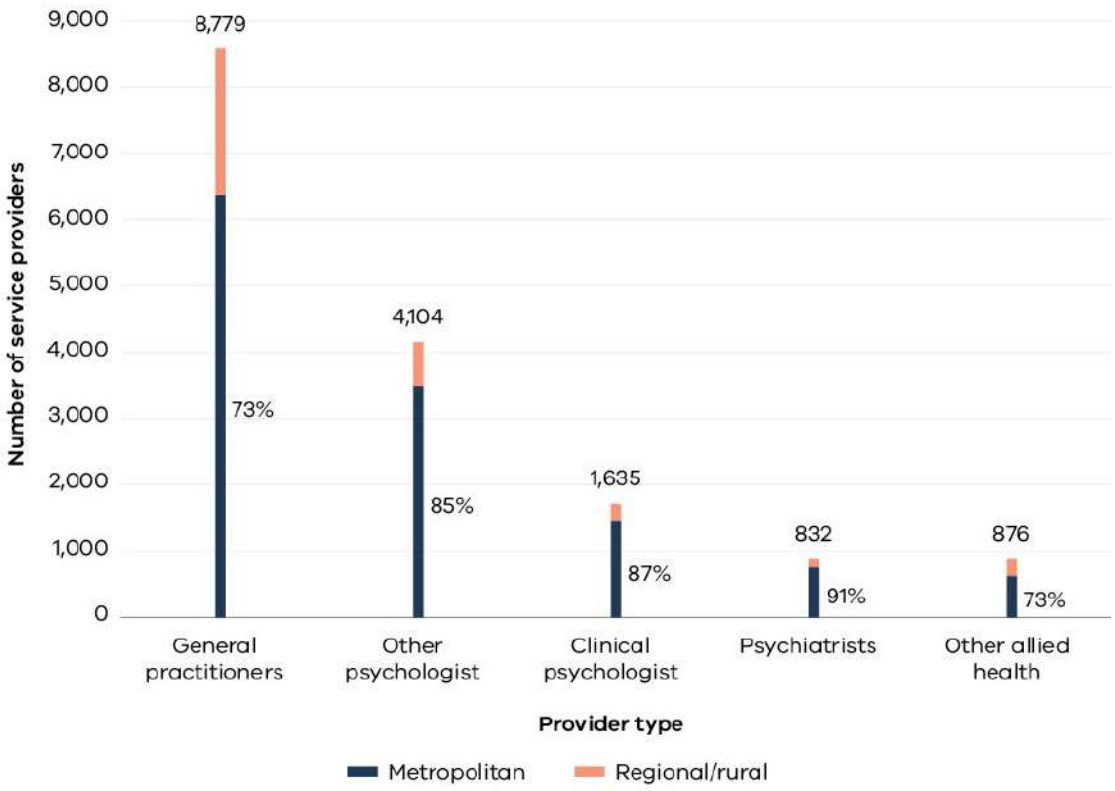
Figure 24.5: Proportion of people accessing focussed psychological strategies and psychological therapy services, by location, Victoria, 2017–18



Sources: Australian Government Services Australia, Medicare Benefits Schedule 2017–18; Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat. no. 3101.0, Canberra .

In part, lower rates of access are driven by the predominantly metropolitan-based location of the mental health specialists who deliver the services (refer to Figure 24.6).[171]

Figure 24.6: Proportion of practitioners who provided Medicare-subsidised mental health services, by provider type and location, Victoria, 2017–18



Source: Australian Government Services Australia, Medicare Benefits Schedule 2017–18.

Note: The same practitioner may have provided services in metropolitan and regional/rural Victoria at some point in 2017–18.

The Commission has also been told there are limited numbers and choices of private mental health providers in rural and regional Victoria,[172] which is felt more keenly by communities in which it may be difficult to maintain privacy.[173]

One regional health service suggested that multiple points of entry are confusing, and make it difficult for people to understand where to get help.[174] As the Commission noted in its interim report, it has heard of the frustration and distress people have felt when facing barriers or delays in trying to identify the right mental health services for themselves or on behalf of someone else.[175]

Barwon Health told the Commission that the difficulty in navigating the system can cause consumers in its region to delay or choose not to access care, leading to poorer outcomes, or seeking help from the emergency system, which is often not appropriate for their needs.[176]

A regionally-based consultant psychiatrist said in relation to finding treatment, care and support for trauma, that:

> the idea of there being no wrong [door] is good in theory, but there are an awful lot of doors out there. And to ensure that [everyone] that's behind those doors is informed and aware of what needs to happen, I think is a fairly large ask.[177]

Smaller health and community organisations have reported a lack of effective communication processes between services, with regards to care and discharge plans.[178] Some consumers with mental health needs that merit early intervention actually access support from tertiary services, because of the limited points of access to the system, and therefore do not receive the most appropriate form of care.[179] One person at a community consultation in Ballarat told the Commission, '[s]ome people don't really need tertiary services but there is nowhere [else] to send them to.'[180]

24.4.4 Specialist expertise is not easily available

The Productivity Commission notes that a person's ability to access specialist mental health care is dramatically reduced outside major capital cities.[181] In a joint submission to the Royal Commission from five rural and regional area mental health services, service providers explained:

> Whilst there is a reasonable range of statewide specialist services within the Victorian mental health system, the vast majority of these are Melbourne based. As a result, these services, including Eating Disorder, Forensic, Personality Disorder, Neuropsychiatry and [Child and Youth Mental Health Services] inpatient beds, are often in high demand resulting in delayed access and a limited ability to provide early intervention. In addition, geographical distance further compounds access issues for patients and their family/carers living in rural and remote areas of Victoria.[182]

Within Victoria, there is an inequitable distribution of specialist expertise across the state, with specialist expertise concentrated in metropolitan Melbourne, including addiction specialists, child and adolescent psychiatrists, and clinical psychologists.[183] The vast majority of specialist mental health services, both inpatient and community-based, for people experiencing eating disorders and personality disorders, forensic patients, people needing neuropsychiatry, and children are based in Melbourne. They are in high demand, meaning it is even harder for consumers, families, carers and supporters living in distant parts of the state to access them.[184]

The Commission has heard from a range of consumers that needing to travel to Melbourne to use specialist services is a challenge:

> Victoria doesn't end at the Westgate Bridge.[185]
>
> I felt that the Melbourne psychiatrist was good, and we made some inroads. However, travel to and from these appointments was a whole day venture. I stopped seeing the Melbourne Psychiatrist because it was too inconvenient and too hard to be away from my work on the farm for that long.[186]
>
> Travelling over 400 kms at a time when you are vulnerable, away from the support of family and friends from an area that already has poor transport connections is not acceptable.[187]

There are a number of areas of specialist treatment that can be difficult to access in rural and regional locations.

The Commission was told there are few services or clinicians to provide support to people using alcohol or drugs in rural and regional communities,[188] despite the fact that these communities can have higher rates of alcohol and drug use.[189]

As discussed in Chapter 22: *Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction*, the relationship between mental illness and substance use or addiction is complex, and each can contribute to the other.[190] Substance use appears to be a factor that can increase the risk of a person experiencing poor mental health, or exacerbate the symptoms of mental illness.[191] Many people with substance use disorders also experience symptoms of mental illness.[192]

Despite recent investment, Victoria has insufficient residential rehabilitation beds for alcohol and drug treatment, particularly bed-based facilities for detoxification, withdrawal and rehabilitation. Hospitalisations related to alcohol in regional Victoria increased by approximately 80 per cent in the four years leading to 2016–17, and more than doubled over the same period for illicit substances.[193] The Victorian Alcohol and Drug Association advised there remains 'a dire need' to address underservicing, including in rural and regional Victoria.[194]

For those consumers receiving pharmacotherapy—the use of medication to assist in the treatment of opioid addiction—service gaps across rural and regional areas may limit access, as consumers have to travel long distances to receive treatment, such as daily dosing.[195]

Many rural and regional agencies said that the people and communities they represent have considerable experiences of past trauma.[196] However, specialist care and treatment for trauma can be limited in rural and regional areas. Dr John Cooper, Consultant Psychiatrist at Bendigo Health and Phoenix Australia (Centre for Post-traumatic Mental Health), highlighted that there are no inpatient trauma services for people aged under 18 in regional services, and they have to be sent to Melbourne to access treatment.[197]

Intergenerational trauma within Aboriginal communities can be communal and individual, and distressingly and tragically affects children and young people.[198] In Victoria (as at 30 June 2018), Aboriginal children were nearly 16 times more likely to be in out-of-home care than non-Aboriginal children, the highest ratio of all Australian states and territories.[199]

One roundtable participant explained how a lack of culturally appropriate services can add to people's trauma and distress:

> Not [being] able to receive such services in a culturally appropriate way also refers to the fact that if somebody can't go to a GP service, you know, that is specific for them in terms of an Aboriginal Health Service, they might try to receive a service in another part of the community, but that service may not be culturally appropriate for them. So that may add to the distress and to the trauma that people can experience. Things like bushfires destroying traditional lands and inability for people to gather is a huge issue.[200]

Another participant said that local regional mental health services 'are not equipped to work with [culturally diverse] communities, lack competency and understanding of working with a cultural lens [or demonstrating] cultural sensitivities and trauma-based, trauma-informed … best practice', and that access to appropriate support is constrained by the cost and availability of interpreters.[201]

Consumers can face a substantial fee gap to pay to see psychologists with advanced skills in assessing and treating consumers with complex needs.[202] Regional consumers with complex needs, such as those diagnosed with borderline personality disorder, may find it hard to access specialised and appropriate support.[203]

Rural and regional Victorians living with mental illness also tend to experience worse physical health than metropolitan consumers.[204] This is likely due to a lack of specialist services and practitioners who are able to help consumers with their physical health challenges, as part of a multidisciplinary service offering. Poor physical health can lead to worsening mental health outcomes, as well as poorer life outcomes.[205]

It can be difficult for GPs and small health services in rural and regional settings to access advice from specialists to help them make appropriate decisions. Associate Professor Moylan told the Commission that both GPs and consumers would benefit from more rapid input from specialists:

> it's so challenging now to get specialist-based input and fast turnaround into things that the GPs, I think, feel a little bit under-prepared for some of these things and then feel uncertain about what to do … I think there's been a functional disconnect and I think if we can really improve that for general practice I think we would find, in a capability building perspective, and a confidence building perspective, that for users accessing the system, they'll find that, when I go to the GP I can get really good specialist-based mental healthcare, but also, very fast turnaround into a specialist system and come back to my GP who is the home of my care.[206]

One regional service leader made a 'plaintive cry' for specialist inreach support:

> [our generalist clinicians] foster relationships with specialist tertiary services in Melbourne. But if I had some specialists to compl[e]ment my generalists, I think that we could start approximating some of the outcomes [in other services]. And certainly, to get [specialists] to come up and spread [their] wisdom outside of Melbourne is always a worthwhile experience. But I think resourcing, training and relationships with the tertiary sector is probably the way that we get by.[207]

In its interim report, the Commission proposed an expansion of the Hospital Outreach Post-suicidal Engagement (HOPE) program (Box 24.2), which is an example of how a networked, inreach approach can support access to services in regional and rural areas.

Box 24.2: A networked approach to regional and local service provision

In its interim report, the Commission recommended the expansion of the Hospital Outreach Post-suicidal Engagement (HOPE) program to all regional area mental health services, to ensure availability throughout the state.

To achieve this, the Commission proposed a networked approach to enable people living in rural and regional areas to receive support. This approach included establishing a connected clinical outreach service in each subregional health service.

> Services delivering care at the sub-regional level often provide a range of more complex services than those delivered at the local level ... These providers bridge the gap between the range of lower-complexity services provided by smaller local rural healthcare providers and the larger regionally based health services.[208]

This networked regional approach facilitates strong collaboration and pathways between GPs, psychiatrists, psychologists and outpatient services, with regional services providing clinical and psychosocial support as required (for example, advisory and consultative support).

Services should have a focus on working with other health and social service providers to respond to local community needs. It is vital that, as part of their recruitment and training, outreach workers gain the ability to meaningfully interact with and support people in these areas. Services should be culturally sensitive and workers should possess an understanding of rural and farming life.

Source: Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, pp.445-458.

As illustrated in Figure 24.7, the Commission has heard from rural and regional consumers, families, carers and supporters, and the workforce about the challenges these communities face in accessing services.

24.4.5 Services for infants, children and young people are limited

According to regional communities consulted by the Commission, mental health services available for infants, children and young people are limited in rural and regional communities.[209] Many Victorian rural and regional providers reported that specialist mental health services including for children and young people are either absent, underfunded or over-extended.[210]

Dr Cooper said that regional services seeking to support children with complex conditions often have to be self-sufficient, relying on 'excellent and resilient generalist clinicians who are jacks of all trade' operating with limited resources.[211]

Some services described the loss of funding for programs such as perinatal and infant mental health,[212] a lack of access to mother and baby units,[213] an absence of services for primary-school-aged children,[214] or waiting lists of more than 12 months for autism assessment services.[215]

The Australian Education Union reported that a survey of teachers found high levels of frustration with a lack of services for children and young people, particularly in rural and regional schools:

> Some respondents, particularly in rural areas, indicated that they virtually had no support while others said that the waiting periods for support undermined their usefulness and left the school to their own devices to meet urgent student needs.[216]

Teachers also reported they were underprepared for managing the psychological and behavioural issues of students, and they had inadequate support when they did have to manage mental health issues.[217]

While most regional tertiary mental health services do deliver care to children and young people, these services are targeted to people with higher levels of need.[218] Therefore, services for less serious mental health concerns are typically being delivered by primary health providers (such as GPs or headspace), or through secondary providers, such as psychologists or psychiatrists.

Primary and secondary health services may be unable to meet demand and are at times fragmented, meaning children and young people are seeking services multiple times, and the flow of inpatients through child and adolescent mental health services may be disrupted.[219]

Rural and regional services report high levels of developmental delay, psychological distress including suicidal ideation, and illicit substance use among children and young people in their communities.[220]

People with neurodevelopmental disorders have higher rates of mental illness compared the general population.[221] Specialist services and clinicians who can diagnose neurodevelopmental disorders —such as autism spectrum disorder, attention deficit and hyperactivity disorder and sensory processing disorders[222]—are very difficult to access in rural and regional communities.[223] This means that children with neurodevelopmental challenges may not receive appropriate assessment, diagnosis and treatment, thereby delaying interventions and supports that could help both the child and their family manage their social, emotional and cognitive needs.

At the Commission's hearings in Maryborough, Dr Bhat said that historically child and adolescent mental health services were not as well planned as adult or older people's mental health services, which has resulted in barriers to access.[224]

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Figure 24.7: Selection of quotes from consumers, families, carers and supporters and the mental health workforce in rural and regional Victoria.

Sources: 1. RCVMHS, *Shepparton Community Consultation — May 2019;* 2. RCVMHS, *Seymour Community Consultation — May 2019;* 3. RCVMHS, *Bendigo Community Consultation — May 2019;* 4. RCVMHS, *Mildura Community Consultation — May 2019;* 5. *Evidence of Trevor Thomas,* 15 July 2019, p. 955; 6. *Evidence of Trevor Thomas,* p. 959; 7. RCVMHS, *Shepparton Community Consultation — May 2019;* 8. RCVMHS, *Bendigo Community Consultation — May 2019;* 9. RCVMHS, *Ballarat Community Consultation — April 2019;* 10. RCVMHS, *Geelong Community Consultation — April 2019;* 11. RCVMHS, *Mildura Community Consultation — May 2019;* 12. RCVMHS, *Shepparton Community Consultation — May 2019.*

Personal story:

Monique

Monique* has worked as a GP in regional Victoria for over 20 years. She combines private practice with work at headspace, where she specialises in youth mental health. Monique is also a parent and carer for her child who has experienced complex mental health challenges from early adolescence and into adulthood.

> The experience as a parent and carer is like being on a massive rollercoaster. The fact that all your love and support can't protect your child from mental health difficulties is pretty confronting for parents. The fear and distress and confusion that their difficulties might be our fault as parents was pretty challenging to deal with, let alone seeing the distress and pain our teenager was going through. Even as well-resourced parents, we were shocked by some of the interactions we and our teenager had whilst navigating [the system].

Accessing specialist help in regional Victoria can bring additional challenges. Monique's child received multiple diagnoses throughout adolescence and early adulthood.

> The various assessments, formulations and explanations we were given over many years completely missed an underlying neurodevelopmental disorder ... This illustrates the importance of holistic, comprehensive, non-fragmented and 'over time' assessments.

Monique notes that where there is a lack of services in rural and regional settings, GPs often hold the responsibility for mental health treatment, care and support.

> GPs often provide a single thread of continuity for some of these young people in rural and regional settings. The [Medicare Benefits Scheme] does not reimburse us for our time or commitment to their care.

Monique's lived experience as a carer has shaped her professional pathway.

> I was ... deeply ashamed of negative attitudes and internalised stigma that some of my medical peers and some other health professionals displayed—it was shocking to me that this was sometimes worse than in the wider community. This made me really driven to make a difference where I could.
>
> In my opinion, kindness, respect, collaborative decision making, clear patient centred explanations, advocacy and support make a huge difference and GPs are a vital cog in the system.

Source: 'Monique' (pseudonym), *Correspondence to the RCVMHS*, November 2020.

Note: *Name has been changed to protect privacy.

A respondent to a workforce survey of staff and volunteers across Victoria's mental health system held aspirations for more equitable access to specialist services for all communities:

> Providing support for rural and regional communities that is commensurate with metropolitan services is vitally important. All state-wide specialist services seem to be based in Melbourne, as are all centres of excellence. It would be great to see a progressive Mental Health Service that is accessible for all Victorians and improves the career prospects and pathways for staff in rural and regional settings, without having to move/travel to the capital.[225]

24.4.6 Digital technology could be better used to improve service access

One of the major benefits of digital technology is its ability to break down geographic barriers,[226] and as the Commission's interim report pointed out, this is particularly the case for people in rural and regional Victoria needing to access mental health services.[227] The potential for greater use of digital technology across the state is discussed in detail in Chapter 34: *Integrating digital technology.* This section focuses specifically on its importance and application in rural and regional settings.

The use of technologies such as video or phone conferencing (telehealth), and online mental health interventions can help by:

- reducing geographical barriers and travel for consumers and mental health workers
- making specialist supports available locally
- facilitating multidisciplinary care when workers are in multiple locations
- providing more options that support people's anonymity, reducing the risk of people experiencing stigma when they seek help, or being concerned that they will experience it
- expanding access to peer supports, helping to reduce feelings of isolation.

Many consumers have found telehealth services to be effective and convenient. Dr Paul Denborough, Clinical Director of Alfred Child and Youth Mental Health Service and headspace, Alfred Health, giving evidence in a personal capacity, told the Commission:

> We are already seeing a massive uptake of use of technology to see and help families via telehealth in the COVID-19 crisis and this has been very well received by families.[228]

Online digital services offer consumers more flexible and personalised services at a time and in a way that is convenient to them. Typically, they provide people with clinician-supported online cognitive behavioural therapy or similar therapeutic services. Around 40 per cent of the registered users of MindSpot—which delivers online mental health interventions—are from rural and regional areas,[229] as are around 30 per cent of users of THIS WAY UP, an online cognitive behavioural therapy program.[230]

But telehealth and other digital services are being underused to help people in rural and regional communities to access mental health services.[231] Despite increased uptake during 2020, digital technologies are still not being used to their full potential to benefit rural and regional communities.

Barwon Health advised that this was the case in its region:

> The use of telehealth and associated technologies has significant potential to improve access to mental health care, particularly to communities with limited local access to specialist services (e.g. regional and rural areas). At Barwon Health, there is untapped potential to utilise telehealth and other technologies to improve access to specialist services across the Barwon region and to support general practitioners in smaller population areas.[232]

Several barriers exist, including the capacity of service providers to deliver digital services; ageing devices and technology;[233] lack of funding and investment in information and communications technology (ICT) infrastructure;[234] inadequate workforce skills and capacity;[235] and lack of affordability of devices for consumers.[236]

Barriers for consumers and service users

The Commission was told that many people in rural and regional communities may struggle to use telehealth services or access digital mental health and wellbeing services. Some small rural towns and regional areas have poor internet connectivity, which can limit people's ability to use telehealth services and other digital tools that require internet data. People in rural and regional areas are less likely to have internet connectivity at home than people in metropolitan areas,[237] and even when they do have internet, it may be less reliable.[238] A business supporting rural and regional farmers told the Commission that lack of connectivity would inhibit online service delivery:

> the move to online [has] got its place. But what [we're] hearing all the time is, 'oh, it's online'. Most of our people don't have connectivity. That's why we set up the IT company … we [tried] to have a farmers meeting this morning … you know, four of them kept dropping out all the time. So how can you deliver services when you can't even get very basic … connectivity let alone a mobile phone service?[239]

Some rural and regional communities have high levels of socioeconomic disadvantage. Digital inclusion is lower for low-income households, those who are unemployed, Aboriginal people, people from culturally diverse backgrounds, and people with a disability.[240] Mr Shane Solomon, partner of Caligo Health, giving evidence in a personal capacity, cited study findings that identified 'a substantial digital divide between richer and poorer Australians', and noted that '[c]onsequently, the potential to take advantage of telehealth and related mobile apps is likely to require some investment in improving access to digital health resources for consumers of mental health services.'[241]

Associate Professor Moylan said Barwon Health has noticed that some consumers have struggled to use telehealth services due to a lack of technology and connectivity, and a lack of access to public libraries and other sources of Wi-Fi:

> In respect of the telehealth services that Barwon Health have able to provide, we noticed a digital divide between consumers who have the necessary technology (i.e. hardware, internet connection and data allowance) and those consumers who do not. The divide is further exaggerated by the fact that the lockdown measures prevent consumers from accessing community based services (i.e. public libraries, internet cafes etc.) which would be available in normal circumstances.[242]

The Commission also observes that, while libraries and other public facilities may provide internet connectivity, people may not be comfortable having personal conversations in proximity to others, nor should they have to. A lack of designated and private space can limit people's ability and willingness to use digital services.

Barriers for service providers

The Commission was told that public mental health services in rural and regional areas often lack the ICT infrastructure and equipment to offer their consumers state-of-the-art digital services. Mr Welch told the Commission that a lack of suitable ICT infrastructure is the predominant barrier to mental health services using telehealth and other digital technologies.[243]

In a joint submission by five rural and regional area mental health services, service providers argued that more funding is needed to support 'innovative approaches to service provision in which distance and cultural differences are a significant challenge', including 'infrastructure to address geographical distance' such as mobile devices (phones and computers for access to digital clinical information at the point of care) and telehealth.[244] Several other services also indicated that a lack of suitable devices, internet and technology limits their ability to offer people telehealth consultations and remote assessments.

As discussed in Chapter 34: *Integrating digital technology,* recent changes to the Medicare Benefits Schedule in response to the COVID-19 pandemic have expanded access to telehealth. Previously, telehealth had been funded through the Medicare Benefits Schedule for specific rural and regional areas in primary health care, and its availability in metropolitan areas was limited. During 2020, the then Department of Health and Human Services purchased additional call volumes for area mental health services in Victoria to support the switch to telehealth.[245]

The Productivity Commission noted how the expanded Medicare Benefits Schedule rebate has improved access to specialist services and supports. It recommended that the Commonwealth Government make the statewide rebate for mental health telehealth services permanent. If this recommendation is accepted, it is anticipated that the statewide rebate will greatly improve rural and regional communities' ability to seek out psychiatric and psychological services.

The Commission welcomes the announcement made subsequently by the Commonwealth Minister for Health, Greg Hunt, that 'for the long term, telehealth will become a permanent part of the Medicare system'.[246]

The Productivity Commission has also recommended that the Commonwealth establishes a new digital platform that includes clinician-supported online interventions. If adopted, these supports will help people living in rural and regional Victoria to use evidence-based digital interventions, either on their own or as part of their broader service supports.

Digital initiatives in mental health are promising, but old systems and infrastructure are preventing people from engaging with and benefiting from digital services in rural and regional Victoria. For these communities to take full advantage of digital technologies, they need state-of-the-art ICT infrastructure, connectivity and devices, as well as support to establish new innovative digital programs that meet the needs of their local people.

This will require:

- giving consumers better access to technology in safe and private environments, so they can use and benefit from telehealth and other digital services
- greater support and funding for rural and regional mental health and wellbeing service providers to build their digital capacity and digital service offerings
- support and partnerships to help rural and regional communities, consumers and service providers to establish, test and share digital interventions that increase consumer access to high-quality services, based on local needs and priorities.

The Commission notes that the Victorian Budget 2020–21 includes investment in technology to facilitate access to telehealth,[247] and to improve mobile coverage and broadband connectivity[248] in rural and regional Victoria.

24.5 Funding to reflect the cost of service delivery

The Commission has heard that Victorian and Commonwealth Government funding arrangements may not adequately cover the additional costs of delivering services in rural and regional areas, or allow for appropriately flexible models of treatment, care and support that reflect the needs of people living in these communities.[249] This has led to some disparities in how services are funded across the state.[250]

One person attending the Commission's consultations in Shepparton observed:

> There are huge funding disparities for mental health services—there are differences between metro and regional areas, and differences region to region. If your lottery of birth wasn't enough, what services you get is also a lottery.[251]

The *National Strategic Framework for Rural and Remote Health* states there are significantly higher costs involved in rural and remote healthcare delivery.[252] While the cost of providing health services increases with remoteness, the availability of existing infrastructure and workforce becomes more limited.[253] Assumptions that can generally be applied to the funding of metropolitan services—such as availability of an appropriately skilled workforce; consumers and provider proximity to services; adequate community and social infrastructure; and robust health care services including private options—do not necessarily hold in rural and regional locations.[254]

The Victorian Auditor-General's *Access to Mental Health Services* report found that current funding models do not take into account that rural and regional services may have inherently higher operating costs than metropolitan services.[255] Current funding models may not adequately account for:

- the vast geography of the catchment areas and additional costs of transport to meet the needs of people living in remote locations (such as practitioner travel times as a consequence of covering large geographical areas to reach a dispersed population group)[256]
- the impact on clinician time of delivering services to consumers in rural communities (for example, required staffing levels)
- the additional costs required to support staff wellbeing in dealing with the unique stressors associated with working in rural settings (such as increased travel).[257]

Dr Bhat told the Commission:

> Current funding arrangements for rural state-funded mental health services do not necessarily take into account the combination of travel times and dispersed population, which does not incentivise assertive community-based mental health treatment and care. Instead, care becomes focused on seeing people in clinics who may require people to travel long distances, medications, and monitoring and risk management.[258]

In its submission, Ballarat Health Services explained the problem with existing funding models:

> funding models disadvantage regional, rural and remote mental health services as the funding does not take into consideration the social, economic and geographical challenges inherent in these catchments.[259]

Area mental health services have reiterated to the Commission the funding issues identified by the Victorian Auditor-General. As a consequence, they advised that funding models are inappropriate in rural and regional areas, because they do not encourage community outreach or home visits. Instead, service provision is focused on people attending clinics, meaning they may be required to travel long distances.[260]

In addition, costs are higher for services with low-volume demand due to population size. South West Healthcare explained:

> Due to the large geography covered by rural services, together with small population numbers and lower bed numbers, rural services struggle to leverage economies of scale when it comes to making the most efficient use of funding.[261]

Latrobe Regional Hospital said that funding reform is needed 'to address the rural and regional context of service delivery and support innovation to provide access to those hard to reach populations who are not receiving service'.[262]

The Rural Health Standing Committee observes that the combination of limited resources and high administrative burdens could endanger services in rural locations:

> Rural and remote services are unlikely to enjoy the same economies of scale as metropolitan-based services, and many small rural facilities experience a significant administrative burden on their limited resources due to multiple accreditation, accountability and reporting requirements ... When these factors combine, small rural health facilities and service providers can find it harder to maintain their viability, and may struggle to continue providing the services their communities need.[263]

The Commission considers that more deliberate planning, design and resourcing of mental health and wellbeing services is needed to keep pace with the population changes and growing needs of rural and regional populations. Larger regional services will need to be more active in supporting rural communities.

As stated in Chapter 1: *The reform landscape*, agencies should work together to create a system that respects the experience and needs of individuals, and ensures that consumers, families, carers and supporters are more easily able to access and receive services.

24.6 Workforce shortages

Workforce shortages in rural and regional communities can negatively affect consumer access to responsive, integrated and person-centred mental health and wellbeing services.[264]

As noted above, workforce shortages for mental health professions are more pronounced in rural and regional areas of Victoria.[265] Service directors and practitioners have told the Commission that rural and regional Victoria struggles to attract psychiatrists, psychologists, GPs, nurses and other community mental health workers.[266] As a consequence, services experience staff shortages that can increase the workloads of existing staff, leaving them at times challenged to provide the level of care they would like.[267]

Area mental health services report that staff shortages result in understaffed mental health units, inexperienced staff, crisis-driven care, and an inability of services to reach or meet the needs of their target consumer populations.[268]

Consumers, families, service providers and communities have said that limited workforce availability has had a negative effect on the mental health and wellbeing of the rural and regional communities across Victoria.[269]

Dr Lynne Coulson Barr OAM, Victoria's former Mental Health Complaints Commissioner, said that workforce shortages in rural areas 'create risks for consumers', particularly where extended vacancies force the high use of poorly trained agency staff.[270] Dr Barr said that Complaints Commission investigations have identified shortcomings in the induction and training of new staff and agency staff to ensure they understand the Mental Health Act, and have sufficient access to skill development in key areas of practice, such as trauma informed care.[271]

24.6.1 Nature of workforce shortages

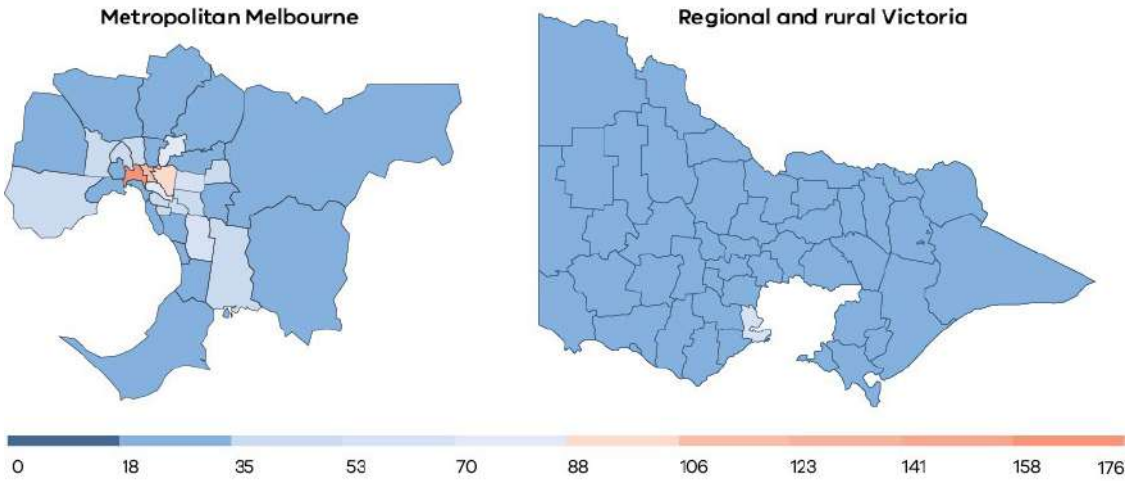
Workforce shortages are evident across primary, secondary and tertiary services, and private practice, including GPs, psychiatrists and medical staff, mental health nurses, psychologists, allied health professionals, social workers and peer support staff.[272]

Nationally, the number of mental health professionals registered with the Australian Health Practitioner Regulation Agency is significantly less per capita across rural and regional areas than in metropolitan locations.[273] In Victoria, most registered professionals working in mental health—including psychiatrists, psychologists, GPs, nurses and occupational therapists—are concentrated in metropolitan Melbourne, as indicated in Figure 24.8.

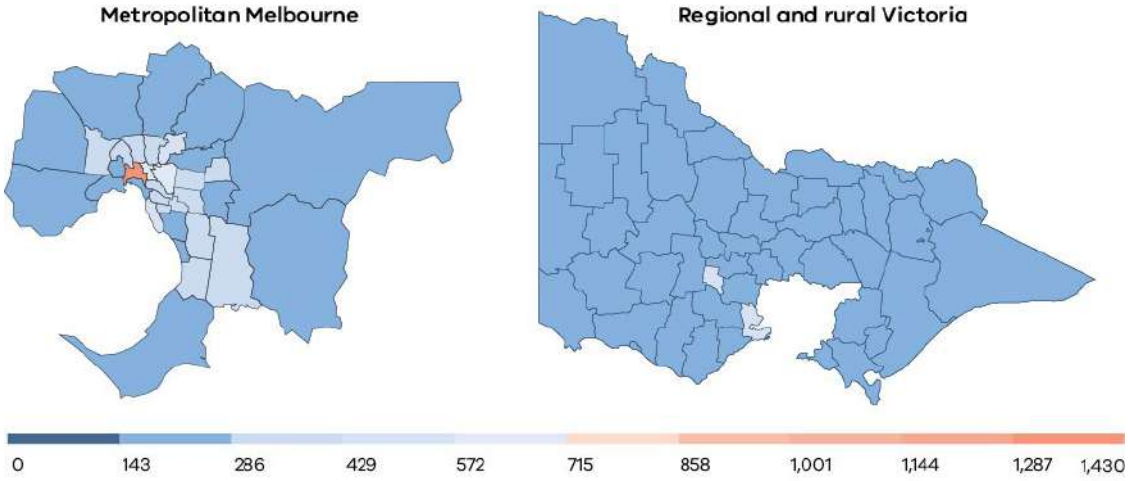
Albury Wodonga Health reported that its catchment has very few private psychiatrists and psychologists, which means the area mental health service is a one-stop shop for primary care right through to acute psychiatric and tertiary care. The service is aiming to build a team of what it considers 'rural clinicians'—mental health clinicians who understand and have a skill set to work in rural communities, and partner with rural agencies and consumers to deliver the best possible care.[274]

Figure 24.8: Number of psychiatrists, psychologists, GPs, nurses and occupational therapists, by local government area, Victoria, 2019

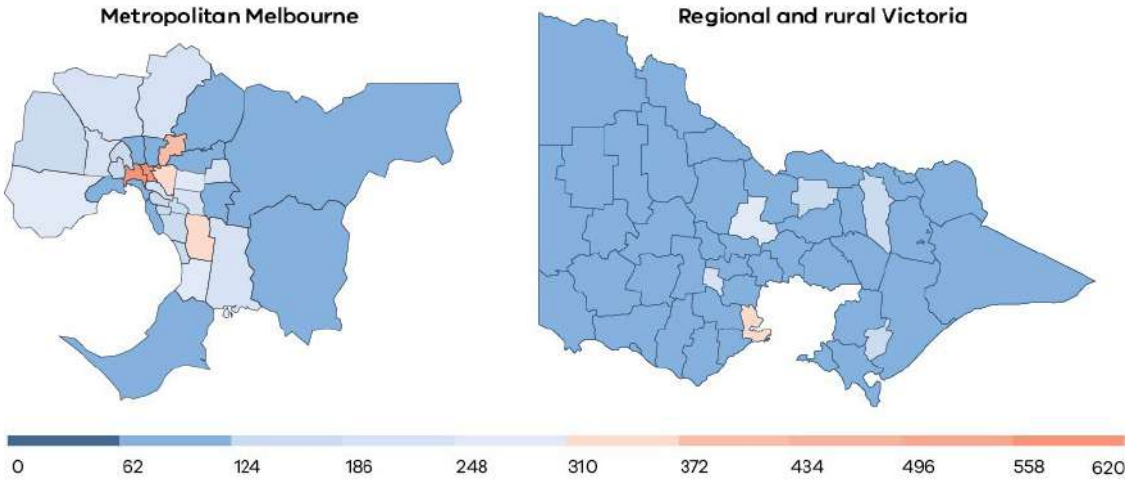
A. Psychiatrists



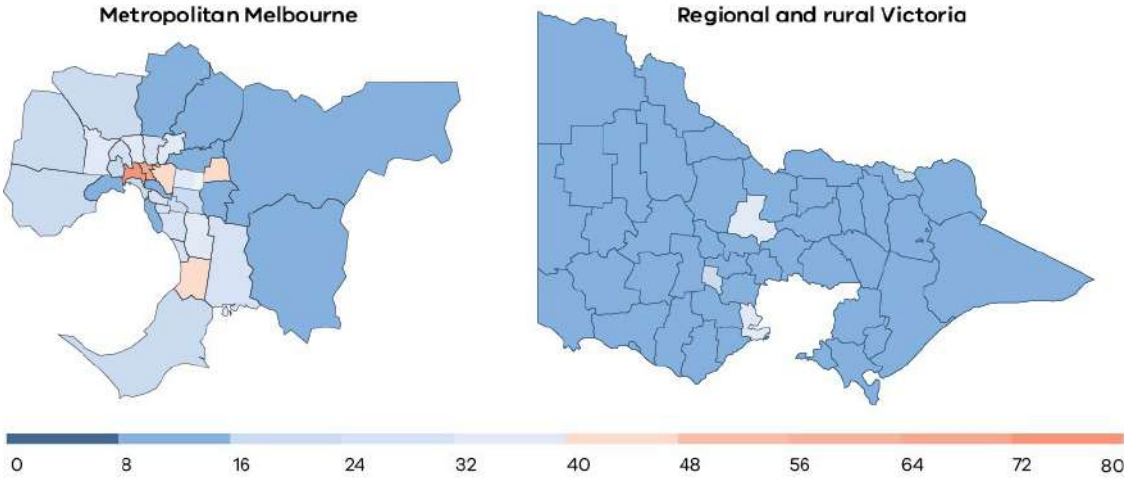
B. Psychologists



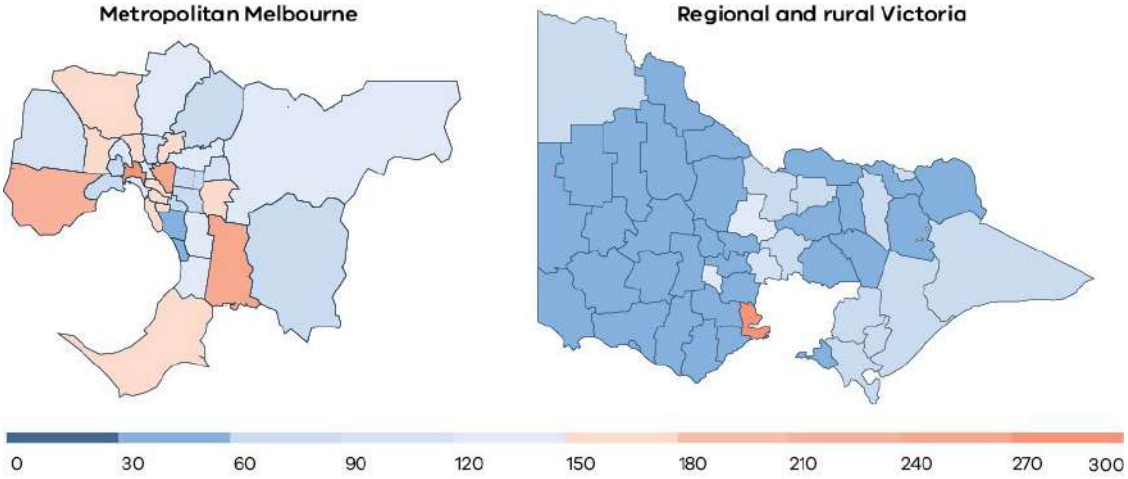
C. Mental health nurses



D. Occupational therapists



E. General practitioners



Source: Commission analysis of Australian Government Department of Health, Health Workforce Data, <hwd.health.gov.au/datatool.html>, [accessed 10 December 2020].

Note: Only includes practitioners working in Victoria in registered professions.

Recruitment of specialist mental health clinicians takes place within a limited and competitive workforce market.[275] Non-government organisations often need to compete with area mental health services to recruit staff, but may be unable to offer competitive wages. This limits their ability to attract highly trained clinicians equipped to provide complex care.[276] Short-term funding cycles causing job insecurity may contribute to challenges with retaining staff in rural and regional areas, particularly in non-government organisations and community-based services.[277]

Rural and regional community members report a desire for workers who are sensitive and respectful of the local culture and history.[278] However, there is a shortage of culturally trained mental health practitioners—for example, a lack of specialised, culturally trained Aboriginal workers.[279] The Commission's interim report recommended actions to grow and develop Aboriginal social and emotional wellbeing teams.[280]

The Royal Flying Doctor Service said the local rural mental health workforce needs to grow and diversify to meet the needs of rural communities. The service used telehealth and 'drive-in/drive-out' models to mitigate workforce shortages in some regions. But it highlighted that more roles such as outreach workers, community connectors and health coaches were needed to assist in addressing local community needs, as well as 'extending the scope of practice of existing trusted rural health professionals' such as community nurses, GPs and Aboriginal health workers.[281]

It has been reported to the Commission that people from culturally diverse backgrounds, including people with traumatic pre-migration experiences, often cannot access appropriate mental health care or interpreters.[282] Health and community service providers report limited access to alcohol and other drug, and dual diagnosis specialist clinicians, which results in increased risk and vulnerability for consumers.[283]

24.6.2 Causes of workforce shortages

Many factors contribute to the shortage of mental health professionals in rural and regional locations. Geography is a particular barrier to attracting suitably skilled professionals to smaller, rural towns. Dr Bhat told the Commission that '[i]n rural areas recruitment is harder with fewer incentives for trained staff to move to regional towns.'[284]

One community member told the Commission:

> We struggle to attract qualified health professionals to our town. We are not metropolitan, we are not a regional centre. We don't have positions with high salaries for people rising in their profession or seeking a career path. We are too far from regional centres for young people or socially dynamic people to visit and return after their working day. We are limited in the profile of people who would find living in our town and providing services to our community attractive.[285]

Accommodation and employment opportunities can be limiting factors. Grampians Health said '[t]he constraints of funding can mean that positions are offered on a fractional basis, and this may not be enough to attract somebody to relocate to that area.' It suggested that financial and housing incentives would encourage staff to work in regional area mental health services.[286]

Family factors—such as housing, educational options for children, spousal employment opportunities and remoteness from family and friends—can be important in influencing professionals to consider rural and regional practice.[287] One systematic review noted that 'in rural settings it is often a whole family that is recruited to an area, not just an individual'. It found that support in securing housing and spousal employment may help attract and retain health workers.[288]

Social and personal satisfaction with rural lifestyle has been found to influence workforce retention over longer periods. People who are older, have school or family connections locally, or have established professional and community networks, are more likely to stay in their post longer, while 'a sense of social and personal isolation may contribute to the decision to leave a rural area'.[289]

Work pressures and safety make it hard to attract and retain skilled mental health professionals.[290] The rural and regional workforce also experiences limited support and networks.[291] Lack of access to supervision limits the capacity to train and employ more junior psychologists in small services in rural and regional areas.[292]

Ms Cook told the Commission about the difficulties rural services face:

> While we are trying to attract experienced skilled workers, there is currently a workforce shortage—especially in rural areas. Workers willing to live outside the metropolitan area will generally elect to go somewhere like Ballarat, which has a shorter commute to Melbourne. As a result, we primarily attract clinicians with less mental health clinical experience such as social work or [occupational therapy] graduates, junior nurses and provisional psychologists, who require high levels of training, supervision and support.[293]

Fewer opportunities for professional development and continuing education are also a disincentive. Travelling to larger regional cities or metropolitan areas for professional development and training can be both expensive and time consuming for professionals and service organisations.[294] The Commission has been told there are minimal incentives to support local training programs in rural and regional areas.

Grampians Health submitted to the Commission:

> Most learning opportunities for mental health professionals and allied health staff are Melbourne centric, which makes participation more challenging. There needs to be greater investment in learning opportunities in regional and rural centres.[295]

Dr Bhat told the Commission:

> Rural state-funded mental health services are not incentivised to develop and sustain local training programs. Even when they exist, they have little support for sub-speciality training such as that in Eating Disorders, Neuropsychiatry etc.[296]

24.6.3 Effects of workforce shortages

Mental health workers in rural and regional areas can be faced with managing high-risk situations with limited workplace support.[297] Smaller teams or limited resources can also result in high levels of pressure.[298] They may lack supports such as direct case supervision, clinical and/or professional practice supervision, multidisciplinary team oversight and support, medical oversight and clinical governance structures.[299]

A regional service provider said that mental health staff needed to have a diverse array of skills, because there is limited scope to refer people to other agencies or specialists.

> There are a lot more hurdles. There are a lot less outside support agencies to help the people that we work with. So we find that we're doing more and more and more. They say to be a social worker in the country means you have to be a jack of all trade[s] ... Everybody has to be skilled in a number of different areas ... because it's not so easy to refer them to somebody down the road who specializes in that area.[300]

Workplaces in rural and regional areas can be professionally isolating for some, with limited informal or peer support.[301] Dr Neil Coventry, Victoria's Chief Psychiatrist, told the Commission:

> providing a variety of clinical services ... requires a critical mass of qualified clinicians for training, clinical supervision commensurate with level of experience, and service provision. Providing an appropriate level of discipline-specific, clinical supervision can be a particular challenge in rural and regional services ...[302]

Workforce shortages impact the wellbeing of mental health staff, who may experience fatigue and burnout when they cannot offer the care that people need due to resource shortages.[303] One professional from a large area mental health service told the Commission:

> they're working with far more acutely unwell people than they have previously in 2020. They're holding a lot of people in the community. And I'm really proud of the work that the teams are doing to be able to hold people who previously may well have been admitted to an inpatient unit. But we're now at the point where that's not a feasible option ...[304]

A lack of appropriately trained and available clinicians has increased the care burden on emergency workers, school communities, sporting clubs, volunteers and local councils.[305] One roundtable participant told the Commission that this places particularly heavy pressure on emergency service personnel who have minimal training to provide a mental health response.[306] There may also be added pressures on mental health workers in small rural towns, who are well known to the community and may feel obliged to meet expectations.[307]

Carers in rural and regional Victoria also report increased psychological distress and poor physical health associated with workforce shortages, lack of supports and a lack of respect for their rights.[308] Changes from previous carer support funding models to the current National Disability Insurance Scheme model have significantly disadvantaged some carers, who no longer have the same respite supports available.[309]

The Commission acknowledges the substantial pressures on the mental health workforce in rural and regional Victoria. However, it has also observed evidence of strong community connections, partnerships and goodwill, which could form the foundation of an improved and innovative future workforce. These connections mean that rural and regional residents are acutely aware of, and attuned to, the mental health and wellbeing of their community members.

While there is a critical need to attract and retain specialist mental health expertise, the Commission recognises great potential for a more diverse future workforce to play a role in health promotion and wellbeing support for rural and regional communities.

24.6.4 Workforce aspirations

In 2020, the Commission engaged ORIMA Research to conduct a survey that was open to all staff and volunteers who provide mental health treatment, care and support across Victoria. A total of 2,920 responses were received from people working in a variety of roles and settings across the state. Around 29 per cent of respondents provided services to people in regional Victoria.[310]

The survey included opportunities for individuals to share their aspirations for the system in the future. Staff shared their hopes for rural and regional communities, and the services that support them.[311]

Themes from regional-facing workforces included hopes that the communities they support will be afforded equal access to mental health treatment, care and support; and that regional and rural mental health services will have sufficient funding and resources to accommodate the differing challenges and needs of rural consumers and settings.

Staff wanted greater capacity to attend rural communities and provide home visits to farming communities, and access to the training and supports they need to work optimally in rural areas to meet needs of consumers. People in rural teams wanted to feel part of the broader state mental health service; for them, this would include partnerships between metropolitan, regional and rural services that provide access to training opportunities, peer and professional supports, and allow isolated staff to share experiences.

Personal story:

Jennifer Rowan

Jennifer Rowan is from the small rural town of Camperdown in Victoria's south-west. Living in a rural area, Jennifer has seen that it can be difficult for those in her community to access specialist mental health support.

> Living in a rural town, we have very limited health services and we experience long wait times for services. With a small number of psychologists in our area, they are inundated with work.

Although digitally enabled mental health services have a role to play, Jennifer emphasises that technology and online access don't necessarily make access easier in rural towns because not everyone has reliable access to the internet.

> It can also be difficult for us to use online services like eheadspace because of issues with internet access and connectivity. Having grown up in the area, I have seen how the gaps in the mental health system affect rural and regional communities.

Jennifer is passionate about mental health and is currently studying a Bachelor of Social Work. She is also a mental health first aid instructor with Mental Health First Aid Australia. Jennifer would like to see more opportunities for young people to enter the mental health field and sees this as a way of building more access to services in rural areas.

She also emphasised the lack of roles for professionals who deliver psychotherapeutic treatment, care and support:

> We have a lot of young people out here who are quite passionate about mental health and who want to become mental health professionals and work in the area, whether that be as a psychologist or social worker. However they find that after their studies if they want to return to the area there is unfortunately no funding for jobs.

In addition, more access to services and professionals would help to break down stigma and encourage people to reach out when they need support.

> I want our communities to get to a point where it is normal to talk about mental health and where we are all comfortable with it.

Source: *Witness Statement of Jennifer Rowan*, 22 April 2020.

> Living in a rural town, we have very limited health services and we experience long wait times for services. With a small number of psychologists in our area, they are inundated with work.

Jennifer Rowan

24.7 The future system: building on the strengths and resilience of rural and regional communities

The Commission's vision is for a mental health and wellbeing system that adapts and responds to the needs of all Victorians. This includes supporting people in rural and regional Victoria with improved access to high-quality services.

Despite the barriers they face in accessing services, the strengths and resilience of rural and regional communities provide a solid foundation for building supports for mental health and wellbeing into the future.

The sense of community spirit and social connectedness in these communities can have a positive impact on the mental health and wellbeing of people.[312]

During community consultations, the Commission heard how volunteers had established local support groups to help each other through difficult times.[313]

Neighbourhood Houses[314] and Men's Sheds[315] have been described as safe and inclusive spaces that support wellbeing and social connection:

> One of the greatest preventative tools introduced is the development of Men's Sheds. These facilities have provided a great sense of belonging and camaraderie to a vulnerable sector of the community.[316]

Local services in rural and regional areas have said that place-based care is essential and achievable.[317] Many mental health service providers have found flexible and creative ways to use limited resources and deliver care.[318] Some tertiary providers are innovating and partnering with others to provide holistic, preventive treatment and care, based in the community.[319] Other initiatives embed mental health treatment, care and support in local primary health settings, such as GPs and dental services.[320]

Ms Medson said that Gippsland Lakes Complete Health has started training programs in drought-affected areas called The Accidental Counsellor 'to provide community members with some skills to listen to their friends and colleagues and make suggestions about seeking further help'.[321] Ms Medson also highlighted the value of community-initiated activities, such as 'bring a plate' dinners that provided social connection and support to people in Sarsfield who lost their homes to bushfires. She said that 'the initiative came from people within the community and that's what works best, not an organisation bringing in a solution'.[322]

This sentiment was shared by a person attending community consultations in Shepparton:

> Relationships and partnerships are the key to embedding service delivery. Community has a role to play. This conversation shouldn't just be about what services can do but what the community can do.[323]

A number of the Commission's recommendations aim to address the barriers faced by rural and regional communities in accessing services and supports. The future integrated mental health and wellbeing system is designed to respond to the specific needs of rural and regional communities in a variety of ways.

24.7.1 Building blocks in the Commission's recommendations

The new integrated mental health and wellbeing system will offer accessible, high-quality treatment, care and support to individuals living in rural and regional Victoria, along with their families, carers and supporters. As stated in Chapter 1: *The reform landscape,* localised community care will be a central feature of the future system. There are several ways in which this will be achieved. The Commission's reforms will support rural and regional communities to have better access to specialist and cohort-specific treatment, care and support closer to home. Overall, a more integrated, networked approach to service delivery will ensure better connections and continuity of care across primary, secondary and specialist mental health and wellbeing services.

Many reforms recommended by the Commission are designed to improve treatment, care and support for all Victorians across the state. A number will have particular benefits for rural and regional communities. Some of the most significant are summarised in Table 24.1.

Table 24.1: The Commission's recommendations with particular benefits for regional and rural communities

Relevant reforms	Benefits for regional and rural communities
Chapter 5: *A responsive and integrated system*	Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services will each tailor the services they deliver to the needs and context of their communities. New Regional Mental Health and Wellbeing Boards will assess the need for mental health and wellbeing services across their populations, and develop and publish plans—unique to each region—to support service providers to respond to their communities' needs.
Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*	Funded 'community collectives' for mental health and wellbeing in each local government area will support local communities to promote social connection and inclusion and connect people to community initiatives that will support their wellbeing. More evidence-informed initiatives and programs will be available to all schools to support student's mental health and wellbeing. Schools in rural and regional areas will be given priority under new funding arrangements to select the most appropriate suite of initiatives for them.
Chapter 12: *Supporting perinatal, infant, child and family mental health and wellbeing*	One of the two new statewide subacute residential family admission centres will be located in regional Victoria. These centres will provide five-day admissions in an intensive therapeutic environment for families with a child aged 0–11 years who is experiencing major behavioural, emotional and relationship difficulties.
Chapter 14: *Supporting the mental health and wellbeing of older people*	Older people in regional and rural communities will receive more support from services located in regional centres through home visits, clinic visits and telehealth. Appropriate referral pathways and community supports will be based on each person's location and ease of access to services.

Relevant reforms	Benefits for regional and rural communities
Chapter 15: *Responding to trauma*	Regional and rural communities will benefit from mental health services trained in trauma-informed care. Mental health professionals working in these settings will receive additional training and support, including digital access to trauma specialist expertise, secondary consultation and peer workers.
Chapter 17: *Collaboration for suicide prevention and response*	The Commission recommends a range of steps to build on its interim report recommendation 3 on suicide prevention and response. Local communities will receive free, online evidence-informed 'community gatekeeper training' for Victorians to develop suicide awareness and prevention skills. A community grants program will support suicide prevention activities that are tailored and responsive to local needs. There will be a particular focus on enabling culturally safe 'community gatekeeper training' for Aboriginal people, and co-producing an aftercare service for LGBTIQ+ people following a suicide attempt. Rural and regional high-risk Victorian industries, such as farming, will receive support to invest in workplace suicide prevention and response programs.
Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*	A new consumer-led agency, and the new Mental Health and Wellbeing Commission, will use digital capabilities and offer online resources, information and supports to consumers in regional and rural Victoria. The agency will have a virtual platform to ensure consumers living in rural and regional Victoria can find vital resources and supports in one place. It will be easier for people with lived experience of mental illness or psychological distress living across Victoria to: • have their perspectives and experiences heard • participate in developing and delivering mental health and wellbeing services • access resources and supports, including peer networks.
Chapter 19: *Valuing and supporting families, carers and supporters*	Families, carers and supporters who are more distant from services will feel more valued and supported in their roles. They will also have better access to appropriate information to help them care for their loved ones. New family and carer-led centres (with physical and online access) will provide tailored information about the supports, services and referral pathways available in their region. Young carers in rural and regional areas will receive targeted support through new co-designed programs, with consideration of diverse needs for Aboriginal communities, culturally diverse communities, and LGBTIQ+ communities.
Chapter 20: *Supporting Aboriginal social and emotional wellbeing*	Building on the interim report's recommendation 4 which supports Aboriginal social and emotional wellbeing, additional funding will be allocated to support culturally appropriate, family-oriented, therapeutic care. This includes a service for infants and children who require intensive social and emotional wellbeing supports.
Chapter 21: *Responding to the mental health and wellbeing needs of a diverse population*	People from diverse communities will be able to access better mental health information. Victorians in regional and rural communities, regardless of first or preferred language, hearing, literacy or neurocognitive ability, will have access to appropriate mental health information and means of communication. Digital technologies will support the delivery of accessible, confidential, timely and user-centric language service delivery for all communities. Local communities will receive support to navigate the mental health and wellbeing system.

Relevant reforms	Benefits for regional and rural communities
Chapter 22: *Integrated approach to treatment, care and support for people living with mental illness and substance use or addiction*	Emergency and crisis services suitable for mental health and alcohol and other drug treatment will be accessible in every region. In addition, all mental health and wellbeing services, including community-based services, will ensure that consumers in rural and regional communities living with mental illness and substance use or addiction can access integrated treatment, care and support. A new statewide specialist service will support education and training initiatives for a broad range of practitioners and clinicians, and provide secondary consultation to mental health and wellbeing and alcohol and other drug practitioners.

Collectively, the Commission's recommendations will deliver an integrated mental health and wellbeing system that responds to the needs of all Victorians, and will have particular benefits for communities that currently face barriers to access. In addition, the Commission recommends new approaches to funding, implementing digital reforms, and attracting workers to target the specific needs of rural and regional communities.

24.7.2 Funding regional services to support rural communities

The Commission's recommendations will achieve a networked approach to service delivery in rural and regional areas, supporting effective collaboration and coordination between services, and allocating funding that recognises the costs of delivering high-quality services in rural and regional areas.

In the future mental health and wellbeing system, services will function in a more integrated way. Promisingly, many models that support remote service delivery from regional and/or metropolitan centres already exist in health services. The Commission's recommendations are designed to support this networked approach, to ensure all Victorians can receive high-quality and innovative treatment, care and support.

Statewide services and Area Mental Health and Wellbeing Services will provide more inreach support (including primary and secondary consultation) and consultation–liaison support to Local Mental Health and Wellbeing Services. In rural and regional Victoria, this model will mean that Area Mental Health and Wellbeing Services located in regional centres, in conjunction with statewide services, will provide inreach support to more geographically isolated or small rural communities This includes providing services through small rural health services, community health services and bush nursing hospitals. Inreach support will be provided to rural and regional services via digital modes of service delivery, providing consumers with greater access and choice over the treatment, care and support they seek.

The Department of Health will also ensure that funding allocations capture the additional costs associated with:

- services located in regional centres providing inreach and primary consultation to rural communities face-to-face and through digital technologies
- adequate resourcing and sustainable ways of working for staff providing inreach support
- attracting and retaining visiting specialist professionals from metropolitan areas to provide sessional services to rural and regional communities

Building on these reforms, the Commission has also recommended a more regional approach to commissioning mental health and wellbeing services in Chapter 5: *A responsive and integrated system*. The establishment of eight Regional Mental Health and Wellbeing Boards will support funding decisions to occur close to communities, informed by the specific needs and preferences of individuals in each region, including in rural and regional communities.

The implementation of activity-based funding,[324] recommended in Chapter 28: *Commissioning for responsive services*, will help redress the inequitable distribution of resources by allocating funding based on each individual consumer's needs and preferences. Similarly, the implementation of more flexible funding approaches, including block funding[325] for smaller providers and capitation funding,[326] will support providers to respond to the unique needs of their communities.

The Department of Health will also recognise the additional costs of delivering services in rural and regional areas by providing additional funding for rural and regional services. One way this can be achieved is by providing additional funding, through a 'loading' or 'adjustment', to the activity-based funding price paid for consumers living in rural and regional areas.

The use of funding loadings, or top-up payments, is consistent with other approaches that recognise additional costs in activity-based funding models. For example, the Independent Hospital Pricing Authority acknowledges additional costs of regional and rural service provision in the national activity-based funding model by providing additional funding for services provided to people living in rural and regional areas.[327]

Similarly, the Department of Health recognises the additional costs of delivering other health services to Aboriginal people, by applying a 30 per cent loading to the price it pays to health services.[328]

These reforms will help ensure that people living in rural and regional areas can access the mental health and wellbeing services they need, when and where it would make the most difference to them. Rural and regional service providers will be encouraged to work together in partnership, with appropriate resources to respond to the unique needs and preferences of their communities.

24.7.3 Accelerated digital service delivery and innovation

Given the potential benefits of technologies to improve access to services, rural and regional communities need support to quickly adopt and grow digital service offerings.

In Chapter 34: *Integrating digital technology,* the Commission recommends creating a digitally-integrated mental health and wellbeing system. This includes new minimum digital service requirements for publicly funded mental health and wellbeing service providers; new funding and regulatory settings to support the adoption of new technologies; and support for consumers to increase their access to devices and data, and improve their digital literacy, where needed. The Commission believes that these statewide reforms will improve all consumers' access to digitally integrated services, regardless of where they live, and in line with their preferences.

All public mental health and wellbeing services need support to build their digital capacity, but challenges in accessing services and expertise in rural and regional Victoria mean that digital service delivery is particularly important in these communities. This need, coupled with the technological challenges and limitations identified, has led the Commission to conclude that the rollout of the proposed digital reforms should start in rural and regional Victoria.

The Department of Health should work with interim regional bodies (or Regional Mental Health and Wellbeing Boards once established) to select two trial sites for digital investment and innovation in rural and regional Victoria in the first two years of reform.

To do this, the department should:

- select the appropriate trial sites in line with the recommended criteria below
- provide selected sites with digital capability funding to support them to work with Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services to build digital capacity and innovation.

The Commission recommends that the department selects two trial sites that have the baseline capacity and resourcing to immediately begin implementing the proposed recommendations. Therefore, they should have:

- a reasonable level of ICT infrastructure already in place to deliver digital services
- staffing capacity and digital literacy skills to realise innovations quickly
- fairly well established Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services that can participate in the partnership.

In addition to the capability funding, the trial sites should be provided with support and funding to ensure they are properly resourced to deliver the reforms, without creating additional burden, and to support timely implementation. This may include funding for administrative staff, or in-kind support. The department should work with each trial site to determine the support required.

The Commission understands that people do not necessarily want digital technology to replace face-to-face care. Technology should augment and improve usage of services and supports, but it should not be the sole solution to the challenges that rural and regional communities face in accessing services and expertise.

Implementation approach in the two trial sites

Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and community members are best placed to identify their specific service needs, the ICT infrastructure required to meet them, and to develop new digital services that deliver on these requirements. However, a coordinated approach needs to be taken to ensure that investment is optimised, and there is consistency in digital service offerings across the region, and the state more broadly.

Each trial site should work with their Local Mental Health and Wellbeing Service and Area Mental Health and Wellbeing Service, community members and consumers and academic leaders to determine priority areas for capability fund investment and innovation. Together, they should:

- complete a digital maturity assessment—with support from the Department of Health—to identify current digital service gaps, ICT infrastructure needs and areas for priority investment
- develop a comprehensive implementation plan that sets out digital opportunities, the planned investment and implementation pathway to realise these opportunities, and targets and metrics to track implementation progress and the service delivery outcomes. The plan should consider:
  - how to support regional centres to provide more inreach and primary consultation to rural communities
  - the needs of local communities (for example, bushfire trauma and recovery mental health programs) or diverse groups (such as rural and regional Aboriginal communities, LGBTIQ+ communities, and refugee and asylum seeker communities) that could be addressed through innovative digital programs.
- administer the digital capability funding to deliver the plan
- monitor progress of the plan, including regular updates to the department
- work with the department to evaluate the effectiveness of new digital innovations, with a view to extending promising innovations more widely across the state.

Urgent upgrades to digital infrastructure

Trial sites should ensure that investment prioritises upgrades to service providers' digital infrastructure, so they can implement the new digital service requirements outlined in Chapter 34: *Integrating digital technology*. This will also ensure that regional services have the foundational infrastructure needed to establish and deliver other innovative digital mental health and wellbeing services in the future.

The investment must also address the current connectivity or privacy challenges that some rural and regional Victorians experience when trying to use telehealth services. All Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services should have the technology and infrastructure necessary to offer telehealth and digital service facilities for consumers who wish to use them. This includes people who are unable or do not wish to do so at home, due to internet connectivity or privacy concerns. The facilities should be therapeutic and give people privacy. New digital support packages recommended in Chapter 34 will also help consumers to access digital services from home if they wish, where they do not have access to appropriate devices or data.

As stated in Chapter 34, the Department of Health should work closely with each trial site to ensure that new digital infrastructure, services and innovations align with minimum digital requirements, and there is a level of consistency in the products and offerings. This will ensure that consumers can access the same level of treatment, care and support, regardless of their location, and that investment is scalable.

The approach to the statewide rollout of Orygen's Moderated Online Social Therapy (MOST) digital program across all state-funded child and adolescent youth mental health services and headspace is one model that could be considered.[329]

Collaboration to deliver innovative digital delivery programs

The upgrades to service provider ICT infrastructure will support the delivery of digital service offerings. They also provide the opportunity to establish, test and grow digital innovation.

Trial sites should support service providers, consumers and innovators to design, develop and trial new digital programs and innovations designed to directly address the needs of the local community.

In Chapter 36: *Research, innovation and system learning*, the Commission recommends giving more support to Regional Mental Health and Wellbeing Boards and local services for innovation. Networks of clinical academic experts, innovators and lived experience experts will provide expertise, support and resources to develop and test new ideas, and translate promising approaches into practice. The Department of Health will be responsible for evaluating their effectiveness and enabling rapid uptake of effective approaches, so that they are widely available across Victoria, including to consumers in rural and regional areas.

24.7.4 Attracting and retaining mental health workers

There are many complex barriers to ensuring adequate supply of the mental health workforce across rural and regional areas of Victoria.[330] The Commission's recommended approach to workforce planning, as outlined in Chapter 33: *A sustainable workforce for the future,* will introduce measures to attract, support and retain workers where they are needed most. Having diverse professional expertise available to meet the needs of all Victorians, regardless of where they live, will be essential to realising the Commission's vision.[331]

As discussed in Chapter 33, the Victorian Government does not hold all the levers that influence workforce supply, distribution, retention or experience in rural and regional Victoria. To create sustainable workforce reforms, the Department of Health will need to work with many stakeholders to ensure the mental health and wellbeing system supports development of a sufficiently diverse and skilled workforce in rural and regional areas. Collaborative activities and targeted partnerships are needed with many parties including the Commonwealth Government, professional regulatory and representative bodies, and education and training providers, as well as services and other stakeholders across Victoria.

Regional Mental Health and Wellbeing Boards will help coordinate regional workforce planning to ensure a suitably diverse workforce that is reflective of the communities they serve. Workforce planning must consider population needs and how to distribute skills and expertise equitably across the region. Priority should be given to initiatives to attract, recruit and retain specialist capability in responding to consumers with the highest intensity support needs.

In Chapter 33, the Commission considers challenges of workforce supply and demand that persist, despite reform efforts at a state and national level over several decades. Many approaches have been tried to improve workforce distribution, and the Productivity Commission did not identify in its *Mental Health Inquiry Report* 'severe drawbacks' to the wide array of initiatives.[332] This suggests there is no clear solution, but that a range of different strategies can be beneficial.

It is the Commission's view that concrete, multifaceted and complementary incentives are necessary to attract and retain a mental health workforce with the capabilities and expertise to meet the needs of communities in rural and regional areas.

A new Mental Health Workforce Rural Incentive Scheme

Attracting and retaining healthcare workers in rural and regional areas is a longstanding challenge in Australia and internationally. A wide range of health workforce retention measures and incentives have been employed, ranging from coercive approaches—such as restricting the location of practice, or making a period of rural service a requirement of professional registration—through to rewards for extended periods of service in rural and regional communities.[333]

The World Health Organization has examined interventions that have been used around the world to reduce inequitable workforce distribution. It identified a diverse range of approaches that use workforce education, regulation, financial incentives, and personal and professional supports.[334]

Examples of evidence-based interventions include:

1. pre-vocational education interventions, such as: prioritising rural and regional students for tertiary places;[335] tertiary education and training located in rural and regional settings;[336] bursaries and scholarships;[337] rurally-oriented theoretical content of training curriculum;[338] clinical placement or rotations in a rural setting;[339] supported postgraduate pathways with flexible entry and exit points;[340] and bonding schemes (providing financial study support linked to agreement to work in rural settings)[341]
2. post-vocational education interventions, such as: training and research fellowship programs;[342] salary loadings, salary packaging or paying a 'rural allowance';[343]and specific retention bonuses based on length of stay[344]
3. personal and professional supports, such as: providing, clear supported career pathways;[345] supporting continuing professional development;[346] providing regular specialist outreach services;[347] providing periods of time-off relief (weekends/holidays/sabbaticals);[348] and addressing family and lifestyle issues (providing flexible working schedules, child-minding services, subsidised schooling, accommodation, or access to recreational facilities).[349]

While state and federal governments have trialled attraction and retention interventions across these domains, most programs have focused on leveraging regulatory requirements and financial incentives. For example, under the Commonwealth's *Stronger Rural Health Strategy*, newly arrived overseas-trained medical practitioners are required to work up to 10 years in under-served regional or rural communities for professional registration and eligibility to bill Medicare.[350]

International recruits account for a higher proportion of GPs in regional and remote Australia.[351] However, the Productivity Commission concluded that expansion of this type of intervention has substantial limitations:

> Expanding [international recruitment] much further is difficult because additional supervision and support is often needed to assist overseas-trained medical practitioners to align with Australian clinical practices and understand the local culture of the people they are there to help.[352]

Financial incentives can be an important component of effective schemes. Remuneration has been rated by some health professions as the most important intervention to motivate attraction and retention in those areas.[353] The Australian National Audit Office assessed such incentives as important to the viability of regional and remote health practice in Australia.[354]

The Productivity Commission concluded that offering higher levels of remuneration is likely to be an effective way to attract healthcare professionals to work outside metropolitan areas:

> State and Territory Governments also have a financial lever through their funding of positions for health workers in public sector providers ... the Productivity Commission has recommended an expansion of services to fill major gaps in available care, which would require public sector providers to hire more health professionals outside major cities. If the funding flows, it is likely that—with the existing incentives and other initiatives—the workforces would respond.[355]

A number of financial incentive programs have been successful. A New South Wales bonding scheme for postgraduate medical students showed an increase in the proportion of workers who remained working in rural areas.[356] Another Australian program increased retention rates of long-serving rural doctors by 86 per cent.[357]

The Commonwealth's Stronger Rural Health Strategy includes a range of incentives, targeted funding and bonding arrangements for doctors, nurses and allied health professionals in rural and remote communities across Australia.[358] The *Workforce Incentive Program* provides financial incentives to support general practices to engage the services of nurses, Aboriginal health practitioners and health workers, in addition to eligible allied health professionals.[359]

Other federal funding initiatives include the *Rural Health Outreach Fund*, to improve access to medical specialists, GPs, allied and other health professionals in rural, regional and remote areas of Australia. Delivery of mental health services is one of four priorities of the program, with funding distributed through state and territory agencies.[360]

Internationally, evaluations of the effectiveness of financial incentive programs are mixed. One systematic review indicated that the majority of programs were associated with increased uptake of rural jobs, but this was not universal.[361] Another found substantial evidence for the effectiveness of financial incentive programs for workforce attraction to rural areas, but more limited impact on long-term retention.[362] The Productivity Commission concluded that while there is little rigorous evaluation, payments in some programs are sufficiently large that 'it would be surprising if they did not have some impact'.[363]

Beyond financial incentives

The most effective incentive schemes take a multifaceted approach to both attraction and retention of practitioners over the long term, particularly for specialist practitioners. As one systematic review concluded, 'multidimensional programs appeared to be more successful than those relying on financial incentives alone'.[364]

In particular, the Productivity Commission reported 'evidence that health professionals are more likely to work in regional and remote locations if they did their training there, or had resided there prior to training elsewhere'.[365]

In 2018–19, the Commonwealth Government invested $95.4 million over four years to set up the Murray–Darling Medical Schools Network, as part of the 'train in the regions, stay in the regions' program under the *Stronger Rural Health Strategy*.[366] The Network consists of five rurally based school programs in the Murray–Darling region of New South Wales and Victoria (including Monash University in Bendigo and Mildura, and the University of Melbourne in Shepparton). The first students commenced their training in 2019.[367] Since 2019, La Trobe University has been funded under the Rural Health Multidisciplinary Training Program 'to establish a new University Department of Rural Health to increase clinical training opportunities for nursing and allied health students in rural Victoria'.[368]

After initial training, strategies are needed to create conditions for, and access to, continued professional development. This could involve tailored mentoring and professional development activities. For example, in Queensland, a continuing professional development program for medical doctors (consisting of tailored continuing education workshops with subsidised travel and accommodation costs, locum support and/or locum rebates) had a positive impact on doctors' confidence in practising in rural and remote locations and the alleviation of professional isolation, as well as on their intention to remain working in rural and remote areas.[369]

One longitudinal study of the Dr DOC (Duty of Care) program that provides social and psychological support and practical interventions for rural GPs found that it helped to reduce intentions to leave rural practice, decrease work-related low morale and distress, and significantly improve doctors' perceived quality of work life, personal mental health and wellbeing.[370]

A retrospective review published in 2019 considered Australia's heavy reliance on overseas medical practitioners in rural communities, and noted the importance of planning and providing access to professional development and career supports in these localities:

> Increasing the locally trained generalist rural workforce requires sustained policies, enrolling rural-origin students into medicine, providing ongoing rural training opportunities, promoting generalist medical careers and building sustainable rural working conditions.[371]

The evidence indicates that 'bundled' incentive programs that package financial, accommodation, educational and family-related incentives together are most likely to be effective in retaining practitioners in rural and regional areas.[372] Combining financial incentives with personal and professional supports—such as accommodation costs, leave and improved working conditions—over the medium-long term appear to be most impactful.[373]

The Commonwealth Rural Health Outreach Fund comprises both targeted financial incentives and professional supports. Delivery of mental health services is one of four priorities of the program, with funding distributed through state and territory agencies.[374]

The Health Workforce Scholarship Program provides funding for postgraduate studies for health professionals (including doctors, nurses and allied health professionals) working in rural and remote areas. The program is delivered through state and territory rural workforce agencies.[375]

Professional and representative bodies made a range of proposals to the Commission about improving workforce attraction and retention, particularly in rural and regional areas (refer to Box 24.3). The Australian Psychological Society told the Commission that programs that provide incentives for mental health workers to live in rural and remote locations would address some access inequity issues.[376] It recommended 'developing a well-supported rural pipeline to support rural students through their psychology training'.[377]

Box 24.3: Examples of attraction and retention incentives proposed by professional and representative bodies

The Australian Services Union reported that members sought greater investment in job security and more attractive salaries for mental health workers.[378] The Health and Community Services Union submitted that workforce supply strategies must consider pay and conditions, and that specific financial incentives must be designed to attract mental health workers to rural and regional Victoria.[379]

The Royal College of General Practitioners suggested providing GPs with incentives, and access to ongoing and advanced mental health training and education, that mitigate the deterrents of financial cost and time away from practice.[380]

The Australian Nursing and Midwifery Federation (Victoria) called for funding of incentives to recruit mental health nurses, nurse practitioners and nurse navigators to rural and regional general practice and community-based programs, and for mental health–specific continuing professional development of nurses and midwives practicing in mental health in rural and regional areas.[381]

The Australian Psychological Society proposed the implementation of a rural pipeline approach 'that includes mandated places for rural students in psychology programs, funded rural placements, scholarships, supported rural internships and registrar opportunities'.[382] It also recommended 'Higher Education Contribution Scheme exemptions for rural and remote practice, implementing financial incentives for rural psychologists who work under Medicare'[383] and implementing incentive packages to attract psychologists to rural and remote schools.[384]

Multiple research reviews emphasise the need for meeting personal and family needs, as part of a 'bundled package' of incentives. One review of international literature concluded:

> As professional and personal needs change over time, other interventions are needed to support the remote practitioner, such as ensuring that financial incentives, including salary loadings or retention bonuses, are commensurate with the job. However, these are insufficient on their own and need to be part of a customised bundle of incentives that might include a retention bonus, continuing professional development opportunities, 'time out', psychological support and/or family support, such as educational cost support for children.[385]

The Commission recommends that the Department of Health develop a Mental Health Workforce Rural Incentive Scheme. The scheme design should take account of the future role of Regional Mental Health and Wellbeing Boards and be undertaken in consultation with the Commonwealth, relevant professional and workforce bodies, regulators, unions and industrial bodies, and other stakeholders.

The Mental Health Workforce Rural Incentive Scheme should focus on existing and emerging workforce supply gaps for clinical, therapeutic and specialised practitioners in rural and regional settings. It should initially target workers with advanced skills in working with people living with the highest intensity support needs as an urgent priority. On an ongoing basis, it should take both a strategic view and respond to local requirements. This must include the workforce needs of all publicly funded mental health and wellbeing services, including those operated by non-government organisations.

The department could consider the value of local training and career opportunities to attract motivated workers, and encourage their commitment to rural and regional settings. Attracting and developing people with skills in clinical and professional practice leadership will be important for providing supervision and support. Particular skills and expertise to be targeted in priority recruitment initiatives are discussed further in Chapter 33: *A sustainable workforce for the future*.

Mental health practitioners at all levels can play important leadership roles, working across disciplines and service functions, to foster cultures of continuous learning and development of professional practice and service delivery, both within and across services. The Mental Health Workforce Rural Incentive Scheme could seek to attract, develop and reward experienced professionals with the skills to lead interprofessional reflective practice and professional practice development activities.

Wherever possible, attraction initiatives should support professional and peer networks within and between services, or through close linkages to regional centres providing inreach supports to rural communities. Clustering positions could mitigate risks of professional isolation, and be a valuable step in developing a specialist mental health workforce in rural and regional settings. Combating professional isolation by reimbursing the cost of travel to training locations and meeting with peers, is a related component of many other state and federal schemes.[386]

In addition to providing professional pathways, the Victorian Government may wish to consider embedding the use of financial and professional incentives into the scheme.

These could include:

- salary loadings, with additional loading for length of stay
- accelerated career advancement opportunities
- access to additional continuing professional development leave, including the costs of travel to attend professional development programs
- access to research grants and projects focused on responding to local needs and priorities, offered in partnership with regional educational institutions
- access to specialist communities of practice and peer professional support networks.

Incentives should be designed to attract existing, highly experienced and highly trained mental health professionals to fill existing gaps in rural and regional areas, as well as suitable graduates. They should support pathways for more people to work in mental health and wellbeing services—both people already based in rural and regional areas (for example, those working in private practice), and others who may be thinking about moving there. These incentives might include training, professional development and career change supports.

Broader attraction and retention initiatives

The Mental Health Workforce Rural Incentive Scheme will complement a range of other workforce development measures recommended by the Commission to build the future workforce across the state, including in rural and regional areas. While the main focus should be on building and sustaining a workforce in rural and regional areas, additional measures to supplement this workforce should also be pursued by the Department of Health, in collaboration with Regional Mental Health and Wellbeing Boards and services.

As identified above, regional areas may continue to see increasing levels of post-COVID-19-pandemic migration from metropolitan Melbourne. This presents an opportunity to pursue community-level strategies to make rural regions a destination of choice.

The Grattan Institute estimates that about a quarter of jobs in the healthcare and social assistance industry are at risk as a result of the COVID-19 pandemic.[387] People in the hospitality industry will be affected the most.[388] The Grattan Institute advises that government policies in areas such as workforce participation can help create preconditions for sustained economic growth.[389]

There may be opportunities to access funding and short-term initiatives to build a more diverse mental health and wellbeing workforce, attracting people who are choosing to move to regional areas. This may include jobseekers with experience in people-facing industries who could be re-trained to undertake existing or new roles—such as wellbeing supports or other roles providing holistic care, and supporting people to access and navigate the system.

Workforce attraction strategies could include campaigns and initiatives designed to attract target workforces to a new lifestyle that fulfils people's growing needs for greater work–life balance and more connection with nature—that is, the desire for a 'tree or sea change'. The Department of Health should consider such initiatives in collaboration with Regional Mental Health and Wellbeing Boards and location-based campaign experts such as Visit Victoria.

In relation to its own recommendations for service expansion in its *Mental Health Inquiry Report*, the Productivity Commission observed that this 'would require public sector providers to hire more health professionals outside major cities. If [government stimulus funding] flows, it is likely that — with the existing incentives and other initiatives — the workforces would respond'.[390]

Research consistently indicates that health professionals who undertook their tertiary education and training in rural and regional locations, or lived there prior to training elsewhere, are more likely to work in rural and regional locations and remain there over the long term.[391]

The Commission considers that exploring opportunities to increase tertiary training locations in rural and regional Victoria, and prioritising students from rural and regional backgrounds for tertiary entry, are both evidence-based strategies to progressively grow workforce capacity and retention in these settings.[392] Early career rotations and rurally oriented educational curricula—such as those implemented in various jurisdictions for teachers, doctors and police—may also grow interest in rural and regional practice.[393]

In Chapter 33: *A sustainable workforce for the future*, the Commission observes that opportunities exist for national collaboration with the Commonwealth and professional bodies in relation to training approaches. The national Specialist Training Program provides vocational training for specialist registrars in settings outside metropolitan teaching hospitals, including regional, rural and remote, and private health services. The program 'aims to improve the quality of the future specialist workforce by providing registrars with exposure to a broader range of healthcare settings'.[394] The Specialist Training Program also 'aims to have a positive influence on future workforce distribution'.[395]

Partnerships between service providers and education institutions should also be actively encouraged to support rotations and placements in rural areas. A new research initiative between Barwon Health and Deakin University called Change to Improve Mental Health Centre of Excellence (CHIME) demonstrates how partnerships can support workforce retention and peer support, as well as support service improvement and innovation (Box 24.4)

The Commission also considers that Project Echo, a digitally enabled support network developed by Dr Ravi Bhat and colleagues and described in Chapter 7: *Integrated treatment, care and support in the community for adults and older adults* provides an exemplary model for how linkages between small rural hospitals and larger regional centres can support regionally based training. It also enables collaborative learning and peer support to people working in professionally isolated contexts.

> It's a highly structured way of learning, and everyone learns, everyone teaches, and that's the motto of the program. So, if you layered a clinical service degree with an educational model, you are much more likely to get synergies ... for capacity building, for fine-tuning the service so that at least people then don't have to travel all the way from, say, Broadford or Wallan to Shepparton, they could go to Kilmore or the nearest smaller rural hospital and have that linkage.[396]

Dr Bhat said the model proves it is possible to provide an environment and training programs in rural settings that are attractive to clinicians such as psychiatrists.[397]

These are currently isolated examples, and the Commission considers there would be great benefit in replicating this kind of approach in a systematic way, to support more widespread collaboration between services across the state.

Box 24.4: Change to Improve Mental Health Centre of Excellence (CHIME)

As described in Chapter 36: *Research, innovation and system learning*, Barwon Health has established a research partnership with Deakin University called CHIME (Change to Improve Mental Health Centre of Excellence) that uses the deep community connections of both organisations to improve access, services and outcomes for rural and regional consumers and carers in the Barwon area.

Initial areas of research for CHIME include better understanding risk factors for poor mental health for youth in the region, and evaluation of mental health telehealth services in response to the COVID-19 pandemic. Barwon Health plans to work with IMPACT (Deakin's Institute for Mental and Physical Health and Clinical Translation) to expand opportunities for consumers and carers across the region to participate in mental health clinical trials and enhance the Barwon community's access to world-leading treatment, care and support.

Associate Professor Steven Moylan, Clinical Director for the Mental Health, Drugs and Alcohol Services at Barwon Health explained:

> Our ultimate goal is to develop a service system that helps consumers feel better … the partnership will ensure consumers and carers across the Barwon area are able to both shape and access evidence-based and contemporary treatment and care. It will drive transformation in mental health services in regional Victoria.

A key goal of the CHIME partnership is to create opportunities for people working in service settings across the region to engage in research and evidence-based policy and practice. These opportunities are intended to enhance attraction and retention of clinicians and clinician-researchers into rural and regional service settings. Barwon Health anticipates that this will also enable more rapid implementation of best evidence-based practice across the region's health providers.

First steps to achieve this include the development of a flexible program of clinical research fellowships and research higher-degree scholarships for clinicians. CHIME will provide opportunities for clinicians at Barwon Health to undertake research or research training at Masters and PhD levels, while maintaining clinical experience and service delivery in rural and regional settings.

Source: RCVMHS, Informal discussions with Barwon Health; Barwon Health, CHIME (Change to Improve Mental Health Centre of Excellence), <www.barwonhealth.org.au/research/our-research/item/chime-change-to-improve-mental-health-centre-of-excellence>, [accessed 15 December 2020].

Dedicated resources could be provided to implement retraining and other pathway support programs to attract people to new mental health and wellbeing workforce roles. Such initiatives—developed through partnerships with Regional Mental Health and Wellbeing Boards, Working for Victoria, Local Mental Health and Wellbeing Services, Area Mental Health and Wellbeing Services and local education providers—should focus on new roles and existing workforce shortages. Priorities could include wellbeing support roles and, where required, clerical staff to relieve administration pressures for people engaged in delivering treatment, care and support.

It is the Commission's view that stronger partnerships with private providers could increase specialist supports Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services in rural and regional Victoria. The Commission understands there may be capacity in some specialist private psychology and psychiatric practices in metropolitan areas that, enabled through telehealth, could be used to increase sessional inreach support to rural and regional services.[398]

Regional Mental Health and Wellbeing Boards could trial incentives that encourage specialist private practitioners based in metropolitan areas to deliver inreach face-to-face and telehealth psychology and psychiatric services to rural and regional consumers of Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services.

In collaboration with the Collaborative Centre for Mental Health and Wellbeing, Regional Mental Health and Wellbeing Boards, Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services could use digital technology to create support networks for Mental Health Workforce Rural Incentive Scheme participants. Drawing on models such as Project Echo, online networks can be used to provide access to specialist communities of practice and peer professional support networks for participants in the scheme, and to help develop specialist capabilities in smaller service settings.

Workforce wellbeing and professional practice initiatives should be a strong focus of attraction and retention strategies. These supports are critical to sustain a workforce, including volunteers, in rural and regional settings. The expansion of senior educator positions across lived experience, clinical and allied health professions should strengthen regionally based training and professional development across services, as well as providing local, tailored programs to meet community needs.

Together, these targeted measures—new approaches to funding rural and regionally based Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services, using the full potential of digital technology, and building a supported and sustainable workforce—will ensure Victorians in rural and regional communities can more fully enjoy the benefits of the Commission's reforms; that is, they can access high-quality services in an integrated and responsive mental health and wellbeing system.

1 Royal Commission into Victoria's Mental Health System, *Interim Report*.

2 *Evidence of Dr Ravi Bhat*, 15 July 2019, p. 979.

3 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*, 2020; South West Healthcare, *Submission to the RCVMHS: SUB.0002.0029.0138*, 2019, p. 17.

4 K Bourne and others, *The Big Movers: Understanding Population Mobility in Regional Australia*, 2020, p. 2.

5 ABC News, Could Coronavirus Have a Silver Lining for Regional Housing Markets as People Flee to the Country?, 26 August 2020, <www.abc.net.au/news/2020-08-26/regional-city-property-markets-covid-urban-tree-changer/12541598>, [accessed 3 December 2020].

6 Australian Bureau of Statistics, 1270.0.55.005 Australian Statistical Geography Standard (ASGS), Volume 5: Remoteness Structure: Overview, *Statistical Geography Standard (ASGS): Volume 5—Remoteness Structure, July 2016,* <www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/1270.0.55.005Main+Features1July%202016?OpenDocument>, [accessed 10 October 2019].

7 *Evidence of Associate Professor Steven Moylan*, 24 June 2020, p. 17.

8 The Australian Bureau of Statistics categorises Australia into five areas of remoteness: (1) Major cities of Australia; (2) Inner Regional Australia; (3) Outer Regional Australia; (4) Remote Australia; and (5) Very Remote Australia. The remoteness of areas is based on measurement of a road distance from a point to the nearest urban centres and localities in five separate population ranges. According to the Map of 2016 Remoteness Areas for Australia, Victoria's level of remoteness is primarily categorised as Inner Regional and Outer Regional, with two Remote areas and no Very Remote areas listed as at 2016. Australian Bureau of Statistics, 1270.0.55.005 Australian Statistical Geography Standard (ASGS), Volume 5: Remoteness Structure: Defining Remoteness Areas, *Australian Statistical Geography Standard (ASGS): Volume 5—Remoteness Structure, July 2016,* <www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/1270.0.55.005Main%20Features15July%202016?opendocument&tabname=Summary&prodno=1270.0.55.005&issue=July%202016&num=&view>, [accessed 10 October 2019].

9 Tracey Varker and others, *What Is the Link Between Trauma and Mental Illness? Report Prepared for the Royal Commission into Victoria's Mental Health System. Phoenix Australia—Centre for Posttraumatic Mental Health: Melbourne*, 2020, p. 27.

10 *Witness Statement of Professor Louise Harms*, 23 May 2020, para. 12.

11 Bourne and others, p. 2.

12 Bourne and others, pp. 12–13.

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

14 Department of Environment, Land, Water and Planning, *Victoria in Future 2016: Population and Household Projections to 2051*, 2016, pp. 6–10; Department of Environment, Land, Water and Planning, *Victoria in Future 2019: Population Projections 2016 to 2056*, p. 9.

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

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

17 Department of Environment, Land, Water and Planning, *Victoria in Future 2016: Population and Household Projections to 2051*, p. 9.

18 Department of Environment, Land, Water and Planning, *Victoria in Future 2019: Population Projections 2016 to 2056*, pp. 13–14.

19 ABC News, Post-COVID-19 Wave of Regional Migration Predicted as People Seek Simpler Life, Get Back to Basics, 10 May 2020, <www.abc.net.au/news/2020-05-10/post-covid-19-pandemic-simpler-life-migration/12229082>, [accessed 3 December 2020].

20 ABC News, Post-COVID-19 Wave of Regional Migration Predicted as People Seek Simpler Life, Get Back to Basics; Bianca Dabu, Will COVID-19 Lead to a Regional Housing Boom?, *Smart Property Investment*, 6 November 2020, <www.smartpropertyinvestment.com.au/research/21868-will-covid-19-lead-to-a-regional-housing-boom>, [accessed 3 December 2020].

21 ABC News, Post-COVID-19 Wave of Regional Migration Predicted as People Seek Simpler Life, Get Back to Basics.

22 Royal Commission into Victoria's Mental Health System, *Interim Report,* pp. 289–308.

23 Victorian Agency for Health Information, *Mental Health and Wellbeing—Victorian Population Health Survey 2017*, 2019, p. 62.

24 Victorian Agency for Health Information, p. 65.

25 South West Healthcare, p. 29; Goulburn Valley Health, *Submission to the RCVMHS: SUB.0002.0029.0213*, 2019, p. 5.

26 Victorian Public Sector Commission, Aboriginal Victoria Today—Aboriginal Cultural Capability Toolkit, <vpsc.vic.gov.au/html-resources/aboriginal-cultural-capability-toolkit/aboriginal-victoria-today/>, [accessed 11 December 2020].

27 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

28 Victorian Auditor-General's Office, *Access to Services for Migrants, Refugees and Asylum Seekers*, 2014, pp. 2–3.

29 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

30 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

DOH.0003.0001.0958

31 Victorian Refugee Health Network, *Submission to the RCVMHS: SUB.0002.0028.0703*, 2019, p. 1.

32 L. J. Kirmayer and others, 'Common Mental Health Problems in Immigrants and Refugees: General Approach in Primary Care', *Canadian Medical Association Journal*, 183.12 (2011), 1–9 (p. 3).

33 Mina Fazel, Jeremy Wheeler and John Danesh, 'Prevalence of Serious Mental Disorder in 7000 Refugees Resettled in Western Countries: A Systematic Review', *The Lancet*, 365 (2005), 1309–1314 (p. 1313).

34 Frances Shawyer and others, 'The Mental Health Status of Refugees and Asylum Seekers Attending a Refugee Health Clinic Including Comparisons with a Matched Sample of Australian-Born Residents', *BMC Psychiatry*, 17.1 (2017), 1–12 (p. 2).

35 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*, 2020.

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

37 Department of Veterans Affairs, *DVA Pensioners and Treatment Card Holders by Local Government Area as at 3 April 2020*, 2020, p. 5.

38 Celia Wilkinson, *Older Australians: Trends and Impacts of Alcohol and Other Drug Use*, 2018, p. 8.

39 Wilkinson, p. 9.

40 Wilkinson, pp. 43–44.

41 The 2017 Victorian Population Health Survey found similar degrees of high to very high levels of psychological distress for adults living in all metropolitan regions and all rural regions—15.2 per cent and 16.3 per cent respectively. Victorian Agency for Health Information, p. 61.

42 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 257.

43 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 257.

44 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 257.

45 headspace, Fact Sheet: Suicide Contagion, 2015, pp. 1–2.

46 Commonwealth Department of Health, Response to Youth Suicide in Greater Geelong, <www1.health.gov.au/internet/publications/publishing.nsf/Content/suicide-prevention-activities-evaluation~Appendices~appendixa~project36>, [accessed 15 December 2020].

47 *Witness Statement of Alan Woodward*, 18 July 2019, para. 24; Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 290.

48 Alison Kennedy and others, 'Suicide and Accidental Death in Australia's Rural Farming Communities: A Review of the Literature', *Rural and Remote Health*, 14.1, 2014, pp. 1–14 (pp. 6–7); *Witness Statement of Dr Alison Kennedy*, 10 July 2019, para. 19.

49 Jessica Collins and others, 'Compositional, Contextual, and Collective Community Factors in Mental Health and Well-Being in Australian Rural Communities', *Qualitative Health Research*, 27.5 (2017), 677–687 (p. 681).

50 Kennedy and others, pp. 7–8; RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

51 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

52 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

53 Victorian Aboriginal Community Services Association Limited, *Submission to the RCVMHS: SUB.0002.0015.0002*, 2019, p. 3.

54 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

55 Department of Health and Human Services, *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017-2027*, 2017, p. 15.

56 Department of Health and Human Services, *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017-2027*, p. 15.

57 Department of Health and Human Services, *Victoria's 10–Year Mental Health Plan: Victorian Suicide Prevention Framework 2016–25*, 2016, p. 2.

58 Department of Health and Human Services, *Victoria's 10–Year Mental Health Plan: Victorian Suicide Prevention Framework 2016–25*, p. 2.

59 Victorian Aboriginal Community Controlled Health Organisation, *Correspondence to the RCVMHS: CSP.0001.0115.0001, Balit Durn Durn Summary*, 2020, p. 15; Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027*, 2017, p. 8; RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; J. Smith and others, *Promising Practice Guide: Improving the Social and Emotional Wellbeing of Young Aboriginal and Torres Strait Islander People with Severe and Complex Mental Health Needs*, 2020, p. 16.

60 Department of Health and Human Services, *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017-2027*, p. 73.

61 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

62 Department of Health and Human Services, *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027*, pp. 11–12.

63 Royal Commission into Victoria's Mental Health System, *Interim Report,* pp. 465–484.

64 National LGBTI Health Alliance, *Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People*, 2020, p. 2.

65 Adam O Hill and others, *Private Lives 3: The Health and Wellbeing of LGBTIQ People in Australia*, 2020, p. 51.

66 Siann Bowman and others, Suicide in Rural High Schools, p. 10.

67 Gabi Rosenstreich, *LGBTI People Mental Health and Suicide: Briefing Paper, Revised 2nd Edition* (National LGBTI Health Alliance, 2013), p. 3.

68 *Witness Statement of Dr Louise Flynn*, 5 July 2019, para. 51.

69 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 292.

70 Siann Bowman, Carol McKinstry and Patrick McGorry, 'Youth Mental Ill Health and Secondary School Completion in Australia: Time to Act: Youth Mental Ill Health and Secondary School Completion', *Early Intervention in Psychiatry*, 11.4, (2017), pp. 277–289 (pp. 279–280).

71 World Health Organization, *Social Determinants of Mental Health*, 2014, p. 8.

72 Jessica Allen and others, 'Social Determinants of Mental Health', *International Review of Psychiatry*, 26.4, 2014, pp. 392–407 (p. 395).

73 World Health Organization, *Social Determinants of Mental Health*, p. 17.

74 AITHER, *Inter-Regional Assessment: An Analysis of Regional Victoria's Strengths and Challenges A Final Report Prepared for Infrastructure Victoria*, 2019, p. 7.

75 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

76 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

77 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

78 South West Healthcare, p. 16.

79 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

80 Regional Development Victoria, *Annual Report 2019–20*, 2020, p. 28.

81 Regional Development Victoria, p. 3.

82 Regional Development Victoria, pp. 51–52.

83 Orygen, *Fit for Purpose: Improving Mental Health Services for Young People Living in Rural and Remote Australia*, 2020, p. 6.

84 South West Healthcare, p. 16.

85 Royal Commission into National Natural Disaster Arrangements, *Royal Commission into National Natural Disaster Arrangements Report*, 2020, p. 345 citing a submission to the Commission.

86 Drought Policy Review Expert Social Panel, *It's About People: Changing Perspectives. A Report to Government by an Expert Social Panel on Dryness*, 2008, p. 60.

87 Kim Usher and others, 'The 2019–2020 Bushfires and COVID-19: The Ongoing Impact on the Mental Health of People Living in Rural and Farming Communities', *International Journal of Mental Health Nursing*, 2020, 1–3 (p. 1).

88 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 293; Victorian Farmers Federation, *Submission to the RCVMHS: SUB.0002.0029.0307*, 2019, p. 1.

89 *Witness Statement of Dr Alison Kennedy*, para. 19(b).

90 Usher and others, p. 1.

91 *Witness Statement of Christine Morgan*, 11 May 2020, para. 118.

92 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*; RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

93 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

94 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

95 *Witness Statement of Dr Sara Renwick-Lau*, 19 May 2020, p. 26.

96 *Witness Statement of Dr Sara Renwick-Lau*, para. 80.

97 *Witness Statement of Dr Sara Renwick-Lau*, para. 28.

98 *Witness Statement of Dr Sara Renwick-Lau*, p. 27.

99 *Witness Statement of Dr Sara Renwick-Lau*, p. 28.

100 Lisa Gibbs and others, *Beyond Bushfires: Community, Resilience, Recovery Final Report*, 2016, p. 12.

101 *Witness Statement of Dr Sara Renwick-Lau*, p.24.

102 Ben Edwards, Matthew Gray, and Boyd Hunter, *The Social and Economic Impacts of Drought*, 2019, p. 5; Holly Vins and others, 'The Mental Health Outcomes of Drought: A Systematic Review and Causal Process Diagram', *International Journal of Environmental Research and Public Health*, 12.10 (2015), 13251–13275 (p. 13260).

103 Alison S. Willis and Peter R. Grainger, 'Teacher Wellbeing in Remote Australian Communities', *Australian Journal of Teacher Education*, 45.5 (2020), 18–37 (p. 33).

104 *Witness Statement of Dr Sara Renwick-Lau*, p.27.

105 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

106 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

107 Ben Huf and Holly McLean, *2019–20 Bushfires Quick Guide: Research Note, No. 1*, 2020, p. 3; The Economist, A Burning Question—Why Was Australia's Government so Ill-Prepared for the Bushfires, 11 January 2020.

108 Department of Jobs, Precincts and Regions, Economic Value of Tourism, <djpr.vic.gov.au/priority-industries-sectors/visitor-economy/economic-value-of-tourism>, [accessed 15 December 2020].

109 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

110 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

111 *Witness Statement of Dr Rob Gordon*, 20 May 2020, para. 39.

112 *Witness Statement of Professor Alexander McFarlane AO*, 14 May 2020, paras. 95–96.

113 *2009 Victorian Bushfires Royal Commission: Final Report Summary*, 2010, p. 18.

114 *2009 Victorian Bushfires Royal Commission: Final Report Summary*, p. 1.

115 Bureau of Meteorology, State of the Climate 2020, <www.bom.gov.au/state-of-the-climate/>, [accessed 11 December 2020].

116 Department of Environment, Land, Water and Planning, *Victoria's Climate Science Report*, 2019, p. 35.

117 Australian Psychological Society, *Submission to the RCVMHS: SUB.0002.0029.0349*, 2019, p. 92.

118 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

119 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

120 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

121 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

122 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

123 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

124 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

125 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

126 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

127 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

128 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

129 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

130 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*; Public Accounts and Estimates Committee, Parliament of Victoria, *Inquiry into the Victorian Government's response to the COVID-19 pandemic: Interim Report*, 2020, p. 79.

131 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

132 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*; RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

133 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 299.

134 Latrobe Health Advocate, *Submission to the RCVMHS: SUB.0002.0029.0102*, 2019, p. 4; RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; South West Healthcare, pp. 17 and 28.

135 *Evidence of Dr Alison Kennedy*, 15 July 2019, pp. 999–1000.

136 Royal Flying Doctor Service Victoria, *Submission to the RCVMHS: SUB.0002.0029.0072*, 2019, p. 5.

137 *Witness Statement of Jennifer Rowan*, 22 April 2020, para. 13.

138 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; RCVMHS, *East Gippsland Roundtable: Record of Proceedings*; Latrobe Health Advocate, p. 4.

139 *Witness Statement of Dr Sara Renwick-Lau*, paras. 25–27.

140 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; RCVMHS, *Shepparton Community Consultation—May 2019*; RCVMHS, *Lived Experience of Suicidal Crisis and Carer Human-Design Focus Group: Record of Proceedings*, 2020; RCVMHS, *Community Integrated Mental Health Services Roundtable 1: Record of Proceedings*, 2020; RCVMHS, *Aged Persons Mental Health Services Roundtable: Record of Proceedings*, 2020; Lisa Costantin, *Brief Comments to the RCVMHS: SUB.0001.0032.0064*, 2019, p. 4; Council on the Ageing, *Submission to the RCVMHS: SUB.1000.0001.0789*, 2019, pp. 10–11.

141 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

142 *Witness Statement of Terry Welch*, 11 July 2019, para. 60.

143 Victorian Farmers Federation, p. 1.

144 South West Healthcare, pp. 31–32; Helen L Berry and others, 'Climate Change and Farmers' Mental Health: Risks and Responses', *Asia Pacific Journal of Public Health*, 23.2 (2011), 119S-132S (pp. 126S–127S).

145 Loddon Mallee Mental Health Carers Network, *Submission to the RCVMHS: SUB.0002.0025.0097*, 2019, p. 4.

146 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

147 Victoria Legal Aid, *Your Story, Your Say*, 2020, p. 9.

148 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

149 South West Healthcare, p. 28.

150 Beyond Blue, In My Shoes: Experiences of Discrimination, Depression and Anxiety Among Gay, Lesbian, Bisexual, Trans and Intersex People, p. 4; as cited in Rosenstreich, p. 13.

151 *Evidence of Dr Ravi Bhat*, p. 976.

152 *Evidence of Emma King*, 19 July 2019, p. 1347.

153 *Witness Statement of Terry Welch*, para. 49.

154 South West Healthcare, pp. 16–17.

155 RCVMHS, *Seymour Community Consultation—May 2019*.

156 *Witness Statement of Terry Welch*, para. 27.

157 *Evidence of Terry Welch*, 15 July 2019, pp. 929–930.

158 Barwon Health, *Submission to the RCVMHS: SUB.0002.0029.0222*, 2019, p. 4.

159 RCVMHS, *Shepparton Community Consultation—May 2019*.

160 Bendigo Health, *Submission to the RCVMHS: SUB.0002.0030.0051*, 2019, p. 12; Goulburn Valley Health, p. 9; Barwon Health, p. 4; RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

161 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; South West Healthcare, p. 20.

162 South West Healthcare, p. 20.

163 Albury Wodonga Health, *Submission to the RCVMHS: SUB.0002.0032.0088*, 2019, p. 16.

164 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; *Witness Statement of Terry Welch*, paras. 36, 43 and 46.

165 *Witness Statement of Karyn Cook*, 21 May 2020, para. 37.

166 Department of General Practice, The University of Melbourne, *Submission to the RCVMHS: SUB.0002.0028.0609*, 2019, p. 11.

167 *Evidence of Professor Malcolm Hopwood*, 10 July 2019, p. 633; *Evidence of Dr Ravi Bhat*, p. 997; Barwon Health, p. 5; Department of General Practice, The University of Melbourne, p. 11; Australian Psychological Society, p. 79.

168 Commission analysis of Commonwealth Department of Health, Health Workforce Data, <hwd.health.gov.au/datatool.html>, [accessed 4 December 2020].

169 Commission analysis of Australian Government Services Australia, *Medicare Benefits Schedule 2017–18;* Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat.no. 3101.0, Canberra.

170 Commission analysis of Australian Government Services Australia, *Medicare Benefits Schedule 2017–18;* Australian Bureau of Statistics, Australian Demographic Statistics, June 2020, cat.no. 3101.0, Canberra.

171 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, 2020, pp. 144–145; Commission analysis of Australian Government Services Australia, *Medicare Benefits Schedule 2017–18*.

172 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

173 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

174 Barwon Health, p. 3.

175 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 167.

176 Barwon Health, p. 3.

177 RCVMHS, *Youth Mental Health Roundtable: Record of Proceedings*, 2020.

178 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

179 Latrobe Regional Hospital, *Submission to the RCVMHS: SUB.0002.0028.0034*, 2019, p. 3; RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

180 RCVMHS, *Ballarat Community Consultation—April 2019*.

181 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, pp. 750–755.

182 Regional and Rural Area Mental Health Services, *Submission to the RCVMHS: SUB.0002.0029.0415*, 2019, p. 8.

183 *Witness Statement of Dr Enrico Cementon*, 25 May 2020, paras. 74–75; *Witness Statement of Dr Neil Coventry*, 29 July 2020, para. 279.

184 Regional and Rural Area Mental Health Services, p. 8.

185 RCVMHS, *Warrnambool Community Consultation—April 2019*.

186 *Witness Statement of Al Gabb*, 11 July 2019, para. 10.

187 Jane McCracken, *Submission to the RCVMHS: SUB.0002.0029.0241*, 2019, p. 2.

188 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

189 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; RCVMHS, *East Gippsland Roundtable: Record of Proceedings*; Law Reform, Road and Community Safety Committee, Parliament of Victoria, *Inquiry into Drug Law Reform*, 2018, p. 155; Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program, Report 10*, 2020, pp. 1 and 8.

190 Christina Marel and others, *Guidelines on the Management of Co-Occurring Alcohol and Other Drug and Mental Health Conditions in Alcohol and Other Drug Treatment Settings*, 2016, p. xi; Turning Point and Karen Fox, *Submission to the RCVMHS: SUB.0002.0028.0533*, 2019, p. 8.

191 L.M. Squeglia, J. Jacobus and S.F. Tapert, 'The Influence of Substance Use on Adolescent Brain Development', *Clinical EEG and Neuroscience*, 40.1 (2009), 1–16 (p. 8); Rebecca Kuepper and others, 'Continued Cannabis Use and Risk of Incidence and Persistence of Psychotic Symptoms: 10 Year Follow-up Cohort Study', *BMJ*, 342:d738 (2011), 1–8 (p. 1); Gabriella Gobbi and others, 'Association of Cannabis Use in Adolescence and Risk of Depression, Anxiety, and Suicidality in Young Adulthood: A Systematic Review and Meta-Analysis', *JAMA Psychiatry*, 76.4 (2019), 426–434 (pp. 430–432).

192 Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results 2007: Tables 1–15, 2008, Table 10; Marel and others, pp. 11–12.

193 Victorian Alcohol and Drug Association, *State Budget Submission 2020–21*, 2020, p. 27.

194 Victorian Alcohol and Drug Association, p. 46.

195 Victorian Alcohol and Drug Association, p. 38; Standing Committee on Legal and Social Issues—Legislation Committee, Parliament of Victoria, *Transcript of Evidence of Mr I. Newton OAM, Inquiry into the Role and Opportunities for Community Pharmacy*, 28 July 2014, pp. 68–69; as cited in Legislative Council, Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into Community Pharmacy in Victoria*, 2014, p. 51.

196 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

197 RCVMHS, *Youth Mental Health Roundtable: Record of Proceedings*.

198 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

199 Department of Health and Human Services, *Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement*, 2018, p. 19.

200 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

201 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

202 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

203 Australian BPD Foundation Limited, *Submission to the RCVMHS: SUB.1000.0001.3092*, 2019, pp. 24–25.

204 Australian Institute of Health and Welfare, *Rural and Remote Health*, 2017, pp. 1–2.

205 Australian Institute of Health and Welfare, Physical Health of People with Mental Illness, <www.aihw.gov.au/reports/australias-health/physical-health-of-people-with-mental-illness>, [accessed 4 December 2020].

206 *Evidence of Associate Professor Steven Moylan*, pp. 20–21.

207 RCVMHS, *Youth Mental Health Roundtable: Record of Proceedings*.

208 Department of Health, *Victorian Health Priorities Framework 2012–2022: Rural and Regional Health Plan*, 2011, pp. 12–13.

209 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

210 Bendigo Health, pp. 9–10; South West Healthcare, p. 2.

211 RCVMHS, *Youth Mental Health Roundtable: Record of Proceedings*.

212 Goulburn Valley Health, p. 7.

213 Goulburn Valley Health, p. 7.

214 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

215 South West Healthcare, p. 26.

216 Australian Education Union, *Submission to the RCVMHS: SUB.1000.0001.0636*, 2019, p. 19.

217 Australian Education Union, p. 18.

218 Department of Health, Child Adolescent Mental Health Services (0–18 Years), <www.health.vic.gov.au/mentalhealthservices/child/index.htm>, [accessed 3 November 2019].

219 Goulburn Valley Health, p. 7.

220 Goulburn Valley Health, p. 6; RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

221 The Royal Australian and New Zealand College of Psychiatrists, *Submission to the RCVMHS: SUB.0002.0029.0231 (Appendix 4)*, 2019.

222 Professor Anita Thapar, Dr Miriam Cooper and Professor Michael Rutter, 'Neurodevelopmental Disorders: A Personal View', *Lancet Psychiatry*, 4.4 (2017), 1–28 (p.4); Catharine Critz, Kiegan Blake and Ellen Nogueira, 'Sensory Processing Challenges in Children', *The Journal for Nurse Practitioners*, 11.7 (2015), 710–716.

223 South West Healthcare, p. 26.

224 *Evidence of Dr Ravi Bhat*, pp. 990–991.

225 ORIMA Research, *Mental Health Workforce Survey*, 2020.

226 Call to Mind, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, pp. 1–2.

227 Royal Commission into Victoria's Mental Health System, *Interim Report,* pp. 308–309.

228 *Witness Statement of Dr Paul Denborough*, 11 May 2020, para. 85.

229 MindSpot, *Submission to the Productivity Commission Inquiry into Mental Health*, 2019, p. 5.

230 *Witness Statement of Dr Hila Haskelberg*, 13 July 2020, para. 28.

231 *Witness Statement of Terry Welch*, para. 71.

232 Barwon Health, p. 6.

233 RCVMHS, *Regional AMHS Provider Information Sharing Roundtable: Record of Proceedings*, 2020.

234 NorthWestern Mental Health (A Division of Melbourne Health), *Submission to the RCVMHS: SUB.0002.0030.0061*, 2019, p. 29.

235 Health Education England NHS, *The Topol Review. Preparing the Healthcare Workforce to Deliver the Digital Future*, 2019, p. 10.

236 Grow Australia, *Submission to the RCVMHS: SUB.0002.0029.0325*, 2019, p. 7.

237 Royal Flying Doctor Service Victoria, p. 5.

238 Grow Australia, p. 7.

239 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

240 *Witness Statement of Professor Rob Moodie*, 9 June 2020, paras. 29–31.

241 *Witness Statement of Shane Solomon*, 22 May 2020, para. 50.

242 *Witness Statement of Associate Professor Steven Moylan*, 29 May 2020, para. 102.

243 *Witness Statement of Terry Welch*, para. 72.

244 Regional and Rural Area Mental Health Services, p. 3.

245 *Witness Statement of Kym Peake*, 4 October 2020, para. 291.

246 The Honourable Greg Hunt MP, Commonwealth Minister for Health, Transcript: Doorstop Interview on 27 November 2020, <www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/doorstop-interview-on-27-november-2020>, [accessed 1 December 2020].

247 Victorian Government, *Victorian Budget 2020–21: Rural and Regional Budget Information Paper*, 2020, p. 17; Victorian Government, *Victorian Budget 2020–21: Overview*, 2020, p. 23.

248 Victorian Government, *Victorian Budget 2020–21: Service Delivery: Budget Paper No. 3*, 2020, pp. 92–93; Victorian Government, *Victorian Budget 2020–21: Rural and Regional Budget Information Paper*, p. 11.

249 Barwon Health, p. 4; South West Healthcare, p. 23; Latrobe Regional Hospital, p. 5; RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

250 Orygen, The National Centre of Excellence in Youth Mental Health and Vivienne Browne, *Submission to the RCVMHS: SUB.2000.0001.0741*, 2019, p. 4.

251 RCVMHS, *Shepparton Community Consultation—May 2019*.

252 Rural Health Standing Committee, *National Strategic Framework for Rural and Remote Health* (Australian Health Ministers' Advisory Council, 2016), p. 6.

253 Rural Health Standing Committee, p. 13.

254 Rural Health Standing Committee, p. 18.

255 Victorian Auditor-General's Office, *Access to Mental Health Services*, 2019, p. 11.

256 For example, Royal Flying Doctor Service Victoria, p. 6; Barwon Health, p 4.

257 South West Healthcare, pp. 23–24. Grampians Area Mental Health Service, *Submission to the RCVMHS: SUB.0002.0029.0161*, 2019, p. 13.

258 *Witness Statement of Dr Ravi Bhat*, 4 July 2019, para. 116.

259 Grampians Area Mental Health Service, p. 13.

260 South West Healthcare, pp. 23–24; Grampians Area Mental Health Service, p. 13.

261 South West Healthcare, p. 24.

262 Latrobe Regional Hospital, p. 5.

263 Rural Health Standing Committee, p. 18.

264 *Witness Statement of Professor Malcolm Hopwood*, 27 June 2019, paras. 42–44; Barwon Health, p. 5; *Evidence of Helen Kennedy*, 16 July 2019, pp. 1060–1061; Department of General Practice, The University of Melbourne, pp. 10–11; Cobaw Community Health, *Submission to the RCVMHS: SUB.0002.0029.0361*, 2019, p. 8; Productivity Commission, *Draft Report on Mental Health, Volume 1*, 2019, pp. 370–371; Australian Association of Social Workers, *Submission to the RCVMHS: SUB.1000.0001.0031*, 2019, p. 11; *Witness Statement of Angus Clelland*, 5 June 2020, para. 18; The Royal Australian and New Zealand College of Psychiatrists, *Submission to the RCVMHS: SUB.0002.0029.0227*, 2019, p. 31.

265 *Evidence of Professor Malcolm Hopwood*, p. 633; *Evidence of Dr Ravi Bhat*, pp. 979–980; Barwon Health, p. 5; Department of General Practice, The University of Melbourne, pp. 10–11; Australian Psychological Society, p. 79.

266 *Witness Statement of Angus Clelland*, para. 18; *Witness Statement of Karyn Cook*, paras. 39, 118, 142, 145, 151 and 161–162; *Witness Statement of Sue Medson OAM*, 15 April 2020, paras. 42 and 45; Bendigo Health, p. 5; South West Healthcare, p. 25; Barwon Health, p. 5.

267 *Witness Statement of Karyn Cook*, paras. 142–144.

268 South West Healthcare, pp. 18, 21–22 and 27; RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

269 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; RCVMHS, *East Gippsland Roundtable: Record of Proceedings*; Barwon Health, p. 5; South West Healthcare, pp. 11–12; Bendigo Health, p. 5.

270 *Witness Statement of Dr Lynne Coulson Barr OAM*, 4 June 2020, para. 257.

271 *Witness Statement of Dr Lynne Coulson Barr OAM*, para. 260.

272 *Witness Statement of Karyn Cook*, paras. 39, 118, 142, 145, 151 and 161–162; *Witness Statement of Sue Medson OAM*, paras. 42 and 45; Bendigo Health, p. 5; South West Healthcare, p. 25; Barwon Health, p. 5.

273 Commission analysis of Commonwealth Department of Health, National Health Workforce Dataset.

274 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

275 Bendigo Health, p. 4.

276 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

277 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

278 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

279 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

280 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 402.

281 Royal Flying Doctor Service Victoria, p. 6.

282 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; South West Healthcare, pp. 29 and 50; Goulburn Valley Health, p. 12; *Witness Statement of Karyn Cook*, para. 35.

283 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

284 *Witness Statement of Dr Ravi Bhat*, para. 121.

285 David Dunne, *Submission to the RCVMHS: SUB.0002.0002.0116*, 2019, p. 6.

286 Grampians Area Mental Health Service, pp. 10 and 12.

287 Anna L Morell and others, 'Attraction, Recruitment and Distribution of Health Professionals in Rural and Remote Australia: Early Results of the Rural Health Professionals Program', *Human Resources for Health*, 12:15 (2014), 1–6 (p. 3).

288 John Humphreys, John Wakerman and others, *Retention Strategies and Incentives for Health Workers in Rural and Remote Areas: What Works?*, 2009, p. 11.

289 Humphreys, Wakerman and others, p. 11; John Humphreys, Judith Jones and others, 'A Critical Review of Rural Medical Workforce Retention in Australia', *Australian Health Review*, 24.4 (2001), 91–102 (p. 95); David A. Perkins and others, 'Far West Area Health Service Mental Health Integration Project: Model for Rural Australia?', *Australian Journal of Rural Health*, 14.3 (2006), 105–110 (p. 109).

290 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; South West Healthcare, pp. 21 and 42; Barwon Health, p. 6; Bendigo Health, pp. 18–19.

291 *Witness Statement of Professor Malcolm Hopwood*, para. 43.

292 Department of Health and Human Services, *Psychology Workforce Report*, 2018, p. 8.

293 *Witness Statement of Karyn Cook*, para. 118.

294 *Witness Statement of Sue Medson OAM*, para. 46.

295 Grampians Area Mental Health Service, p. 12.

296 *Witness Statement of Dr Ravi Bhat*, para. 124.

297 *Witness Statement of Professor Malcolm Hopwood*, para. 43; Victorian and Tasmanian PHN Alliance, *Submission to the RCVMHS: SUB.0002.0029.0176*, 2019, p. 21.

298 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

299 The Senate, Community Affairs References Committee, Parliament of Australia and others, *Accessibility and Quality of Mental Health Services in Rural and Remote Australia*, 2018, pp. 139–165.

300 RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

301 Goulburn Valley Health, p. 12; *Evidence of Dr Ravi Bhat*, p. 994.

302 *Witness Statement of Dr Neil Coventry*, 2020, para. 302(b).

303 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

304 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

305 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*; RCVMHS, *East Gippsland Roundtable: Record of Proceedings*.

306 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

307 The Senate, Community Affairs References Committee, Parliament of Australia and others, p. 138.

308 Loddon Mallee Mental Health Carers Network, pp. 3–4.

309 Loddon Mallee Mental Health Carers Network, pp. 3–4.

310 ORIMA Research, *Mental Health Workforce Survey*, pp. 4 and 14.

311 ORIMA Research, *Mental Health Workforce Quotes from Survey*, 2020.

312 Royal Commission into Victoria's Mental Health System, *Interim Report,* p. 291.

313 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

314 *Witness Statement of Sue Medson OAM*, para. 41; *Witness Statement of Jim Williamson*, 11 May 2020, para. 69; RCVMHS, *Shepparton Community Consultation—May 2019*; Neighbourhood Houses Victoria, *Submission to the RCVMHS: SUB.0002.0028.0171*, 2019.

315 RCVMHS, *Swan Hill Community Consultation—May 2019*; RCVMHS, *Seymour Community Consultation—May 2019*; Commissioner for Senior Victorians, *Ageing Well in a Changing World*, 2020, pp. 28–29; Latrobe Health Advocate, p. 7; Municipal Association of Victoria, *Submission to the RCVMHS: SUB.1000.0001.2218*, 2019, p. 5.

316 West Wimmera Shire Council, *Submission to the RCVMHS: SUB.0002.0023.0006*, 2019, p. 2.

317 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

318 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

319 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

320 RCVMHS, *North Eastern Victoria Roundtable: Record of Proceedings*.

321 *Witness Statement of Sue Medson OAM*, para. 38.

322 *Witness Statement of Sue Medson OAM*, para. 40.

323 RCVMHS, *Shepparton Community Consultation—May 2019*.

324 An activity-based funding model distributes funding to providers for the number of times they provide services to a person, with the amount based on each person's individual needs. See Department of Health and Human Services, *Clinical Mental Health Funding Reform: Building a Stronger Foundation for Funding Adequacy, Growth and Fairness*, 2020, pp. 4–5.

325 Block funding, also known as input-based funding or grant funding, involves providers receiving a fixed sum of funding to deliver a particular service or function. See Austin Health, *Submission to the RCVMHS: SUB.0003.0001.0001*, 2019, p. 5.

326 Under a capitation funding model, providers receive a fixed amount of funding for each person who registers with them for a specified time period, usually a year. See Michael E Porter and Robert S Kaplan, *How Should We Pay for Health Care? Working Paper 15-041*, 2015, p. 3.

327 Independent Hospital Pricing Authority, *National Efficient Price Determination 2020–21*, 2020, pp. 13–14.

328 Department of Health and Human Services, *Policy and Funding Guidelines 2019–20: Policy Guide*, 2019, p. 26.

329 *Witness Statement of Associate Professor Simon Stafrace*, 14 August 2020, para. 190.

330 Victorian Auditor-General's Office, *Access to Mental Health Services*, p. 35.

331 *Witness Statement of Professor Malcolm Hopwood*, paras. 42–44; Barwon Health, p. 5; Department of General Practice, The University of Melbourne, pp. 10–11; Cobaw Community Health, p. 8; Productivity Commission, *Draft Report on Mental Health, Volume 1*, pp. 370–371; Australian Association of Social Workers, p. 11; *Witness Statement of Angus Clelland*, para. 18; The Royal Australian and New Zealand College of Psychiatrists, *Submission to the RCVMHS: SUB.0002.0029.0227*, p. 31.

332 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 752.

333 Humphreys, Wakerman, and others, p. 25.

334 World Health Organization, *Increasing Access to Health Workers in Remote and Rural Areas Through Improved Retention: Global Policy Recommendations*, 2010, p. 10.

335 John Wakerman and others, 'Remote Health Workforce Turnover and Retention: What Are the Policy and Practice Priorities?', *Human Resources for Health*, 17:99 (2019), 1–8 (p. 5); Carmen Dolea, Laura Stormont and Jean-Marc Braichet, 'Evaluated Strategies to Increase Attraction and Retention of Health Workers in Remote and Rural Areas', *Bulletin of the World Health Organization*, 88.5 (2010), 379–385 (pp. 380–381); Matthew R McGrail, Deborah J Russell, and David G Campbell, 'Vocational Training of General Practitioners in Rural Locations Is Critical for the Australian Rural Medical Workforce', *Medical Journal of Australia*, 205.5 (2016), 216–221 (pp. 217 and 221).

336 N W Wilson and others, 'A Critical Review of Interventions to Redress the Inequitable Distribution of Healthcare Professionals to Rural and Remote Areas', *Rural and Remote Health*, 9 (2009), 1–21 (p. 4).

337 Wilson and others, p. 7; Jodie Jackson and others, 'A Comparative Assessment of West Virginia's Financial Incentive Programs for Rural Physicians', *The Journal of Rural Health*, 19.5 (2003), 329–339 (p. 331).

338 Dolea, Stormont, and Braichet, p. 380.

339 Dolea, Stormont, and Braichet, p. 380.

340 Wakerman and others, p. 5.

341 JS Dunbabin, K McEwin and I Cameron, 'Postgraduate Medical Placements in Rural Areas: Their Impact on the Rural Medical Workforce', *Rural and Remote Health*, 6, 2006, pp. 1–10 (p. 1).

342 Wilson and others, p. 7.

343 Cheryl Cashin and Y-Ling Chi, Major Developments in Results-Based Financing (RBF) in OECD Countries: Country Summaries and Mapping of RBF Programs Australia: The Practice Incentives Program (PIP), 2011, p. 10.

344 Dolea, Stormont and Braichet, p. 381.

345 Wakerman and others, p. 5.

346 Col White and others, 'Making a Difference: Education and Training Retains and Supports Rural and Remote Doctors in Queensland', *Rural and Remote Health*, 7 (2007), 1–8 (p. 1); Maria Gardiner and others, 'Impact of Support Initiatives on Retaining Rural General Practitioners', *Australian Journal of Rural Health*, 14.5 (2006), 196–201 (pp. 197 and 200); Dolea, Stormont, and Braichet, p. 381.

347 Wilson and others, p. 4.

348 Wilson and others, p. 4.

349 Wilson and others, p. 4.

350 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 753.

351 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 753.

352 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 753.

353 Judith Jones, John Humphreys, and Michael Adena, 'Rural GPs' Ratings of Initiatives Designed to Improve Rural Medical Workforce Recruitment and Retention', *Rural and Remote Health*, 4.3 (2004), 1–10 (p. 1).

354 Cashin and Chi, p. 10.

355 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 754.

356 In 1988, the NSW Department of Health developed the NSW Rural Resident Medical Officer Cadetship Program, which offered bonded scholarships to provide financial support for medical students during their final two years of undergraduate study. In return, cadets were contracted to complete two of their first three postgraduate years in the NSW rural hospital network. 43 per cent of Cadets who entered the Program before 1999 were still working in rural locations in 2004 (compared to 20.5% of medical practitioners nationally). Dunbabin, McEwin, and Cameron, pp. 1 and 6.

357 Dolea, Stormont and Braichet, p. 381.

358 Commonwealth Department of Health, Stronger Rural Health Strategy—Factsheets, <www1.health.gov.au/internet/main/publishing.nsf/Content/stronger-rural-health-strategy-factsheets>, [accessed 20 December 2020].

359 Commonwealth Department of Health, Workforce Incentive Program Factsheet, <www1.health.gov.au/internet/main/publishing.nsf/Content/work-pr-wip-factsheet>, [accessed 20 December 2020].

360 Commonwealth Department of Health, Rural Health Outreach Fund, <www1.health.gov.au/internet/main/publishing.nsf/Content/budget2011-flexfund-rural13.htm>, [accessed 20 December 2020].

361 Xiaoyun Liu and others, 'Analysis of Context Factors in Compulsory and Incentive Strategies for Improving Attraction and Retention of Health Workers in Rural and Remote Areas: A Systematic Review', *Human Resources for Health*, 13:61, 2015, pp. 1–8 (p. 1).

362 Gisèle Mbemba and others, 'Interventions for Supporting Nurse Retention in Rural and Remote Areas: An Umbrella Review', *Human Resources for Health*, 11:44, 2013, pp. 1–9 (p. 5).

363 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 754.

364 Wilson and others, p. 7.

365 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 753; McGrail, Russell, and Campbell, p. 219; Marcella M. S. Kwan and others, 'The Rural Pipeline to Longer-Term Rural Practice: General Practitioners and Specialists', ed. by Annette M. Mercer, *PLOS ONE*, 12.7 (2017), 1–15 (p. 7).

366 Commonwealth Department of Health, *Stronger Rural Health Strategy: The Murray-Darling Medical Schools Network*, 2020.

367 The University of Melbourne, First Students Welcomed in New Murray Darling Rural Medical Program, <about.unimelb.edu.au/newsroom/news/2019/february/first-students-welcomed-in-new-murray-darling-rural-medical-program>, [accessed 20 December 2020].

368 Commonwealth Department of Health, *Stronger Rural Health Strategy: The Murray-Darling Medical Schools Network*, p. 2.

369 White and others, p. 1; Dolea, Stormont and Braichet, p. 381.

370 Gardiner and others, p. 200; Dolea, Stormont and Braichet, p. 381.

371 Belinda O'Sullivan and others, 'Reviewing Reliance on Overseas-Trained Doctors in Rural Australia and Planning for Self-Sufficiency: Applying 10 Years' MABEL Evidence', *Human Resources for Health*, 17:8, 2019, pp. 1–9 (p. 7).

372 Humphreys, Wakerman and others, p. 6; Wakerman and others, p. 6.

373 Wilson and others, p. 7.

374 Commonwealth Department of Health, Rural Health Outreach Fund.

375 Commonwealth Department of Health, Health Workforce Scholarship Program, <www1.health.gov.au/internet/main/publishing.nsf/Content/health-workforce-scholarship-program>, [accessed 20 December 2020].

376 Australian Psychological Society, p. 25.

377 Australian Psychological Society, pp. 13 and 32.

378 Australian Services Union, *Submission to the RCVMHS: SUB.0002.0030.0025*, 2019, p. 23.

379 Health and Community Services Union, *Submission to the RCVMHS: SUB.0002.0030.0180*, 2019, p. 19.

380 Royal Australian College of General Practitioners, *Submission to the RCVMHS: SUB.1000.0001.1063*, 2019, p. 8.

381 Australian Nursing and Midwifery Federation, Victoria, *Submission to the RCVMHS: SUB.2000.0001.0002*, 2019, p. 148.

382 Australian Psychological Society, p. 48.

383 Australian Psychological Society, p. 48.

384 Australian Psychological Society, p. 57.

385 Wakerman and others, p. 6.

386 Examples of incentive programs include: the Victorian Government's Medical Professional Development Program (for ongoing professional development of GPs, registrars, graduates and interns); the Australian Government's Health Workforce Scholarship Program (which provides professional development support to GPs, nurses and allied health); the Victorian Government's Rural Allied Health Support Program (for specific allied health professionals); and the Australian Government-funded Remote Vocational Training Scheme (which involves 3 or 4 years of distance training for medical practitioners, giving them a qualification that meets requirements for registration of the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners). Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 751.

387 Brendan Coates and others, *Shutdown: Estimating the COVID-19 Employment Shock*, 2020, p. 20.

388 Coates and others, p. 22.

389 Coates and others, p. 43.

390 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 754.

391 Dolea, Stormont and Braichet, pp. 380–381; Kwan and others, p. 7; McGrail, Russell and Campbell, p. 219.

392 Dolea, Stormont and Braichet, pp. 380–381; Wakerman and others, p. 5.

393 Dolea, Stormont and Braichet, pp. 380–381; Wakerman and others, p. 5.

394 Commonwealth Department of Health, Specialist Training Program, <www1.health.gov.au/internet/main/publishing.nsf/Content/work-spec>, [accessed 7 December 2020].

395 Commonwealth Department of Health, Specialist Training Program.

396 *Evidence of Dr Ravi Bhat*, p. 982.

397 *Evidence of Dr Ravi Bhat*, p. 993.

398 *Witness Statement of Associate Professor Steven Moylan*, para. 33; The Royal Australian and New Zealand College of Psychiatrists, *Victorian Psychiatry Workforce: Executive Summary*, 2017, p. 69; Rural Health Standing Committee, pp. 23 and 28; Department of Health, *Victorian Health Priorities Framework 2012–2022: Rural and Regional Health Plan*, p. 32.

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Chapter 25

Addressing stigma and discrimination

Recommendation 41:

Addressing stigma and discrimination

The Royal Commission recommends that the Victorian Government:

1. fund and support the Mental Health and Wellbeing Commission (refer to recommendation 44) to work with a network of partners, including research organisations, to lead the design and delivery of anti-stigma programs that:
   - **a.** continue on a long-term basis; and
   - **b.** aim to reduce the impact of stigma in a range of settings including, but not limited to, healthcare settings, workplaces and schools.
2. design and deliver an anti-stigma grants program to:
   - **a.** support community-led organisations and community members to deliver projects that challenge stigma in Victorian settings and communities; and
   - **b.** focus, as an immediate priority, on communities and social groups at increased risk of stigma.
3. conduct a comprehensive evaluation of anti-stigma efforts to:
   - **a.** develop evidence about effective ways to address mental health stigma across Victoria; and
   - **b.** inform the design and delivery of anti-stigma programs.
4. support and establish mechanisms to:
   - **a.** address systemic issues of mental health discrimination;
   - **b.** enhance individual access to legal protection from mental health discrimination; and
   - **c.** enable one or two independent legal services with a demonstrated connection or ability to connect with people with lived experience of mental illness or psychological distress to initiate legal claims, including test cases relating to systemic mental health discrimination.

25.1 Our shared responsibility to end stigma and discrimination

The Commission's reforms are guided by a desire to enhance the lives of people with lived experience of mental illness. Having the opportunity to fully and meaningfully participate in public life, free from discrimination, stigma or exclusion, is fundamental to mental health and wellbeing, and is a basic human right.[1] However, as highlighted in the interim report,[2] stigma, discrimination and prejudice remain pervasive and harmful influences on the lives of people living with mental illness or psychological distress and on the lives of families, carers and supporters.

As a community, we have struggled to understand or be compassionate about lived experience of mental illness, and the varying ways people experience mental health or psychological distress. This has meant that people with lived experience of mental illness have been excluded from society. Experiences of stigma and discrimination deprive people of their dignity and constrain opportunities to fully participate in society.[3]

Stigma and discrimination reinforce harmful perceptions that mental illness and psychological distress are not valid and cannot be managed.[4] Stigma and discrimination act as barriers to seeking mental health services and can adversely affect treatment, care and support provided.

Stigma causes people to avoid socialising with, employing or working with, renting to, living near, or providing services to, people with lived experience of mental illness or psychological distress.[5] In some circumstances, this behaviour amounts to discrimination. The impacts of social exclusion adversely affect people's mental and physical health, financial security, job security and social relationships.[6] As such, stigma and discrimination are both determinants and outcomes of mental illness and psychological distress.[7]

Confronting stigma and discrimination in the community is crucial to creating the basic conditions for the attainment of good mental health and wellbeing. Tackling stigma and discrimination, respecting the dignity of every person and ensuring equality, are collective responsibilities. Individuals, families, communities, schools, workplaces, service providers and government all have a role to play.

Fundamentally, people with lived experience must be given the resources and opportunities to take the lead in these efforts. Governments, services providers, workplaces and the general community have much to learn from the insights and experiences of people with lived experience and must be prepared to act on the advice of their leadership.

As detailed later in this chapter, stigma and discrimination are complex and pervasive, occurring and manifesting in a range of ways. While actions to address stigma and discrimination at an individual and community level are critical, the Commission recognises that broader structural reform is needed to address entrenched stigma and to end discrimination.

The Commission's vision for the future mental health and wellbeing system is designed to effect this structural change. In addition to the recommendations outlined in this chapter, the Commission anticipates that other recommendations included in the report that will support anti-stigma and anti-discrimination efforts are:

- the establishment of the Collaborative Centre for Mental Health and Wellbeing. As outlined in the interim report, the Collaborative Centre will play a key role in helping to demystify perceptions that perpetuate the stigma and discrimination that people living with mental illness continue to experience[8]
- developing system-wide roles for consumers, including key roles across the mental health and wellbeing system, and developing and supporting their leadership capabilities (refer to recommendation 28)
- facilitating the leadership of people with lived experience in decision-making processes about mental health policies and programs, by requiring that the Mental Health and Wellbeing Commission has at least one Commissioner with lived experience of mental illness or psychological distress, and one Commissioner with lived experience as a family member or carer (refer to recommendation 44)
- the establishment of a consumer-led agency to create opportunities to better understand the diverse, rich and powerful experiences of consumers (refer to recommendation 29)
- a focus on immediately reducing the use of seclusion, restraint and compulsory treatment (refer to recommendation 54 and 55), and increasing access to non-legal advocacy services and legal representation for people who are subject to, or at risk of, compulsory treatment (refer to recommendation 56)
- the development of a Victorian Mental Health and Wellbeing Workforce Capability Framework, in collaboration with people with lived experience, to support learning and professional development activities across the whole mental health and wellbeing workforce (refer to recommendation 58).

25.2 Defining stigma and discrimination

In this chapter, except for sections that discuss stigma and discrimination in general terms:

- **'stigma'** relates to the stigma associated with mental ill-health, unless otherwise specified
- **'discrimination'** relates to the discrimination associated with mental illness, unless otherwise specified.

25.2.1 Defining stigma

The World Health Organization defines stigma as a 'mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society'.[9] In his foundational discussion of stigma, Erving Goffman described stigma as an 'attribute that is deeply discrediting' and that reduces the bearer 'from a whole and usual person to a tainted, discounted one'.[10] Stigma has also been described as the process of labelling differences, linking those labels to negative stereotypes, and shaming and 'othering' or devaluing individuals based on these stereotypes, which results in status loss and discrimination.[11]

Stigma is therefore a fundamentally social process—different characteristics or traits are not inherently negative; 'rather, through a complex social process, they become defined and treated as such'.[12] This process leads to social exclusion.[13]

As outlined in Figure 25.1, stigma occurs in four main ways. These different forms of stigma are interdependent and mutually reinforcing.[14]

Figure 25.1: Stigma occurs at four main levels

Source: *Witness Statement of Dr Chris Groot*, 4 September 2019; *Witness Statement of Dr Michelle Blanchard*, 27 June 2019.

25.2.2 Defining discrimination

There are many definitions of discrimination, and the distinction between stigma and discrimination is not always clear. One view is that stigma relates to 'the attitudes or beliefs held by a person, whereas discrimination is behaviour or perceived behaviour'.[15] Another view is that the two concepts are interchangeable. One witness relayed to the Commission their perception that the impacts of stigma are often minimised, and that sometimes stigma is viewed as acceptable in a way that discrimination is not:

> As a cultural phenomenon, our society almost accepts stigma as being acceptable, but considers that discrimination is problematic and illegal. Society does not seem to consider that a consequence of stigmatising a cross-section of our community can lead to unlawful discrimination. A language change by governments and the media is necessary to change this stigma, as is calling out this negative behaviour as discrimination.[16]

At its most basic, discrimination refers to the prejudicial treatment of people based on their individual or collective characteristics. What makes a behaviour an instance of discrimination is not the mere presence of differential treatment, but rather, differential treatment that is worse for the people concerned than if they were treated in the same way as the broader population.[17] Discrimination results in an individual being excluded from participating in many aspects of society.[18] Discrimination is also sometimes described or understood as a manifestation of structural stigma (for further details, refer to section 25.2.3).

As one person told the Commission:

> Discrimination is real—you are treated as a second-class citizen if you have a diagnosis, and it's disgusting. This is done by services and the government.[19]

Box 25.1: *Equal Opportunity Act 2010* (Vic)

In Victoria, the *Equal Opportunity Act 2010* makes it unlawful to discriminate on the basis of 'disability' (which is defined to include a 'mental or psychological disease or disorder')[20] in certain settings, including health care, employment and schools. This can be through 'direct discrimination', such as when someone is treated unfavourably because of a personal characteristic like mental illness.[21] This kind of discrimination can involve a refusal to treat someone, provide them access to services or admit them to a school, because they have a mental health diagnosis.

The law also protects against 'indirect discrimination', where an unreasonable requirement, condition or practice disadvantages a person or group of people, based on a characteristic.[22]

Anti-discrimination law in Victoria goes beyond protecting individuals or groups, to providing a positive duty for organisations to eliminate discrimination.[23] This requires organisations such as schools, education providers and workplaces to eliminate discrimination as far as possible.[24]

The positive duty arises in response to discrimination occurring at an individual level, as well as structural or systemic levels.[25] Structural or systemic discrimination 'describes patterns or practices of discrimination that are the result of interrelated policies, practices and attitudes that are entrenched in organisations or in broader society'.[26] For people with lived experience, this can manifest in fewer workforce and leadership opportunities.

The Commission notes, however, that the *Equal Opportunity Act 2010* does not provide the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) with powers to enforce this duty.[27]

25.2.3 Structural stigma and systemic discrimination

Although stigma and discrimination are perhaps most readily considered as interpersonal, isolated experiences, it is clear that stigma and discrimination against people with lived experience of mental illness or psychological distress is entrenched and also occurs at a structural or systemic level.

Structural stigma refers to the 'societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing for stigmatised populations'.[28] As the Commission acknowledged in its interim report, the low priority given to mental health funding is a structural manifestation of the stigma associated with mental illness.[29]

Systemic discrimination 'describes patterns or practices of discrimination that are the result of interrelated policies, practices and attitudes that are entrenched in organisations or in broader society.'[30] People with lived experience face systemic discrimination in Victoria. Systemic discrimination is manifested in, for example, people with lived experience having poorer physical health and healthcare than other citizens.[31] The Victorian Mental Illness Awareness Council points to local evidence that their 'members who are labelled with SPMI [serious and persistent mental illness] are likely to die 30 years younger than the rest of the Australian community'.[32] The Commission has heard that the pervasiveness of systemic discrimination is compounded by the fact that this often renders it 'hidden'[33]—that is, those in society who are not directly impacted by it, are often 'blind' to it.[34]

25.2.4 Drivers of stigma and discrimination

In order to design and target interventions to prevent and address stigma and discrimination, it is critical to understand what 'drives' or causes stigma and discrimination to occur in the first place.

Stigma and discrimination are social processes that reflect and reinforce power imbalances across society between those with lived experience and those without. As Professor James Livingston, stigma researcher at Saint Mary's University in Canada notes:

> stigma reveals more about society than it does about individuals who carry stigmatized characteristics or persons who harbour negative beliefs about others. It sheds light on who in society has access to the power and privilege necessary to define rules and apply sanctions for violating them—those who do, become the beneficiaries of stigma; those who do not, become its subjects. In turn, the subjects of stigma are redirected on a path where their identities are engulfed, their relationships transformed, and the direction of their lives shifted because they have been marked by a stereotyped attribute.[35]

In her foreword to the *Like Minds, Like Mine National Plan 2003–2005,* Ms Mary O'Hagan MNZM, Manager of Mental Wellbeing at Te Hiringa Hauora, New Zealand, described the underlying reason for discrimination against people with lived experience of mental illness:

> People often say [discrimination] starts with fear, ignorance, misunderstanding, pity or malice. But these are just some of the clothes discrimination wears. Take off all the clothes and we are left with one thing; the devaluing of madness and the entwined assumptions that mad people are full of nonsense and incompetence.[36]

25.3 People with lived experience are stigmatised

There is longstanding ignorance about mental illness and the stigma that is experienced by people with lived experience of mental illness or psychological distress.[37] Historically, people with lived experience of mental illness or psychological distress were stigmatised and discriminated against in many ways,[38] including through institutionalisation, where people were locked away from their communities, often in brutal and inhumane conditions.[39] Despite decades of deinstitutionalisation, deeply held prejudices towards people with lived experience of mental illness or psychological distress and unfavourable treatment remain widespread.

In its *Mental Health Inquiry Report*, the Productivity Commission found that in Australia, most people with lived experience 'report experiencing stigma, although the degree, nature and experience of stigma varies by type of mental illness, age, gender and cultural background'.[40] In particular, people diagnosed with what was termed 'severe' mental illness are subject to high levels of stigma.[41]

Many witnesses with lived experience of mental illness or psychological distress relayed their experiences of stigma to the Royal Commission. It is clear that stigmatising attitudes and beliefs about mental illness are wide ranging.[42] They include beliefs that mental illness is a sign of personal weakness and 'not a real medical illness', and beliefs that people living with mental illness are dangerous and unpredictable.[43]

One witness reported experiencing the stigmatising—and false—narrative of 'you're weak'.[44] She also spoke of deeply rooted assumptions about people being incapable of making their own decisions once they had received a mental health diagnosis.[45]

Language used in relation to mental illness can perpetuate and reinforce stigma.[46] For example, diagnostic labels can affect the way people are perceived and treated, particularly by mental health practitioners.[47] There remains widespread perceptions that people diagnosed with borderline personality disorder are difficult and manipulative.[48] In a submission to the Commission, one consumer conveyed the following:

> The reason I resisted [dialectical behaviour therapy] is because it is associated with a Borderline Personality Disorder diagnosis. People diagnosed with BPD can experience a lot of stigma and discrimination within mental health services. For example, they're often unfairly characterised as being manipulative. I'm aware of this having spoken to clients I work with, so was resistant to the label being applied to me.[49]

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Ms Janet Meagher AM, an advocate for people with lived experience, and former Mental Health Commissioner for the National Mental Health Commission, shared her own experiences of stigma and discrimination with the Commission:

> Many people who experience mental health issues are labelled impersonally as, 'a patient', 'a client' or 'the consumer' or have a diagnosis that represents only what is seen as their 'sick' or 'broken' parts. People see them not so much as a person, but more so as a diagnosis (e.g. 'a depressive', 'a schizo', a 'crazy one' ... etc. etc.) and frequently as inherently dangerous and not to be trusted. This can lead to people being fearful or afraid when they come across people with mental health issues. I have experienced this fear first hand after people have become aware of my mental health status.[50]

One insidious and harmful aspect of stigma is that stigmatising attitudes held by the community can be internalised by people experiencing mental illness. That is, people with lived experience can adopt the prejudicial views held by others. Ms Erandathie Jayakody, witness, explained the burden and constant effort required to call out and reject stigmatising attitudes and discriminatory behaviour (refer to Box 25.2).

Box 25.2: The effect of prejudice, stigma and discrimination

'I have worked in the lived experience work-space for the past eight years, and you would be surprised by the things I hear. For example, "this is a very complex role. It is not suitable for someone with a lived experience", "people with a lived experience should be given part-time jobs not full-time jobs", "peer workers have high turnover rates" and "peer workers become unwell".

Such views are not acceptable. They come from the fundamental belief that people with lived experience are weak, incompetent and somehow "lesser" than other workers because of their mental health challenges.

Yet, people actually do not think twice before making such comments. These statements often go unchallenged in meetings. That is how blind we as a society are to overt stigma and discrimination. Those kinds of comments reinforce the sentiment that "people with mental health challenges are incompetent and are incapable and are weak". By not challenging these statements we continue to perpetuate that narrative. This narrative is incorrect ...

I have worked hard to reject the prejudice. But I am exposed to it all the time. Society tends to see people with mental conditions in a one-dimensional way, that is, it only sees the mental health condition (or probably more accurately, society's perception of mental health conditions). In a recent discussion about workforces a colleague said "personally I think people with a lived experience should be given part-time jobs not full-time jobs". I thought "oh wow, how could you hold that view?" and then immediately after I thought to myself, "oh yes, I did take a bit of sick leave last year". I am amazed how quickly I revert back to that 16 year old self where I think, "I'm weak". It is so quick. That is the effect of the prejudice, discrimination and stigma—that people with lived experience accept the prejudice as truth. I then have to pull myself up again, and reject the prejudice, which is exhausting. So much energy is spent doing a good job and managing a health condition and then on top of that you have to constantly challenge these prejudices with little support and not let it get to you.

There is no understanding about how damaging these seemingly "insignificant" comments can be. It undermines a person's capabilities to work and limits their ability to reach their full potential. People begin to doubt themselves and it erodes their self-confidence. Not only is it a loss of opportunity and loss of potential at an individual level, but it is a loss for the organisation, the mental health sector and the community.'[51]

25.4 People with lived experience face widespread discrimination

Many people with lived experience of mental illness or psychological distress reported experiences of discriminatory behaviour, which, in some cases, left them socially and economically excluded from society.

The Victorian Equal Opportunity and Human Rights Commission (VEOHRC) is an independent organisation with responsibilities under Victoria's anti-discrimination and human rights laws. A core function of VEOHRC's role is resolving individual complaints of discrimination under the *Equal Opportunity Act 2010* which includes protections for people with 'mental health issues'.

Disability discrimination accounts for the largest number of enquiries and complaints that VEOHRC receives each year,[41] with mental health discrimination being a significant portion of these (refer to Table 25.1).[52] Between 1 July 2013 and 31 December 2019, 2,212 people made complaints to VEOHRC about discrimination based on disability. Of those, 472 people (21 per cent) made complaints of discrimination based on mental health.

Table 25.1: Number of disability complaints received by the Victorian Equal Opportunity and Human Rights Commission, by mental health status, Victoria, 2013 to 2019

Area	Number of disability complaints	Number of disability complaints– mental health	Proportion of mental health disability complaints
Employment	674	235	35%
Goods and services	1,005	163	15%
Accommodation	262	29	11%
Education	247	44	18%
Sport	19	1	5%
Clubs	4	0	0%
Local government	1	0	0%
Total	**2,212**	**472**	**21%**

Source: Victorian Equal Opportunity and Human Rights Commission, Resolve database, 24 March 2020.

Note: Collection period is 1 July 2013 to 31 December 2019.

Education complaints are generally made in the context of tertiary education. They typically concern students who experience difficulty completing course requirements because of their mental health, but 'are refused extensions or additional time to complete examinations'.[53] VEOHRC also received complaints by prospective students with a pre-existing 'mental health issue' who were denied access to a course or degree.[54]

Personal story:

Ruth

Ruth* is a peer researcher and consumer advocate living in Melbourne. Ruth grew up in a regional city in Victoria and is now in their mid-20s.

Ruth first experienced severe anxiety and depression at around 16 years old. At 19, they were diagnosed with an eating disorder, borderline personality disorder and were experiencing complex trauma. Ruth has a psychosocial disability and has been receiving support via the National Disability Insurance Scheme. On many occasions, however, Ruth has felt dismissed by mental health services as not meeting the eligibility criteria and has been declined mental health services in times of crisis.

> Services would say 'you're not early intervention, we can't help you', or 'you're not complex enough'. A lot of [Crisis Assessment and Treatment] teams just won't help me at all. And I've had a lot of hospital admissions, where they don't support me at all, and then just discharge me, only to still be in crisis.

Ruth has had some good experiences with services, for example at a Youth Prevention and Recovery Centre (YPARC) and the 12 months they spent at a youth residential rehabilitation program in Melbourne.

Ruth has felt discriminated against many times because of their mental health, including from people close to them, the media, and also from hospitals and mental health services. When Ruth was in the first semester of a course at a TAFE, it declined their requests for flexible learning options.

> I was in hospital for my mental health and was missing a lot of class and so I had to get special consideration, but they weren't really able to do much to help me. They're kind of like, oh well, you need to do this, it's a 'hurdle assessment', you need to do this assessment to continue the course. And they just weren't at all flexible. So I had to drop out of that course.

Due to the nature of Ruth's disability, it was difficult for them to complete practical assessments. However, Ruth said that the TAFE refused to reschedule, despite knowing about their disability. Ruth tried to negotiate flexible learning options and requested disability support through the student support services; however, they felt the TAFE lacked compassion or understanding about disability or mental health.

> So now I just feel like there is too much trauma associated with it to go back. I don't feel like I could handle a TAFE course, because of where I'm at, and because of what TAFE was like with supporting people like me.

Ruth did not finish the first semester of TAFE, and has tried to complete other education courses, including at university. Ruth describes being impacted so greatly by their experience at TAFE, that they have not subsequently been able to complete any tertiary education or certificates. As Ruth said, 'I dropped out of university another two times because of my mental health.' This has had a negative impact on Ruth's confidence and their mental health has deteriorated.

Ruth struggled to secure any full-time or ongoing employment, and was limited to casual work arrangements, a few hours a week, while remaining on the disability support pension. More recently, Ruth has gained additional casual work as a peer researcher and consumer representative. Ruth hopes for a future mental health system that is more responsive and caring for people experiencing psychological distress, particularly when in crisis.

> I'm really passionate about ensuring safe and effective mental health care, and I'm starting to work in the lived experience workforce, and I'm really excited and passionate about that.

Source: RCVMHS, *Interview with 'Ruth' (pseudonym),* November 2020.

Note: *Name has been changed to protect privacy.

This reflects what has been documented by the Victorian Mental Illness Awareness Council, which provides non-legal advocacy for people with lived experience:

> At universities, multiple VMIAC members have raised how there is a failure to make reasonable adjustments, and that these are often based on stigmatising statements and attitudes. For example, members who have gone through a mental or emotional crisis are often not given flexible learning options to re-engage with their university degrees. We also hear how young people are told that they should reconsider university, either by the universities themselves, or by clinicians involved in their care, because they are not considered competent or well enough to do so.[55]

In relation to 'the provision of goods and services, the most common complaints relate to income protection insurance'.[56] VEOHRC also commonly receives complaints about people with lived experience of mental illness or psychological distress being refused entry into public venues, often where the person seeking entry is in a state of distress.[57] Accommodation complaints typically relate to the denial of a rental property after 'an applicant has volunteered information about their disability', or revealed that they receive the disability support pension.[58] Complaints are also made about eviction, where a person is unable to pay rent because of their 'mental health issue'.[59]

In its submission to the Commission, VEOHRC emphasised that there 'is likely significant under-reporting of discrimination against people with mental illness'.[60] VEOHRC highlighted that complaints figures, when taken as a proportion of the Victorian population, are quite different from the proportion of the Victorian population experiencing mental illness:

> Given that one in five Australians experienced a mental or behavioural condition in 2017–18, there is likely significant under-reporting of discrimination against people with mental illness for a range of reasons.[61]

This observation has been made at the national level, with the Productivity Commission also concluding that 'it is likely that the number of people experiencing discrimination on the basis of mental illness greatly exceeds the number of complaints made'.[62]

National surveys of people with lived experience indicate a higher incidence of discrimination than is reflected in the number of complaints made to VEOHRC. For example, the *2010 Survey of High Impact Psychosis* study found that 37.9 per cent of respondents 'had experienced stigma or discrimination because of their experience of a psychotic disorder in the past year'.[63]

More recently, SANE's 2020 *National Stigma Report Card* found that, based on the *Our Turn to Speak* survey, Australians with 'complex mental health issues are commonly subject to pervasive, unrelenting, and impactful stigma and discrimination.'[64] Of those surveyed and who answered questions for the relevant life domain, in relation to the preceding 12 months:

- 95.6 per cent indicated they had experienced stigma and discrimination in relationships
- 60 per cent reported 'frequent' or 'very frequent' experiences of stigma and discrimination in health care
- more than 50 per cent reported 'frequent' or 'very frequent' experiences of stigma and discrimination in employment.[65]

25.5 Stigma and discrimination have profound impacts on people's lives

Stigma and discrimination undermine the dignity and wellbeing of people with lived experience of mental illness or psychological distress and unfairly limit their full participation in society. For people diagnosed with complex mental health issues, stigma and discrimination often pervade all aspects of life, including relationships, employment, healthcare services, mental health treatment, care and support services, housing, social media, welfare and social services, education and financial and insurance services.[66]

This has mental health and wellbeing consequences for people with lived experience. Stigma 'erodes confidence, damages self esteem and contributes to an overwhelming sense of isolation and fear'.[67] Stigma and discrimination can create or exacerbate mental illness and present barriers to accessing treatment and recovery.[68] People who are affected by stigma are more likely to withdraw from pursuing opportunities in the various domains of life.[69] For example, research indicates racism is associated with poor social and emotional wellbeing in Aboriginal young people, including anxiety, depression and suicide risk.[70]

Stigma and discrimination create and compound issues in other parts of people's lives. It has been found that 'experiencing discrimination can cause stress and anxiety and increase the risk of mental health issues, as well as lead to other forms of social disadvantage, such as unemployment, poor education and social isolation, and an increased risk of physical illness'.[71]

Stigma and discrimination are barriers to meaningful social and economic participation. Stigma and discrimination can reduce opportunities to make or maintain friendships, have intimate relationships, gain employment, be granted flexible work arrangements and receive adequate health care.[72]

The Commission has heard that social exclusion of this kind is very damaging for people's mental health, contributing to stress and depression, along with poor physical health.[73] It diminishes people's chances to lead successful and fulfilling lives through a lack of personal relationships that can be drawn on for practical, material and moral support to achieve aspirations. This consequence is described further in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*.

Ms Kristen Hilton, VEOHRC Commissioner, described the harm caused by stigma and discrimination:

> There is strong stigma associated with having [a] mental health condition. This stigma can lead to a misconception that mental health conditions are caused by a weakness of character, rather than an illness, or that people with mental health conditions are dangerous. This can cause shame, a reluctance to disclose a diagnosis and the perception that a person should be able to manage their condition on their own. ... Stigma leads to discrimination and marginalisation, which can, in turn, affect peoples' economic, social and housing security, as well as their general health and wellbeing.[74]

This exclusion and disadvantage is compounded when more than one form of discrimination and stigma affects a person. For example, people living with mental illness and substance use or addiction often endure 'double-stigma' or 'double-discrimination' in their daily lives.

As outlined in Chapter 22: *Integrated approach to treatment, care and support for people living with mental illness and substance abuse or addiction*, exposure to this dual form of prejudice can make it especially difficult for people to participate in society and receive proper treatment, care and support in the mental health system. People living with mental illness and substance use or addiction are also frequently blamed for their circumstances, with prevailing sentiment in the community being that addiction is 'self-induced'.[75] Such a reaction dismisses and diminishes the hardships that may have led to a person's use of or addiction to alcohol or other drugs. As Mr Patrick Lawrence, CEO of First Step, explains:

> There can be judgment directed to people who appear to not be investing any energy into their life and making improvements. The strategy I often employ is to have direct discussions with people which tends to challenge stigma. I often explain that many of the people that may be stigmatised are likely to have been neglected or abused when they were children. Our society does not tolerate the abuse or neglect of children and has a visceral reaction to this. However, the people who are most in need of the support of organisations like First Step are these abused children who are now 'grown up'.[76]

There remains a lack of comprehensive and current data on the nature, extent and impacts of stigma and discrimination experienced by people living with mental illness or psychological distress in different domains of life. While research has been conducted to understand mental health stigma, it is not comprehensive. As highlighted in SANE's 2020 *National Report Card*, 'few Australian research or practice initiatives have specifically targeted stigma and discrimination for people with complex mental health issues'.[77] Consequently, the impacts of mental health stigma and discrimination remain poorly understood.

25.5.1 Experiences of consumers seeking mental health treatment, care and support

Many people shared with the Commission their experiences of stigma and discrimination within healthcare settings, including mental health settings. Consumers spoke of being ignored, judged, dismissed,[78] undermined and not believed,[79] particularly in relation to their personal history and treatment needs[80]—and often during periods of crisis.

There are many consequences that arise from this stigma and discrimination. Research indicates that stigma within healthcare settings is a deterrent to seeking care.[81] People described being dehumanised and devalued by health professionals, being excluded from decisions about care, being threatened with coercive treatment, and being spoken to in a demeaning manner.[82] These experiences often reflect a lower quality of care,[83] breaches of consumer human rights,[84] and poorer health outcomes:[85]

> These mental health services render me and my actions as non-compos mentis. I can sign a contract. I can run a business. I can have a family. But I am considered incapable of making decisions about my treatment, and I am strapped to a bed.[86]

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Figure 25.2: Experiences of consumers seeking mental health treatment, care and support

> I have experienced so much shame and stigma calling mental health triage helplines and attending emergency rooms, that I now have a fear of using these services unless I have already harmed myself. In my experience, services are incredibly hard to gain access to, and fall short of meeting my needs when I am experiencing emotional distress.
>
> I have had too many experiences of calling triage for support and being made to feel ashamed or like I was just seeking attention. I have only ever called triage when I was in genuine distress and this distress was often increased when I was made to feel ashamed by the person on the other end of the phone for reaching out for support. I now choose not to reach out to triage services to seek support myself ...[1]

> I was patronised and blamed for my experiences. For example, when I disclosed the dark space I was in, the therapist rebutted 'well, with an attitude like that ...'. As a result of this, I didn't get the help I needed and ended up getting worse[2]

> The clinical system lacks the basic human needs—when you enter the clinical system you lose your right to make decisions, but you also don't get the basic things people need for healing. You can't talk to anyone. There are no activities that are interesting or healing—a therapy dog once a week is not an 'activity'. You enter with the clothes you are wearing and often stay in those clothes during the whole admission. You don't get to make choices about food, your toothpaste or shampoos.[3]

> When I asked for a female doctor, because I had women's health issues that I wanted to discuss, that was refused. They said that my case was 'too complex' for anyone else to take over. I asked to be shifted to another hospital to be under a female treating team, but they refused. As a result, my physical health was ignored.[4]

> Sometimes you have to ring triple zero just to get services to arrive. Police arrive, and then often you're treated worse than perpetrators in the justice system.[5]

Sources: 1. *Witness Statement of Rachel Bateman (pseudonym)*, 16 June 2020, paras. 20–21; 2. Victoria Legal Aid, *Your Story Your Say, Story #26*; 3. Victoria Legal Aid, *'Your story your say: Consumers' priority issues and solutions for the Royal Commission into Victoria's Mental Health System'*, 2020; 4. Victoria Legal Aid, *'Your story your say: Consumers' priority issues and solutions for the Royal Commission into Victoria's Mental Health System'*, 2020; 5. *RCVMHS, Preston Community Consultation — May 2019.*

The effect of these misconceptions was described in the evidence of Dr Chris Groot, Lecturer at the Melbourne School of Psychological Sciences, University of Melbourne:

> there is a common perception in mental health workers that people labelled with [borderline personality disorder] are manipulative and may not actually be at risk of suicide when they present as such to crisis services; however, they are 45 times more likely to die by suicide than people in the general population.[87]

Stigma and discrimination can also result in 'diagnostic overshadowing', where health professionals incorrectly attribute physical symptoms to mental illness, leading to delays in access to crucial physical health treatment.[88] This is in part reflected by evidence that people labelled with severe and persistent mental illness are likely to die 30 years younger than the rest of the Australian community.[89]

Associate Professor Dan Siskind, Clinical Academic Psychiatrist at the Princess Alexandra Hospital and academic at the University of Queensland, pointed to the discrepancies in diagnosis and treatment for cancer, noting:

> people with schizophrenia are no more or less likely to develop cancer, but are much more likely to die of it; they are less likely to be investigated for cancer and, even if they are investigated for cancer, they are less likely to get evidence-based care.[90]

People with comorbidities told the Commission they did not receive coordinated care due to stigma and discrimination. Victoria Legal Aid's *Your Story, Your Say* project shared the views of Imogen Gandolfo:

> The clinical system doesn't address physical health—despite being in a hospital, mental health units don't care for people's physical health issues. Your access to medication that is not for mental health is very limited to non-existent. It's a lengthy process, and unlikely to happen, that you will get your regular medications without an authority from another doctor.[91]

One person with lived experience of mental illness or psychological distress described being denied access to medication for their physical health issues:

> In many of my admissions, I couldn't access my medications for my physical health issues. I was denied my insulin for over a day, which resulted in an emergency department admission. There was no justification for being denied my medication. This resulted from a lack of communication between staff and a lack of understanding of my physical health needs. The physical health of many people in psychiatric wards often deteriorates.[92]

The Commission also heard that consumers' concerns regarding side effects of medication were not always heard. One participant in Victoria Legal Aid's *Your Story, Your Say* project said:

> I was forcibly medicated for 6 months. I was prescribed aripiprazole, which was meant to have the fewest side effects. There were plenty of harmful effects on me and I had a formal letter from my specialist telling the treating team they had got it wrong. Some of the side effects included severe chest pain and breathing issues, chronic fatigue, loss of concentration, loss of motivation, loss of eyesight and hair falling out as well as developing depression. I increased three dress sizes as a result of the increased appetite for food that went totally against my normally strict autoimmune diet. For all of this I saw no benefits from the medication. I wasn't ever given a say nor was I respected when I complained about the extensive side effects. It was coercive and draconian.[93]

In the *Our Turn to Speak* survey, on average, 63 per cent of participants said they expected to experience future discrimination in health care—for example, by being unfairly denied care when seeking help for physical health problems.[94]

Figure 25.2 provides first-hand accounts of stigma and discrimination that consumers encountered in healthcare settings.

25.5.2 Discrimination against lived experience workers

Lived experience workers (workers with lived experience of mental illness or psychological distress or workers with lived experience as a family member, carer or supporter) in the mental health system can also encounter stigma and discrimination. Witnesses described encountering negative beliefs about the capabilities of lived experience workers, hearing people living with mental illness described and treated in demeaning ways, being made to feel less capable than other staff, being paid less than others for commensurate roles, and being denied opportunities for career progression.[95]

Ms Jayakody told the Commission:

> In my experience, even when I have clearly disclosed I am a consumer worker, people say and get away with statements like 'peer workers can't work full-time'. There is lack of recognition that such statements are discriminatory. It is often left up to the consumer worker like myself to challenge these statements.[96]

Most people in the lived experience workforce are employed part-time.[97] There may be many reasons for this, including the worker's preference. However, the Commission heard that a commonly held view is that lived experienced workers can only manage part-time work, and that as a result, lived experience workers are often only offered part-time positions. The belief that lived experience workers are only capable of part-time work was something many lived experience workers had encountered, as reflected in the following statement:

> There is a fallacy that peer workers can't do full time work which I believe to be quite discriminatory.[98]

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Stigma and discrimination can result in workers being passed over for promotion as a result of misguided concerns about their capability, or assumptions that they, as lived experience workers, cannot 'cope' with full-time work:[99]

> When the funding did become recurrent funding, my employer wanted me and my colleague to reapply for our positions. When we reapplied for our positions, they re-hired my colleague, and instead of also re-hiring me, they hired an external applicant instead of me, which is fine—it is all part of the process. I would have understood if the successful applicant simply had a higher level of skill than I had. However, my then supervisor said afterwards that they thought my diagnosis may not be a good fit for working in that area. When I brought this up as something that wasn't okay for them to say, they did not understand why it was not okay.[100]

The Commission also heard that the treatment of lived experienced workers reflected the community's and mental health system's tendency to make people with lived experience the problem, rather than examining their own behaviours or structures:

> I have repeatedly heard people say 'the peer worker can't cope so they're leaving', without having any regard to issues with the environment in which they are working. I am shocked by how prevalent these kinds of comments are ... Why a peer worker decides to leave is never about working conditions, team dynamics, role clarity or personal choice. There is no examination about whether a person can actually flourish in the environment. This is not limited to lived experience workers in the mental health sector, it applies to lived experience workers across all sectors; whatever the role it is always about the person with lived-experience, and not the environment.[101]
>
> This standard is not extended to other disciplines and so is a double standard.[102]

As the *Leading the Change* report on consumer workforce challenges and opportunities finds, much of this relates to 'strong hierarchy and power imbalance in the mental health workforce, in which consumer workers occupied the lowest level'.[103] These examples and their drivers reflect discriminatory systems that undermine the development and sustainability of a lived experience workforce.[104]

As outlined in Chapter 33: *A sustainable workforce for the future*, there will be significant growth in the size and diversity of lived experiences workforces in Victoria's future mental health and wellbeing system. In addition, support will be provided to develop the leadership capabilities of people with lived experience of mental illness or psychological distress (refer to recommendation 28).

25.5.3 Stigma and discrimination in workplaces

The Commission heard evidence that people living with mental illness or psychological distress face dismissive treatment or lack of understanding of their illness at work.[105] In her witness statement, Associate Professor Nicola Reavley, Head of the Population Mental Health Unit and Deputy Director of the Centre for Mental Health, University of Melbourne, highlighted the following findings in the *National Survey of Mental Health Literacy and Stigma*:

> **In the domain of the workplace or people searching for work, the most common types of discrimination included dismissive treatment or lack of understanding of the illness (identified by 27% of respondents), being forced to change responsibilities or being denied opportunities at work (24%), being fired (15%), or being treated as incompetent (13%).[106]**

People with lived experience are reluctant to disclose their diagnosis to employers.[107] Witnesses have described it as being 'career limiting' to do so.[108] They have also described the risk of being 'time-capsuled,'[109] whereby a person is defined by the disclosure of their mental illness. As Dr Michelle Blanchard, Deputy CEO of SANE Australia and Founding Director of the Anne Deveson Research Centre, explains, non-disclosure can be detrimental because it can mean the person is 'unable to access flexible work arrangements or reasonable adjustments that they might find helpful to remain in the workforce'.[110]

However, people can experience stigmatising attitudes when they require flexibility—for example, to accommodate medical appointments or when they need 'reasonable adjustments' in order to work.[111] Ms Hilton, VEOHRC Commissioner, told the Commission that 35 per cent of mental health discrimination complaints relate to workplaces, many of which involve employers refusing to make 'reasonable adjustments' for people who disclose a mental illness.[112]

Fears about disclosing one's lived experience are not unfounded. Research by SuperFriend found that 45 per cent of working Australians with 'mental health conditions' reported experiencing stigma at work.[113] Research by the Monash Sustainable Development Institute indicates that Australian employers hold more stigmatising attitudes towards people with 'mental health issues' than towards those with physical disabilities, because they feel 'mental health issues' are 'unpredictable and often loosely defined'.[114]

Drawing on previous research, the Productivity Commission's *Mental Health Inquiry Report* highlights that employers 'expect workers with mental ill-health to have lower productivity and higher absenteeism than other workers, and will either fail to hire, or fail to promote those with mental ill-health'.[115] The report noted evidence that many employers are inclined to overlook a potential employment candidate when discovering they have a mental illness, believing 'they would be taking on an unreliable employee and possibly a liability'.[116] The Productivity Commission identified the reluctance to disclose mental illness, due to fears of discrimination and the lack of employer support, as a significant problem.[117]

Research also indicates that systemic discriminatory workplace practices exist towards people living with mental illness, based on the beliefs that they lack competence, that they need supervision, or that work is not healthy for them.[118]

Dr Blanchard told the Commission that for people diagnosed with 'complex mental health issues', structural discrimination manifests in the workplace in three main ways:

- poor mental health can lead to people not completing secondary or post-secondary education, which can limit their opportunities to join the workforce
- people can find it difficult to enter the workforce if they disclose they have lived experience of poor mental health. Where there are gaps in a person's CV due to periods of severe ill health, the person faces the choice of disclosing their illness, or not explaining the gaps. Either approach can make it difficult for people to secure work
- the episodic nature of many mental illnesses can make it difficult for a person to anticipate their ill health. In taking on a job, people can feel unsure how their illness will play out and affect their ability to participate in the workforce.[119]

During a community consultation hosted by the Commission, one participant described her daughter's experience in seeking work:

> My daughter went to Centrelink and at the end of her appointment they said we'll try to find you a job but just don't tell anybody you're schizophrenic.[120]

Ms Lisa Annese, witness and CEO of the Diversity Council of Australia, explained that employers may not see their actions as discriminatory, and may believe they are in fact looking after their fellow employees:

> I do think it is important though to note that some people might not view their prejudices as stigma or as harassment; they might view them as reasonable prejudices to have. For example: someone might think, I cannot hire this person or promote this person because you know this is a really challenging work environment and the pressure might be too much. They may think that they are being benevolent about their reasons for discriminating, but we need to be careful with 'benevolent discrimination'. People need to step back and realise that they are not the best decision-makers when it comes to the mental health and wellbeing of other people. [121]

Ms Annese also spoke of the 'self-editing' that happens, even in psychologically safe places, due to self-stigma and people's 'fear that if they disclose something, it will change the way they are perceived'.[122] In his witness statement, Mr David Pearl, innovator, author and public speaker of The Studios, London, giving evidence in a personal capacity, noted that it can be career limiting to disclose an ongoing issue:

> A common experience I've heard in organisations is that it's cool and accepted to talk about mental wellness; it's not career limiting to disclose to people that you have had a mental disturbance. But it is career limiting to say that you think you might have it in the future. In other words, people could accept that an employee has a history of mental disturbance. It's almost like 'Oh, you've got a history of diabetes,' it is something for HR, it is a kind of mitigated risk. But if employees say 'I'm okay but I'm really feeling the wheels might fall off,' they very often feel that, although nothing is said, people just pull away from them and start to assign the work in different ways. It is like it is a dangerous thing to say, which is interesting, because actually that's the thing you really want people to be able to say without fear of repercussion: 'Look, I'm fine, but I can feel … keep an eye on me'.[123]

A flow-on effect of workplace stigma for people with lived experience can be a reluctance to seek employment, in anticipation of stigma and discrimination.[124] Furthermore, 'a person's self-stigma will impact on whether or not they are going to put themselves forward for a job, a relationship or an opportunity in different environments'.[125]

The contrast between workplace understanding of, and responses to, physical and mental illnesses is stark. One witness, Theresa, highlighted the lack of social norms in relation to mental illness, and the isolation she felt as a result:

> If I had taken sick leave at work because of physical illness like breast cancer, everyone would be sending me flowers and could easily name the problem. However, when it comes to mental illness, I have the impression that people are unsure what to do. People seem to be hypersensitive [about] mental illness. It is not spoken about openly. It's ok to be unwell. But we aren't sure if it's acceptable to be mentally unwell. There seems to be a fear about naming mental health problems. I had never heard anyone at my workplace say that they have spent time in a psychiatric hospital. When a person disappears for a time and then returns on a special project, it is only talked about quietly. When I was the one experiencing this, it felt really lonely.[126]

One consequence of discrimination in the workplace is that people are not engaged in meaningful work. This can be distressing, isolating and financially disadvantageous:[127]

> Often the employee gets to a crisis point in the employment and ends up leaving, as they are unable to manage their health and wellbeing needs alongside their work. Some people end up under-employed, or end up working in areas that are different from those applicable to their qualifications. This can then have flow-on effects for their financial position and access to safe and secure housing.[128]

In its submission to the Commission, Beyond Blue relayed stories that had been shared with them describing the challenges people with lived experience of mental illness or psychological distress face in the workplace:

> Workplaces treat you differently. I am passed over for opportunities because I might not be able to handle extra stress … Co-workers see you as less competent or attention seeking. It's better not to ask for assistance because work tends to make a big issue…[129]

A 2014 report published by the Organisation for Economic Co-operation and Development highlighted that people living with mild or moderate 'mental health conditions' are two to three times more likely to be unemployed than the general population.[130] This figure increases to six to seven times for people with 'severe mental health conditions'.[131] Dr Blanchard told the Commission that people living with a psychological disability in Australia have the lowest workforce participation rate (29 per cent), and the highest unemployment rate (20 per cent).[132] This can have flow-on effects on the person's family and loved ones, as the person becomes more isolated and reliant on them. The experiences of caring for someone with mental illness are outlined in detail in Chapter 19: *Valuing and supporting families, carers and supporters*.[133]

In turn, the stigma associated with mental illness means some families, carers and supporters feel they cannot talk openly in the workplace about their caring responsibilities. This can result in an employer being less willing to provide flexibility to work non-standard hours or to work from home, because they are unaware of the employee's additional responsibilities:[134]

> A real difficulty for carers can be the episodic nature of mental illness ... [which] is often all-consuming and requires carers to drop everything to provide support. This does not fit in neatly with the traditional structures of paid employment, particularly where people are expected to work set hours at the workplace, and have fixed amounts of leave.[135]

The significance of workplaces as sites for mental health promotion and prevention, and the crucial role that the mental health workforce plays in people's opportunities for mental health and wellbeing, are explored in detail in Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect,* and Chapter 33: *A sustainable workforce for the future*.

25.5.4 Stigma and discrimination in other settings

Evidence before the Commission indicates that people living with mental illness also face stigma and discrimination in many other domains of life, including the private rental market[136] and the insurance sector. These issues are explored in detail in the Productivity Commission's *Mental Health Inquiry Report* and SANE's 2020 *National Stigma Report Card*.

In the private rental market, there is a perception that people with lived experience are 'difficult' tenants.[137] As identified in the Productivity Commission's report, prospective renters who disclose a mental illness are less likely to receive a response to their rental inquiries, be told that an advertised unit is available, or be invited to inspect an available unit.[138] There is also a greater expectation on them than others to produce guarantees of support or references, in order to secure a private rental.[139]

As safe and secure housing is fundamental to recovery, and as there is very limited public and social housing in Victoria, these barriers to accessing the private rental market create a major challenge for recovery. Jenny Smith, CEO of the Council to Homeless Persons, told the Commission:

> In a competitive rental market, where real estate agents have multiple applicants for rental properties, this very commonly leads to discrimination. Real estate agents select the preferred tenant using objective criteria such as income, as well as subjective criteria, such as appearing to be someone who may be a 'good tenant'.[140]

Chapter 16: *Supported housing for adults and young people,* explores the intersection between mental health and housing in further detail.

The stigma towards, and discrimination against, people with lived experience of mental illness or psychological distress by the insurance sector is also well recognised.[141] People with a mental illness often find it difficult to obtain, and claim on, different types of insurance products, such as travel insurance, income protection, total and permanent disability, and life insurance.[142]

Ms Meagher recounted her experience of such discrimination:

> [because of a history of mental illness] I was never able to get income insurance and when I travel I struggle to get travel insurance.[143]

The widespread nature of discriminatory insurance denial is documented in the Mental Health Council of Australia and Beyond Blue survey *Mental Health Discrimination and Insurance: A Survey of Consumer Experiences 2011,* which was cited by the Productivity Commission in its *Mental Health Inquiry Report*.[144] Approximately 22 per cent of respondents who identified as a 'mental health consumer' reported having an insurance application declined due to mental health. When the applications concerned life insurance and income protection insurance, the rates of rejection reported were higher, increasing to 36 and 45 per cent respectively.[145]

25.5.5 Stigma and discrimination across Victoria's diverse communities and social groups

Some Victorian communities face multiple forms of stigma and discrimination. For example, Aboriginal people,[146] LGBTIQ+ people, people from culturally and linguistically diverse backgrounds, people who are deaf or hard of hearing, refugees and asylum seekers,[147] and people with dual disabilities[148] are subjected to intersectional discrimination.[149] Intersectional discrimination or psychological distress occurs where a person experiences intersecting forms of discrimination on the basis of multiple, personal attributes such as disability and race, which interact with and compound one another.'[150] This can worsen marginalisation and disadvantage.

As Rainbow Health Victoria outlined:

> The recognition of age, class, gender, race, sexuality, cultural background and disability offers a framework for inclusive consideration of multiple intersecting disadvantage. People who are LGBTIQ and from an Aboriginal and Torres Strait Islander or culturally and linguistically diverse background, or who have a disability can face multiple, compounding disadvantages, and are more likely to delay, avoid or prematurely cease mental health care. The effectiveness of programs and supports depends on intersectional needs being recognised and addressed in policy and service design, and service delivery.[151]

While discrimination on the basis of attributes other than mental illness is outside the Commission's letters patent, intersectionality (the meeting point of all components of one's identity)[152] means that attempting to distinguish discrimination based on mental illness from discrimination based on other attributes can be fraught. The Commission also acknowledges that stigma and discrimination contribute to psychological distress and that they are a risk factor for post-traumatic stress disorder, depression and anxiety.[153] This is often understood and examined through the Minority Stress Model, which conceptualises how greater vulnerability for some communities emerges from their subjection to unique stressors as a marginalised group.[154]

The issues underlying stigma and discrimination are not uniform across Victoria's diverse communities.

Indigenous Australians continue to suffer serious marginalisation and deprivation at a rate that is higher than any cultural group in the country. On various measures of wellbeing and prosperity, such as life expectancy, children's mortality, education, employment, income, and housing, Indigenous Australians are the most disadvantaged citizens.[155]

Ro Allen, Commissioner for LGBTIQ+ communities (formerly the Victorian Commissioner for Gender and Sexuality), highlighted how the 'pathologisation' of identity impacts LGBTIQ+ communities:

> One of the most profoundly negative experiences for a LGBTIQ person who seeks mental health support is when the clinician, service provider or support worker assumes that the person's mental health issues are the direct result of their sexuality, gender identity or intersex status.[156]

Commissioner Allen went on to highlight how homosexuality remained a 'diagnosed mental disorder' until the 1970s, and a criminal offence in Victoria until 1981.[157]

Some people from culturally and linguistically diverse communities can also experience double stigma, where racism in society and within mental health services compounds public and internalised shame around mental illness.[158]

Older Victorians (aged 65 and over) experience intersecting stigma and discrimination relating to both their age and mental health challenges. This acts as a barrier to accessing mental health and wellbeing treatment, care and support. Evidence suggests that older Australians are often subjected to ageist beliefs and stereotypes that do not accurately reflect the nature of this cohort.[159]

For some communities, stigma, and particularly self-stigma, can be a barrier to disclosing mental health concerns and seeking help. This is particularly apparent in some migrant communities, and in rural and regional communities.

Different cultural conceptions of mental health can make self-stigma particularly acute in some culturally diverse communities, where mental health issues are seen as taboo or as bringing shame on the family.[160]

Among parents in migrant communities, perceived stigma, combined with a lack of understanding of mental health, poses a barrier to children accessing care, with parents worried about the stigma of mental health negatively affecting a child's future study and work opportunities.[161] In a study carried out by Foundation House, young asylum seekers used the terms 'embarrassment', 'guilt', 'judgment', 'pity', 'mockery', and 'taboo' to describe how their peers, families and communities felt about mental illness and accessing mental health services.[162]

Similarly, the 'close-knit' nature of many rural and regional communities, combined with a culture of independence and stoicism, can cause shame about mental illness, and reluctance to risk 'exposure' by seeking help.[163]

As the Commission found in its interim report, the reluctance of people in rural and regional communities to seek help often stems from a fear of judgement or embarrassment or a fear that their circumstances might become public knowledge.[164]

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In some communities, mental health workers are well known to the people they support. This kind of familiarity can sometimes be an asset, but it can also result in a perceived lack of anonymity or confidentiality when seeking support.

Mr Terry Welch, CEO of Maryborough District Health Service, observed:

> In regional towns, one of the challenges is that when a resident presents at the GP (which is the access point); they know the person who is at the reception desk. People are not likely to seek and engage with support in those circumstances.[165]

This reluctance to seek help can be exacerbated by what has been described to the Commission as the 'tough it out' attitude among rural people and the '"*we'll be right*" approach; the stoic rural way'.[166]

Small towns built on a culture of independence and self-sufficiency can restrict frank and open discussion about mental health, leading people to shy away from asking for help. The Royal Flying Doctor Service Victoria submitted:

> In rural and remote communities, stigma, in particular, self-stigma, is a key barrier to progress. There [is still a] strong cultural desire for independence and [an] attitude that [aligns] asking for help with failure.[167]

The Commission believes that community-led organisations and community members are best placed to understand the particular challenges faced by their community, and to design and deliver projects that challenge that stigma.

25.6 Confronting stigma and discrimination sets the foundations for mental health and wellbeing

A central goal of the Commission is to see the full participation of people with lived experience of mental illness or psychological distress in public life. Achieving this will require the entire Victorian community to take action to reduce barriers to participation in public life that exclude people with lived experience.

This duty is grounded in human rights obligations that extend to all Victorians, irrespective of whether they experience poor mental health. All people should enjoy human rights equally. Under the *Charter of Human Rights and Responsibilities Act 2006* (Vic), every person has 'the right to enjoy his or her human rights without discrimination', and the right to 'effective protection against discrimination'.[168] These rights are further embedded in the Equal Opportunity Act, which protects people with lived experience against direct and indirect discrimination.[169]

Unfortunately, routine experiences of stigma and discrimination against people with lived experience often reflect a failure to uphold human rights. This is despite existing measures designed to protect and safeguard their humanity.

The Commission appreciates that exclusion from services, education, housing and employment represent profound human rights issues. People with lived experience have described how this causes a sense of shame, through no fault of their own. One person, who had experienced compulsory mental health treatment, spoke about their combined experiences of stigma and discrimination:

> For all the bad things that happen in my life, my 'mental illness' is blamed, instead of my forced medication. Weight gain, being tired and lazy, having a boring brain and no motivation, physical issues—these are all apparently because of my 'mental illness', not because of my forced medication ...[170]

The person also spoke of being monitored by services, while at the same time being shut out from society:

> The other thing about living regionally is that everyone knows what's going on with you. Your business is everyone's business, and once you've been tagged with a mental illness, they won't answer their phones, talk to you or serve you. It's discrimination.[171]

These experiences of shame and exclusion are not isolated incidents—they reflect a failure of the broader Victorian community to be inclusive of people with lived experience.

In addition to the harm caused, stigma and discrimination prevents the community from enjoying the benefits and contributions that people with lived experience have to offer. The Victorian Mental Illness Awareness Council has told the Commission that:

> consumers are too often framed in the negative. We, as consumers must routinely respond to questions that presume we lack capacity, fortitude or 'insight'. Beyond the harm this causes us, it cuts the broader community off from the wisdom that can arise from our lived experience, or as some say, 'madness'. Our members present world views—through debate, music, and other forms of art—that enrich the community. The present problem is less that we lack any individual skills or capacities, and more that we have been systematically excluded from platforms to share these gifts.[172]

The failure to include and promote these voices diminishes the Victorian community's understanding of mental health and wellbeing. The Commission has received submissions from Hearing Voices groups across Victoria,[173] which tackle stigma by supporting individuals with lived experience of mental illness or psychological distress and encouraging the public to consider new ways of understanding and responding to hearing voices (refer to Box 25.5).

These approaches, and the voices of people with lived experience more generally, remain stigmatised by, or excluded from, the mainstream community.

This exclusion of people with lived experience of mental illness or psychological distress from the community and public also represents a continuing challenge to Australia's obligations under the *UN Convention on the Rights of People with a Disability* (CRPD). The CRPD—which the Australian Government ratified in 2009—makes clear that governments have the obligation to ensure that people with a disability enjoy equal participation in political and public life,[174] and that they are consulted and actively involved in decisions regarding the development and implementation of legislation and policies that affect them.[175] Evidence regarding stigma and discrimination in Victoria suggests there is still considerable work to do in realising these obligations.

The Commission understands that, as both an obligation and a practical necessity, stigma and discrimination must be addressed in order for Victorians to enjoy a more inclusive society that promotes, rather than undermines, mental health and wellbeing.

Box 25.3: Hearing Voices Networks

The Hearing Voices Network[1] is a collection of organisations and individuals who advocate for an alternative approach to hearing voices (often termed 'auditory hallucinations'), having seeing visions (often termed 'visual hallucinations'), and having unusual beliefs (often termed 'delusions') to what is typically offered within clinical mental health services.

Proponents of this approach describe alternative ways of understanding these experiences:

> hearing voices, seeing visions and related phenomena are meaningful experiences that can be understood in many ways; hearing voices is not, in itself, an indication of illness—but difficulties coping with voices can cause great distress; when people are overwhelmed by their experiences, support offered should be based on respect, empathy, informed choice and an understanding of the personal meaning voices have in someone's life.

In addition to providing support for people hearing voices and who may have experienced trauma,[2] these networks combat stigma by encouraging the public to consider new ways of understanding and responding to unusual experiences and behaviours like voice hearing.[3] These approaches ask the public to support people with lived experience to explore the meaning behind these experiences, and are supportive of individuals who choose to take, or abstain from taking, medication for these experiences. There are several Hearing Voices groups set up across metro and regional Victoria, with several witnesses endorsing their value for people with lived experience and the community.[4]

Source: 1. Rory Neirin Higgs, 'Reconceptualizing Psychosis: The Hearing Voices Movement and Social Approaches to Health', *Health and Human Rights Journal*, 22.1 (2020), 133–144 (p. 133); 2. Witness Statement of Indigo Daya, para. 26; 3.Dirk Corstens and others, 'Emerging Perspectives From the Hearing Voices Movement: Implications for Research and Practice', *Schizophrenia Bulletin*, 40. 4 (2014), S285–S294 (p. S285); 4. Witness Statement of Dr Chris Groot, para. 74.

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25.7 Strategies to reduce stigma have not materially shifted attitudes

The Commission recognises that responding to stigma against mental illness requires long-term cultural change. Deeply embedded perceptions and stereotypes about mental illness are difficult to shift, particularly when reinforced by discriminatory policies and practices.

25.7.1 Changing community attitudes

Evidence before the Commission indicates it is possible to change public knowledge and attitudes in relation to mental illness.

In recent years, stigma about more common experiences of mental illness, such as anxiety and depression, has reduced. Between 1995 and 2011, people's mental health literacy—the ability to recognise a mental illness, beliefs about treatments, causes, prevention, prognosis and how to help others—has improved, particularly in relation to depression.[176] People are now much more willing to disclose that they have depression, and are much more likely to know someone with depression.[177]

Targeted and sustained awareness-raising campaigns, together with the high prevalence of anxiety and depression in the community, are likely to have contributed to the community's understanding of depression.

While there have been considerable efforts to reduce the stigma associated with more common diagnoses, such as depression and anxiety, other diagnoses that are considered more 'complex', such as borderline personality disorder and schizophrenia, remain poorly understood and highly stigmatised.[178]

In the community, there remains a 'desire for social distance'[179] from people with lived experience of mental illness or psychological distress—that is, an unwillingness to interact socially or professionally with people with mental illness, and a desire to avoid them.[180] Between 2003–2004 and 2011, this desire for social distance decreased, although there was no decrease in a desire for social distance from people with chronic schizophrenia.[181]

Of particular concern is that there has been 'an increase in perceptions of the dangerousness and unpredictability of people living with depression, depression with suicidal thoughts, or schizophrenia'.[182] This includes perceptions that people living with schizophrenia are violent, dangerous and unpredictable, unable to care for themselves, and that they have no chance of recovery.[183]

Box 25.4: Anti-stigma interventions

Beyond Blue has implemented several multi-modal and long-term anti-stigma interventions to improve public attitudes and behaviours around depression and anxiety. These interventions have included media advertising, community education programs, training prominent people as champions, disseminating print and digital materials, mental health literacy and community discussion forums.[184]

Other examples of interventions include:

- Mental Health First Aid training, which started as a small volunteer effort in 2000 and has since been replicated in other countries
- Mind Matters programs in high school that are incorporated into regular lessons
- RUOK Day, where people ask others about their mental wellbeing
- Rotary community forums on mental illness that bring elected officials into contact with ordinary citizens across the country
- Mindframe, a national media initiative that provides training programs and guidelines for responsible reporting about suicide.[185]

Evidence indicates that these initiatives have had a positive impact on raising depression awareness in Australia and have made progress in reducing stigma and social barriers.[186] However, it is unclear whether people with depression have experienced a reduction in stigma and discrimination as a result of the interventions.[187]

While tragic incidents have resulted from dangerous behaviour by people experiencing a mental health crisis, the perception that all people with lived experience are dangerous is unfounded and wrong. Such perceptions are a barrier to people's recovery and their meaningful social inclusion. Distinguished Professor James Ogloff AM, Executive Director, Victorian Institute of Forensic Mental Health, Distinguished Professor, Centre for Forensic Behavioural Sciences at Swinburne University, giving evidence in his personal capacity, said::

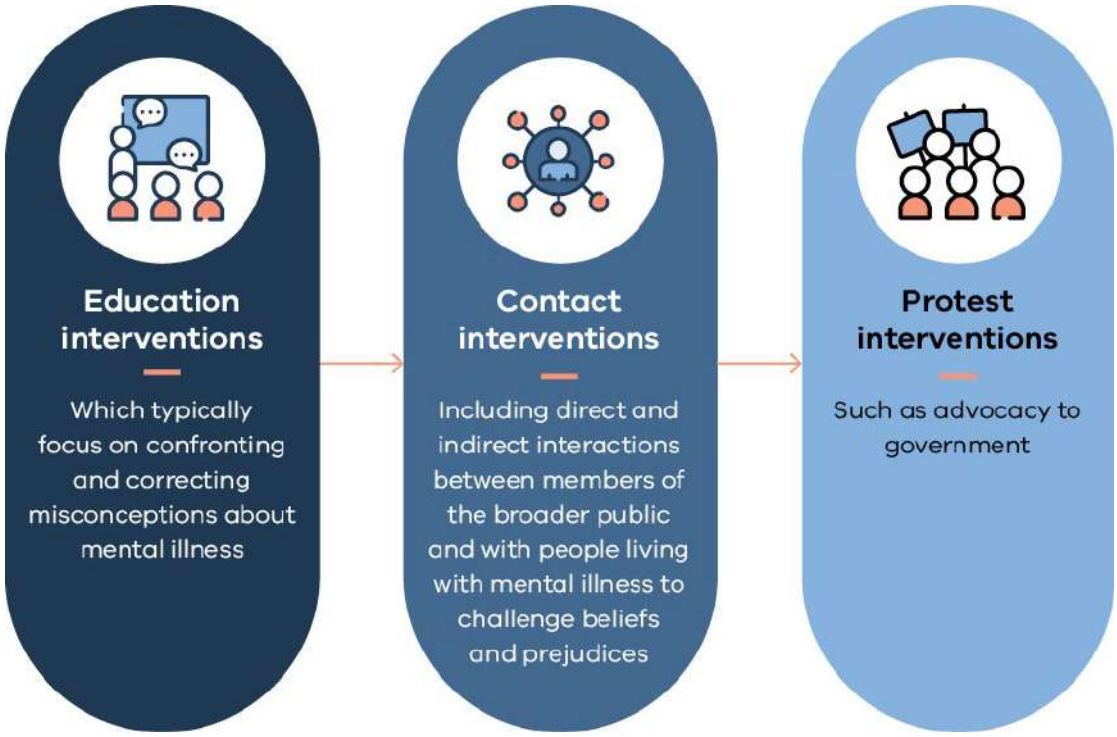
> The discourse needs to shift from people living with mental illnesses are dangerous, unpredictable, and should be in institutions to better reflect the reality of the situation, as conveyed in the research findings ... That is, the vast majority of people living with mental illness are not violent and do not offend.[188]

Stigma researcher Dr Groot told the Commission that there is a long way to go in changing perceptions about severe and complex mental illness, noting, 'we certainly do not see schizophrenia regularly featuring in positive mass media stories about hope and help seeking, for instance'.[189] The Commission is aware, for example, of the widespread concern among Australian consumers and consumer peak organisations about the depiction of poor mental health in Australian television shows and the failure of those shows to interview a person with lived experience of mental illness or psychological distress when making links between mental health and violence.[190]

25.7.2 Lack of strong evidence about effective measures

There is also a lack of strong evidence about effective ways to eliminate stigma. Research focused on the main approaches currently taken (refer to Box 25.4) indicates there is limited evidence about the success of these approaches. Systematic reviews of these approaches found only small to moderate short-term benefits, and little evidence of the long-term benefits across multiple settings.[191] Evidence suggests that, on the whole, short-term stigma reduction programs may yield short-term, if any, benefits.

Figure 25.3: Main types of stigma interventions



Source: Nicolas Rüsch and others, 'Mental Illness Stigma: Concepts, Consequences, and Initiatives to Reduce Stigma', *European Psychiatry*, 20.8 (2005), 529–539; Patrick W. Corrigan and others, 'Challenging the Public Stigma of Mental Illness: A Meta-Analysis of Outcome Studies', *Psychiatric Services*, 63.10 (2012), 963–973 (p. 963).

An intervention that works in one setting or within one population group may have little impact in another. For example, contact approaches that work generally for adults may be less effective for youth,[192]or may, in fact, be detrimental.[193] This makes it difficult to draw conclusions about the effectiveness of different approaches to reducing stigma.

It is important to note that the absence of strong evidence does not necessarily mean stigma reduction efforts are of little value. There are a number of factors that affect the ability to draw conclusions about the effectiveness of interventions, including factors related to study design and quality, differences in indicators used to assess the effectiveness of interventions, and difficulty in attributing changes to specific interventions.[194]

The Commission has also heard that use of 'biogenetic explanations' of mental illness, for example reducing distress to heredity brain disease and a 'chemical imbalance', can inadvertently reinforce negative stereotypes, by promoting the idea that symptoms associated with mental health are inevitable and permanent.[195]

Research also indicates that this stereotyping endorses notions that people with psychological problems are dangerous and that they are unlikely to recover.[196] Ultimately, where they reinforce negative stereotypes, biogenetic explanations can increase, rather than decrease, the desire for social distance.[197]

25.7.3 Efforts to reduce stigma are too often designed and delivered without the input or leadership of consumers

The Commission recognises the importance of lived experience participation and leadership in the planning, design, development and implementation of mental health programs.[198] A criticism of current approaches to stigma research and interventions is a failure to draw on the expertise of people with lived experience of mental illness or psychological distress. It has been noted that many social scientists and researchers do not come from groups who experience stigma. This can mean that theories are given more weight than the lived experiences and perceptions of the people who are the subjects of those theories.[199]

In addition, stigma reduction programs that do not involve the meaningful participation of people living with mental illness or psychological distress, but instead appropriate lived experience stories, may replicate the same power dynamic that the lived experience movement seeks to disrupt.[200] Lived experience advocates point out that anti-stigma campaigns effectively 'sanitise' stories (by removing details the public may find too confronting), and 'do little to change the way that agencies function or to address broader issues such as poverty, unemployment and discrimination'.[201]

The Commission has also heard that there are few opportunities for lived experience researchers to lead, co-design or deliver stigma programs, and that a range of barriers stand in the way of people with lived experience becoming researchers and academics. This includes an increased risk of socioeconomic disadvantage,[202] or interruption to traditional education. Low incomes can present a barrier to entry into higher education research degrees,[203] and there are limited scholarships to redress inequality.

More than a decade ago, the University of Melbourne was the first university in Victoria to establish a lived experience academic role. Ms Cath Roper now holds this role in the Centre for Psychiatric Nursing. In her witness statement, Ms Roper discussed the importance of lived experience researchers in co-producing programs and services. She also noted that while there are lived experience researchers in Victoria, there has not been any appreciable increase in these roles.[204]

It can also be difficult to pursue the research interests of consumers and survivors, because research roles are often tied to a clinical discipline, such as nursing, social work or psychology. Consequently, people with lived experience of mental illness or psychological distress may not be able to pursue research interests that do not also relate to a clinical discipline.

As service user academic, Professor Diana Rose, said:

> Conventional research has focussed on clinical issues and interventions such as pharmacological and psychological ones and outcomes measured largely in terms of symptoms reduction with occasional nod towards measures of quality of life. These concerns may not be those that matter most to service users and patients.[205]

A related issue is that lived experience researchers are likely to be less successful in competitive research funding grants. Funding programs are typically geared towards clinical researchers (and clinical research), and few recognise and support the different experience and qualifications of people with lived experiences of mental illness or psychological distress.

The limited scope of consumer-led research is a lost opportunity to improve the quality of mental illness research across multiple domains. Australian National University academic, Dr Michelle Banfield, describes how lived experience researchers can break down the barriers between consumers and researchers, and in the process, change perceptions about the importance of consumers in research:

> Academic researchers who also have lived experience have the potential to bridge the gap between the consumer sector and traditional academic researchers, bringing together the lived experience of mental health issues with academic training (Griffiths 2002). By breaking down the dichotomy between 'lay consumer' and 'academic researcher,' lived experience researchers may increase the acceptance of people with lived experience as equal partners in the research process by other researchers and may influence both the research sector and the wider community on the importance of involving other consumers in the research process.[206]

Effective stigma prevention and reduction approaches in other jurisdictions—including the programs See Me in Scotland[207] and Like Minds, Like Mine in New Zealand—demonstrate that consumer expertise is central to success.[208] The appointment of at least one lived experience Commissioner in the Mental Health and Wellbeing Commission is a key part of the reforms described in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress,* and Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*. This Commissioner will be responsible for the design and delivery of anti-stigma efforts described in this chapter.

Scotland's Lived Experience Research Collective provides another example of an anti-stigma program that has developed a strong and influential lived experience research workforce. In 2015, See Me formed the Lived Experience Research Collective, a consortium of applied researchers, all of whom have lived experience of mental illness or psychological distress. The consortium's role was originally to share and develop new anti-stigma initiatives for See Me.[209] It has now moved from See Me to the Mental Health Foundation in Scotland, where it 'acts as a think tank for the Foundation on emerging issues and topics that might form the basis for future research projects and validates and comments on the Foundation's ongoing research activities'.[210] It also 'bids for research projects that require or benefit from the active involvement of people with lived experience', and 'champions and promotes co-production, inclusivity, collaboration and consensus in the way it works with the Foundation and with other research partners.'[211]

The Commission encourages the Victorian Government to create pathways to higher education research degrees for people with lived experience of mental illness or psychological distress, including fellowships and scholarships focused on anti-stigma efforts.

Box 25.5: Like Minds

'The Like Minds, Like Mine (Like Minds) programme was established in 1997 by the [New Zealand] Ministry of Health in response to the 1996 Mason Report. It was one of the first comprehensive national campaigns in the world to counter stigma and discrimination associated with mental illness. The programme has combined national television and other media and communication activities with community action to bring about social change'.[212]

Like Minds, Like Mine is founded on the following core principles:

- the social model of disability, which views disability as a process that happens when one group of people creates barriers by designing a world only for their way of being
- a human rights approach, which values the dignity of all people and asserts their right to be free of discrimination
- the power of contact, encouraging equal contact between members of excluded groups and those that exclude. This approach has been shown to promote attitude change.[213]

Like Minds, Like Mine was developed and delivered with people with lived experience of mental illness. This approach built lived experience capability, expertise and skills, including increasing the capacity for people with lived experience to advocate for their rights and for material changes to discriminatory policies and practices.[214]

25.7.4 Efforts to reduce stigma usually focus on public stigma

A further limitation of stigma interventions is that they almost exclusively focus on reducing public (interpersonal) stigma (attitudes towards people living with mental illness),[215] without sufficiently recognising or acknowledging the impact of other forms of stigma.

As noted earlier in this chapter, stigma manifests at many levels—public (interpersonal) stigma, self-stigma (intrapersonal stigma), structural stigma and stigma by association. These layers are deeply linked and bi-directional.[216] Research has indicated that stigma reduction efforts at one level can influence stigma, either positively or negatively, on other levels.[217]

The emphasis on public stigma has meant that investment in stigma reduction has typically focused on public media campaigns, or education and awareness training in organisational settings.[218]

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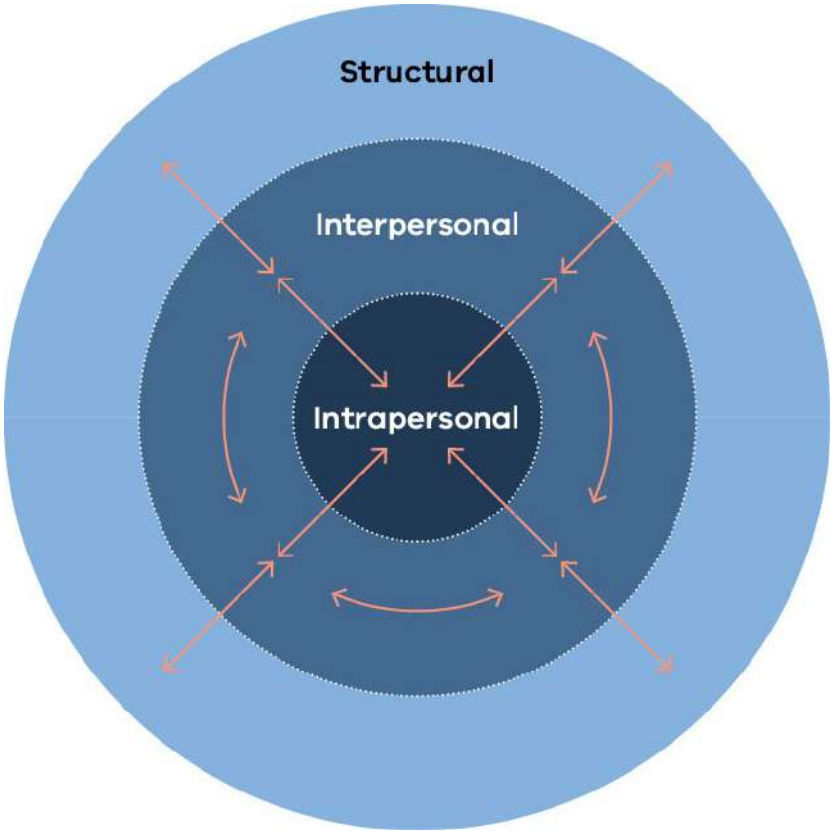
Figure 25.4: Stigma reduction efforts at one level can influence stigma at other levels



Source: Adapted from Jonathan Cook and others, 'Intervening within and across Levels: A multilevel approach to stigma and public health', *Social Science Medicine* 103(2014),101–109.

This focus on widespread awareness is warranted to some degree; public stigma is easily identifiable, and its existence points to a need for improvements in knowledge and attitudes. However, not enough attention has been paid to the impact of structural stigma, including discriminatory policies, organisational cultures and a lack of opportunities for people living with mental illness, which can undermine anti-stigma efforts.

Efforts to change attitudes and behaviours of health professionals towards people with lived experience have had limited success against a 'backdrop' of low levels of funding and the historically coercive philosophy of care.[219] Similarly, an entrenched organisational culture in health care that describes some experiences in purely biogenetic terms and labels people as 'difficult' can undermine interventions to improve the attitudes and behaviour of individual staff members.[220]

Ensuring there is genuine cultural change requires confronting the role stigma plays in determining someone's chances in life, and the influence it has on health and wellbeing for people with lived experience.

Ms O'Hagan discussed the importance of thinking beyond interpersonal stigma when considering what constitutes success in stigma interventions, saying:

> Programs that are effective at reducing stigma and discrimination of people with mental distress are those that promote human rights and greater social inclusion. I think the ultimate indicators of whether people who use mental health services are socially included at a population level are things like: What is our participation in the labour market? How many of us are partnering and having children and keeping them? How many friends do we have? What are our relationships like with our families of origin? Are we in stable housing? The challenge is that we don't have very good data on these indicators.[221]

25.7.5 The potential benefits of targeting organisational settings

The Commission has also heard of the need for, and potential benefits of, targeting organisational settings for stigma reduction, particularly in healthcare settings and workplaces.[222]

Box 25.6: Targeted settings for stigma reduction

Healthcare settings:[223] Stigma towards people with lived experience is entrenched in many healthcare settings. Inadequate funding and resources, the historically low priority given to mental health, and the use of restrictive practices have contributed to this stigma. While the Commission's structural reforms, including workforce reforms, will go a significant way to changing practices and recalibrating norms, there remains a need for programs specifically directed to stigma in healthcare settings. This will enable the progressive realisation of Victorians' right to the highest standard of health and health care.

Workplaces:[224] Workplace stigma has long been identified as a barrier to participation in the workforce, and social and economic inclusion.[225] While considerable effort has gone into building work environments that promote good mental health,[226] stigma remains prevalent. People with lived experience need to be supported and resourced to design and deliver programs that will call out stigma and outline practical steps to overcome stigma embedded in workplace cultures. However, these programs will only be effective with meaningful leadership, support and 'buy in' from employers, unions, and industry leaders.

Schools: Another priority setting for anti-stigma programs is schools. As detailed in Chapter 4: *Working together to support good mental health and wellbeing* and Chapter 11: *Supporting good mental health and wellbeing in the places we work, learn, live and connect*, the Commission's reforms place strong emphasis on prevention and early intervention. Researchers have observed stigmatising or discriminatory perspectives and behaviour in even the youngest school children. [227]

Schools offer an important setting through which to break the cycle of stigma and shame and to make it easier for children and young people to talk about mental health and to seek help. Anti-stigma programs in schools are also fundamental to encouraging understanding, compassion and empathy, in relation to mental illness. Schools need to be a focus to ensure cultural change and to promote good habits long term.

25.7.6 Data is a necessary foundation for future strategies

As noted above, there is a lack of consistent, high-quality data on the nature, extent and impacts of stigma and discrimination on people with lived experience of mental illness or psychological distress in different domains of life. The data gaps include longitudinal Australian data on trends in mental health stigma, particularly regarding diagnoses termed 'severe' mental illness, and data in relation to specific target groups, such as employers and families.[228] This lack of data has hampered efforts to monitor and address stigma.[229]

The collection of data is an important tool for identifying patterns of disadvantage caused by discrimination, and determining the most suitable course of action to tackle it.[230] Data on practices, policies and procedures inside institutions and organisations can provide evidence of discrimination, by indicating that disparities in treatment and outcomes are not random, but are the consequence of individual prejudices and structural biases.[231] Data also enables targeted policy efforts to prevent discrimination occurring in the first place.

The National Stigma Report Card seeks to address the existing data gap. It is a multi-year partnership between SANE Australia's Anne Deveson Research Centre and the University of Melbourne, with the support of the Paul Ramsay Foundation. Between October 2019 and March 2020, the project conducted the *Our Turn to Speak* survey to examine how Australians living with 'complex mental health issues' experience stigma and discrimination across a range of areas, including housing, education, employment, health services, interpersonal relationships and media representations.[232]

The Commission regards the specialist knowledge of people with lived experience as indispensable for understanding mental health and psychological distress. It recognises the advantages of seeking out that knowledge in order to gain a proper appreciation of the extent and nature of stigma and discrimination. The Commission envisages the Mental Health and Wellbeing Commission, through the leadership of at least one Commissioner with lived experience of mental illness or psychological distress, being an important source of information, and a critical link into the broader lived experience community in Victoria, about the stigma and discrimination affecting people with lived experience. The Commission foresees the consumer advocacy function playing an important role in engaging with consumers to understand where stigma and discrimination remain an issue.

25.8 The success of international programs in reducing mental health-related stigma

There are several international examples of long-term, targeted and evidence-based programs that have achieved positive results in reducing mental health-related stigma,[233] including Canada's Opening Minds program,[234] Sweden's Hjärnkoll,[235] Scotland's See Me,[236] and Like Minds, Like Mine in New Zealand.

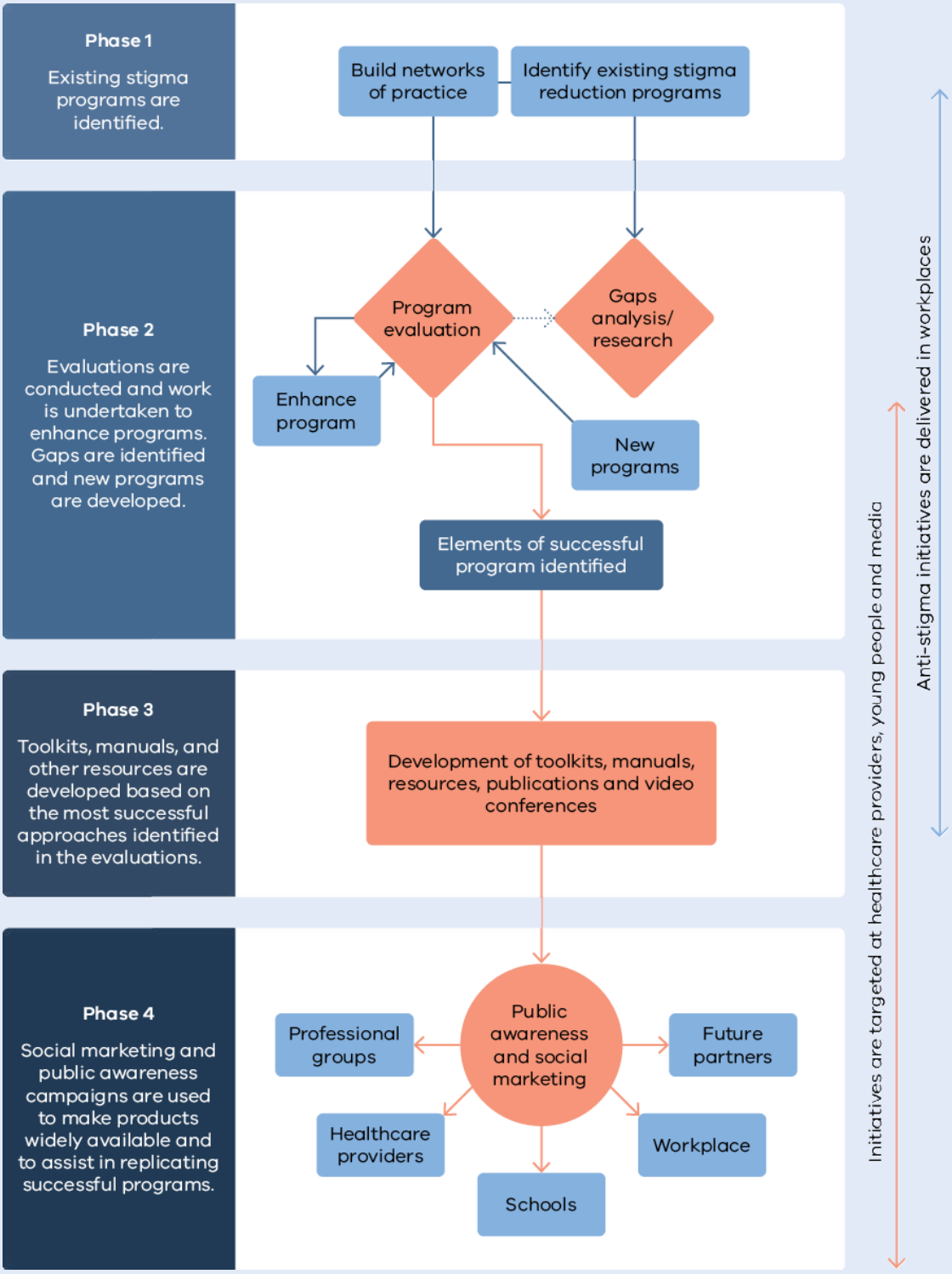
While each of these comprehensive stigma-reduction programs differs in its approach, many share several common features, including:

- a mix of intervention types (with extensive use of contact with people with lived experience of mental illness or psychological distress)
- a focus on particular groups in addition to, or instead of, the general public
- rigorous evaluation by academic researchers[237]
- being well funded and long running.[238]

Mike Pietrus, Director of Opening Minds, and the Opening Minds team, told the Commission the critical success factors of the Opening Minds program were:

- the **long-term nature** of stigma reduction approaches, and the need to manage expectations around the speed and depth of impact, noting that significant change may take a generation
- the **input of lived experience** through a lived experience advisory group
- the need for **sustained funding commitment**—Opening Minds is delivered by the Mental Health Commission of Canada, the source of funding security that allowed the program to be established and rolled out. Secure funding was also important because the time it took to establish programs differed across settings
- the **cost effectiveness** of the approach—the program was cheaper to implement than a mass media campaign. It is now self-sustaining, with Opening Minds charging (on a cost-recovery basis) to deliver interventions. Organisations such as workplaces pay for Opening Minds to deliver interventions
- the **importance of partnerships** to the success of program. This includes partnerships with academics and universities, as well as with grass roots community organisations and businesses who deliver stigma programs. Buy-in from business leaders was integral to the success of the workplace programs
- the role of the program in **developing research capability**—the Opening Minds model has significantly expanded stigma research capacity in Canada. The approach sees one or more senior researchers overseeing young researchers and students to develop an evidence base for interventions. Research is published in academic journals and used to inform program development
- the **ability to adapt** programs as new evidence emerges. For example, the program has responded to evidence of the benefits of 'top up' sessions in workplaces to improve the long-term impact, and tangible practical tools such as workbooks, which have proven effective in workplaces.[239]

Figure 25.5: Opening Minds process model



Source: Adapted from Mental Health Commission of Canada, *Opening Minds: Interim Report*, November 2013.

Box 25.7: Opening Minds

The Canadian stigma reduction campaign, Opening Minds, which is delivered through Canada's Mental Health Commission, is arguably the most comprehensive approach to stigma reduction of the international models.[240]

Opening Minds has taken a different approach to what has been practised in most other countries. Instead of launching a large-scale social marketing campaign, the program focuses on developing evidenced-based interventions for specific groups—health care, youth and workplaces (and media, which has taken a slightly different approach). The main features of the program are:

- identifying and evaluating existing anti-stigma programs in each of the target groups
- developing anti-stigma program toolkits based on these findings for each target group—including tailoring toolkits for specific subgroups, for example, community health centres, emergency departments
- working with partners to replicate interventions across the country
- ongoing monitoring and evaluation of the programs.

Opening Minds involves a network of partnerships with various universities, research organisations and service providers. The program also aims to foster networks of practice so local programs found to be effective can develop a wider reach and program leaders can act as mentors to newly established programs.

The program is also informed by lived experience, through a 10-person consumer group from across Canada that provides input and feedback into research and intervention design.

Figure 24.5 outlines the development process. The key process components include:

- **Phase 1**—establishing a research network and doing a stocktake of existing interventions
- **Phase 2**—evaluating the effectiveness of programs and identifying gaps
- **Phase 3**—creating toolkits based on best practice
- **Phase 4**—rolling out within targeted settings.

25.9 Confronting stigma will require a coordinated, multilevel response

The slow-to-change, pervasive and multilevel nature of stigma means a coordinated long-term and multilevel response is required to bring about cultural and structural change.[241] This must start by placing consumers at the centre of Victoria's leadership and response to stigma, including the design and delivery, research and evaluation of stigma interventions.

A key part of the reforms described in Chapter 18: *The leadership of people with lived experience of mental illness or psychological distress*, and Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*, is the appointment of at least one Commissioner with lived experience of mental illness or psychological distress in the Mental Health and Wellbeing Commission. This Commissioner will be responsible for the design and delivery of anti-stigma efforts described in this chapter.

The Commission's recommended approach focuses on confronting stigma within organisational settings, including healthcare settings, workplaces and schools, and supporting community organisations and people with lived experience to design and deliver anti-stigma approaches tailored to the needs of different communities.

The Commission's recommended program to tackle stigma will draw on the strengths of the various international approaches discussed in this chapter, including:

- developing a strong evidence base for interventions and adapting as new evidence emerges
- building on existing programs where possible, as well as trialling new approaches
- addressing settings or groups most in need of intervention, including healthcare settings, workplaces and schools
- building and supporting research and lived experience researcher capacity
- supporting community-led organisations (particularly those with lived experience capacity) to deliver programs
- building community, academic and industry partnerships to effect long-term change.

The approaches will be founded on three core principles:

- that anti-stigma efforts are co-designed with people with lived experience (as a minimum level of participatory design), and that some funding and initiatives must be coproduced, and others entirely consumer-led
- that consumers are engaged in anti-stigma projects as academics, co-leaders, co-researchers and leaders, not just as participants
- that anti-stigma efforts recognise and respond to the diversity of Victoria's population.

In November 2020, the Productivity Commission made a recommendation in its *Mental Health Inquiry Report* for the implementation of a 'national stigma reduction strategy'.[242] The Commission's view is that efforts at the state and national level ought to be complementary and mutually reinforcing, and that this will create the level of momentum required to engender change.

The Commission understands that, in addition to formal government or academic efforts, one of the greatest potential opportunities to respond to stigma lies in the lived experience community, which is already working to change societal attitudes. The Commission has heard that when people with lived experience of mental illness or psychological distress find the agency and resources to speak and stand up for themselves, society changes. Ultimately, this is what anti-stigma work is striving for.

Box 25.8: The role of the arts sector in reducing mental health stigma

Art can influence the way we think about the world and the way we behave. Throughout the ages, drama, music, painting, sculpture, storytelling, poetry and other forms of art have inspired movements for change by criticising established traditions, raising awareness about issues, and mobilising action for a cause. Messages conveyed through art can shift attitudes and prompt thinking about long-held beliefs. As an expressive outlet, art opens up public conversations and has the potential to shift the wider cultural context of society by challenging negative stereotypes and exposing oppressive dynamics. As Darren Walker, president of the Ford Foundation, summed it up, the arts are 'a space where we can give dignity to others while interrogating our own circumstances'.[243]

In Victoria, the arts sector has a long history of challenging negative stereotypes and attitudes about mental illness.

For example, the Arts Wellbeing Collective is a body made up of hundreds of arts and cultural organisations working together to promote positive mental health within the arts sector. Since launching, the Arts Wellbeing Collective has delivered more than 200 workshops and presentations, 18 mental health first aid courses, 220 hours of consulting and approximately 150,000 copies of digital print resources.[244] Through this engagement, the Arts Wellbeing Collective has shared knowledge, skills and ideas for reducing stigmatising attitudes and behaviours, and supported organisations to implement changes that promote positive mental health.

Another arts sector program involved in mental health advocacy is run by the Listening to Voices Theatre based in Wodonga.[245] In this program, theatre methods are used to share the many realities of living with mental health challenges in the hope that audiences gain a better appreciation of people's lived experiences of mental illness or psychological distress. Through this process, empathy is built, and stigma is reduced. The performances of the program include scenes on such themes as accessing and navigating the mental health system, trauma, understanding and listening to voices that other people cannot hear, diagnosis, and stigma.

Art has potential to be an important vehicle for reducing the stigma that surrounds mental illness. Mr Justin Heazlewood, actor and humourist, and witness to the Commission, shared his views on how the transformative potential of the arts can be further realised in relation to schizophrenia:

> I think a dedicated, funded body which includes writers, artists, publicists and social media strategists should be employed with the express purpose of raising awareness of schizophrenia, and in turn other aspects of mental illness. It isn't always enough to provide dry, corporate information. The material needs to be dazzling, intimate and original enough to engage with a subject they are used to putting to one side.[246]

The power of art to influence our thoughts and feelings, and to start a process of internal reflection on taken-for-granted assumptions, is an important reason why the arts sector should receive further support in its efforts to reduce mental health stigma.

25.10 Confronting discrimination and ensuring equality

It has been unlawful to discriminate against people on the basis of mental illness in Victoria for almost 40 years.[247] For decades, organisations such as the Victorian Mental Illness Awareness Council (VMIAC) and the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) have passionately advocated for the equal treatment of people living with mental illness.

Despite this legal protection and sustained advocacy, the Commission has heard that people with lived experience of mental illness or psychological distress continue to be treated less favourably, because of their mental health, across multiple domains of life, including in health care, when seeking to access the workforce, in the workplace, in education, when securing a home, and obtaining goods and services such as insurance. The problem should not be misunderstood as discrete and isolated instances of discrimination; instead, discrimination against people with lived experience of mental illness or psychological distress is long standing, entrenched and pervasive.

People with lived experience of mental illness or psychological distress need to be better supported to enforce their right to equal treatment and to redress discrimination. Fundamentally, though, to engender systemic change—particularly for people who are unwilling or unable to bring individual complaints—greater legal powers are needed to redress systemic discrimination.

25.10.1 People should be better supported to bring individual complaints of discrimination

Currently, the system relies on individuals to enforce their right to protection against discrimination. As noted earlier in this chapter, 'it is likely that the number of people experiencing discrimination on the basis of mental illness greatly exceeds the number of complaints made'.[248] There are likely to be several reasons for this.

First, many people are not aware of their legal rights, or the channels through which to enforce those rights.[249] The current complaints process is complex and formal, and people can find it difficult to navigate.[250]

The Equal Opportunity Act categorises mental illness under the umbrella attribute 'disability' (as opposed to regarding it as a standalone attribute), which might be leading to less reporting. Because it is not immediately obvious that mental illness is a disability, people may be unaware that mental health discrimination is unlawful.[251] As Ms Kristen Hilton, VEOHRC Commissioner, explained in her witness statement, 'people who have experienced mental health discrimination might not necessarily consider themselves to have a disability'.[252]

Dr Blanchard highlighted that 'people with lived experience don't always see mental illness as a disability, and in fact, seeing it as a disability is quite counter to the recovery framework'.[253] The Commission acknowledges that many people would find the term 'disability' (and the definition 'malfunction of part of the body including a mental or psychological disease or disorder'[254]) stigmatising.

Second, the Commission has been told that people avoid the formal complaints process in order to preserve their mental wellbeing. Currently, an aggrieved individual must lodge a complaint in order to activate the legal process. This is a substantial task, which many people find daunting.[255] Commissioner Hilton explained the issue:

> Presently, the burden of complaint making rests with the individual who has suffered discrimination. As a result, the system relies on people who have had traumatic experiences knowing that their rights have been infringed, and then finding the correct place to make their complaint. They are then required to go through a complaints process which can be re-traumatising despite VEOHRC's best efforts. This can deter a person from making a complaint. Of those who do make a complaint, one in six of all the people who disclosed to us that they are living with a mental health condition withdrew their complaint before attempting dispute resolution.[256]

Victoria Legal Aid highlighted the burden on people with lived experience:

> A significant weakness of Victorian Discrimination laws is its reliance on a complaints-based system, where people experiencing discrimination, including on the basis of their mental health, bear the burden of bringing a complaint against services and people who have discriminated against them to access justice. Through our casework we also see the mental health strains of bringing a discrimination complaint.[257]

Third, the majority of complaints to VEOHRC on the basis of mental health discrimination relate to the workplace, and it is likely that the threat of retaliation from a person's employer plays an important part in the reluctance to embark on a legal path of recourse to remedy discrimination.[258]

Fourth, intersecting forms of disadvantage are a barrier to people exercising their legal rights. People living with mental illness are at greater risk of financial instability, poverty, unemployment and housing insecurity,[259] and are less likely to complete a high school education.[260] As a result, people may lack the resources necessary to pursue discrimination complaints.

These issues are compounded by the limited availability of free or affordable legal services. Without the benefit of legal advice, representation and advocacy, complainants must identify their legal rights; identify where to bring the claim and how to make a claim; articulate the unlawful conduct; and respond to any counter arguments, all unaided.[261] Discrimination, and particularly indirect discrimination,[262] raises difficult legal questions.

As outlined in this chapter, despite being unlawful, there remains widespread, systemic discrimination against people with lived experience of mental illness or psychological distress. While everyone has the legal right to equal and effective protection against discrimination, many people find it difficult to exercise that right. People with lived experience need to be better supported, through legal advocacy and representation, to bring individual complaints to redress discrimination and to uphold their rights.

The Commission recommends increased and continuing funding to independent legal services that have a demonstrated connection or capacity to connect with people with lived experience, in order to enhance individual access to legal advocacy and support, and the protection of the legal right to equality.

This reform measure is designed to overcome the disadvantages and constraints that people face when exercising the legal protection against discrimination. It will increase the accessibility and availability of legal services.

Most obviously, legal services give people the opportunity to be represented in courts and other legal proceedings, when they would otherwise not have the benefit of legal expertise and advocacy. However, the benefits of legal services go much further. Legal services can be a source of moral support, guidance, advice and information on how best to navigate a complex legal system. Legal services can also provide assistance to settle discrimination claims on terms that respect the person's rights. This spares people from a potentially arduous path of legal action.

Mr Julian Gardner, member of the Expert Advisory Committee, a human rights expert and former Public Advocate of Victoria, highlighted the value of such public interest advocacy from legal services:

> This approach empowers people by providing them with information so that they can resolve their own disputes in a way that is consistent with the Act. It meets the objective of facilitating the earliest possible resolution of disputes and removing the burden of pursuing complaints from the complainant. [263]

The Victorian Government should allocate funding to legal services in ways that encourage them to apply their skills and expertise towards the elimination of mental health discrimination. Legal services that receive such funding should be required to use it to assist people who have experienced mental health discrimination. They should also be required to consult people with lived experience in designing, delivering and evaluating the services. The funding should be allocated so that clients can receive free expert advice and representation in relation to mental health discrimination.

The effectiveness of this proposed reform depends on people with lived experience being aware of it. People are only likely to take advantage of legal services that are dedicated to ending mental health discrimination if they know those services are readily available and affordable. As such, the Victorian Government should resource the Mental Health and Wellbeing Commission to support awareness-raising of the availability of these legal services.

Discrimination on the basis of mental health is pervasive and widespread. Progress will require sustained efforts over many years. The Commission therefore recommends the Victorian Government commits to a long-term program of funding for legal services, to ensure a consistent supply of financial resources is available to target mental health discrimination.

Box 25.9: Justice Connect and public interest legal services

Justice Connect is a not-for-profit legal referral service that operates from Melbourne and Sydney. It was founded in 2013 through a merger of the Melbourne and Sydney arms of the Public Interest Law Clearing House (PILCH). The organisation follows the model of 'New York Lawyers for the Public Interest', a non-profit civil rights law firm located in New York City that specialises in the areas of disability rights, access to health care and environmental justice.

Justice Connect aims to improve access to justice by providing pro bono legal services to people who would otherwise be unable to obtain legal services. This includes helping 'people who are chasing stolen wages, older people facing abuse, and those who are struggling to pay the rent or experiencing homelessness.'[264]

The organisation is also involved in campaigns to achieve systemic change. As stated on its annual report:

> When laws are unfair, we advocate to change them. When systems and policies are confusing or hard to navigate, we develop ways to improve them.[265]

There are over 10,000 pro bono lawyers who offer their time and expertise to support the organisation's services, 88 staff who run its offices, and numerous volunteers and secondees who are also a part of the organisation's workforce.[266] The specific services offered by the organisation are in the fields of homeless law, seniors law, public interest law, domestic building legal services, self-representation services and not-for-profit law.[267]

Justice Connect provides a useful example of a legal service that could receive government support to address mental health discrimination.

25.10.2 The need for stronger mechanisms to confront systemic discrimination

As outlined above, the current legislative framework places the burden on individuals, who may be marginalised and disadvantaged,[268] to make sure people, particularly employers, are compliant with the Equal Opportunity Act. This is problematic because the number of people experiencing discrimination on the basis of mental illness is likely to greatly exceed the number of complaints made.[269]

VEOHRC submitted to the Commission that:

> Reducing the onus on individuals to enforce the law is important in a mental health context, since people with mental health issues are likely to find bringing a complaint stressful and the process may exacerbate their existing condition.[270]

Various legal and human rights experts drew attention to this shortcoming in the legal framework.[271] As Mr Gardner, told the Commission:

> I do think as long as we rely upon some of the most disadvantaged and oppressed people to run a system, whereby they're required to enforce the law rather than it being enforced on their behalf, it's just not going to work.[272]

Another participant in the Commission's Anti-Discrimination roundtable, Professor Penelope Weller, told the Commission:

> I do support all of the calls for broader systemic powers of investigation for various governance bodies. It's been a long-standing problem in Victoria, that complaints-driven systems don't produce the systemic outcomes that we need.[273]

In addition, the existing laws do not provide a mechanism for redress against systemic discrimination:

> When the discrimination is 'systemic' in that it results from policies, practices and attitudes that are entrenched in organisations or broader society, it can be difficult, if not impossible, to successfully bring an individual claim.[274]

In 2019, VEOHRC conducted an investigation into the travel insurance industry, and found that discrimination on the basis of mental health was 'prevalent and widespread'.[275] The investigation was launched following a successful individual complaint against an insurance company, and since it was conducted, all insurers removed (or are taking steps to remove) blanket mental health exclusions from their travel insurance policies.[276] However, given VEOHRC lacked the powers to compel their participation and attendance, the investigation 'was only possible because the insurance companies chose to cooperate'.[277]

Given the adverse impacts of discrimination on people's wellbeing—'including worsening of psychological distress, inhibition of help seeking and treatment adherence, limiting of personal relationships, and a reduction in their ability to achieve educational and vocational goals'[278]—and the current burden on people with lived experience to take action against discrimination, it is the Commission's strong position that there is a need for greater mechanisms to identify and redress systemic discrimination.

A multilevel approach is required. First, the Commission recommends that the Victorian Government support and establish mechanisms to identify and address systemic issues of discrimination on the basis of mental health. The Commission has received strong calls for power to conduct own-motion inquiries into discrimination, including powers to compel information, enter enforceable undertakings and issue compliance notices.[279]

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The appropriate powers and body to enforce legal protections against discrimination are outside the Commission's letters patent. They are properly a matter for the Attorney-General of Victoria, as the First Law Officer of the State, and the Department of Justice and Community Safety. In considering the appropriate powers and body to enforce legal protections against discrimination, the Attorney-General and the Department of Justice and Community Safety should give due consideration to the harm caused by all forms of discrimination, and the potential challenges of distinguishing discrimination on the basis of mental health from discrimination on the basis of other attributes.

Second, as outlined in Chapter 27: *Effective leadership and accountability for the mental health and wellbeing system—new system-level governance*, the Mental Health and Wellbeing Commission will have own motion inquiry powers that will extend to stigma and discrimination related to mental illness and psychological distress. In considering the matter of mental health discrimination, it is the Commission's view that powers to address systemic discrimination on the basis of mental health are conferred to the Victorian Equal Opportunity and Human Rights Commission. However, in considering the matter of discrimination in full, the Victorian Government may determine that the Mental Health and Wellbeing Commission or another body is better placed to address systemic mental health discrimination and confer powers accordingly. Regardless, the Commission envisions the consumer advocacy function playing an important role in engaging with consumers to understand where stigma and discrimination, particularly structural stigma and systemic discrimination, remain an issue, and should play a key role in advising the relevant body of the lived experience community's observations and experiences. Where the Mental Health and Wellbeing Commission finds there has been discrimination, such findings will be referred to the appropriate body for any enforcement action.

Third, the Commission recommends that the Victorian Government fund independent legal services with a demonstrated connection or ability to connect with people with lived experience of mental illness or psychological distress, to initiate legal claims of systemic mental health discrimination.

1 General Assembly, United Nations, *International Covenant on Economic, Social and Cultural Rights 1976*, Article 27.

2 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, pp. 230–231.

3 World Health Organization, *The World Health Report 2001. Mental Health: New Understanding, New Hope*, 2001, p. 16.

4 *Witness Statement of Associate Professor Nicola Reavley*, 3 July 2019, para. 10 and 17; *Witness Statement of Erandathie Jayakody*, 4 June 2020, para. 18; *Witness Statement of Janet Meagher AM*, 1 July 2019, para. 33; World Health Organization, p. 16.

5 World Health Organization, p. 16.

6 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, 2019, p. 58.

7 VicHealth, *Evidence-Based Mental Health Promotion Resource: Executive Summary*, 2006, p. 2.

8 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 412.

9 *Witness Statement of Associate Professor Nicola Reavley*, para. 8; World Health Organization, p. 16.

10 Bruce G Link and Jo C Phelan, 'Conceptualizing Stigma', *Annual Review of Sociology,* 27 (2001), 363–385 (p. 364).

11 Link and Phelan, p. 367.

12 James D Livingston, *Mental Illness-Related Structural Stigma: The Downward Spiral of Systemic Exclusion Final Report,* 2013, p. 6.

13 Mark L Hatzenbuehler, Jo C Phelan and Bruce G Link, 'Stigma as a Fundamental Cause of Population Health Inequalities', *American Journal of Public Health,* 103.5 (2013), 813–821 (p. 817).

14 Jonathan E Cook, Valerie Purdie-Vaughns, Ilan H. Meyer and Justin T.A. Busch, 'Intervening within and across Levels: A Multilevel Approach to Stigma and Public Health', *Social Science and Medicine,* 103 (2014) 101–109 (p. 106).

15 *Witness Statement of Associate Professor Nicola Reavley,* para. 8.

16 *Witness Statement of Dr Elizabeth Deveny,* 8 June 2020, para. 36.

17 Cambridge Dictionary, Discrimination, <dictionary.cambridge.org/dictionary/english/discrimination>, [accessed 22 September 2020].

18 *Witness Statement of Associate Professor Nicola Reavley*, para. 8.

19 *Personal Story Number 20, Collected by Victoria Legal Aid,* 2020.

20 *Equal Opportunity Act 2010* (Vic), secs. 4 and 6. The Commission recognises that terms such as 'psychological disease or disorder' can be pathologising and stigmatising.

21 *Equal Opportunity Act 2010* (Vic), sec. 8.

22 *Equal Opportunity Act 2010* (Vic), sec. 9.

23 *Equal Opportunity Act 2010* (Vic), secs. 14 and 15.

24 *Equal Opportunity Act 2010* (Vic), sec. 15.

25 Hatzenbuehler, Phelan and Link, p. 813.

26 Department of Justice, *An Equality Act for a Fairer Victoria: Equal Opportunity Review Final Report,* 2008, p. 11.

27 Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259,* 2019, pp. 24–25.

28 Mark L Hatzenbuehler and Bruce G Link, 'Introduction to the Special Issue on Structural Stigma and Health', *Social Science and Medicine*, 103 (2014), 1–6 (p. 2).

29 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 555.

30 Department of Justice, p. 11.

31 *Witness Statement of Associate Professor Dan Siskind,* 27 April 2020, para. 70.

32 Victorian Mental Illness Awareness Council, *Correspondence to the RCVMHS: CSP.0001.0125.0001, Response to Questions on Issues Affecting Consumers Labelled with 'Serious and Persistent Mental Illness',* 2020, p. 17.

33 Department of Justice, p. 112.

34 *Witness Statement of Erandathie Jayakody,* para. 22.

35 Livingston, p. 6.

36 Ministry of Health, New Zealand, *Like Minds, Like Mine National Plan 2003-2005: Project to Counter Stigma and Discrimination Associated with Mental Illness,* 2003, p. 4.

37 Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into Human Rights of People with Mental Illness Volume 2,* 1993, p. 908.

38 Carlos Espí Forcén and Fernando Espí Forcén, 'Demonic Possessions and Mental Illness: Discussion of Selected Cases in Late Medieval Hagiographical Literature', *Early Science in Medicine,* 19.3 (2014), 258–279; Brewminate, A History of Mental Illness Since the Ancient World, <brewminate.com/a-history-of-mental-illness-since-the-ancient-world/>, [accessed 27 October 2020].

39 Lawrence O Gostin, 'Old' and 'New' Institutions for Persons with Mental Illness: Treatment, Punishment or Preventive Confinement?', *Public Health,* 122.9 (2008), 906–913 (p. 907).

40 Productivity Commission, *Mental Health Inquiry Report, Volume 2,* 2020, p. 361.

41 *Witness Statement of Associate Professor Nicola Reavley,* paras. 20 and 25; Dr Christopher Groot and others, *National Stigma Report Card: Report on Findings from the Our Turn to Speak Survey,* 2020, p. 22.

42 *Witness Statement of Associate Professor Nicola Reavley,* para. 10.

43 *Witness Statement of Associate Professor Nicola Reavley,* paras. 10 and 17; W*itness Statement of Erandathie Jayakody,* para. 18; *Witness Statement of Janet Meagher AM,* para. 32.

44 *Witness Statement of Erandathie Jayakody,* para. 12.

45 *Witness Statement of Erandathie Jayakody,* para. 143.

46 Victoria Legal Aid, *Your Story, Your Say,* 2020, p. 2.

47 L. Johnstone and M. Boyle, *The Power Threat Meaning Framework: Towards the Identification of Patterns in Emotional Distress, Unusual Experiences and Troubled or Troubling Behaviour, as an Alternative to Functional Psychiatric Diagnosis* (Leicester: The British Psychology Society, 2018), pp. 16–17.

48 Stephanie Knaak, Ed Mantler and Andrew Szeto, 'Mental Illness-Related Stigma in Healthcare: Barriers to Access and Care and Evidence-Based Solutions', *Healthcare Management Forum,* 30.2 (2017), 111–116 (p. 111).

49 *Personal Story of Natasha Swingler, Collected by Victoria Legal Aid*, 2020.

50 *Witness Statement of Janet Meagher AM,* para. 32.

51 *Witness Statement of Erandathie Jayakody*, paras. 21–22 and 27–28.

52 Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259,* p. 13.

53 *Witness Statement of Kristen Hilton,* 15 July 2020, para. 17.

54 *Witness Statement of Kristen Hilton,* para. 17.

55 Victorian Mental Illness Awareness Council, *Correspondence to the RCVMHS: CSP.0001.0134.0001, Response to request for further information: Stigma and Discrimination,* 2020.

56 *Witness Statement of Kristen Hilton,* para. 19.

57 *Witness Statement of Kristen Hilton,* para. 19.

58 *Witness Statement of Kristen Hilton,* para. 20.

59 *Witness Statement of Kristen Hilton,* para. 20.

60 Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259,* p. 13.

61 Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259,* p. 13.

62 Productivity Commission, *Mental Health Inquiry Report, Volume 2,* p. 365.

63 *Witness Statement of Dr Chris Groot*, 4 September 2019, para. 58.

64 Groot and others, p. 22.

65 Groot and others, p. 22.

66 Groot and others, pp. 22–23.

67 Human Rights and Equal Opportunity Commission, p. 443.

68 Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259*, p. 2.

69 Groot and others, p. 27.

70 Naomi C Priest and others, 'Racism as a Determinant of Social and Emotional Wellbeing for Aboriginal Australian Youth', Medical Journal of Australia, 194.10 (2011), 546–550 (p. 546).

71 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217,* p. 57.

72 Groot and others, pp. 22–23.

73 *Witness Statement of Professor Rob Moodie,* 9 June 2020, para. 7.

74 *Witness Statement of Kristen Hilton,* para. 57.

75 Turning Point, *Submission to the RCVMHS: SUB.0002.0028.0533,* 2019, p. 5.

76 *Witness Statement of Patrick Lawrence,* 28 May 2020, para. 60.

77 Groot and others, p. 27. The Productivity Commission has expressed a similar view. See Productivity Commission, *Mental Health Inquiry Report*, Volume 2, p. 382.

78 RCVMHS, *Preston Community Consultation*—May 2019.

79 RCVMHS, *Pakenham Community Consultation*—April 2019; Witness Statement of Associate Professor Nicola Reavley, para. 25(a)–25(h).

80 *Witness Statement of Associate Professor Nicola Reavley,* para. 25(e).

81 S. Clement and others, 'What Is the Impact of Mental Health-Related Stigma on Help-Seeking? A Systematic Review of Quantitative and Qualitative Studies', *Psychological Medicine,* vol. 45 (2015), 11–27 (p. 11).

82 Stephanie Knaak, Ed Mantler and Andrew Szeto, 'Mental Illness-Related Stigma in Healthcare: Barriers to Access and Care and Evidence-Based Solutions', *Healthcare Management Forum,* 30.2 (2017), 111–116 (pp. 111–112).

83 Knaak, Mantler and Szeto, (pp. 111–112).

84 Victorian Mental Illness Awareness Council, *Policy Position Paper #2: Preventing and Responding to Violence, Abuse and Neglect,* 2020, p. 2.

85 Clement and others, p. 11.

86 *Personal Story Number 9, Collected by Victoria Legal Aid,* 2020.

87 *Witness Statement of Dr Chris Groot,* para. 31.

88 Productivity Commission, *Mental Health Inquiry Report,* Volume 2, p. 742.

89 Victorian Mental Illness Awareness Council, *Correspondence to the RCVMHS: CSP.0001.0125.0001, Response to Questions on Issues Affecting Consumers Labelled with 'Serious and Persistent Mental Illness'*, 2020, p. 17; Joanne Suggett and others, 'Natural Cause Mortality of Mental Health Consumers: A 10–year Retrospective Cohort Study', *International Journal of Mental Health Nursing*, 2020, 1–11 (p. 1).

90 *Witness Statement of Associate Professor Dan Siskind,* para. 70.

91 *Personal Story of Imogen Gandolfo, Collected by Victoria Legal Aid*, 2020.

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

93 *Personal Story Number 3, Collected by Victoria Legal Aid*, 2020.

94 Groot and others, pp. 22–23.

95 *Witness Statement of Erandathie Jayakody,* paras. 22–29; *Witness Statement of 'Rachel Bateman' (pseudonym),* 16 June 2020, paras. 95–96; *Witness Statement of Indigo Daya,* 12 May 2020, paras. 106–110.

96 *Witness Statement of Erandathie Jayakody,* para. 23.

97 *Witness Statement of 'Rachel Bateman' (pseudonym)*, para. 95.

98 CoHealth, *Submission to the RCVMHS: SUB.0002.0029.0410*, 2019, p. 30.

99 Tim Fong, Anthony Stratford, Janet Meagher, Fay Jackson and Erandathie Jayakody, *Peer work in Australia* (Sydney: Flourish Australia, 2018) pp. 57 and 168.

100 *Witness Statement of 'Rachel Bateman' (pseudonym)*, para. 84.

101 *Witness Statement of Erandathie Jayakody*, para. 24.

102 *Witness Statement of Erandathie Jayakody*, para. 25.

103 Susan Ainsworth and others, *Leading the Change: Co-Producing Safe, Inclusive Workplaces for Consumer Mental Health Workers,* 2020, p. 3.

104 Ainsworth and others, p. 3.

105 *Witness Statement of Associate Professor Nicola Reavley,* para. 25; *Witness Statement of Dr Michelle Blanchard,* 27 June 2019, para. 48.

106 *Witness Statement of Associate Professor Nicola Reavley,* para. 25(c).

107 Productivity Commission, *Mental Health Inquiry Report: Supporting Material (Appendices B–K),* 2020, p. 72.

108 *Witness Statement of David Pearl,* 11 May 2020, para. 24.

109 *Joint Witness Statement of Lisa Annese and David Morrison AO,* 14 July 2020, para. 26.

110 *Witness Statement of Dr Michelle Blanchard*, para. 48.

111 *Witness Statement of Dr Michelle Blanchard*, para. 52.

112 *Witness Statement of Kristen Hilton,* para. 15.

113 *Witness Statement of Dr Michelle Blanchard,* 27 June 2019, para. 57.

114 *Witness Statement of Dr Michelle Blanchard*, para. 59.

115 Productivity Commission, *Mental Health Inquiry Report: Supporting Material (Appendices B–K),* p. 72.

116 Productivity Commission, *Mental Health Inquiry Report: Supporting Material (Appendices B–K),* p. 72.

117 Productivity Commission, *Mental Health Inquiry Report: Supporting Material (Appendices B–K),* p. 72.

118 Evelien PM Brouwers, 'Social Stigma Is an Underestimated Contributing Factor to Unemployment in People with Mental Illness or Mental Health Issues: Position Paper and Future Directions', *BMC Psychology,* 8.36 (2020), 1–7 (p. 3).

119 *Witness Statement of Dr Michelle Blanchard*, para. 65.

120 RCVMHS, *Melbourne Community Consultation*—May 2019.

121 *Joint Witness Statement of Lisa Annese and David Morrison AO,* para. 76.

122 *Joint Witness Statement of Lisa Annese and David Morrison AO,* para. 72.

123 *Witness Statement of David Pearl*, para. 24.

124 A. Üçok and others, 'Anticipated Discrimination among People with Schizophrenia: Anticipated Discrimination in Schizophrenia', *Acta Psychiatrica Scandinavica,* 125 (2012), 77–83 (p. 80).

125 *Witness Statement of Dr Michelle Blanchard*, para. 44.

126 *Witness Statement of Teresa,* 28 June 2019, para. 49.

127 *Witness Statement of Dr Michelle Blanchard*, para. 80.

128 *Witness Statement of Dr Michelle Blanchard*, para. 52.

129 Beyond Blue, *Submission to the RCVMHS: SUB.0002.0029.0099, 2019,* p. 11.

130 Emily Hewlett and Valerie Moran, *Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care*, (OECD, 2014), p. 44.

131 Hewlett and Moran, p. 44.

132 *Witness Statement of Dr Michelle Blanchard*, para. 60.

133 *Witness Statement of Dr Michelle Blanchard*, para. 80.

134 *Witness Statement of Dr Michelle Blanchard*, para. 83.

135 *Witness Statement of Dr Michelle Blanchard*, para. 84.

136 Victorian Council of Social Service, *Submission to the RCVMHS: SUB.0002.0029.0282,* 2019, p. 46.

137 Productivity Commission, *Mental Health Inquiry Report, Volume 3,* 2020, p. 969.

138 Productivity Commission, *Mental Health Inquiry Report, Volume 3,* p. 970, drawing on J. Hammel, J. Smith, S. Scovill, R. Campbell and R. Duan, *Rental Housing Discrimination on the Basis of Mental Disabilities: Results of Pilot Testing,* 2017.

139 Productivity Commission, *Mental Health Inquiry Report,* Volume 3, p. 970.

140 *Witness Statement of Jenny Smith,* 15 June 2020, para. 31.

141 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, pp. 373–378; Victorian Equal Opportunity and Human Rights Commission, *Fair-Minded Cover: Investigation into Mental Health Discrimination in Travel Insurance*, 2019, pp. 4–11; *Witness Statement of Dr Chris Groot*, para. 15.

142 Productivity Commission, *Mental Health Inquiry Report, Volume 2,* p. 372, quoting Beyond Blue, *Submission to the Senate Economics References Committee Inquiry into Consumer protection in the banking, insurance and financial sector,* 2017, p. 3.

143 *Witness Statement of Janet Meagher AM,* para. 32.

144 Productivity Commission, *Mental Health Inquiry Report, Volume 2,* p. 372.

145 Productivity Commission, *Mental Health Inquiry Report, Volume 2,* p. 372.

146 Victorian Aboriginal Children and Young People's Alliance, *Submission to the Productivity Commission Inquiry into Mental Health: The Social and Economic Benefits of Improving Mental Health,* 2019, p. 3.

147 Foundation House, *Submission to the RCVMHS: SUB.1000.0001.0868,* 2019, p. 40.

148 RCVMHS, Neurocognitive Roundtable: Record of Proceedings.

149 Victorian Equal Opportunity and Human Rights Commission, S*ubmission to the RCVMHS: SUB.1000.0001.5259, 2019,* p. 16.

150 Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259,* p. 16.

151 Rainbow Health Victoria, Thorne Harbour Health and Switchboard, *Submission to the RCVMHS: SUB.0002.0028.0150,* 2019, p. 33.

152 *Witness Statement of Adriana Mendoza,* 2 July 2019, para. 20.

153 Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259,* p. 16.

154 Ilan H Meyer, 'Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence', *Psychological Bulletin,* 129.5 (2003), 674–697 (p. 674).

155 Department of the Prime Minister and Cabinet, *Closing the Gap Report 2020,* 2020, pp. 6–13.

156 *Witness Statement of Commissioner Ro Allen,* 2 July 2019, para. 87.

157 *Witness Statement of Commissioner Ro Allen,* para. 89.

158 Patrick W. Corrigan, Benjamin G. Druss and Deborah A. Perlick, 'The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care', *Psychological Science in the Public Interest,* 15.2 (2014), 37–70, (p. 43).

159 The Benevolent Society, *The Drivers of Ageism,* 2017, pp. 9, 15 and 16.

160 Multicultural Youth Advocacy Network (Australia), *Submission in Response to the Draft Report from the Productivity Commission Inquiry into Mental Health,* 2020; Ethnic Communities' Council of Victoria, *Submission to the RCVMHS: SUB.0002.0029.0366,* 2019; Foundation House, p. 15.

161 Victorian Refugee Health Network, *Submission to the RCVMHS: SUB.0002.0028.0703,* 2019, p. 7.

162 Foundation House, p. 15.

163 Royal Flying Doctor Service Victoria, *Submission to the RCVMHS: SUB.0002.0029.0072,* 2019.

164 For example: Latrobe Health Advocate, *Submission to the RCVMHS: SUB.0002.0029.0102,* 2019, p. 4; *Evidence of Terry Welch,* 15 July 2019, p. 936.

165 *Witness Statement of Terry Welch,* 11 July 2019, para. 60.

166 *Witness Statement of Terry Welch,* para. 46.

167 Royal Flying Doctor Service Victoria, p. 5.

168 *Charter of Human Rights and Responsibilities Act 2006* (Vic), secs. 8(2)–8(3).

169 People with lived experience are covered by the 'disability' protected attribute in the *Equal Opportunity Act 2010* (Vic), sec. 6.

170 *Personal Story of Awhina Poki,* Collected by Victoria Legal Aid, 2020.

171 *Personal Story of Awhina Poki,* Collected by Victoria Legal Aid.

172 Victorian Mental Illness Awareness Council, *Correspondence to the RCVMHS: CSP.0001.0134.0001, Response to Request for Further Information: Stigma and Discrimination.*

173 Hearing Voices Footscray, *Submission to the RCVMHS: SUB.0002.0016.0067,* 2019; UnitingCare Prahran Mission, Welcome to Voices Vic, <unitingprahran.org.au/ourservices/voices-vic/>, [accessed 25 November 2020].

174 United Nations, *Convention on the Rights of Persons with Disabilities,* 6 December 2006, Article 29.

175 United Nations, Article 4(3).

176 *Witness Statement of Associate Professor Nicola Reavley,* para. 18.

177 *Witness Statement of Associate Professor Nicola Reavley,* para. 18.

178 *Witness Statement of Associate Professor Nicola Reavley,* para. 20; Witness Statement of Dr Michelle Blanchard, para. 68.

179 *Witness Statement of Associate Professor Nicola Reavley*, para. 11.

180 *Witness Statement of Associate Professor Nicola Reavley,* para. 10(c).

181 *Witness Statement of Associate Professor Nicola Reavley,* para. 19.

182 Productivity Commission, *Mental Health Inquiry Report, Volume 2,* p. 363.

183 Amy J. Morgan, Nicola J. Reavley, Anna Ross, Lay San Too and Anthony F. Jorm, 'Interventions to Reduce Stigma towards People with Severe Mental Illness: Systematic Review and Meta-Analysis', *Journal of Psychiatric Research,* 103 (2018), 120–133 (p. 120).

184 Committee on the Science of Changing Behavioral Health Social Norms and others, *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change* (Washington, D.C.: National Academies Press, 2016), p. 81.

185 Committee on the Science of Changing Behavioral Health Social Norms and others, pp. 86–87.

186 Jane Pirkis and others, 'An Evaluation of Beyondblue, Australia's National Depression Initiative', *International Journal of Mental Health Promotion,* 7.2 (2005), 35–53 (pp. 42–43).

187 Pirkis and others, p. 43.

188 *Witness Statement of Distinguished Professor James Ogloff AM,* 6 August 2020, para. 98.

189 *Witness Statement of Dr Chris Groot,* para. 61.

190 See three peak bodies in Victoria, Western Australia and New South Wales: Victorian Mental Illness Awareness Council, Mental Health Consumers Dismayed by Misleading Four Corners Report, <www.vmiac.org.au/mental-health-consumers-dismayed-by-misleading-four-corners-report/>, [accessed 16 December 2020]; Consumers of Mental Health WA, CoMHWA Calls for an Apology from Four Corners, <comhwa.org.au/blog/comhwa-calls-for-an-apology-from-four-corners>, [accessed 16 December 2020]; BEING—Mental Health Consumers Inc., PUBLIC STATEMENT: Four Corners Report, <being.org.au/public-statement-four-corners-report/>, [accessed 16 December 2020].

191 Graham Thornicroft and others, 'Evidence for Effective Interventions to Reduce Mental-Health-Related Stigma and Discrimination', *The Lancet,* 387 (2016), 1123–1132 (p. 1123); Morgan, Reavley, Ross, Too and Jorm (p. 120); Nisha Mehta and others, 'Evidence for Effective Interventions to Reduce Mental Health-Related Stigma and Discrimination in the Medium and Long Term: Systematic Review', *British Journal of Psychiatry,* 207.5 (2015), 377–384 (p. 377); Claire Henderson and others, 'Mental Health-Related Stigma in Health Care and Mental Health-Care Settings', *The Lancet Psychiatry*, 1 (2014), 467–482 (p. 479).

192 Patrick W. Corrigan, Scott B. Morris, Patrick J. Michaels, Jennifer D. Rafacz and Nicolas Rüsch, 'Challenging the Public Stigma of Mental Illness: A Meta-Analysis of Outcome Studies', *Psychiatric Services,* 63.10 (2012), 963–973 (p. 963).

193 Claire Henderson and Petra Gronholm, 'Mental Health Related Stigma as a "Wicked Problem": The Need to Address Stigma and Consider the Consequences', *International Journal of Environmental Research and Public Health,* 15.6 (2018), 1158-1170 (p. 1160).

194 Mehta and others, pp. 381–382.

195 Erlend P Kvaale, Nick Haslam and William H Gottdiener, 'The "Side Effects" of Medicalization: A Meta-Analytic Review of How Biogenetic Explanations Affect Stigma', *Clinical Psychology Review*, 33.6 (2013), 782–794 (p. 783).

196 Kvaale, Haslam and Gottdiener, p. 783.

197 Bernice A Pescosolido and others, '"A Disease Like Any Other"? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence', *American Journal of Psychiatry,* 167.11 (2010), 1–19 (p. 4).

198 *Witness Statement of Cath Roper,* 2 June 2020, paras. 15-28; *Witness Statement of Erandathie Jayakody,* paras. 40–76.

199 Link and Phelan, p. 365.

200 Imogen Tyler and Tom Slater, 'Rethinking the Sociology of Stigma', *The Sociological Review Monographs,* 66.4 (2018), 721–743 (p. 724).

201 Lucy Costa and others, 'Recovering Our Stories: A Small Act of Resistance', *Studies in Social Justice,* 6.1 (2012), 85–101 (p. 90).

202 Brotherhood of St Laurence, *Submission to the RCVMHS: SUB.1000.0001.1686*, 2019, p. 9.

203 Productivity Commission, *The Demand Driven University System: A Mixed Report Card Research Paper*, 2019, pp. 11–12.

204 *Witness Statement of Cath Roper,* paras. 35–37.

205 Diana Rose, 'Reflections on the Contemporary State of Service User-Led Research', *The Lancet Psychiatry,* 2.11 (2015), 959–960 (p. 959).

206 Michelle Banfield and others, 'Lived Experience Researchers Partnering with Consumers and Carers to Improve Mental Health Research: Reflections from an Australian Initiative', *International Journal of Mental Health Nursing,* 27.4 (2018), 1219–1229 (p. 1220).

207 'See Me' Management Group, Scotland, *See Me So Far: A Review of the First 4 Years of the Scottish Anti-Stigma Campaign,* 2006, pp. 3–5.

208 Ministry of Health and Health Promotion Agency, New Zealand, *Like Minds, Like Mine: National Plan 2014–2019: Programme to Increase Social Inclusion and Reduce Stigma and Discrimination for People with Experience of Mental Illness,* 2014, p. 13.

209 Mental Health Foundation, United Kingdom, Lived Experience Research Collective, <www.mentalhealth.org.uk/projects/lived-experience-research-collective>, [accessed 15 September 2020].

210 G. Johnston and others, *Untapped Potential,* 2018, p. 4.

211 Johnston and others, p. 4.

212 Ministry of Health and Health Promotion Agency, New Zealand, p. 3.

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

214 Ministry of Health and Health Promotion Agency, New Zealand, p. 13.

215 Hatzenbuehler and Link, pp. 1-2; Miriam Heijnders and Suzanne Van Der Meij, 'The Fight against Stigma: An Overview of Stigma-Reduction Strategies and Interventions', *Psychology, Health and Medicine,* 11.3 (2006), 353–363 (pp. 353–354).

216 Jonathon E. Cook, Valerie Purdie-Vaughns, Ilan H. Meyer and Justin T.A. Busch, 'Intervening within and across Levels: A Multilevel Approach to Stigma and Public Health', *Social Science and Medicine*, 103 (2014), 101–109 (p. 102).

217 Cook, Purdie-Vaughns, Meyer and Busch, p. 106; Anne L. Stangl, 'The Health Stigma and Discrimination Framework: A Global, Crosscutting Framework to Inform Research, Intervention Development, and Policy on Health-Related Stigmas', *BMC Medicine*, 17.31 (2019), 1–13, (p. 2).

218 Heijnders and van der Meij, p. 359; Hatzenbuehler and Link, pp. 4–5.

219 Henderson and others, p. 468.

220 Henderson and others, pp. 472–473.

221 *Witness Statement of Mary O'Hagan,* 16 June 2020, para. 39.

222 *Witness Statement of Associate Professor Nicola Reavley,* para. 41.

223 Livingston, p. 11; Groot and others, pp. 110–128.

224 Groot and others, pp. 90–109.

225 Family and Community Development Committee, Parliament of Victoria, *Inquiry into Workforce Participation by People with Mental Illness,* 2012.

226 *Witness Statement of Lucinda Brogden AM,* 11 May 2020, paras. 25–31.

227 Howard M Schachter and others, 'Effects of School-Based Interventions on Mental Health Stigmatization: A Systematic Review', *Child and Adolescent Psychiatry and Mental Health,* 2:18 (2008), 1–14.

228 *Witness Statement of Dr Chris Groot,* 4 September 2019, para. 58; *Witness Statement of Associate Professor Nicola Reavley,* 3 July 2019, paras. 41–42; Nisha Mehta and others, 'Evidence for Effective Interventions to Reduce Mental Health-Related Stigma and Discrimination in the Medium and Long Term: Systematic Review', *British Journal of Psychiatry,* 207.5 (2015), 377–384.

229 *Witness Statement of Dr Chris Groot,* para. 58; *Witness Statement of Associate Professor Nicola Reavley,* paras. 41–42.

230 Department of Justice, pp. 111–112.

231 Department of Justice, pp. 111–112.

232 Groot and others, p. 25.

233 Shu-Ping Chen and others, 'Chapter 14: Fighting Stigma in Canada: Opening Minds Anti-Stigma Initiative', in *The Stigma of Mental Illness - End of the Story?* (Switzerland: Springer International Publishing, 2017), pp. 237–261.

234 Claire Henderson and Graham Thornicroft, 'Evaluation of the Time to Change Programme in England 2008-2011', *British Journal of Psychiatry,* 202.s55 (2013), s45–s48 (p. s46); L. Hansson, S. Stjernswärd, and B. Svensson, 'Changes in Attitudes, Intended Behaviour, and Mental Health Literacy in the Swedish Population 2009–2014: An Evaluation of a National Antistigma Programme', *Acta Psychiatrica Scandinavica,* 134.s446 (2016), 71–79.

235 Henderson and Thornicroft, p. s46; Hansson, Stjernswärd and Svensson.

236 'See Me' Management Group, Scotland, pp. 3 and 5.

237 C Henderson, H Stuart and L Hansson, 'Lessons from the Results of Three National Antistigma Programmes', *Acta Psychiatrica Scandinavica,* 134.s446 (2016), 3–5 (p.3).

238 Productivity Commission, *Mental Health Inquiry Report, Volume 2,* p. 368.

239 RCVMHS, *Interview with Mike Pietrus,* July 2020.

240 Chen and others, pp. 238–239.

241 *Witness Statement of Associate Professor Nicola Reavley,* paras. 43–44.

242 Productivity Commission, *Mental Health Inquiry Report, Volume 2,* p. 371.

243 National Museum of American History, How Do the Arts Promote Social Change, <americanhistory.si.edu/blog/powerofgiving-18>, [accessed 4 December 2020].

244 Arts Centre Melbourne, Arts Wellbeing Collective Brochure, 2020, p. 10.

245 Listening to Voices Theatre Group, *Submission to the RCVMHS: SUB.0002.0032.0032,* 2019.

246 *Witness Statement of Justin Heazlewood,* 22 April 2020, para. 84.

247 *Equal Opportunity (Discrimination Against Disabled Persons) Act 1982* (Vic); *Equal Opportunity Act 1977* (Vic).

248 Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 365; See also Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259*, p. 13.

249 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217*, pp. 19 and 27; *Witness Statement of Kristen Hilton*, para. 60.

250 Department of Justice, p. 57.

251 *Witness Statement of Kristen Hilton*, para. 60.

252 *Witness Statement of Kristen Hilton*, para. 60.

253 *Witness Statement of Dr Michelle Blanchard*, para. 51.

254 *Equal Opportunity Act 2010* (Vic), sec. 3.

255 Department of Justice, p. 8.

256 *Witness Statement of Kristen Hilton,* para. 62.

257 Victoria Legal Aid, *Submission to the RCVMHS: SUB.0002.0030.0217,* p. 30.

258 *Witness Statement of Kristen Hilton,* para. 63.

259 Victorian Council of Social Service, p. 5.

260 Brotherhood of St Laurence, pp. 9–10.

261 Department of Justice, pp. 57 and 76–77.

262 *The State of Queensland (Queensland Health) v Che Forest* [2008] FCAFC 96, p. 2

263 Department of Justice, p. 63.

264 Justice Connect, *Annual Report 2018–19,* 2019, p. 2.

265 Justice Connect, *Annual Report 2018–19,* p. 4.

266 Justice Connect, *Annual Report 2018–19,* p. 18.

267 Justice Connect, Home Page, <justiceconnect.org.au/>, [accessed 4 December 2020].

268 Department of Justice, p. 12.

269 Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259*, p. 13; Productivity Commission, *Mental Health Inquiry Report, Volume 2*, p. 365.

270 Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259*, p. 24.

271 RCVMHS, *Anti-Discrimination and Human Rights Roundtable: Record of Proceedings*, 2020; Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259*, pp. 9–13.

272 RCVMHS, *Anti-Discrimination and Human Rights Roundtable: Record of Proceedings.*

273 RCVMHS, *Anti-Discrimination and Human Rights Roundtable: Record of Proceedings.*

274 Department of Justice, p. 8.

DOH.0003.0001.1029

275 Victorian Equal Opportunity and Human Rights Commission, *Fair-Minded Cover: Investigation into Mental Health Discrimination in Travel Insurance*, p. 3.

276 Victorian Equal Opportunity and Human Rights Commission, *Fair-Minded Cover: Investigation into Mental Health Discrimination in Travel Insurance*, p. 3.

277 Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259*, p. 24.

278 SANE Australia, *Submission to the RCVMHS: SUB.0002.0030.0197*, 2019, p. 30.

279 Victorian Equal Opportunity and Human Rights Commission, *Submission to the RCVMHS: SUB.1000.0001.5259,* pp. 3-4; RCVMHS, *Anti-Discrimination and Human Rights Roundtable: Record of Proceedings.*

Glossary

The Commission notes that several of the terms within this glossary differ from phrasing used in its letters patent. Where this is the case, the Commission has either made a deliberate choice to provide greater clarity on a term, or to enable a more inclusive interpretation. The Commission has inquired into all matters as per the expectations set in the letters patent.

Aboriginal community controlled health organisation	A primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health services to the community that controls it, through a locally elected board of management. This definition is consistent with that stated by the National Aboriginal Community Controlled Health Organisation.[1]
Aboriginal people	We recognise the diversity of Aboriginal people living throughout Victoria. While the terms 'Koorie' or 'Koori' are commonly used to describe Aboriginal people of south-east Australia, we have used the term 'Aboriginal' in this report to include all people of Aboriginal and Torres Strait Islander descent who are living in Victoria. This approach is consistent with the language conventions of key Victorian frameworks such as the *Aboriginal Affairs Framework 2018–2023*.[2]
Activity-based funding	While similar to a fee-for-service funding model, an activity-based funding model distributes funding to providers for the number of times they provide services to a person, with the amount based on each person's individual needs.[3]
Acute mental health inpatient services	Acute mental health beds, or acute inpatient units, support people experiencing an acute episode of mental illness that calls for treatment in hospital. These services include acute mental health beds for young people, adults and older adults.

Adult and Older Adult Area Mental Health and Wellbeing Services

Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 26 years or older in both community and bed based settings.

Adult and Older Adult Area Mental Health and Wellbeing Services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services.

Services will be delivered through a partnership between a public health service or public hospital and a non-government organisation that delivers wellbeing supports (currently known as psychosocial supports). Access to these services will require a referral from a medical practitioner or Local Mental Health and Wellbeing Service.

Adult and older adult community mental health and wellbeing system

Future system that will provide treatment, care and support to Victorians over the age of 26 years. The Commission has taken an expansive view of what makes up the community mental health and wellbeing system, beyond mental health and wellbeing services. The system can be considered to span six levels, where the top level engages with the most people and each subsequent level supports a decreasing proportion of the population. The six levels are:

- families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest
- a broad range of government and community services
- primary and secondary mental health and related services
- Adult and Older Adult Local Mental Health and Wellbeing Services
- Adult and Older Adult Area Mental Health and Wellbeing Services
- statewide services.

Within this system, there will be an older adult mental health and wellbeing service stream that provides treatment, care and support for people with complex and compounding mental health needs generally related to ageing who are over the age of 65.

Adult and Older Adult Local Mental Health and Wellbeing Services

Future services that will deliver treatment, care and support to people aged 26 years or older. They will be delivered in a variety of settings where people first access services and receive most of their treatment, care and support. People will access these services either directly or via referral, and services will operate with extended hours. Services will deliver the Commission's recommended core functions for community mental health and wellbeing services. Service delivery may involve Area Mental Health and Wellbeing Services.

Area Mental Health and Wellbeing Services	Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams in both community and bed based settings. Area Mental Health and Wellbeing Services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services or in partnership with them. Services will be delivered through a partnership between a public health service and a non-government organisation that delivers wellbeing supports. There will be separate Area Mental Health and Wellbeing Services for infants, children and young people and for adults and older adults. For infants, children and young people there will be two service streams: Infant, Child and Family Area Mental Health and Wellbeing Services (0–11); and Youth Area Mental Health and Wellbeing Services (12–25). There will also be Adult and Older Adult Area Mental Health and Wellbeing Services (for people over the age of 26).
Area mental health services	The current state-funded area mental health services provide clinical community-based and inpatient care. Seventeen of Victoria's public health services operate area mental health services. Note: For the purposes of clarity, the current system is referred to in lower case and elements of the new service system have been capitalised in this report.
Allied mental health service	A service delivered by a diverse workforce such as psychologists, social workers and occupational therapists, working in a range of public, private, community and primary care settings.
Ambulatory care	Care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics. The term also refers to care provided to patients of community-based (non-hospital) healthcare services.[4]

Assertive outreach	A term applying to a broad range of models of care delivered in different service contexts. Generally, assertive outreach recognises that some people may require services to be more proactive in engaging or following up with them. Traditionally, assertive outreach models have included low caseloads, a multidisciplinary team, availability outside business hours, team autonomy and psychiatrist input. A variety of assertive outreach models are now in operation in Australia and internationally.
Assessment Order	An order made under the *Mental Health Act 2014* (Vic) that authorises a person to be compulsorily examined by an authorised psychiatrist to determine whether the treatment criteria, specified in the Mental Health Act, apply to the person. The order can either be an Inpatient Assessment Order or a Community Assessment Order, which reflects the location of where the examination is to occur.[5]
Authorised psychiatrist	A psychiatrist appointed by a designated mental health service to exercise the functions, powers and duties conferred on this position under the *Mental Health Act 2014* (Vic), the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) or any other Act.[6]
Blended care	Providing care through integrating digital and face-to-face supports. In blended care, digital supports are used to complement face-to-face services and to build on the gains achieved in face-to-face delivery.[7]
Capitation funding	Under a capitation payment model, providers receive a fixed amount of funding for each person who registers with them for a specified period, usually a year.[8] Capitation funding is similar to block funding; however, the funding is based on the number and mix of people who are registered with the service.
Care	The provision of ongoing support, assistance or personal care to another person.[9]
Carer	A person, including a person under the age of 18 years, who provides care to another person with whom they are in a relationship of care.[10]

DOH.0003.0001.1034

Clinical governance	'[T]he systems and processes that health services need to have in place to be accountable to the community for ensuring that care is safe, effective, patient-centred and continuously improving'.[11]
Coercion	The action or practice of persuading in a way that uses or implies force and threats—forcing someone to do something.
Commissioning	While there is no single agreed definition, commissioning can be understood as a cycle that involves planning the service system, designing services, selecting, overseeing and engaging with providers, managing contracts and undertaking ongoing monitoring, evaluation and improvement.[12] Co-commissioning or joint commissioning refers to the ways in which organisations work together and with their communities to make the best use of limited resources in the design and delivery of services and to improve outcomes.[13]
Community care unit	A unit that provides clinical care and rehabilitation services in a homelike environment.
Community health services and integrated care services	Services that provide primary health, human services and community-based supports to meet local community needs.
Community mental health and wellbeing services	Services provided outside a hospital setting—in community settings such as clinics or centres, in people's homes or other places, or delivered by phone or videoconferencing, or online.[14] Community mental health and wellbeing services delivered by hospitals are sometimes referred to as 'community ambulatory services' and include care delivered by hospitals, but not always in the hospital itself, such as through outpatient or day clinics.[15]

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Community mental health and wellbeing services core functions

The core functions are recommended by the Commission to ensure consistency in treatment, care and support delivered across Victoria. The core functions, which are common across all age ranges, are:

- integrated treatment, care and support proportionate to consumers' needs, consisting of:
  - treatment and therapies—including a broad range of psychological and psychiatric therapies, other therapeutic interventions, support for physical health, and support for substance use or addiction
  - wellbeing supports—including supports for community connection and social wellbeing, building life skills, securing and maintaining housing, and education, training and employment supports
  - education, peer support and self-help—through education, peer self-help and guided self-help
  - care planning and coordination—to ensure that treatment, care and support is proportionate to needs and to provide continuity of care
- services to help people find and access treatment, care and support and in Area Mental Health and Wellbeing Services to respond 24 hours a day, seven days a week to people experiencing a mental health crisis
- support for primary and secondary services (for example, GPs), including primary and secondary consultation and comprehensive shared care.

Comorbidity

A situation where a person has two or more health problems at the same time. Also known as multimorbidity.

Compulsory patient

Under section 3 of the *Mental Health Act 2014* (Vic) a compulsory patient means a person who is subject to an Assessment Order, Court Assessment Order, Temporary Treatment Order or Treatment Order under the Act. Compulsory patients are sometimes referred to as 'involuntary patients'.

Compulsory treatment	The treatment of a person for mental illness subject to an order under the *Mental Health Act 2014* (Vic), the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) or the *Sentencing Act 1991* (Vic). This can include the administration of medication, hospital stays, electroconvulsive treatment or neurosurgery for mental illness. Compulsory treatment is sometimes referred to as 'involuntary treatment'.
Consecutive order	When a person is placed on a new compulsory treatment order, in anticipation of the current order ending,[16] to create a continuous duration and includes an Assessment Order, a Temporary Treatment Order and a Treatment Order.
Consumer	People who identify as having a living or lived experience of mental illness or psychological distress, irrespective of whether they have a formal diagnosis, have used mental health services and/or received treatment, care or support.
Consumer-completed measures and family-, carer- and supporter-completed measures	These measures collect information on the effectiveness of mental health and wellbeing services directly from the people who access services. They are a direct measure of experiences or outcomes, as determined by the individual. This information can be collected using a range of tools including questionnaires or standardised surveys.[17]
Consumer streams	The Commission uses the streams to describe how, at any given point in time, a person experiencing mental illness or psychological distress will need one of: • support from their communities and primary care services (communities and primary care stream) • treatment, care and support from primary and secondary mental health and related services (primary care with extra supports stream) • short-term treatment, care and support from a Local Mental Health and Wellbeing Service or an Area Mental Health and Wellbeing Service (short-term treatment, care and support stream) • ongoing treatment, care and support from a Local Mental Health and Wellbeing Service or an Area Mental Health and Wellbeing Service (ongoing treatment, care and support stream) • ongoing intensive treatment, care and support from a Local Mental Health and Wellbeing Service or an Area Mental Health and Wellbeing Service (ongoing intensive treatment, care and support stream).

Co-production	This involves people with lived experience of mental illness or psychological distress leading or partnering across all aspects of an initiative or program from the outset—that is, co-planning, co-designing, co-delivering and co-evaluating.[18]
Cultural safety	An environment that is safe for people—where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening.
Culturally appropriate	'An approach to policy, intervention, service delivery and intergroup interaction that is based on the positive acceptance of the cultural values and expectations of Aboriginal people.'[19] Culturally appropriate care is important for people from a broad range of cultures.
Culturally diverse	Term used in this report to reflect the fact that the Victorian population is diverse and that culture and language can influence people's needs and their access to mental health services that meet their needs.
Designated mental health service	A health service[20] that is prescribed in the Mental Health Regulations 2014 (Vic) to provide compulsory treatment[21] (includes Forensicare).
Digital mental health technology	The use of online and other digital technologies to improve mental health and wellbeing, including access to information, service delivery, education, promotion and prevention. It encompasses a vast range of technologies including apps, portals, social media, smartphones, augmented or virtual reality, wearables, activity tracking, e-referral, notifications and artificial intelligence. Other common terminology includes 'e-mental health' (health services that are online), 'm-health' (mobile and app-based support) and 'virtual health'.[22] This report uses 'digital mental health technology' as an overarching term that encompasses many types of technology. Where relevant, however, the report names specific technologies.

Discrimination	At its most basic, discrimination refers to the prejudicial treatment of people based on their individual or collective characteristics. In Victoria, the *Equal Opportunity Act 2010* (Vic) makes it unlawful to discriminate on the basis of 'disability' (which is defined to include a 'mental or psychological disease or disorder')[23] in certain settings including health care, employment and schools. This can be through 'direct discrimination' such as when someone is treated unfavourably because of a personal characteristic like mental illness.[24] This could be a refusal to treat someone, provide them access to services or admit them to a school because they have a mental health diagnosis. The law also protects against 'indirect discrimination', where an unreasonable requirement, condition or practice disadvantages a person or group of people based on a characteristic.[25]
Dual diagnosis service	Term historically used to describe services in Victoria that provide treatment, care and support to consumers living with mental illness and substance use or addition.
Dual disability	Term defined in the Commission's interim report as people living with both mental illness and an acquired or neurodevelopmental disability (such an intellectual disability, autism spectrum disorder, attention-deficit/hyperactivity disorder or a communication disorder).[26]
Early intervention	Includes prevention and early treatment. Early intervention can involve equipping people to deal with the signs and symptoms of illness or distress and helping people as soon as possible once mental distress is identified in order to improve the prospect of recovery (for example, following exposure to trauma).
Electroconvulsive treatment	The 'application of electric current to specific areas of a person's head to produce a generalised seizure'.[27] Also known as electroconvulsive therapy.
Enrolment	Refers to a consumer voluntarily enrolling with a service provider who is responsible for coordinating their comprehensive care. The consumer is free to get care through this 'responsible' provider, or through alternative providers. Enrolment may or may not be associated with a 'capitated' payment that is linked to the number of consumers enrolled (refer to definition: 'Capitation funding').

Family	May refer to family of origin and/or family of choice.
Fee for service	Under a fee-for-service funding model, service providers receive funding based on the number and mix of procedures, treatments and services they deliver.[28]
Forensic mental health service	A service that provides treatment, care and support services to people living with mental illness who have come into contact with the criminal justice system.
Forensic patient	A person under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) through an order of a court and detained at a designated mental health service (usually at Forensicare's Thomas Embling Hospital).[29]
Good mental health	A state of wellbeing in which a person realises their own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to their community.
Harm minimisation	A health policy approach that recognises there are complex and interrelated health, social and economic consequences of substance use or addiction that affect individuals, families and the community. A harm minimisation approach recognises that drug use is individual and occurs from occasional use to dependency. The approach does not condone drug use but recognises a range of strategies are required to support a progressive reduction in substance-related harm. A harm minimisation approach is based on three pillars: • Harm reduction aims to reduce high-risk behaviours associated with substance use and providing safer settings such as smoke-free areas or free water at music festivals. • Demand reduction is about preventing uptake of substances. Demand reduction also involves helping people who use substances to recover through a range of evidence-based care, treatment and support options. • Supply reduction is about controlling the supply and availability of substances.

Indicators	Qualitative or quantitative measures that can help determine change or progress and can be used to determine whether short-, medium- or long-term outcomes are being achieved. When indicators are used to measure the outcomes of a particular program or intervention (for example, resulting from reforms) they are measured from a baseline (before the program or intervention), at regular intervals after the intervention starts, and at the end.[30]
Infant, Child and Family Health and Wellbeing Hubs	Future local mental health and wellbeing services for people aged 0–11 years that will take the form of Infant, Child and Family Health and Wellbeing Hubs. These hubs will take a one-stop shop approach to child health by prioritising infants and children with emotional (for example, mental health challenges), developmental (for example, intellectual disability, autism spectrum disorder, speech delay) and physical health challenges (for example, asthma, allergies, chronic disease) that have continued to affect their wellbeing despite previous support. The hubs will provide age-appropriate treatment, care and support, use a whole-of-family approach, conduct a range of assessments as needed and be supported by Infant, Child and Family Area Mental Health and Wellbeing Services.
Infant, Child and Family Area Mental Health and Wellbeing Services	Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 0–11 years. Infant, Child and Family Area Mental Health and Wellbeing Services are a service stream of the 13 Infant, Child and Youth Area Mental Health Services. These services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services or in partnership with them. Infant, Child and Youth Area Mental Health Services will be delivered through a partnership between a public health service (or public hospital) and a non-government organisation that delivers wellbeing supports.

DOH.0003.0001.1041

Infant, child and family mental health and wellbeing service stream

Future service stream that will provide treatment, care and support to Victorians under the age of 12 years. It is one service stream within the broader infant, child and youth mental health and wellbeing system.

The Commission has taken an expansive view of what makes up this service stream, beyond mental health and wellbeing services. The service stream can be considered to span six levels, where the top level engages with the most people and each subsequent level supports a decreasing proportion of the population. The six levels are:

- families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest
- a broad range of government and community services
- primary and secondary mental health and related services
- Infant, Child and Family Local Health and Wellbeing Services
- Infant, Child and Family Area Mental Health and Wellbeing Services within Infant, Child and Youth Area Mental Health Services
- statewide services.

Infant, Child and Youth Area Mental Health and Wellbeing Services

Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 0–25 years in both community and bed based settings.

The 13 Infant, Child and Youth Area Mental Health and Wellbeing Services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services.

Within these services will be two service streams: Infant, Child and Family Area Mental Health and Wellbeing Services and Youth Area Mental Health and Wellbeing Services.

Services will be delivered through a partnership between a public health service or public hospital and a non-government organisation that delivers wellbeing supports (currently known as psychosocial supports). Access to these services will require a referral from a medical practitioner or Local Mental Health and Wellbeing Service.

Infant, child and youth mental health and wellbeing system	Future health system that will provide treatment, care and support to Victorians aged 0–25 years. Within this broad system, there are two service streams—the infant, child and family mental health and wellbeing service stream for people aged 0–11 years and the youth mental health and wellbeing service stream for people aged 12–25 years. At the area level, there will be shared clinical governance across the age range of 0–25 years through the 13 Infant, Child and Youth Area Mental Health Services.
Information collection, use and sharing	'Information collection' refers to mental health information a service provider or entity may collect as part of its organisational functions. 'Use' refers to the use of information for the purpose of delivering services to consumers, or for directly related purposes, such as administration. 'Use' also refers to who can see and use this information, and in what circumstances. It includes the protections and securities put in place to ensure privacy standards are met. 'Information sharing' broadly refers to the disclosure of information to another worker, provider, organisation or person for the purposes of treatment, support or accountability.
Inpatient	Relating to an admission to an inpatient unit of a designated mental health service.
Integrated care service	A service that provides a range of services and supports, including primary care and mental health care.
Intersectionality	Drawing on the Victorian Government's 2019 *Everybody Matters: Inclusion and Equity Statement*, the Commission describes intersectionality as a theoretical approach that understands the interconnected nature of social categorisations—such as gender, sexual orientation, ethnicity, language, religion, class, socioeconomic status, gender identity, ability or age—which create overlapping and interdependent systems of discrimination or disadvantage for either an individual or group.[31]
Lived experience	People with lived experience identify either as someone who is living with (or has lived with) mental illness or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or psychological distress. People with lived experience are sometimes referred to as 'consumers' or 'carers'. The Commission acknowledges that the experiences of consumers and carers are different.

DOH.0003.0001.1043

Lived experience workforces	A broad term to represent two distinct professional groups in roles focused on their lived expertise—people with personal lived experience of mental illness ('consumers') and families and carers with lived experience of supporting a family member or friend who has experienced or is experiencing mental illness. Within each professional discipline there are various paid roles, among them workers who provide support directly to consumers, families and carers through peer support or advocacy, or indirectly through leadership, consultation, system advocacy, education, training or research.
Local Mental Health and Wellbeing Services	Future services that will provide treatment, care and support in a variety of settings where people first access services. People will access these services either directly or via referral, and services will operate with extended hours. Services will deliver the Commission's recommended core functions. Service delivery may occur in partnership with area services. These services will be a combination of primary and secondary responses supported by some tertiary-level responses. There will be separate local services for each of three age groups: Infant, Child and Family Local Health and Wellbeing Services (0–11), Youth Local Mental Health and Wellbeing Services (12–25) and Adult and Older Adult Local Mental Health and Wellbeing Services (over 26).
Medicare-subsidised mental health-specific service	Service in which the Medicare Benefits Scheme and the associated Better Access Initiative provide subsidised access to GPs and other health professionals such as psychiatrists, psychologists and other allied health practitioners.
Mental health and wellbeing	An optimal state of mental health, including as it relates to people with lived experience of mental illness or psychological distress. It can also be used to refer to the prevention, avoidance or absence of mental illness or psychological distress.

Mental Health and Wellbeing Commission	A new independent statutory authority recommended by the Royal Commission to: • hold government to account for the performance and quality and safety of the mental health and wellbeing system • support people living with mental illness or psychological distress, families, carers and supporters to lead and partner in the improvement of the system • monitor the Victorian Government's progress in implementing the Royal Commission's recommendations • address stigma related to mental health.
Mental health and wellbeing information	Information or an opinion about a consumer's physical, mental or psychological health, a health service provided, a consumer's expressed wishes about future service delivery, and personal information collected to provide health services. Information from others, including families, carers and supporters may also be included in mental health information, where appropriate.
Mental health and wellbeing system	The Commission outlines in this report its vision for a future mental health and wellbeing system for Victoria. Mental health and wellbeing does not refer simply to the absence of mental illness but to creating the conditions in which people are supported to achieve their potential. As part of this approach, the Commission has also purposefully chosen to focus on the strengths and needs that contribute to people's wellbeing. To better reflect international evidence about the need to strike a balance between hospital-based services and care in the community, the types of treatment, care and support the future system offers will need to evolve and be organised differently to provide each person with dependable access to mental health services and links to other supports they may seek. The addition of the concept of 'wellbeing' represents a fundamental shift in the role and structure of the system.
Mental health system	Overarching term that takes in services (with various funders and providers) that have a primary function of providing treatment, care or support to people living with mental illness and/or their carers. This term is used to describe the current and historical system.
Mental Health Tribunal	Independent statutory tribunal established under the *Mental Health Act 2014* (Vic) to hear and determine the making of Treatment Orders and other applications, including applications to perform electroconvulsive treatment when a person does not have decision-making capacity or is under the age of 18 years and applications to perform neurosurgery for mental illness.[32]

Mental illness	A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.[33] The Commission uses the above definition of mental illness in line with the *Mental Health Act 2014* (Vic). However, the Commission recognises the Victorian Mental Illness Awareness Council Declaration released on 1 November 2019. The declaration notes that people with lived experience can have varying ways of understanding the experiences that are often called 'mental illness'. It acknowledges that mental illness can be described using terms such as 'neurodiversity', 'emotional distress', 'trauma' and 'mental health challenges'.
Mental wellbeing	A dynamic state of complete physical, mental, social and spiritual wellbeing in which a person can develop to their potential, cope with the normal stresses of life, work productively and creatively, build strong and positive relationships with others and contribute to their community.
Neurosurgery for mental illness	Any of the following three procedures, provided to treat a person meeting the criteria for mental illness: a) 'any surgical technique or procedure by which one or more lesions are created in a person's brain on the same or on separate occasions for the purpose of treatment b) the use of intracerebral electrodes to create one or more lesions in a person's brain on the same or on separate occasions for the purpose of treatment c) the use of intracerebral electrodes to cause stimulation through the electrodes on the same or on separate occasions without creating a lesion in the person's brain for the purpose of treatment'.[34]
Nominated person	The formal nomination of a person under the *Mental Health Act 2014* (Vic) by a person to provide them with support and help and to represent their interests and rights at times when they are at risk of receiving compulsory treatment or are receiving compulsory treatment. The nominated person also receives information from the authorised psychiatrist at certain points and is consulted as part of decision-making processes under the Act.[35]

Older adult mental health and wellbeing service stream	Future service stream that will provide treatment, care and support to Victorians with mental health support needs generally related to ageing. It is a service stream within the broader adult and older adult mental health and wellbeing system. The Commission has taken an expansive view of what makes up this service stream, beyond mental health and wellbeing services. The service stream can be considered to span six levels, where the top level engages with the most people and each subsequent level supports a decreasing proportion of the population. The six levels are: • families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest • a broad range of government and community services • primary and secondary mental health and related services • Adult and Older Adult Local Mental Health and Wellbeing Services • Adult and Older Adult Area Mental Health and Wellbeing Services, which will include older adult mental health and wellbeing specialist multidisciplinary teams • statewide services.
Outcome domains	Categories or groups of outcomes relating to broad areas of mental health and wellbeing. For example, outcome domains could relate to providing safe and high-quality mental health services or could relate to consumer satisfaction with service delivery and treatment and care.
Outcomes	Changes to the health or wellbeing of a person, group or population that results from some kind of intervention or multiple interventions. Interventions are defined very broadly and include particular models of care or treatment or making health services more accessible or acceptable to consumers.[36] Individual health outcomes are measures of individual health and wellbeing status. These can be measured in the short, medium and long term. Population-level outcomes are measures of aggregated data on the health of a population—for example, the population of Victoria or Australia.[37] Outcomes are measured using indicators.
Output funding model	The Victorian Government uses an 'output funding model' whereby departments use the investment allocated in the budget process to deliver on the government's objectives[38] and outputs.[39] Output performance measures are used to specify the expected performance standard at which these services are to be delivered,[40] covering measures such as the quantity of services provided, timeliness, quality and cost.[41]

Postvention bereavement support	A range of support services provided to people who have been bereaved by suicide.
Prevention and recovery care unit	Generally a short-term service (up to 28 days) that provides recovery-focused treatment in a community-based residential setting.
Primary care	Health services where consumers access care, treatment and support without the need for a referral or without needing to meet certain eligibility criteria. Primary care settings include general practices, community health services and some allied health services. Primary care services are widely distributed, are the most accessible form of health care and are provided in most local communities across Victoria. Typical primary care providers are GPs or allied health professionals such as social workers or mental health nurses. However, primary care can be offered by a wide range of professionals including psychologists, paediatricians and maternal child and health workers.
Primary consultation	A consultation between a mental health clinician or multidisciplinary mental health team and a consumer that may be conducted in person or through teleconferencing or phone. A primary consultation can occur following a referral—for example, where a GP makes a referral for a consumer to have a primary consultation with a psychiatrist.
Primary Health Networks	Networks that commission a variety of mental health, alcohol and drug, and suicide prevention services. Services commissioned can vary but may include: referral and support services; primary and specialist consultation services; prevention and early intervention services; services to reduce the harm associated with alcohol and other drugs; and capacity-building activities such as workforce education and training.[42] Refer to Box 29.4 in Chapter 29: *Encouraging partnerships* for detail.
Primary prevention	Strategies that aim to stop the onset of a health condition or disease from ever occurring by addressing the underlying causes or determinants of that condition. Primary prevention is distinct from secondary prevention, also referred to as early intervention, which aims to minimise the progress of a condition or disease at an early stage. It is also distinct from tertiary prevention, which aims to stop further progression of the condition and address the impacts that have already occurred.

DOH.0003.0001.1048

Private hospital	Includes acute care and psychiatric hospitals, as well as private freestanding hospitals that provide day-only services.
Professional practice supervision	Refers to a formal professional relationship between two mental health practitioners that is designed to enable reflective practice, support professional self-care, maintain standards of professional practice, refine relational and clinical competencies and explore ethical issues. It is distinct from line management and performance management and is not a form of therapy.
Psychiatric assessment and planning unit	A unit that offers assessment and treatment for people experiencing an acute episode of mental illness and that minimises the need for an extended hospital stay in an inpatient unit.
Psychological distress	'One measure of poor mental health, which can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness.'[43] This is consistent with the definition accepted by the National Mental Health Commission.
Public specialist mental health services	Services that provide both clinical and non-clinical mental health services. These are largely delivered by area mental health services operated by 17 public health services in Victoria.
Quality assurance	A range of strategies, including regulation, used to provide assurance that services are meeting minimum quality or safety standards and expectations.
Quality and safety oversight	Monitoring either system or service performance to identify and report on the quality and safety of mental health treatment, care and support. This can include oversight of specific practices (such as monitoring the use of electroconvulsive treatment), of the performance of an individual service, or of the whole system. Oversight often involves a degree of independence from the practice or service that is subject to oversight.
Recovery-oriented practice	Practice that supports people to autonomously build and maintain a self-defined, meaningful and satisfying life and personal identity, whether or not there are ongoing symptoms of mental illness.[44]

DOH.0003.0001.1049

Reflective practice	Interprofessional and collaborative group-directed processes of learning through and from experience to gain new insights via: • reflection on experiences of delivering care, treatment and support to consumers, families, carers and supporters • examining and critically reflecting on assumptions underlying everyday practices • reflecting on challenging interpersonal dynamics.
Regional Mental Health and Wellbeing Boards	Skills-based boards (rather than a representative board) recommended by the Commission that will include people with lived experience. Regional Boards will seek to support communities to achieve the highest attainable standard of mental health and wellbeing through achieving the following objectives: • Services respond to the needs of local communities. • Services respond to individual needs and preferences, with a focus on community-based service provision. • Services are integrated. • Safe services are incentivised. • Resources are allocated to improve outcomes. • Resources are allocated in a way that maximises value. Regional Boards will have a range of responsibilities. This includes being responsible for understanding need and planning services, supporting collaboration, funding and monitoring service providers, workforce planning and engaging with communities.
Regional Multiagency Panels	New coordinating structures recommended by the Commission in each region to bring together different service providers to support collaboration and accountability in providing services to consumers by multiple service agencies.
Restrictive interventions	May include 'bodily restraint', which is defined as a form of physical or mechanical restraint that prevents a person from having free movement of their limbs (excluding the use of furniture), or 'seclusion', which is the sole confinement of a person to a room or any other enclosed space from where the person is not free to leave.[45]

Seclusion and restraint

The *Mental Health Act 2014* (Vic) currently defines two forms of 'restrictive interventions':

- **Bodily restraint** is a form of **physical** or **mechanical** restraint that prevents a person having free movement of their arms or limbs but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's ability to get off the furniture.[46]
- **Seclusion** is the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave.[47]

Under the Act, seclusion and restraint can only be used in designated mental health services.[48]

The Act also prescribes that restrictive interventions (including seclusion and restraint) may only be used after 'all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable'.[49]

Restrictive interventions can also be called 'restrictive practices'. This term is used throughout the report when necessary to reflect the use of the term in source data or evidence.

Secondary care

Health services that require a referral from a primary care provider (usually a GP). A common example is a referral from a GP to a private psychologist under the Better Access scheme. Another common form of secondary care is where a GP refers a consumer to a psychiatrist for a mental health assessment.

Secondary consultation

A discussion between mental health clinicians about a particular consumer. This can enable different care providers to work collaboratively to discuss issues with the consumer's care. Other models of secondary consultation focus on the needs of consumers more generally—for example, consumers with particular mental health needs or a specific diagnosis. This model focuses on sharing knowledge and expertise between different care providers.

Secure extended care unit

A unit offering secure services on a general hospital site for people who need a high level of secure and intensive clinical treatment for severe mental illness.

Security patient	A prisoner who is placed on an order under the *Mental Health Act 2014* (Vic) or the *Sentencing Act 1991* (Vic) and detained at a designated mental health service (usually at Forensicare's Thomas Embling Hospital).[50]
Self-determination	In a collective sense, this term is used to refer to the 'ability of Aboriginal peoples to freely determine their own political, economic, social and cultural development as an essential approach to overcoming Indigenous disadvantage'.[51] Some materials referenced by the Commission also use the term 'self-determination' to refer to individual autonomy and each person's ability to make choices about themselves and their life.
Service and capital plan	A plan that 'identifies present and, as best as possible, future demand for services' and is intended to 'guide the future allocation of resources'.[52] Also called a 'service and infrastructure plan'.
Service standards	The Commission has developed service standards to assist the Victorian Government and Regional Mental Health and Wellbeing Boards to select service providers—including new providers, such as consumer-led providers—with adequate capacity and capability to deliver mental health services. Refer to Chapter 28: *Commissioning for responsive services* for detail.
Shared care	A structured approach between two or more health services that each take responsibility for particular aspects of a consumer's care. This responsibility may relate to the particular expertise of the health service. Shared care is supported by formal arrangements, including clear care pathways and clinical governance, and all health services involved share a joint and coordinated approach to the health and wellbeing of the consumer. Shared care approaches can also benefit health providers—for example, by providing them with access to expert advice, which can increase their capabilities over time.
Social and emotional wellbeing	Being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life. This is consistent with *Balit Murrup*, Victoria's Aboriginal social and emotional wellbeing framework.

Social determinants of mental health	A person's mental health and many common mental illnesses are shaped by social, economic, and physical environments, often termed the 'social determinants of mental health'. Risk factors for many common mental illnesses are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk.[53]
Social housing	Term covering two distinct forms of subsidised rental housing: public housing, which is owned and operated by the Victorian Government, and community housing, which is owned and operated by community housing providers.[54]
Statewide services	Based on the evidence presented, the Commission characterises statewide services as those that usually involve: • a workforce with a high level of expertise and knowledge • a dedicated research focus • the provision of treatment, care and support to a proportionately small number of people, often with higher levels of needs.
Stigma	The World Health Organization defines stigma as a 'mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society'.[55] Stigma is a fundamentally social process—different characteristics or traits are not inherently negative, 'rather, through a complex social process, they become defined and treated as such'.[56] This process leads to social exclusion.[57]
Structural stigma	Refers to the 'societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and wellbeing for stigmatised populations'.[58]
Substance use or addiction	Substance use means the use of alcohol, tobacco or other drugs (prescription or illicit). Substance use may become harmful to a person's health and wellbeing or can have other impacts on someone's life or that of their family and broader social network. Addiction to substances means compulsive substance use that is outside a person's control, even when it has harmful effects on that person or their family.
Substituted decision making	Where a third party makes treatment decisions for the consumer.

Supported decision making	The process that supports a person to make and communicate decisions with respect to personal or legal matters. This may be achieved by offering consumers access to a variety of tools and resources such as non-legal advocates and peer workers.[59]
Systemic discrimination	Term that 'describes patterns or practices of discrimination that are the result of interrelated policies, practices and attitudes that are entrenched in organisations or in broader society'.[60]
Telehealth	Video teleconferencing using some form of online software or phone-conferencing to deliver services and supports directly to a consumer.[61]
Temporary Treatment Order	An order made under the *Mental Health Act 2014* (Vic) by an authorised psychiatrist following an examination under an Assessment Order that requires a person to be provided with compulsory treatment. The order is either an Inpatient Temporary Treatment Order or a Community Temporary Treatment Order.[62]
Tertiary care services	Highly specialised medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.
Treatment	When 'a person receives treatment for mental illness if things are done in the course of the exercise of professional skills to remedy the person's mental illness; or to alleviate the symptoms and reduce the ill effects of the person's mental illness'.[63]
Treatment, care and support	The Commission uses this phrase consistently with its letters patent. This phrase has also been a deliberate choice throughout this report to present treatment, care and support as fully integrated, equal parts of the way people will be supported in the future mental health and wellbeing system. In particular, wellbeing supports (previously known at 'psychosocial supports') that focus on rehabilitation, wellbeing and community participation will sit within the core functions of the future system.
Treatment Order	An order made under the *Mental Health Act 2014* (Vic) by the Mental Health Tribunal following a period of treatment under a Temporary Treatment Order that requires a person to be provided with compulsory treatment. The order is either an Inpatient Treatment Order or a Community Treatment Order.[64]

Value-based care	Care whose goal is to create more value for consumers by focusing on the outcomes that matter to them, rather than just focusing on cost-efficiency. Some funding approaches are designed to encourage greater value, such as bundled payments.[65]
Voluntary patient	A person who receives treatment for a mental illness or psychological distress who is not subject to a compulsory assessment or treatment order.
Wellbeing supports	Used to describe supports for wellbeing in the future system. Includes supports currently known as 'psychosocial supports'.
Whole of government	Although there is no universally agreed definition of 'whole-of-government' approaches (often interchangeably referred to as 'joined-up' approaches), the Commission uses this phrase to denote different areas of government (for example, health, human services, justice and corrections) working together to achieve shared outcomes.[66]
Whole of system	The Commission's terms of reference define the mental health system by reference to mental health services that are funded wholly, or in part, by the Victorian Government. When the Commission refers to 'whole of system' in relation to the mental health system, the reference is to a broader system. This includes not only public sector bodies and organisations at the federal, state and local government levels; it includes all people and organisations who participate in—or are connected with—the new mental health and wellbeing system recommended by the Commission.
Youth Area Mental Health and Wellbeing Services	Future services that will provide tertiary-level, high-intensity and complex support responses via multidisciplinary teams to people aged 12–25 years. Youth Area Mental Health and Wellbeing Services are a service stream of the 13 Infant, Child and Youth Area Mental Health Services. Youth Area Mental Health and Wellbeing Services will deliver all the core functions of community-based mental health services for those requiring a higher intensity of treatment, care and support than can be provided through local services or in partnership with them. Infant, Child and Youth Area Mental Health Services will be delivered through a partnership between a public health service (or public hospital) and a non-government organisation that delivers wellbeing supports.

Youth Local Mental Health and Wellbeing Services

Future services that will deliver treatment, care and support to people aged 12–25 years or older.

The role of Youth Local Mental Health and Wellbeing Services in the youth mental health and wellbeing service stream will be predominantly played by the network of headspaces across Victoria, although, over time, other providers may also choose to deliver this level of service.

Youth Local Mental Health and Wellbeing Services and Youth Area Mental Health and Wellbeing Services will be formally networked within each of the 13 areas. They will work together in partnerships to provide treatment, care and support to young people.

Youth mental health and wellbeing service stream

Future service stream that will provide treatment, care and support to Victorians aged 12–25 years. It is one service stream within the broader infant, child and youth mental health and wellbeing system.

The Commission has taken an expansive view of what makes up this service stream, beyond mental health and wellbeing services. The service stream can be considered to span six levels, where the top level engages with the most people and each subsequent level supports a decreasing proportion of the population. The six levels are:

- families, carers and supporters, informal supports, virtual communities and communities of place, identity and interest
- a broad range of government and community services
- primary and secondary mental health and related services
- Youth Local Mental Health and Wellbeing Services
- Youth Area Mental Health and Wellbeing Services within Infant, Child and Youth Area Mental Health Services
- statewide services.

Shortened forms

The following shortened forms are frequently used in this report. Other shortened forms are explained where they are used.

AC	Companion of the Order of Australia
AM	Member of the Order of Australia
AO	Officer of the Order of Australia
CEO	Chief Executive Officer
DNA	deoxyribonucleic acid
GP	general practitioner
IT	information technology
LGBTIQ+	lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning
MP	Member of Parliament
OAM	Medal of the Order of Australia
PSM	Public Service Medal
TAFE	Technical and Further Education

1 National Aboriginal Community Controlled Health Organisation, *Submission to the Productivity Commission Inquiry into Human Services: Identifying Sectors for Reform*, 2016, p. 4.

2 Victorian Government, *Victorian Aboriginal Affairs Framework: 2018–2023*, 2018, p. 1.

3 Department of Health and Human Services, *Clinical Mental Health Funding Reform: Building a Stronger Foundation for Funding Adequacy, Growth and Fairness*, 2020, p. 3.

4 Australian Institute of Health and Welfare, *Mental Health Services in Australia 2004–05*, 2007.

5 *Mental Health Act 2014* (Vic), sec. 28.

6 *Mental Health Act 2014* (Vic), sec. 150.

7 Doris Erbe and others, 'Blending Face-to-Face and Internet-Based Interventions for the Treatment of Mental Disorders in Adults: Systematic Review', *Journal of Medical Internet Research*, 19.9 (2017), 1–15 (p. 2).

8 Michael E Porter and Robert S Kaplan, *How Should We Pay for Health Care? Working Paper 15-041*, 2015, p. 3.

9 *Carers Recognition Act 2012* (Vic), sec. 3.

10 *Carers Recognition Act 2012* (Vic), sec. 3.

11 Department of Health and Human Services, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care. Report of the Review of Hospital Safety and Quality Assurance in Victoria*, 2016, p. 3.

12 Karen Gardner and others, 'A Rapid Review of the Impact of Commissioning on Service Use, Quality, Outcomes and Value for Money: Implications for Australian Policy', *Australian Journal of Primary Health*, 22.1 (2016), 40–49 (p. 40); Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, Inquiry Report*, 2017, p. 21.

13 Helen Dickinson and others, 'Making Sense of Joint Commissioning: Three Discourses of Prevention, Empowerment and Efficiency', *BMC Health Services Research*, 13.S6 (2013), p. 1.

14 Royal Commission into Victoria's Mental Health System, *Interim Report*, 2019, p. 615.

15 Australian Institute of Health and Welfare, *State and Territory Community Mental Health Care Services*, 2019, p. 15; Productivity Commission, *Mental Health Inquiry Report, Volume 2*, 2020, p. 570.

16 Note: Where there is a gap of no more than five minutes between the orders.

17 Kathryn Williams and others, *Patient-Reported Outcome Measures: Literature Review* (Australian Commission on Safety and Quality in Health Care, 2016), pp. 1 and 18.

18 Cath Roper, Flick Grey and Emma Cadogan, *Co-Production: Putting Principles into Practice in Mental Health Contexts*, 2018, p. 2.

19 Pet Dudgeon, Helen Milroy and Roz Walker (eds.), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing*, Second Edition (Canberra: Commonwealth of Australia, 2014), p. 544.

20 *Health Services Act 1988* (Vic), sec. 3. Note: the reference to a health service includes a public hospital, public health service, denomination hospital, privately-operated hospital or private hospital within the meaning of the *Health Services Act 1988* (Vic).

21 *Mental Health Act 2014* (Vic), sec. 3.

22 Ana Hategan, Caroline Giroux and James A. Bourgeois, 'Digital Technology Adoption in Psychiatric Care: An Overview of the Contemporary Shift from Technology to Opportunity', *Journal of Technology in Behavioral Science*, 4 (2019), 171–77 (p. 171).

23 *Equal Opportunity Act 2010* (Vic) secs. 4 and 6. The Commission recognises that terms such as 'psychological disease or disorder' can be pathologising and stigmatising.

24 *Equal Opportunity Act 2010* (Vic), sec. 9.

25 *Equal Opportunity Act 2010* (Vic), sec. 10.

26 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 35.

27 *Mental Health Act 2014* (Vic), sec. 3.

28 Porter and Kaplan, p. 2.

29 *Mental Health Act 2014* (Vic), sec. 305.

30 Centers for Disease Control and Prevention, United States, Indicators: CDC Approach to Evaluation, <www.cdc.gov/eval/indicators/index.htm>, [accessed 3 December 2020].

31 Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 50; Family Safety Victoria, *Everybody Matters: Inclusion and Equity Statement*, 2018.

32 *Mental Health Act 2014* (Vic), sec. 153.

33 *Mental Health Act 2014* (Vic), sec. 4.

34 *Mental Health Act 2014* (Vic), sec. 3.

35 *Mental Health Act 2014* (Vic), sec. 24.

36 Peter C Smith, Elias Mossialos and Irene Papanicolas, *Performance Measurement for Health System Improvement: Experiences, Challenges and Prospects* (World Health Organization, 2008), p. 4.

37 Smith, Mossialos and Papanicolas, p. 4.

38 Department of Treasury and Finance, *Performance Management Framework: For Victorian Government Departments March 2016*, 2017, p. 18.

39 *Witness Statement of David Martine PSM*, 28 June 2019, para. 17.

40 Department of Treasury and Finance, p. 12.

41 *Witness Statement of David Martine PSM*, para. 17.

42 PHN Eastern Melbourne, Mental Health, AOD and Suicide Prevention, <www.emphn.org.au/what-we-do/mental-health>, [accessed 24 October 2019].

43 National Mental Health Commission, *Monitoring Mental Health and Suicide Prevention Reform: National Report 2019*, 2019, p. 87.

44 Department of Health, Victoria, *Framework for Recovery-Oriented Practice*, 2011, p. 2; Geoff Shepherd, Jed Boardman and Mike Slade, *Making Recovery a Reality Policy Paper*, 2008, p. 2.

45 *Mental Health Act 2014* (Vic), sec. 3.

46 *Mental Health Act 2014* (Vic), sec. 3.

47 *Mental Health Act 2014* (Vic), sec. 3.

48 *Mental Health Act 2014* (Vic), secs. 105, 110 and 113.

49 *Mental Health Act 2014* (Vic), sec. 105.

50 *Mental Health Act 2014* (Vic), sec. 3.

51 Dudgeon, Milroy and Walker, p. 548.

52 Douglas G Travis, *Travis Review: Increasing the Capacity of the Victorian Public Hospital System for Better Patient Outcomes*, 2015, pp. 1 and 39.

53 World Health Organization and the Calouste Gulbenkian Foundation, Social Determinants of Mental Health, p. 43, <www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/>, [accessed 4 December 2020].

54 Victorian Auditor-General's Office, *Managing Victoria's Public Housing*, 2017, p. vii.

55 *Witness Statement of Associate Professor Nicola Reavley*, 3 July 2019, para. 8; World Health Organization, *The World Health Report 2001. Mental Health: New Understanding, New Hope*, 2001, p. 16.

56 James D Livingston, *Mental Illness-Related Structural Stigma: The Downward Spiral of Systemic Exclusion Final Report*, 2013, p. 6.

57 Mark L. Hatzenbuehler, Jo C. Phelan and Bruce G. Link, 'Stigma as a Fundamental Cause of Population Health Inequalities', *American Journal of Public Health*, 103.5 (2013), 813–821 (p. 817).

58 Mark L. Hatzenbuehler and Bruce G. Link, 'Introduction to the Special Issue on Structural Stigma and Health', *Social Science and Medicine*, 103 (2014), 1–6.

59 M. B. Simmons and P. M. Gooding, 'Spot the Difference: Shared Decision-Making and Supported Decision-Making in Mental Health', *Irish Journal of Psychological Medicine*, 34.4 (2017), 1–12 (p. 5); General Assembly, United Nations, *Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General, Human Rights Council, Tenth Session, Agenda Item 2*, 26 January 2009, p. 15.

60 Department of Justice, *An Equality Act for a Fairer Victoria: Equal Opportunity Review Final Report*, 2008, p. 7.

61 Mental Health Commission of Canada, *Toolkit for E-Mental Health Implementation*, 2018, p. 12.

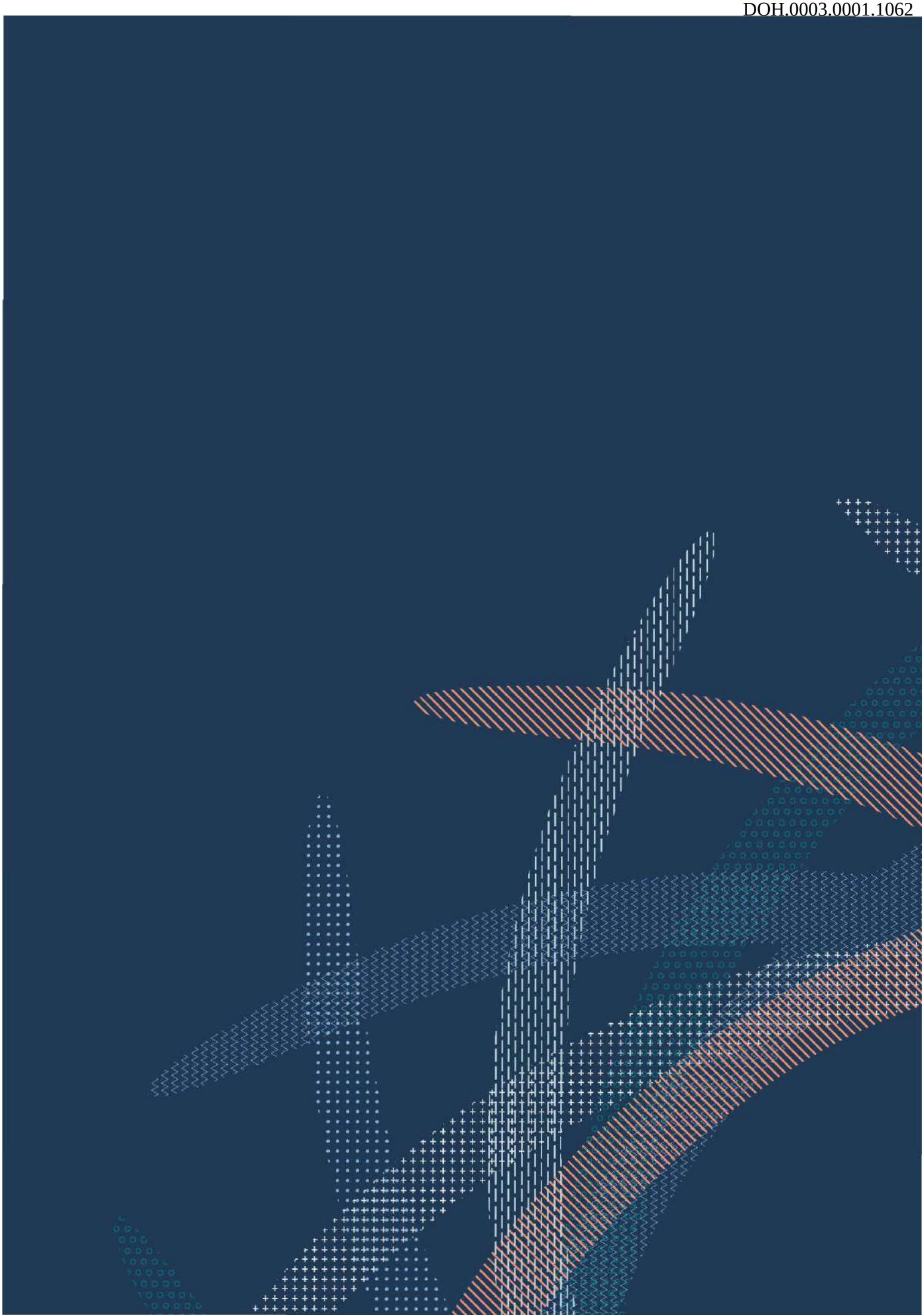
62 *Mental Health Act 2014* (Vic), sec. 45.

63 *Mental Health Act 2014* (Vic), sec. 6.

64 *Mental Health Act 2014* (Vic), sec. 52.

65 Dr Shalika Hegde and Dr Rebecca Haddock, *Re-Orienting Funding from Volume to Value in Public Dental Health Services, Issues Brief No. 32*, 2019, p. 44.

66 State Services Authority Victoria, *Joined up Government: A Review of National and International Experiences Working Paper No. 1*, 2007, p. 2.



Media Release

Coroners Court of Victoria

Thursday 20 January 2022

New report shows Victorian Aboriginal and Torres Strait Islander suicides nearly doubled in 2021

Concerning figures released today by the Coroners Court of Victoria show that the number of suicides of Aboriginal and Torres Strait Islander people increased by 75% in 2021.

The report - *Suicides of Aboriginal and Torres Strait Islander people in Victoria, 2018 – 2021* – presents comprehensive demographic data for the last four years and reveals that there were 35 suicides in 2021, compared to 20 in 2020, 21 in 2019 and 16 in 2018.

In Victoria, Aboriginal and Torres Strait Islander people currently die by suicide at a rate three and a half times higher than the non-Indigenous population and are, on average, younger than non-Indigenous people who die by suicide.

Other key findings in the report include:

- Aboriginal and Torres Strait Islander suicides occur most frequently in regional areas.
- Suicide frequencies remain higher amongst males than females (66.3% male, 33.7% female).
- Males between 25–34 (27.9%), 45–54 (24.6%), and 35–44 (21.3%) continue to be most at risk.
- Amongst females, those aged 18–24 (38.7%) and 25–34 (25.8%) are the highest risk groups.
- The stressors are complex, including contact with the justice system, insecure access to accommodation, family violence, and difficulties in accessing support services immediately prior to passing.

This is the third data release on suicides of Aboriginal and Torres Strait Islander people in Victoria by the Coroners Court. The reports aim to provide accessible, accurate and culturally responsive information to guide actions across the Indigenous mental health and suicide prevention sector.

Developed by the Coroners Koori Engagement Unit (CKEU) and Coroners Prevention Unit, the report utilises data from the Victorian Suicide Register, a real-time database recording all suicides reported to and investigated by Victorian coroners since 1 January 2000.

Since the Koori led CKEU was established in 2019, the Court has enhanced identification and accuracy of information for current and historic reportable Aboriginal and Torres Strait Islander passings – specifically with regard to data from 1 January 2018 to 31 December 2021.

The Court's December 2021 monthly suicide report presenting data on all suicides in Victoria for 2021 has also been released today. The report shows that suicides rates in Victoria overall decreased with 683 suicides in 2021, compared to 712 in 2020, 700 in 2019.

Quotes from the State Coroner, Judge John Cain

"It is deeply concerning to see the suicide rates of Aboriginal and Torres Strait Islander people in Victoria rise so sharply, while the overall Victorian suicide rate has gone down."

"In releasing this data today, the Coroners Court aims to support community-led organisations and government services that can strengthen prevention networks.'

"Coroners are also currently conducting thorough investigations into these passings, to develop recommendations that can drive positive change."

Media contact: Mel Lancuba 0407 403 371 | mediaenquiries@coronerscourt.vic.gov.au

Media Release

Coroners Court of Victoria

Quotes from Troy Williamson (Yuin), Manager, Coroners Koori Engagement Unit

“The increase in suicides of Aboriginal Victorians is heartbreaking. It is a reminder of the systemic inequalities our communities face and this report needs to be used to drive change for our people."

"Our communities are hurting. Although confronting, I hope this report can start conversations that empower our people."

"Suicide is complex and has many layers. It is vital that barriers to seeking support are dismantled and culturally competent practices are put in place to save lives.”

A copy of the Suicides of Aboriginal and Torres Strait Islander people in Victoria, 2018 – 2021 can be found here: https://www.coronerscourt.vic.gov.au/victorian-suicides-aboriginal-and-torres-strait-islander-people-victoria-2018-2021

A copy of the Coroners Court Monthly Suicide Report for December 2021 can be found here: https://www.coronerscourt.vic.gov.au/coroners-court-monthly-suicide-report-december-2021-update

Media contact: Mel Lancuba 0407 403 371 | mediaenquiries@coronerscourt.vic.gov.au

OVERVIEW | 2021-2022 STATE BUDGET

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CONTENTS

04
Chief Executive's Foreword

05
ENABLE
Key Budget Initiatives

06
ENABLE
> Skills & Training

07
ENABLE
> Energy
> Infrastructure

08
GROW
Key Budget Initiatives

09
GROW
> Innovation & Commercialisation

10
GROW
> Inudstry Support & Development

11
GROW
> Export Support

12
GROW
> Environment

13
EASE
Key Budget Initiatives

14
EASE
> Taxation

15
EASE
> State Regulation & Planning
> Budget numbers at a glance

16
State Budget 2021 - 2022 Small Business and Regional Overview

FOREWORD

The 2021-22 Victorian Budget is a third-year fiscally-responsible budget of restrained, yet targeted spending which largely reflected our budget submission; to enable, grow and ease the conditions necessary for business prosperity. It ticks a lot of boxes for business in the areas of job creation, addressing skills gaps, powering innovation and manufacturing, and creating more inclusive workplaces for women.

The Victorian Chamber is pleased that the Budget recognised that COVID-19 disproportionately impacted certain sectors including the visitor economy, CBD businesses, international education, events, and the arts.

The Budget acknowledged that regional Victoria spurred our recovery from COVID-19, with significant funding to enable regional communities to continue on that trajectory. It's a great budget for regional businesses which now have the lowest payroll tax rate in the country.

Every Victorian will welcome the once in a generation reform to our mental health system and we should not underestimate the flow on effects that a fit for purpose system will have on our society and economic growth. However, business is once again going to pick up the bill during a period when costs on major projects are blowing out. The Victorian Chamber is concerned about the impact on Victoria's credentials as the best place in Australia to operate a business.

Business is not only the engine room of the economy, they're also the heart of our communities. The State Government needs to stop treating business as a fund of last resort.

Next year, we expect to see a pre-election Budget with a further focus on business and jobs which will be needed to propel our economy. There was an opportunity missed in the Budget to change stamp duty for a more efficient and equitable property tax. The Victorian Chamber will continue to lead the advocacy for this important structural economic change.

Paul Guerra
Chief Executive,
Victorian Chamber of Commerce and Industry

2021-22 State Budget Review with VCCI Chief Executive Paul Guerra

KEY BUDGET INITIATIVES

ENABLE

Victorian businesses are efficient and have become even more resilient since COVID-19 hit. They will be aided by having access to the skills they need through further funding for apprenticeships, and further infrastructure spending.

Skills & Training

- $393.8 million investment in skills, training and higher education including:
- $85.9 million to establish a new Victorian Skills Authority.
- $88.8 million to provide subsidised VET to eligible students.
- $99.2 million to boost funding rates for TAFES.
- $72.4 million to upgrade TAFE campuses, including Bendigo Kangan Institute Broadmeadows campus and $10.7 million to redevelop the GOTAFE Shepparton campus.
- $12 million to make sure TAFEs have the modern equipment and tools to teach apprentices and trainees
- $14.9 million for placement officers to better coordinate mandatory practical placements for TAFE students.
- $6.2 million to increase places for pre-accredited digital literacy and employability training courses.
- $51 million to support recovery in international education, including expanding the Global Education Network and Offshore Study hubs.

Energy

- $2.1 million in funding provided to the Essential Services Commission (ESC) to support trials of innovative energy products and services.
- $600,000 to support for the expansion of the Victorian Energy Upgrades program.

Infrastructure

- $1.6 billion for school infrastructure, including upgrades at 52 schools, building 13 new schools and additional stages at three further schools, and expanding six more across Victoria
- $265 million to plan, upgrade and maintain suburban, rural and regional roads
- $349.6 million to deliver an additional 82 secure mental health beds and supporting infrastructure through major works at Thomas Embling Hospital.
- $101.1 million investment to build a purpose-built Home of the Matildas with a state-of-the-art facility for La Trobe University's Bundoora Sports Park in a major advancement for women's sport in Australia.
- $31.7 million for Parks Victoria.

ENABLE

SKILLS AND TRAINING

Victorian Skills Authority

- $85.9 million to establish a new Victorian Skills Authority to coordinate teaching and training across the VET sector.
- Building on the work of the Skills Commissioner, this investment will further drive innovation across the VET sector, delivering better planning for Victoria's future training needs and providing an integrated approach to the quality of teaching and training.
- It will also lead the development of an annual Victorian Skills Plan to better guide our state's training delivery. The VSA is expected to be launched in July 2021 and is a key response to the recommendations in Skills for Victoria's Growing Economy led by former Federal Minister Jenny Macklin and reflecting recommendations by VCCI.

Subsidised VET to eligible students

- $88.8 million to provide subsidised VET to eligible students, including continuing the successful Asylum Seeker VET program, to improve people's skills and job opportunities as they build their new life in Victoria.
- This will deliver up to an extra 12,200 training places, 7,400 of which are at TAFEs.

TAFE campus redevelopments

- $72.4 million to upgrade TAFE campuses as part of the Building Better TAFEs Fund, including:
  - $60 million to redevelop the Bendigo Kangan Institute Broadmeadows campus
  - $10.7 million to redevelop the GOTAFE Archer Street Shepparton campus.

Modern equipment for TAFEs

- $12 million will make sure our TAFEs have the modern equipment and tools they need to teach apprentices and trainees, such as mobile cranes and 3D Metal Printers

Placement officers

- $14.9 million means support for placement officers to better coordinate mandatory practical placements for TAFE students in areas such as allied health, community services and early childhood, education and training.
- A new Office of TAFE Coordination and Delivery will be established in DET to enhance collaboration across the TAFE network.

Pre-accredited digital literacy and employability training courses

- $6.2 million will increase places for pre-accredited digital literacy and employability training courses, as well as enable a new literacy and numeracy assessment tool for TAFE and training providers, including Learn Locals.

Chinatown.

ENERGY

Expansion of regulatory activities of the Essential Services Commission (ESC)

> $2.1 million in funding provided to the Essential Services Commission (ESC) to support trials of innovative energy products and services, such as microgrids and virtual power plants, which are not currently permitted under energy rules. The ESC will also report on the outcomes of these trials and make recommendations to the Government on ways to further reduce red tape for the energy sector.

Expansion of the Victorian Energy Upgrades program

> $600,000 to support for the expansion of the Victorian Energy Upgrades program. Funding is provided to the ESC to support the recent expansion of targets to the Victorian Energy Upgrades program. This includes upgrades to the ESC's information technology system to give expanded services to program participants.

INFRASTRUCTURE

Metropolitan Roads Upgrades

Funding is provided for several upgrades on metropolitan roads to improve safety and travel times, and to develop high-priority projects for future upgrades, at locations including:

> Springvale Road and Virginia Street intersection, Springvale;

> Canterbury Road and Heathmont Road intersection, Heathmont;

> Bulla Road and Tullamarine Freeway Interchange;

> Somerton Road, Mickleham Road to Roxburgh Park Drive;

> Craigieburn Road East, Hume Freeway Overpass to Epping Road;

> York Road between Swansea Road and Monbulk Road, Mount Evelyn;

> Derrimut Road, Hopkins Road and Boundary Road in Tarneit; and

> Punt Road, Princes Highway East to Swan Street, Richmond.

Regional Roads Upgrades

Funding is provided for a number of upgrades on regional roads to improve network efficiency and road safety, and to develop high-priority projects, at locations including:

> Western Freeway and Learmonth Road intersection;

> Corridor Improvements, Surf Coast Highway;

> Corridor Improvements, Bellarine Link Stage 1, Geelong;

> Bunurong Road, Cape Paterson;

> Traffic Controllers, Barwon Heads; and

> Black Forest Drive, Woodend.

Central Pier Docklands redevelopment

> $3 million in funding is provided to develop the concept design and business case for demolition and redevelopment of Central Pier at Docklands.

Limestone mine in Melbourne, Australia.

Infrastructure & Manufacturing

$3.2b

for public transport including maintenance and new trains to be manufactured in Ballarat.

KEY BUDGET INITIATIVES

GROW

We need Victorian businesses to grow in their current industries while also expanding into emerging ones. There is support for nearly all Victorian industries that will allow them to contribute to Victoria's economic growth.

Innovation & Commercialisation

- $179 million to deliver stage one of the Fishermans Bend Innovation Precinct.
- $1 million for digital infrastructure upgrade: Cremorne

Industry support & development including mental health

- $986 million to build 25 brand-new X'Trapolis trains.
- $288 million investment in the creative economy.
- $107 million for a Melbourne central business district economic package.
- $10 million for the Morwell Food Manufacturing Precinct to enable the centre to manage greater water and energy demands.
- $31 million in small business and industry guidance for COVID-19
- $5.4 million for a Defence Capture Plan
- $788 million to reduce the impact of bushfires on Victorian communities, the economy and the environment.
- $11.2 million for Puffing Billy to protect local jobs and support its operations as it recovers strongly and draws tourists and day-trippers by the thousands.
- $55 million to Visit Victoria for crucial new campaigns to draw visitors to Melbourne and across the state.
- $42.9 million for the Business Events Program
- $40.6 million to continue maximising local jobs and local content by enabling suppliers to compete for government projects.

Export Support

- $4.2 million to continue the operation of the Victorian Government Trade and Investment Network and the appointment of new investment professionals in strategic markets.
- $5 million for the Trade Mission Program.

Environment

- $10 million to enhance capability to drive progress towards Victoria's emissions reduction targets and support job creation in clean and competitive industries in Victoria.
- $8.4 million for resilient water markets, regional communities and infrastructure.
- $24.5 million supporting regional communities through healthy waterways.
- $2.8 million for the Port Phillip EcoCentre redevelopment
- $8.8 million for the Port Phillip Bay Fund to rehabilitate Port Phillip Bay ecosystems
- $31.7 million for Parks Victoria
- $76.6 million for the Environment Protection Authority.

INNOVATION AND COMMERCIALISATION

Fishermans Bend Innovation Precinct

- $179 million to support stage one of the Fishermans Bend Innovation Precinct development at the former General Motors Holden site – four kilometres from the city centre.
- As many as 300 people will work on the project at any one time, with close to 700 indirect jobs also supported. Stage one is expected to unlock developable land capable of supporting 2,000 jobs by 2024.
- Fishermans Bend will house the University of Melbourne's School of Engineering from 2024 and the innovation precinct is forecast to be capable of supporting up to 30,000 STEM jobs by 2051.
- The precinct will cement Victoria's status as a powerhouse of advanced manufacturing and support high-paid innovation jobs in defence, aerospace, clean energy and transport.

MRNA capability

- $50 million to secure and scale mRNA vaccine and therapeutic manufacturing capability in Victoria.
- This will be facilitated through collaboration with the Commonwealth and world-leading experts from Monash University, the University of Melbourne, the Doherty Institute, other leading research institutes and industry partners.
- The establishment of local a mRNA manufacturing capability will provide vaccine security, ensure manufacturing can be contracted locally to mitigate global supply chain risks and create a more robust defence against future pandemics.

NGV - Waterwall.

Prom Country Cheese.

Essential Skills for Businesses

$384m

for TAFE training and infrastructure, and the establishment of the Victorian Skills Authority.

INDUSTRY SUPPORT AND DEVELOPMENT

International education recovery and growth

- $51 million to support recovery in international education, including expanding the Global Education Network and Offshore Study hubs.
- This includes continuing the Study Melbourne brand, Study Melbourne Student Centre, and the Study Melbourne Inclusion and Empowered Programs. This initiative also continues delivery of the Global Education Network and Study Melbourne Hubs.

Maximising local jobs and local content

- $40.6 million to ensure that opportunities for local businesses and workers associated with government procurement are maximised.
- The Office of the Local Jobs First Commissioner and Industry Capability Network Victoria will be resourced to oversee and enforce compliance with the Local Jobs First Act 2003 and the Local Jobs First Policy.
- Funding is provided to support the operation of Ethical Clothing Australia and the accreditation process for the Ethical Supplier Register.
- Funding is provided to establish the Fair Jobs Code Unit in the Department of Jobs, Precincts and Regions to support implementation of the Fair Jobs Code, including undertaking education and compliance activities.

Defence Capture Plan

- $5.4 million for Victoria's defence industry and supply chains to be supported to secure roles in delivering major defence contracts through advocacy, advisory and capability development activities.

Visitor economy

- $8.9 million to support new Visitor Economy Partnerships, driving more tourists to our regional communities.
- $55 million of funding to support Victoria's visitor economy through targeted drive, short-haul flight, long-haul flight and growth marketing campaigns to encourage tourism visitation
- $10 million distillery door grant scheme will continue to grow Victoria's distillery industry, supporting jobs and the visitor economy.
- $11.2 million for Puffing Billy to protect local jobs and support its operations as it recovers strongly and draws tourists and day-trippers by the thousands.

Business Events Program

- $42.9 million to attract a strong pipeline of business events to Melbourne and regional Victoria.
- As a high-yielding sector of the visitor economy, business events provide a pipeline of visitors during the off-peak and shoulder seasons and will continue to support the State's economic recovery.

Melbourne central business district economic package

- $107 million to help drive economic activity and revitalise Melbourne's central business district.
- Including $7.4 million for a new voucher scheme to entice Melburnians and visitors to city cafes and restaurants, and support CBD arts and cultural events.

Creative economy

- $288 million to boost Victoria's creative sector, including:
- $121 million to transform the Victorian screen industry by growing jobs, developing home-grown talent, and promoting our people and content to the world.
- $79 million to support institutions and the companies they support – like Arts Centre Melbourne, the Geelong Arts Centre and the Melbourne Theatre Company.
- $34 million to invest in our cultural institutions, including new immersive exhibitions at Melbourne Museum. This will include a new Triceratops Gallery showcasing the recent acquisition of the most complete Triceratops fossil skeleton ever found.
- $24 million to deliver a sustainable multiyear investment funding framework for non-government creative organisations. This will mean greater certainty for these organisations, while attracting audiences and supporting new opportunities for Victoria's creatives.

EXPORT SUPPORT

- $11 million to extend the Music Works program to support musicians, managers, technicians, venues, peak bodies and small to-medium businesses and organisations to accelerate the recovery and growth of Victoria's music scene.
- $4.5 million to invest in established and emerging creative neighbourhoods by supporting affordable creative spaces for artists and enterprises. This will promote the creative reputation of these communities and help to create jobs in metro, regional and outer-suburban areas. An Emporium Creative Hub will be created in Bendigo together with the establishment of the Brunswick Design District.
- $4.0 million in support for Victorians from First Peoples, youth and diverse backgrounds to obtain secure, well-paid work, and support leadership programs for a diverse cohort of mid-career and established creatives. This includes support for First Peoples' festivals and platforms such as Yirramboi, Blak & Bright Literature Festival and the Koorie Art Show, attracting more visitors to Victoria and creating new local jobs.

Jobs Growth

38,000

jobs each year over the next 4 years.

Support for seasonal agriculture workforce

- $19.3 million in funding is provided for a response to the seasonal harvest workforce shortage to attract seasonal workers and ensure farmers have the workers they need. Support includes the seasonal harvest sign-on bonus for jobseekers who take up a harvest job; a co-contribution to quarantine costs for workers under the Commonwealth Government's Pacific mobility schemes; and Seasonal Workforce Industry Support grants.

Victoria's Fruit Fly Strategy

- $6.4 million in funding is provided for Victoria's Fruit Fly Strategy, which will focus on preparedness and prevention activities, strengthening shared responsibility in the management of the Queensland Fruit Fly.

Transforming traceability

- $11.6 million Agricultural traceability systems will be strengthened to enhance Victoria's reputation for high-quality food and fibre products, driving growth in both local and export market access. This will be achieved by implementing a traceability and product integrity action plan which will provide increased information on traceability systems and improve biosecurity risk management.

Victorian Rural Women's Network

- $1.4 million in funding provided to continue the Victorian Rural Women's Network. This program will deliver upskilling, leadership and capability building opportunities, thereby supporting the economic participation and resilience of rural women in Victoria.

Accelerating Victoria's agriculture sector response to changing climate

- Funding of $20 million to position Victoria as a leader in low-emissions agriculture, including through accelerating research in emissions reducing technologies, delivering on-farm action plans to measure and reduce emissions, updating the Victorian Land Use Information System and developing an Agricultural Climate Spatial Tool.

Victorian Government Trade and Investment Network

- $4.2 million to continue the operation of the Victorian Government Trade and Investment Network and the appointment of new investment professionals in strategic markets.
- $5 million for the Trade Mission Program. resilience of rural women in Victoria.

ENVIRONMENT

Twelve Apostles.

Seizing the economic opportunity of a net zero, climate resilient state

> $10 million is provided to enhance capability to drive progress towards Victoria's emissions reduction targets and support job creation in clean and competitive industries in Victoria.

Zero and low emission vehicles: commercial sector

> $5 million in funding is provided for a new innovation fund to encourage the early adoption of zero and low emission vehicles by the commercial sector, including the commercial passenger vehicle, freight and construction sectors. This initiative will invite proposals from industries that support transition towards zero and low emission technologies.

Effective water management and supply

> $8.4 million is provided for community engagement and capacity building to support irrigators and Traditional Owners. This includes grants for infrastructure projects to enable farms to modernise and optimise water efficiency.

> $24.5 million is provided for a package of on-ground environmental works to improve the health of rivers and wetlands. Sites targeted will be of high recreational and tourism importance.

Environment and biodiversity

> $2.8 million is provided to contribute to the design and construction of a new facility for the Port Phillip EcoCentre in St Kilda. The EcoCentre is a leading community-managed organisation with a dedicated team of scientists, educators and volunteers who design and implement innovative environmental programs.

> $8.8 million is provided to continue the Port Phillip Bay Fund, which provides grants to local government authorities to rehabilitate Port Phillip Bay ecosystems.

Protecting regional environments

> $8.8 million is provided for the continued resourcing of the Office of the Conservation Regulator to ensure it can oversee regulatory functions in conservation and environment in Victoria. This includes educating the community about conservation and environment protection in Victoria, providing guidance to support compliance, and undertaking enforcement action when necessary.

Parks Victoria

> $31.7 million is provided to ensure priority parks and public spaces remain staffed, maintained, and available to enhance the health and wellbeing of Victorians.

Planning, building and heritage

> $6.6 million is provided to continue to implement and conduct a five-year review of Plan Melbourne, the whole of government strategy that seeks to integrate long-term land use, infrastructure, and transport planning to meet the city's future needs.

Statutory activities and environment protection

> $76.6 million is provided for the EPA to ensure it can continue to protect Victoria's environment from pollution and waste and fulfil its obligations under the Environment Protection Amendment Act 2018.

KEY BUDGET INITIATIVES

EASE

Businesses need an environment that is more conducive to investment through improvements to the regulatory and tax environment. This will lead to a decrease in operational costs, so that more capital can be invested in employees, research, and equipment, which will make Victoria a more attractive location to invest. The cuts to payroll tax will keep regional Victoria the most attractive destination for business in Australia. However, there remains room to calibrate the competitiveness of Victoria's tax environment with other jurisdictions – under current settings more Victorian businesses are required to pay payroll tax than interstate counterparts.

Taxation

- The Government will bring forward increases in the payroll taxfree threshold, which will increase from $650 000 to $700 000 from 1 July 2021.
- To support regional Victorian jobs the Government will bring forward reductions in the regional employer rate of payroll tax. The regional employer rate will reduce from 2.02 per cent to 1.2125 per cent from 1 July 2021.
- From 1 January 2022, the tax-free threshold for general land tax rates will increase from $250 000 to $300 000.
- For contracts entered into from 1 July 2021, a new land transfer duty threshold for high-value property transactions will be introduced. For property transactions with a dutiable value above $2 million, the land transfer duty payable will increase to $110 000 plus 6.5 per cent of the dutiable value in excess of $2 million.
- Increase in eligibility for the off-the-plan concession to $1 million for principal place of residence.
- A concession of up to 100 per cent of the land transfer duty payable will be provided on the purchase of new residential property, in the Melbourne local government area, with a dutiable value of up to $1 million.
- Vacant residential land tax exemption for new developments will be extended to apply for up to two years.

State regulation and planning

- $14 million to continue Streamlining for Growth.
- $6.6 million for ongoing implementation of Plan Melbourne.

EASE

TAXATION

Degraves Street.

Payroll Tax
Threshold increased from
$650,000 to **$700,000**
for all of Victoria and the regional rate moving to 1.2125 per cent.

Backing Victoria's Racing Industry

- $196.2 million is provided. Wagering and betting tax will increase from 8 per cent to 10 per cent of net wagering revenue from 1 July 2021, bringing Victoria into line with the rate that applies in New South Wales, and remaining below the rate that applies in other states.

Payroll Tax

- $27.9 million to support Victorian jobs the Government will bring forward increases in the payroll taxfree threshold, which will increase from $650 000 to $700 000 from 1 July 2021.
- $29.9 million to support regional Victorian jobs the Government will bring forward reductions in the regional employer rate of payroll tax. The regional employer rate will reduce from 2.02 per cent to 1.2125 per cent from 1 July 2021.

Land Tax

- $1.5 billion is funded. From 1 January 2022, the land tax rate for taxpayers with larger property holdings will increase by:
  - 0.25 percentage points for taxable landholdings exceeding $1.8 million; and
  - 0.3 percentage points for taxable landholdings exceeding $3 million.
- $102 million is provided. From 1 January 2022, the tax-free threshold for general land tax rates will increase from $250 000 to $300 000. This means for land not held on trust, land tax will only be payable if the total taxable value of Victorian land is equal to or exceeds $300 000. The trust rate scale will remain unchanged.
- $761 million is funded. For contracts entered into from 1 July 2021, a new land transfer duty threshold for high-value property transactions will be introduced. For property transactions with a dutiable value above $2 million, the land transfer duty payable will increase to $110 000 plus 6.5 per cent of the dutiable value in excess of $2 million.

Property tax

- A concession of up to 100 per cent of stamp duty for new dwellings worth up to $1 million in the Melbourne local government area.
- Temporarily increasing the eligibility thresholds to $1 million for all home buyers off-the-plan purchases.
- Extending the vacant residential land tax exemption for new developments will be extended to two years.

State Revenue

- $24.4 million is provided to the State Revenue Office (SRO) to modernise its Revenue Management System. This will provide a better customer experience and increase the SRO's efficiency and effectiveness in collecting a range of State taxes, duties and levies, as well as broader administration of a range of programs.

STATE REGULATION AND PLANNING

Cape Bridgewater.

Victorian Civil and Administration Tribunal digital service transformation

> Funding to VCAT to upgrade digital services infrastructure including the case management system and increase process automation, to deliver more accessible and timely provision of justice to citizens and businesses.

Streamlining for growth

> $14 million for growth Funding is provided to continue the Streamlining for Growth program administered by the Victorian Planning Authority (VPA) to assist local government authorities to plan and manage growth. This funding includes assistance for reducing capacity constraints on council approval processes, reducing delays associated with utility approvals, and improving guidelines for local government authorities and developers to reduce the uncertainty associated with turning precinct structure plans into subdivision permits.

Plan Melbourne implementation

> $6.6 million is provided to continue to implement and conduct a five-year review of Plan Melbourne, the whole of government strategy that seeks to integrate long-term land use, infrastructure and transport planning to meet the city's future needs.

Budget numbers at a glance

Victoria's economic forecast (%)	2019-20 actual	2020-21 forecast	2021-22 forecast	2022-23 forecast	2023-24 projection	2024-25 projection
Real gross state product	(0.5)	(2.00)	6.50	3.25	2.75	2.75
Employment	1.2	(1.00)	2.50	1.25	1.75	1.75
Unemployment rate	5.4	6.50	5.75	5.50	5.25	5.25
Consumer price index	1.7	1.50	1.50	1.75	2.00	2.25
Wage price index	1.5	0.00	0.30	1.20	1.70	1.70

Sources: Department of Treasury and Finance, Australian Bureau of Statistics

OVERVIEW

2021-2022 SMALL BUSINESS AND REGIONAL STATE BUDGET

Victorian Chamber of Commerce and Industry

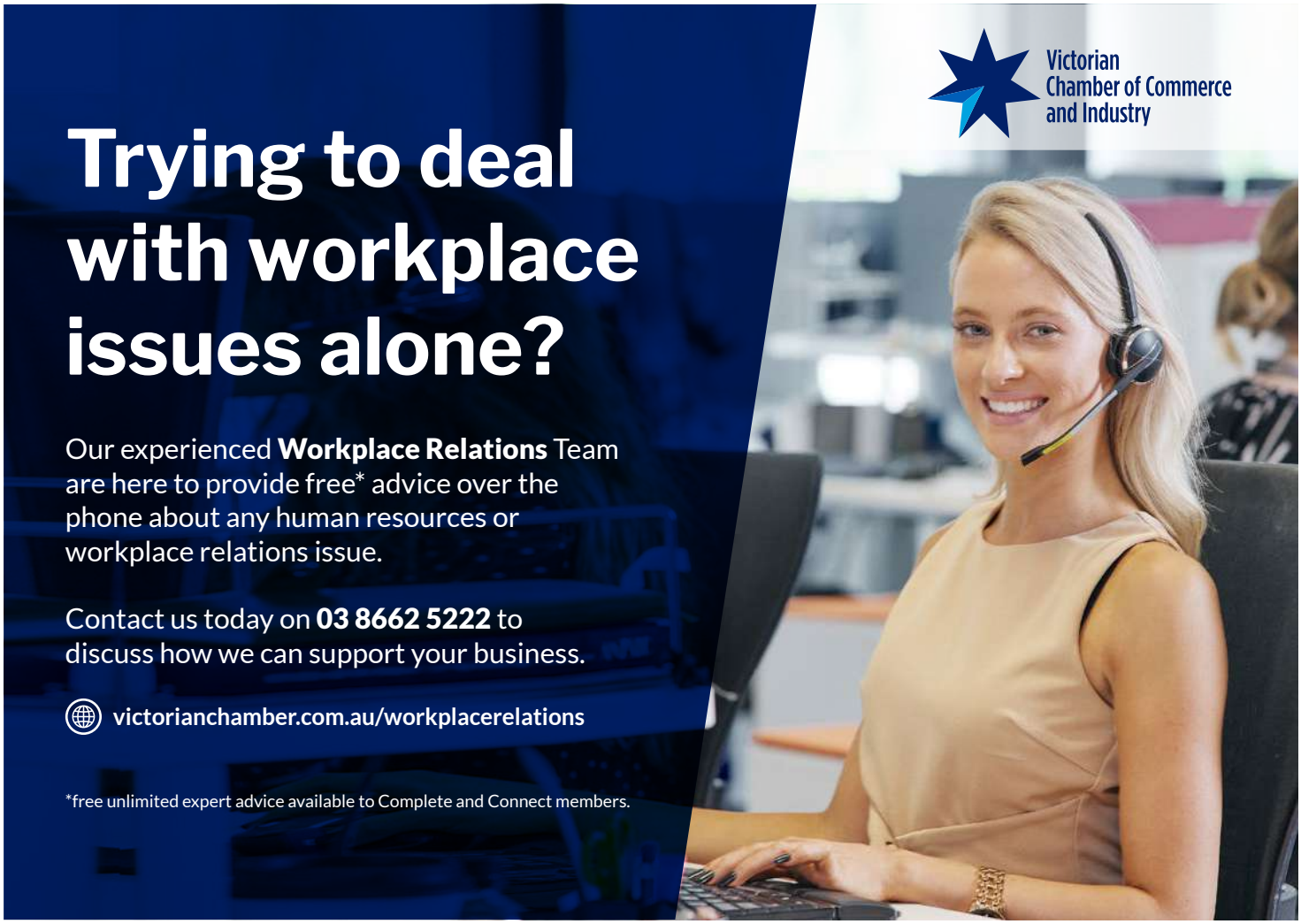
> SMALL BUSINESS

ENABLE, GROW AND EASE	
Victorian Chamber Recommendation	**State Budget Outcome**
Enable > Establish an Industry COVID-19 Recovery Fund providing grants to assist businesses to transform their operations. **Grow** > Virtual Trade Missions and eCommerce programs must continue to provide the vital services to Victorian export businesses throughout the 2021-2022 financial year. **Ease** > Payroll tax reform: increase the payroll tax threshold to $1million and reduce the payroll tax rate to four per cent for metropolitan Victorian employers and one per cent for Regional Victorian employer to make Victoria the competitive State in for doing business in Australia. > Streamline the Environmental Effects Statement to be more efficient and provide greater certainty to applicants as to the likelihood of success.	**Enable** > $31 million in small business and industry guidance for COVID-19 prevention measures. **Grow** > $4.2 million to continue the operation of the Victorian Government Trade and Investment Network and the appointment of new investment professionals in strategic markets. > $5 million for the Trade Mission Program. **Ease** > The Government will bring forward increases in the payroll tax free threshold, which will increase from $650 000 to $700 000 from 1 July 2021. > To support regional Victorian jobs the Government will bring forward reductions in the regional employer rate of payroll tax. The regional employer rate will reduce from 2.02 per cent to 1.2125 per cent from 1 July 2021. > $107 million for a Melbourne central business district economic package. > $14 million to continue the Streamlining for Growth program administered by the Victorian Planning Authority (VPA) to assist local government authorities to plan and manage growth.

> REGIONAL

ENABLE, GROW AND EASE

Victorian Chamber Recommendation	State Budget Outcome
Enable > Increase investment in pre-apprenticeship programs that provide full-time, one-year training programs that count towards an apprenticeship. > Continue to provide Parks Victoria with a significant increase in capital funding to build new assets and experiences that support the visitor economy. **Grow** > Establish a defence manufacturing support fund to leverage the Federal $450 billion, 10-year commitment. > Further develop and harmonise Victoria's local content policies to stimulate Victorian manufacturing. The current local content requirements are complicated, confusing and resource intensive, instead acting as a barrier to boosting local content. As a priority, health sector procurement should be de-mystified and opened to create more opportunities for small local suppliers to tender for contracts. > The continuation of the Mode Shift Incentive Scheme (MSIS) for Victorian regional exporters. This $4 million per-year scheme helps promote the use rail rather than road. Government has renewed the MSIS on a year-by-year basis over recent times. The Victorian Chamber calls on the State Government to commit long-term to the scheme. **Ease** > Stamp duty tax reform: follow NSW and the ACT and switch stamp duty for land tax for all property purchases to improve efficiency and remove a market distorting tax. > Waive existing COVID-19 business payroll and land tax deferrals still owed by employers with Victorian payrolls of up to $10 million (based on their 2019-20 financial year annual reconciliation returns). > Payroll tax reform: increase the payroll tax threshold to $1million and reduce the payroll tax rate to four per cent for metropolitan Victorian employers and one per cent for Regional Victorian employer to make Victoria the competitive State in for doing business in Australia.	**Enable** > $1.6 billion for school infrastructure, including upgrades at 52 schools, building 13 new schools and additional stages at three further schools, and expanding six more across Victoria. > $265 million to plan, upgrade and maintain suburban, rural and regional roads. **Grow** > $5.4 million for a Defence Capture Plan. > $10 million for the Morwell Food Manufacturing Precinct to enable the centre to manage greater water and energy demands. > $986 million to build 25 brand-new X'Trapolis 2.0 trains and the infrastructure they need to modernise the state's train fleet. > $11.2 million for Puffing Billy to protect local jobs and support its operations as it recovers strongly and draws tourists and day-trippers by the thousands. > $20.5 million investment in tech schools in the regions. > Funding for the continuation of the Mode Shift Incentive Scheme (MSIS) for only one year and at a reduced rate of $3.6 million. VCCI will continue to lobby government for a longer-term commitment to encourage more freight mode shift in Victoria. > $60 million Bendigo Kangan redevelopment. > $10.7 million to redevelop the GOTAFE Archer Street Shepparton campus. > $10 million distillery door grant scheme. > $24.5 million supporting regional communities through healthy waterways. > $19.3 million in funding is provided for a response to the seasonal harvest workforce shortage to attract seasonal workers and ensure farmers have the workers they need. > $6.4 million in funding is provided for Victoria's Fruit Fly Strategy. > $1.4 million in funding provided to continue the Victorian Rural Women's Network. > $20 million to position Victoria as a leader in low-emissions agriculture. > Creative Hub established in Bendigo. **Ease** > To support regional Victorian jobs the Government will bring forward reductions in the regional employer rate of payroll tax. The regional employer rate will reduce from 2.02 per cent to 1.2125 per cent from 1 July 2021.



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Victorian Chamber of Commerce and Industry

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Victorian Budget 2021/22

Creating Jobs, Caring for Victorians

SERVICE DELIVERY

Budget Paper No. 3

Presented by Tim Pallas MP
Treasurer of the State of Victoria

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Budget Paper No. 4 – State Capital Program
Budget Paper No. 5 – Statement of Finances
(incorporating Quarterly Financial Report No. 3)

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Service Delivery

2021-22

Presented by

Tim Pallas MP

Treasurer of the State of Victoria

for the information of Honourable Members

Budget Paper No. 3

TABLE OF CONTENTS

Chapter 1 – Output, asset investment, savings and revenue initiatives 1
Whole of government – Aboriginal Affairs 3
Whole of government – Mental Health and Wellbeing 8
Department of Education and Training 21
Department of Environment, Land, Water and Planning 36
Department of Families, Fairness and Housing 46
Department of Health 59
Department of Jobs, Precincts and Regions 70
Department of Justice and Community Safety 88
Department of Premier and Cabinet 102
Department of Transport 107
Department of Treasury and Finance 122
Parliament 128
Court Services Victoria 133
Revenue initiatives 138
Savings 142

Chapter 2 – Department performance statements 143
Department of Education and Training 147
Department of Environment, Land, Water and Planning 171
Department of Families, Fairness and Housing 199
Department of Health 223
Department of Jobs, Precincts and Regions 248
Department of Justice and Community Safety 279
Department of Premier and Cabinet 312
Department of Transport 327
Department of Treasury and Finance 347
Parliament 364
Court Services Victoria 381

Appendix A – Output performance measures for review by the Public Accounts and Estimates Committee 389
Department of Education and Training 389
Department of Environment, Land, Water and Planning 390
Department of Families, Fairness and Housing 392
Department of Health 393
Department of Jobs, Precincts and Regions 394
Department of Justice and Community Safety 396
Department of Premier and Cabinet 397
Department of Transport 399
Department of Treasury and Finance 400
Parliament 401
Appendix B – Local government financial relations 403
Supporting sustainable and effective local government 403
Funding sources to local government in Victoria 404
Community Support Fund 407
Disaster Response 407
2021-22 Budget initiatives 408
Style conventions 413

CHAPTER 1 – OUTPUT, ASSET INVESTMENT, SAVINGS AND REVENUE INITIATIVES

Budget Paper No. 3 *Service Delivery* outlines the Government's priorities for the goods and services it provides to Victorians and details the Government's budget decisions.

The *2021-22 Budget* provides funding of $19.0 billion over five years in output initiatives since the *2020-21 Budget* and $7.1 billion TEI in new capital investment. This builds on the Government's $29.2 billion investment in output initiatives and up to $19.8 billion in capital projects in the *2020-21 Budget*.

Budget Paper No. 3 *Service Delivery* provides information on how the Government is meeting its performance targets for delivering outputs to the community, and how these outputs contribute to key objectives.

Table 1.1: Output summary **($ million)**

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*
Aboriginal Affairs	1.0	75.9	82.1	42.3	21.1
Mental Health and Wellbeing	2.4	551.4	820.9	932.2	1 021.3
Education and Training	115.4	502.3	484.8	454.5	482.0
Environment, Land, Water and Planning	34.1	325.3	284.0	187.1	156.0
Families, Fairness and Housing	43.3	714.0	430.3	397.7	376.9
Health	351.8	2 716.9	982.8	961.1	950.3
Jobs, Precincts and Regions	262.6	666.6	380.8	173.3	156.1
Justice and Community Safety	106.6	482.2	301.5	177.8	140.8
Premier and Cabinet	21.5	94.9	67.9	18.8	18.0
Transport	317.6	334.3	177.6	73.7	61.0
Treasury and Finance	20.2	47.2	57.3	43.4	39.1
Parliament	0.6	11.6	11.1	8.2	7.6
Court Services Victoria	10.4	56.2	51.9	40.7	32.7
Total output initiatives [(a)]	**1 287.6**	**6 578.7**	**4 132.9**	**3 510.8**	**3 462.9**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Table 1.2: Asset summary **($ million)**

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*	*TEI*
Aboriginal Affairs	..	5.1	1.6	..	..	6.6
Mental Health and Wellbeing	6.4	36.8	200.8	232.2	29.6	506.9
Education and Training	..	440.7	582.5	479.8	77.4	1 581.2
Environment, Land, Water and Planning	..	14.0	12.0	11.0	11.0	48.0
Families, Fairness and Housing	..	1.5	1.5	1.6	..	4.6
Health	11.9	230.8	369.9	487.5	143.0	1 247.7
Jobs, Precincts and Regions	..	40.6	81.6	74.5	..	196.6
Justice and Community Safety	6.4	70.9	35.8	10.3	3.1	126.5
Premier and Cabinet	10.0	13.6	8.3	..	..	31.9
Transport	228.7	680.9	766.9	548.0	534.2	3 082.9
Treasury and Finance	0.3	137.1	7.6	5.9	5.9	156.6
Parliament	..	0.4	0.2	0.2	0.1	0.8
Court Services Victoria	0.2	41.3	26.8	15.7	5.0	89.0
Total asset initiatives [(a)]	**263.8**	**1 713.6**	**2 095.4**	**1 866.8**	**809.2**	**7 079.3**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding. The TEI includes funding beyond 2024-25.

WHOLE OF GOVERNMENT – ABORIGINAL AFFAIRS

Output initiatives

Table 1.3: Output initiatives – Aboriginal Affairs **($ million)**

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*
Aboriginal family violence refuge for Wimmera South West area	..	0.2	0.9	1.6	1.7
Aboriginal strong and healthy	..	2.0	..	..	..
An advanced Aboriginal cultural heritage protection system for a growing economy	..	7.1	7.1	..	..
Delivering a Victorian truth and justice process	1.0	18.6	19.9	18.8	..
Delivering the State's commitment to Treaty for Victoria	..	8.0	8.9	..	..
Empowering Victorian Aboriginal communities through infrastructure and organisational sustainability	..	9.9	12.5	2.2	2.4
Marrung (Koorie Initiatives Package)	..	8.7	10.2	9.9	10.5
Marrung: Preserving Aboriginal Languages	..	0.6	0.7	0.7	0.7
Medical Research: Aboriginal Health and Medical Research Accord	..	0.4	0.4	..	..
Pathway to Aboriginal Prosperity: Capacity building for self-determination	..	0.4	0.4	0.4	0.4
Preventing Aboriginal deaths in custody	..	10.9	14.4	4.4	1.5
Progressing Traditional Owner Settlements	..	2.6	0.3	0.3	..
Self-determination and delivering on Victoria's commitment to Closing the Gap	..	6.4	6.5	4.0	4.0
Total output initiatives [(a)]	**1.0**	**75.9**	**82.1**	**42.3**	**21.1**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Aboriginal family violence refuge for Wimmera South West area

Refer to the asset initiative for a description of this initiative.

Aboriginal strong and healthy

Continued support is provided for maternal, child and family health services delivered in Aboriginal organisations. Funding is also provided for the Aboriginal Metropolitan Ice Partnership, which helps improve access to services for Aboriginal people affected by methamphetamine and other drugs.

This initiative contributes to the Department of Health's:

- Drug Prevention and Control output; and
- Maternal and Child Health and Early Parenting Services output.

An advanced Aboriginal cultural heritage protection system for a growing economy

Funding is provided to continue investment in Victoria's Aboriginal cultural heritage management system, boost capacity in cultural heritage decision-making for Traditional Owners, and invest in strong, inclusive and effective Traditional Owner groups.

Extending the Aboriginal Heritage Officer program will support Registered Aboriginal Parties to undertake statutory compliance and enforcement functions.

This initiative contributes to the Department of Premier and Cabinet's Aboriginal Policy, Strengthening Aboriginal Cultural Heritage and Communities output.

Delivering a Victorian truth and justice process

Funding is provided to establish the Yoo-rrook Justice Commission in Victoria as a formal truth-telling process with Aboriginal Victorians to recognise historic wrongs and address ongoing injustices. It will also support government and the First Peoples' Assembly engagement in the Commission's activities.

This initiative contributes to the Department of Premier and Cabinet's Aboriginal Policy, Strengthening Aboriginal Cultural Heritage and Communities output.

Delivering the State's commitment to Treaty for Victoria

Funding is provided to enable the State to continue advancing Phase 2 of Treaty negotiations with the First Peoples' Assembly of Victoria, including communications to continue building public understanding of Treaty as the process moves towards Phase 3 negotiations. The Assembly's second election process will be funded to ensure it is held by no later than December 2023, as required under the Assembly's constitution.

This initiative contributes to the Department of Premier and Cabinet's Aboriginal Policy, Strengthening Aboriginal Cultural Heritage and Communities output.

Empowering Victorian Aboriginal communities through infrastructure and organisational sustainability

Funding is provided to empower Aboriginal Victorians by returning decision-making and resources to Aboriginal communities and organisations, building economic sustainability and prioritising Aboriginal-led service delivery solutions. The Aboriginal Community Infrastructure Fund will be extended to fund the infrastructure needs of Victorian Aboriginal organisations. Two of Victoria's peak Aboriginal organisations (Koorie Youth Council and Koorie Heritage Trust) will receive further support to continue critical service delivery for young people and members of the Stolen Generations.

This initiative contributes to the Department of Premier and Cabinet's Aboriginal Policy, Strengthening Aboriginal Cultural Heritage and Communities output.

Marrung (Koorie Initiatives Package)

Funding is provided to deliver on the actions of *Marrung: Aboriginal Education Plan 2016-2026* (Marrung) to improve the educational outcomes of Koorie students in Victoria. This includes funding to continue the Koorie Literacy and Numeracy program, expand the Koorie Pre-School Assistants program to four new locations, and continue the Koorie Families as First Educators and Koorie Engagement Support Officer programs. In addition, funding supports the introduction of a two-year statewide consultation and co-design process, to progress Aboriginal self-determination in education.

Funding for this initiative is linked to the Early Intervention Investment Framework.

This initiative contributes to the Department of Education and Training's:

- Early Childhood Education output;
- School Education – Primary output; and
- School Education – Secondary output.

Marrung: Preserving Aboriginal Languages

Funding is provided to deliver a Certificate II and III in Learning an Australian First Nations Language for free at TAFE for Victorian Aboriginal learners, delivered in partnership with the Victorian Aboriginal Education Association and other Aboriginal Community Controlled Organisations.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

Medical Research: Aboriginal Health and Medical Research Accord

Funding is provided to finalise an Aboriginal Health and Medical Research Accord in partnership with the Victorian Aboriginal Community Controlled Health Organisation, supporting culturally safe practices in medical research in Victoria.

The Accord is a 2018 election commitment and will advance Aboriginal self-determination by ensuring that Aboriginal people are leading the identification of Aboriginal health and medical research priorities and informing research ethics review processes.

This initiative contributes to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Pathway to Aboriginal Prosperity: Capacity building for self-determination

Funding is provided to support greater prosperity and opportunity for Aboriginal Victorians. The Victorian Aboriginal Employment and Economic Council research, evaluation and recognition fund will undertake research, data collection and consultation to ensure the advice it gives to the Government is evidence-based, comprehensive and reflects the views and aspirations of Aboriginal Victorians. Annual Aboriginal Business and Excellence Awards will improve community and government awareness and recognition of the outstanding achievements of Aboriginal businesses and individuals.

This initiative contributes to the Department of Jobs, Precincts and Regions' Jobs output.

Preventing Aboriginal deaths in custody

Funding is provided to reduce the over-representation of Aboriginal people in the Victorian justice system and prevent Aboriginal deaths in custody through:

- continuing after-hours family violence support and regional legal assistance to meet the needs of Aboriginal communities;
- operation of Ngarra Jarranounith Place for Aboriginal men and expanded capacity of Baroona Youth Healing Place;
- provision of an early intervention family service and specialist family practitioners for keeping children under 14 years of age out of the criminal justice system;
- continued delivery of the Wadamba Prison to Work Program, The Torch in-prison art program and provision of Aboriginal Welfare Officers;
- continuing the Wayapa Healing Circle Program for men, culturally safe healthcare, and establishment and operation of a purpose-built, 20-bed Aboriginal Healing Unit for Aboriginal women in the Dame Phyllis Frost Centre, Victoria's main women's prison; and
- provision of women's and men's diversion programs.

This initiative contributes to the Department of Justice and Community Safety's Advocacy, Human Rights and Victim Support output.

Progressing Traditional Owner Settlements

Funding is provided to progress Traditional Owner Settlements and complete the Traditional Owner Settlements First Principles Review.

This initiative contributes to the Department of Justice and Community Safety's Justice Policy, Services and Law Reform output.

Self-determination and delivering on Victoria's commitment to Closing the Gap

Funding is provided to build on whole of government Aboriginal self-determination reform and to implement the new National Agreement on Closing the Gap.

This initiative contributes to the Department of Premier and Cabinet's Aboriginal Policy, Strengthening Aboriginal Cultural Heritage and Communities output.

Asset initiatives

Table 1.4: Asset initiatives – Aboriginal Affairs **($ million)**

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*	*TEI*
Aboriginal family violence refuge for Wimmera South West area	..	3.2	1.6	..	..	4.7
Preventing Aboriginal deaths in custody	..	1.9	..	..	..	1.9
Total asset initiatives [(a)]	**..**	**5.1**	**1.6**	**..**	**..**	**6.6**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Aboriginal family violence refuge for Wimmera South West area

Funding is provided to construct and operate a new refuge in Horsham, with six independent residential units in a secure setting for Aboriginal victim survivors of family violence. The refuge builds on the existing statewide family violence refuge redevelopment program and will support communities in the Wimmera South West area.

This initiative contributes to the Department of Families, Fairness and Housing's Housing Assistance output.

Preventing Aboriginal deaths in custody

Refer to the output initiative for a description of this initiative.

WHOLE OF GOVERNMENT – MENTAL HEALTH AND WELLBEING

Output initiatives

Table 1.5: Output initiatives – Mental health and wellbeing ($ million)

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*
A mental health and wellbeing system with lived experience at the core	..	10.2	5.8	1.3	1.2
A new approach to commissioning: integrated regional governance	..	5.2	12.3	11.4	5.9
A new approach to information management to facilitate better information sharing for consumers	..	2.5	..	..	..
Designing a new statewide trauma service to better support people with lived experience of trauma	..	0.9	0.8	..	..
Enabling the mental health and wellbeing workforce to deliver a reformed system	..	55.1	68.3	41.2	41.7
Expanding statewide services to improve support for high and specialised needs	..	7.6	3.2	..	..
Facilitating government and community-wide suicide prevention and response	..	46.6	44.8	41.2	40.8
Facilitating translational research to support ongoing system improvement	..	3.8	4.9	5.0	4.9
Improving the quality and safety of services and promoting consumer rights	..	4.6	6.8	6.3	6.4
Integrated care for people living with mental illness and substance use or addiction	..	4.6	10.0	12.5	15.2
Mental health-led emergency responses for Victorians in crisis	..	3.7	3.8	..	..
Mental health reform in education: setting up children and young people to thrive	..	9.5	47.4	71.7	89.2
New legal foundations and supporting consumers to exercise their rights	1.2	4.9	12.4	14.0	15.0
New local services for adults and older adults in their communities	..	5.9	36.3	78.1	143.4
New safe and compassionate models of care for bed-based services	1.2	87.9	104.1	87.6	89.2
Promoting good mental health and wellbeing and preventing mental illness	..	6.2	8.5	8.5	8.9
Redesigning and expanding Victoria's mental health and wellbeing infrastructure	..	10.0	10.0	..	..
Reformed area services to better support the mental health and wellbeing of adults and older adults	..	144.4	225.2	295.5	289.2
Strengthening system leadership, governance and accountability	..	17.9	18.2	17.3	17.8
Support for regulators and complaints handling bodies	..	5.6	0.9	1.0	1.0
Supported housing for adults and young people living with mental illness	..	3.4	6.8	14.6	15.6

	2020-21	2021-22	2022-23	2023-24	2024-25
Supporting Aboriginal social and emotional wellbeing	..	22.9	28.8	32.2	32.3
Supporting families and carers	..	5.9	25.9	29.5	31.4
Supporting mental health for trans and gender-diverse young people	..	5.5	5.1	5.3	5.4
Supporting the mental health and wellbeing of infants, children and families	..	22.5	49.8	61.0	62.5
Supporting the mental health and wellbeing of people in contact with the criminal and youth justice systems	..	5.1	8.9	8.2	8.5
Supporting the mental health and wellbeing of rural and regional Victorians	..	2.9	1.9	4.2	4.3
Supporting the mental health and wellbeing of young people	..	40.0	63.5	78.5	84.0
Working in partnerships to improve accessibility for diverse communities	..	6.1	6.4	6.2	7.5
Total output initiatives [(a)]	**2.4**	**551.4**	**820.9**	**932.2**	**1 021.3**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

A mental health and wellbeing system with lived experience at the core

Funding is provided to strengthen leadership of Victoria's mental health and wellbeing system by people with lived experience of mental illness or psychological distress. A new non-government agency, residential service and website will be developed and led by people with lived experience, providing better access to information, treatment and support. Funding is also provided to expand the capacity of the Victorian Mental Illness Awareness Council, the peak advocacy organisation in Victoria for people with a lived experience of mental health problems or emotional distress.

This initiative contributes to the Department of Health's Mental Health Community Support Services output.

A new approach to commissioning: integrated regional governance

Eight new interim regional bodies will be established to help develop, coordinate and plan mental health and wellbeing services across Victoria, supporting better responses to local needs. Eight regional multi-agency panels will also be established to improve coordinated care for those requiring ongoing intensive treatment, care and support from multiple services.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

A new approach to information management to facilitate better information sharing for consumers

Funding is provided to design a contemporary mental health and wellbeing information and communications technology system, including a review of data required for service delivery and systems administration.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Designing a new statewide trauma service to better support people with lived experience of trauma

Funding is provided to design a new statewide trauma service to achieve the best possible mental health and wellbeing outcomes for people with lived experience of trauma. This includes community engagement, policy development and co-design of the service with stakeholders and Victorians with lived experience of trauma.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Enabling the mental health and wellbeing workforce to deliver a reformed system

Funding is provided to commence building the pipeline of workers required to deliver the reform agenda set out by the Royal Commission into Victoria's Mental Health System. The mental health nursing workforce expansion continues with ongoing funding for 120 graduate placements for nurses and 140 postgraduate mental health nurse scholarships per year. Entry points into mental health professions will be increased through funding new allied health graduate positions and government-funded psychiatry rotations for junior medical officers.

The initiative will also support and increase the lived experience workforce in Victoria's mental health system, through new training programs, ongoing education and career pathways.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Expanding statewide services to improve support for high and specialised needs

Funding is provided to redesign statewide mental health services to support Victoria's new mental health and wellbeing system, and to provide an uplift in the capacity of community-based statewide service providers to relieve immediate community demand. Existing support for mental health consultation and liaison services will also continue.

This initiative will also implement a service capability framework for mental health and wellbeing services.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Facilitating government and community-wide suicide prevention and response

Victoria's suicide prevention and response initiatives will be expanded, including the establishment of a new intensive 14-day support program for people experiencing psychological distress. This initiative will also support the state-wide implementation of the Hospital Outreach Post-suicidal Engagement (HOPE) program, including ongoing funding for nine adult HOPE sites in metropolitan Melbourne and regional Victoria, delivery of four new child and youth HOPE sites and additional clinical outreach services in each sub-regional health service. These new services will be coordinated through the establishment of a new suicide prevention and response office within the Department of Health.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Facilitating translational research to support ongoing system improvement

Funding is provided to establish the Collaborative Centre for Mental Health and Wellbeing. The Centre will bring together people with lived experience of mental illness or psychological distress, carers, researchers, and experts to provide clinical and non-clinical services, conduct research and disseminate knowledge across the state to deliver the best possible outcomes for people living with mental illness.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Improving the quality and safety of services and promoting consumer rights

Funding is provided to improve the quality and safety of acute mental health services, including through the establishment of a mental health improvement unit within Safer Care Victoria.

This initiative will also commence work to eliminate the practices of seclusion and restraint through workforce education and training, and by embedding the Safewards model of care within all mental health, emergency and general health units in public hospitals.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Integrated care for people living with mental illness and substance use or addiction

Funding will establish statewide specialist services for people living with mental illness and substance use or addiction. These services will support integration of mental health and alcohol and other drugs treatment, care and support. New addiction medicine specialist hubs will also be established to support those with the most complex needs.

To support the capability and capacity uplift in the mental health and addiction workforce, funding has been provided to build, train, and strengthen the dual diagnosis workforce.

This initiative contributes to the Department of Health's Drug Treatment and Rehabilitation output.

Mental health-led emergency responses for Victorians in crisis

Funding is provided to commence work on establishing Ambulance Victoria as the lead responder to triple zero calls primarily concerning mental illness or psychological distress, including program design and development.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Mental health reform in education: setting up children and young people to thrive

Funding is provided to establish a School Mental Health Fund, enabling schools to select and implement mental health and wellbeing initiatives that best suit their students' needs from an evidence-based menu. The initiative will be rolled out to regional and rural government schools from Term 3 2022, before roll-out to all government schools by 2024. Funding is also provided to improve supports available to young carers and referral pathways through the mental health and wellbeing, and education systems.

Funding will expand the Mental Health in Primary Schools pilot to include 90 government schools and 10 non-government schools in 2022. Funding will also continue the Maroondah Positive Education initiative, which aims to increase the wellbeing and educational outcomes of students in 27 schools. These initiatives will provide vital support to these schools and inform best practice mental health across the school system.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

New legal foundations and supporting consumers to exercise their rights

Funding is provided for an opt-out non-legal advocacy service for clients subject to, or at risk of, compulsory treatment orders, and increase access to legal representation for clients who appear before the Mental Health Tribunal. Funding will also be provided to develop and deliver new legislation to replace the *Mental Health Act 2014*.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

New local services for adults and older adults in their communities

Funding is provided to establish the first 20 new local adult and older adult mental health and wellbeing services for Victorians experiencing mild to moderate mental health challenges.

The services will be accessible and locally based, and will provide integrated mental health treatment, care and wellbeing supports delivered by a multidisciplinary team.

An integrated alcohol and other drug services trial will be delivered in select sites to improve outcomes of people with a mental illness and substance misuse issues.

The first six of these 20 services will be established in the following municipalities:

- Benalla;
- Brimbank;
- Frankston;
- Greater Geelong;
- Latrobe Valley; and
- Whittlesea.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

New safe and compassionate models of care for bed-based services

Funding is provided for bed-based mental health services to increase access to acute care for Victorians living with mental illness. This includes making 53 recently built adult and youth beds available for patients, opening a 35-bed women's mental health unit, and continuing mental health hospital in the home as a substitute for care in hospitals.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Promoting good mental health and wellbeing and preventing mental illness

Funding is provided to establish a new mental health and wellbeing promotion office within the Department of Health, to lead development and coordination of mental health promotion and prevention activities across Victoria. A Victorian mentally healthy workplaces framework will also be developed to define roles and responsibilities of workplaces in promoting mental health and reducing psychological injury at work.

Social prescribing trials will be established across eight regions and will operate for three years in partnership with Victoria's new local mental health and wellbeing services.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Redesigning and expanding Victoria's mental health and wellbeing infrastructure

The Government's response to the Royal Commission into Victoria's Mental Health System will result in changes to how mental health services are delivered including operating models and the required infrastructure.

Funding is provided to undertake coordinated and comprehensive service and capital planning across the mental health system to guide future investment. This may include upgrades to existing assets, new community service facilities and more new acute beds.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Reformed area services to better support the mental health and wellbeing of adults and older adults

Funding will establish 22 reformed adult and older adult area mental health and wellbeing services to replace current area mental health services. These 22 services will have a greater capacity to treat, care and support adults and older adults experiencing severe and complex mental health and wellbeing challenges. A core function of these services will be to provide support to general practitioners and other primary and secondary care providers. This funding will also include pilots of integrated alcohol and other drugs treatment and wellbeing supports. Services will be delivered through a partnership between a public health service (or public hospital) and a non-government organisation that provides wellbeing supports.

Funding is also provided to continue the provision of existing community mental health service hours for adults and older adults, establish a specialist behaviour response team to respond to high risk unsafe behaviour in inpatient units and expand the physical footprint of both area and new local services to accommodate increased service delivery requirements.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Strengthening system leadership, governance and accountability

Funding is provided to support the establishment of an independent statutory authority, the Mental Health and Wellbeing Commission, and the transfer of functions from Mental Health Reform Victoria to the new Mental Health and Wellbeing Division of the Department of Health, led by a Chief Officer for Mental Health and Wellbeing.

Funding is also provided to bolster accountability structures for Victoria's mental health system, including developing a mental health and wellbeing outcomes framework and a new performance monitoring and accountability framework.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Support for regulators and complaints handling bodies

Statutory bodies will be supported to manage demand and ensure that safeguarding arrangements are in place to protect the most vulnerable members of the community. This includes additional funding for the Mental Health Tribunal, Mental Health Complaints Commissioner, Victorian Disability Worker Regulation Scheme and the Disability Services Commissioner.

Funding is also provided to strengthen compliance and enforcement of the *Non-Emergency Patient Transport Act 2003* for patients who require clinical monitoring or supervision during transport and to regulate the first aid sector for the first time. Funding is also provided to the Commission for Children and Young People to support the implementation of new Child Safe Standards, which require all Victorian organisations working with children to take steps to protect our children and young people.

This initiative contributes to the Department of Health's:

- Ambulance Non-Emergency Services output; and
- Mental Health Clinical Care output.

This initiative contributes to the Department of Families, Fairness and Housing's:

- Child Protection and Family Services output; and
- Disability Services output.

Supported housing for adults and young people living with mental illness

Funding is provided for accommodation and wellbeing supports to 2 000 Victorians living with a mental illness and allocated supported housing places as part of the Big Housing Build. Funding is also provided to undertake co-design and planning for a further 500 supported housing places for young people living with mental illness.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

This initiative contributes to the Department of Families, Fairness, and Housing's Housing Assistance output.

Supporting Aboriginal social and emotional wellbeing

Funding is provided to establish new structures and self-determined services across Victoria to support and promote Aboriginal social and emotional wellbeing.

This includes expanding social and emotional wellbeing teams to Aboriginal Community Controlled Health Organisations (ACCHOs) across Victoria, as well as funding the Victorian Aboriginal Controlled Health Organisation to establish an Aboriginal social and emotional wellbeing centre of excellence. ACCHOs will also be funded to commission the delivery of culturally appropriate social and emotional wellbeing services for children and young people.

Funding is also provided to resource Infant, Child and Youth Area Mental Health Services to support Aboriginal Community Controlled Organisations, with the creation of Koori mental health liaison officer positions.

This initiative contributes to the Department of Health's Mental Health Community Support Services output.

Supporting families and carers

Funding is provided to support families and carers of people with mental illness, including establishing eight family and carer-led centres across Victoria. Funding will be increased for the Carer Support Fund, Tandem and its carer participation registers. The Families where a Parent has a Mental Illness (FaPMI) program will be expanded, and funding will be provided to co-design and expand supports for young carers.

This initiative contributes to the Department of Health's Mental Health Community Support Services output.

Supporting mental health for trans and gender-diverse young people

Additional mental health support, primary medical care and peer supports will be provided for transgender and gender diverse young people. This includes an expansion of mental health services and primary care in the Monash Health and Royal Children's Hospital catchments and the development of a clinical pathway from the Royal Children's Hospital Gender Service to Orygen.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Supporting the mental health and wellbeing of infants, children and families

Funding is provided to establish 13 reformed infant and child area mental health and wellbeing services to provide a dedicated service stream for infants, children and families (aged 0-11), to ensure treatment, care and support is adapted to the needs of this age group.

Three infant, child and family hubs will be established based on a one-stop approach for child health, including emotional and developmental health, as well as providing culturally safe wrap around support for vulnerable and disadvantaged children and their families. Funding is also provided for evidence-informed online parenting programs, and group-based parenting sessions offered through the infant, child and family hubs.

Community perinatal mental health teams will also be expanded in area adult and older adult mental health and wellbeing services across Victoria.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Supporting the mental health and wellbeing of people in contact with the criminal and youth justice systems

Funding is provided to expand the Custodial Forensic Youth Mental Health Service delivered by Orygen at the Parkville and Malmsbury Youth Justice Precincts. Additional hours for specialist mental health assessment and treatment interventions will be provided for young people in custody.

Additional resources will also be provided for mental health support services in the justice system through:

- increased care and supports for prisoners transitioning out of custody, including specialist transition support social workers and coordinators;

- increased access to the Hospital Outreach Post-suicidal Engagement (HOPE) program; and
- preliminary policy and service design focused on future service delivery.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

This initiative contributes to the Department of Justice and Community Safety's:

- Prisoner Supervision and Support output; and
- Youth Justice Custodial Services output.

Supporting the mental health and wellbeing of rural and regional Victorians

Funding is provided to incentivise mental health workers to find employment in rural and regional areas. Funding is also provided to run two trials of digital mental healthcare delivery and to support the Live 4 Life and Be Well in the Ranges programs, all to operate in rural and regional areas.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Supporting the mental health and wellbeing of young people

Funding is provided to support more hours of mental health treatment, care and support to young people through Youth Area Mental Health and Wellbeing Services, including for extended hours and targeted assertive outreach. Funding is also provided to begin integrating support for general wellbeing and alcohol and other drug treatment into Youth Area Mental Health and Wellbeing Services. Funding is also provided to maintain the research, online delivery, and operational activities of organisations delivering mental health care to young people.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Working in partnerships to improve accessibility for diverse communities

A diverse communities' mental health and wellbeing framework will be co-designed and developed in partnership with people from diverse communities. Funding is provided to community organisations and peak bodies to enable engagement in the mental health reform process and support communities to navigate the mental health and wellbeing system.

Funding is provided to expand the Rainbow Door program to support people who identify as LGBTIQ+ to access and navigate the mental health and wellbeing system, and to continue the Healthy Equal Youth project to support young LGBTIQ+ Victorians. Support also continues for community-based mental health programs targeted at young asylum seekers and refugees.

This initiative contributes to the Department of Health's Mental Health Community Support Services output.

Asset initiatives

Table 1.6: Asset initiatives – Mental health and wellbeing ($ million)

	2020-21	2021-22	2022-23	2023-24	2024-25	TEI
Additional acute mental health beds in Warrnambool	..	4.1	6.2	0.6	..	10.9
Expanding and improving bed-based forensic mental health services: Thomas Embling Hospital	6.4	28.6	128.0	178.6	8.0	349.6
Expanding mental health treatment facilities for Victoria's youth [(a)]	..	2.0	65.0	52.0	21.0	141.0
Supported housing for adults and young people living with mental illness	..	2.2	1.6	1.0	0.6	5.4
Total asset initiatives [(b)]	**6.4**	**36.8**	**200.8**	**232.2**	**29.6**	**506.9**

Source: Department of Treasury and Finance

Notes:
(a) The TEI includes funding beyond 2024-25.
(b) Table may not add due to rounding.

Additional acute mental health beds in Warrnambool

Funding is provided to deliver an additional five acute mental health beds at the mental health Acute Inpatient Unit at Warrnambool. This will improve access and provide contemporary and high-quality treatment and care in the south-west region.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System interim and final reports.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Expanding and improving bed-based forensic mental health services: Thomas Embling Hospital

Funding is provided to deliver an additional 82 beds at Thomas Embling Hospital in Fairfield, along with some refurbishment of existing beds and supporting infrastructure. This expansion will allow timely and more effective therapeutic treatment in contemporary facilities that are safe for both patients and staff.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System interim and final reports.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Expanding mental health treatment facilities for Victoria's youth

Funding is provided to deliver five new 10-bed youth prevention and recovery care units in the Barwon South West, Gippsland, Grampians, Hume and North Eastern Metropolitan regions.

Three existing youth prevention and recovery care units will be upgraded in Bendigo, Dandenong and Frankston. This will give young people the care they need, closer to where they need it, to assist in their clinical and personal recovery.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System interim and final reports.

This initiative contributes to the Department of Health's Mental Health Clinical Care output.

Supported housing for adults and young people living with mental illness

Refer to the output initiative for a description of this initiative.

Revenue initiatives

Table 1.7: Revenue initiatives – Mental health and wellbeing ($ million)

	2020-21	2021-22	2022-23	2023-24	2024-25
A new approach to mental health investment: the Mental Health and Wellbeing Levy	..	386.7	804.7	841.4	881.7
Total revenue initiatives	**..**	**386.7**	**804.7**	**841.4**	**881.7**

Source: Department of Treasury and Finance

A new approach to mental health investment: the Mental Health and Wellbeing Levy

The Government will implement the recommendation of the Royal Commission into Victoria's Mental Health System to introduce a new revenue mechanism for the provision of operational funding for mental health services.

The Mental Health and Wellbeing Levy will begin from 1 January 2022. It will be implemented as a payroll tax surcharge on wages paid in Victoria by businesses with national payrolls over $10 million a year. A rate of 0.5 per cent will apply for businesses with national payrolls above $10 million, and businesses with national payrolls above $100 million will pay an additional 0.5 per cent. The surcharge rates will be paid on the Victorian share of wages above the relevant threshold. Existing payroll tax exemptions for private schools, hospitals, charities, local councils, and wages paid for parental and volunteer leave will apply for the Levy.

The Government will legislate that revenue from this surcharge will be spent on mental health services, supporting a substantial increase in investment in Victoria's mental health system, supplementing the current level and future expected growth of the Government's existing funding commitments as recommended by the Royal Commission.

DEPARTMENT OF EDUCATION AND TRAINING

Output initiatives

Table 1.8: Output initiatives – Department of Education and Training ($ million)

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*
Early Childhood Education					
Additional support for early years management	..	7.0	7.9	7.9	8.4
Child Link	..	23.4	21.5	22.6	18.6
Continuation of the early childhood language program	..	..	2.7	..	..
Giving vulnerable and disadvantaged kids the best start in life	..	8.6	8.2	8.5	8.5
Kindergarten enrolment-based funding	2.3	4.7	4.8	4.9	5.1
Maintaining universal access to 15 hours of four-year-old kindergarten	..	8.1	8.1	..	..
Ready for school: Kinder for every three-year-old	..	21.3	23.4	15.0	62.7
School Education					
Addressing the cost of delivering education	..	6.1	9.4	9.9	16.3
Addressing underperformance in schools	..	2.6	5.3	11.6	..
Doctors in Secondary Schools	..	5.9	12.1	12.4	12.6
English as an Additional Language	..	12.5	12.8	..	..
Enhanced school cleaning	30.0	..	..	..	..
Enhancing secondary vocational pathways	..	..	8.8	..	..
Essential maintenance and compliance	..	18.0	30.0	30.0	30.0
Increasing access to Tech Schools	..	2.3	6.0	6.2	6.0
Music in Schools	..	0.5	1.0	1.0	1.0
New schools construction	..	0.7	10.8	17.4	18.1
Relocatable Buildings Program	..	9.0	3.0	3.0	3.1
School enrolment-based funding	82.6	167.2	171.4	175.7	180.1
School information technology: onsite technical support	..	4.0	5.3	6.4	7.5
School upgrades: growth for 2024	..	..	..	1.2	2.4
Student health and wellbeing	..	2.1	4.1	4.2	2.1
Swimming and water safety education	..	8.7	18.0	18.6	9.9
Targeted initiatives to attract more teachers	..	3.2	1.4	0.2	..
Victorian Academy of Teaching and Leadership	..	21.3	34.5	34.9	35.7
Support for Students with Disabilities					
Students with Disabilities Transport Program	..	25.2	..	..	..
Support for students with disabilities and additional needs	..	4.8	9.8	5.0	..
Support Services Delivery					
Reducing the administrative burden on principals	..	2.6	3.1	3.2	3.3
Social cohesion through education	..	0.7	0.7	0.8	0.8

	2020-21	2021-22	2022-23	2023-24	2024-25
Training, Higher Education and Workforce Development					
Carmichael Centre	..	0.5	..	..	..
Establishing the Victorian Skills Authority	0.6	17.7	22.2	22.5	22.9
Increasing the funding of high-quality and accessible training	..	14.1	29.6	29.8	25.5
More training places for the TAFE and training system	..	84.3	1.5	1.5	1.5
Skills and Jobs Centre bus for the Mallee	..	1.1	0.3	..	..
Tackling the digital skills divide to get Victorians into jobs	..	3.1	3.1	..	..
TAFE reform	..	11.0	4.0	..	..
Total output initiatives [(a)]	**115.4**	**502.3**	**484.8**	**454.5**	**482.0**
Base and efficiency review [(b)]	0.5	(31.9)	(62.8)	(94.6)	(111.3)

Source: Department of Treasury and Finance

Notes:
(a) Table may not add due to rounding.
(b) These savings acquit whole of government efficiencies announced in the 2019-20 Budget.

Early Childhood Education

Additional support for early years management

Funding is provided to increase support for early years management services. Increased funding will support management of community-based kindergartens, improving service viability, access and quality. Funding is also provided to meet projected demand for kindergarten services to access these arrangements.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Child Link

Funding is provided to complete the establishment of the Child Link register in accordance with the *Child Legislation Amendment (Information Sharing) Act 2018*. Child Link will provide factual information about a child to authorised users to enable information sharing and promote child wellbeing and safety outcomes.

The *2019-20 Budget* allocated funds to plan this work, and the *2020-21 Budget* allocated funds to progress implementation.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Continuation of the early childhood language program

Funding is provided to continue the early childhood language program. This includes grants to kindergartens to support delivery of language programs, along with further professional support and training.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Giving vulnerable and disadvantaged kids the best start in life

Funding is provided to deliver tailored support for vulnerable and disadvantaged children to participate in early childhood education and care. This includes:

- expanding early intervention outreach support through the Access to Early Learning program;
- trialling new, intensive early education supports for vulnerable children affected by complex trauma;
- continuing Kindergarten Improvement Advisers to work with services to strengthen service capacity and child level outcomes; and
- expanding kindergarten programs at the Royal Children's Hospital Education Institute.

Funding for this initiative is linked to the Early Intervention Investment Framework.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Kindergarten enrolment-based funding

Additional funding is provided to meet the increased level of kindergarten enrolments.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Maintaining universal access to 15 hours of four-year-old kindergarten

Additional funding is provided to support the maintenance of universal access to 15 hours per week of four-year-old kindergarten in 2022.

Ready for school: Kinder for every three-year-old

Further funding is provided to continue the roll-out of universal three-year-old kindergarten, supporting children to access the benefits of two years of kindergarten before school. Funding will also expand workforce attraction and retention activities, to support the supply of qualified early childhood teachers.

Funding will also support continued expansion of kindergarten infrastructure, in partnership with local government and other eligible providers.

This initiative contributes to the delivery of the Government's election commitment as published in *Labor's Financial Statement 2018*.

This initiative contributes to the Department of Education and Training's:

- Early Childhood Education output; and
- Training, Higher Education and Workforce Development output.

School Education

Addressing the cost of delivering education

Additional funding will be provided to schools for transport costs associated with swimming and water safety education, and for essential materials for students undertaking vocational education and training (VET) subjects as part of senior secondary schooling.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

Addressing underperformance in schools

Funding is provided to continue all 17 Turnaround Teams in government schools. Turnaround Teams will continue to work intensively with schools facing significant and complex challenges to improve student outcomes and create sustainable change by building leadership capability and transforming school processes and structures.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

Doctors in Secondary Schools

Students in participating secondary schools will have access to primary health care in schools through the continuation of funding for the Doctors in Secondary Schools program.

This initiative contributes to the Department of Education and Training's School Education – Secondary output.

English as an Additional Language

Support will continue to be provided for government school students who do not speak English at home to become more proficient.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

Enhanced school cleaning

Additional funding is provided for enhanced cleaning of government schools in 2020-21. This will support regular cleaning of high-touch surfaces to help minimise the risk of coronavirus (COVID-19) transmission in schools, and deep cleans for schools with a student or staff member with COVID-19.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

Enhancing secondary vocational pathways

Funding will continue to support secondary students to access high-quality VET offerings for the second half of 2022. The Head Start Apprenticeship and Traineeship program will also continue, giving students the opportunity to undertake a traineeship or apprenticeship while completing their senior secondary certificate.

This initiative contributes to the Department of Education and Training's School Education – Secondary output.

Essential maintenance and compliance

Funding is provided for the Annual Contracts and Essential Safety Measures program. This program allows schools to meet their occupational health and safety and other compliance obligations.

Funding is also provided to continue the Safe Tree program to fund arborist inspections and tree removal where needed.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

Increasing access to Tech Schools

Additional funding is provided for Tech Schools in the Ballarat, Banyule Nillumbik, Bendigo, Casey, Geelong, Gippsland, Monash, Whittlesea, Wyndham and Yarra Ranges regions, to build students' science, technology, engineering and mathematics skills and connect them to jobs of the future. This initiative will expand on site and virtual delivery capabilities of existing Tech Schools and pilot a mobile Tech School delivery model for students in remote areas of Gippsland.

This initiative contributes to the Department of Education and Training's School Education – Secondary output.

Music in Schools

Funding is provided to continue the Music in Schools program to ensure student access to quality music education in government schools. This comprises a teacher professional learning program to build teachers' capacity to deliver high-quality music education and grants for government schools to buy musical instruments and other musical resources.

This initiative contributes to the Department of Education and Training's School Education – Primary output.

New schools construction

Refer to the asset initiative for a description of this initiative.

Relocatable Buildings Program

Refer to the asset initiative for a description of this initiative.

School enrolment-based funding

Additional funding is provided to government and non-government schools to meet student enrolment growth in the 2021 school year.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

School information technology: onsite technical support

Additional funding is provided for onsite school technical support services for government schools, to ensure technology used by students and teachers is reliable and information technology issues are promptly addressed.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

School upgrades: growth for 2024

Refer to the asset initiative for a description of this initiative.

Student health and wellbeing

Funding is provided to continue implementation of the school-wide positive behaviour support (SWPBS) framework. Implementation in schools will be supported by 17 specialist SWPBS coaches, working with schools to improve teachers' capability to effectively manage student behaviour and foster respectful school environments.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

Swimming and water safety education

Funding is provided to continue swimming and water safety education programs to government, Catholic and specialist schools, and to introduce these programs to government English language schools. Funding also continues the Public Water Safety Initiative, which delivers workshops and other resources to improve students' swimming and water safety competency.

This initiative contributes to the Department of Education and Training's School Education – Primary output.

Targeted initiatives to attract more teachers

Additional funding is provided to attract and develop quality teachers in Victorian schools, including:

- an additional 95 teaching students to be equipped to work in schools in disadvantaged areas through employee-based pathway programs; and
- further developing 10 existing and establishing two new Teaching Academies of Professional Practice (TAPP) partnerships between schools and universities. TAPPs will continue to develop and support professional school-based mentors for the purpose of improving initial teacher education.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

Victorian Academy of Teaching and Leadership

Funding is provided to establish the Victorian Academy of Teaching and Leadership. This new specialist statutory entity will have a dedicated focus on delivering advanced professional learning for Victorian teachers and educational leaders.

In addition to expanded professional learning offerings, the Academy's Teaching Excellence Program will be a centre of excellence for high-performing teachers to advance their professional practice by drawing on contemporary research and best practice across key curriculum areas.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

Support for Students with Disabilities

Students with Disabilities Transport Program

Funding is provided to continue delivering transport assistance through the Students with Disabilities Transport Program, supporting eligible students to attend their designated government specialist education setting.

This initiative contributes to the Department of Education and Training's Support for Students with Disabilities output.

Support for students with disabilities and additional needs

Funding is provided to continue the demonstration pilot of outside school hours care and school holiday programs for young people with disability which delivers free, high-intensity support at six government school sites.

This initiative contributes to the Department of Education and Training's Support for Students with Disabilities output.

Support Services Delivery

Reducing the administrative burden on principals

Funding is provided to expand and establish new support to reduce the burden of administrative and compliance activities on school principals, enabling them to focus on leading teaching and learning, reducing workload and supporting workforce wellbeing. Principals will be assisted by a new advisory service to reduce time spent on operational, policy and compliance tasks, and expansion of the Local Administration Bureau service to more small schools, providing centralised advisory and processing support in finance and human resources.

This initiative contributes to the Department of Education and Training's Support Services Delivery output.

Social cohesion through education

Funding will continue to support school communities and young people in Broadmeadows, Dandenong, North Melbourne, Shepparton, West Heidelberg, and Wyndham areas to be more engaged and informed to reduce the risk of isolation, marginalisation and attraction to violent extremism.

This initiative is linked to the Department of Justice and Community Safety's Initiatives to counter violent extremism initiative.

This initiative contributes to the Department of Education and Training's Support Services Delivery output.

Training, Higher Education and Workforce Development

Carmichael Centre

Funding is provided to contribute to the establishment of the Laurie Carmichael Distinguished Research Fellow position at the Carmichael Centre, in affiliation with RMIT University.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

Establishing the Victorian Skills Authority

Funding is provided to establish the Victorian Skills Authority (VSA) to support implementation of the *Skills for Victoria's Growing Economy* review recommendations. The VSA will be an anchor organisation, bringing together industry, providers and other stakeholders to produce insights on priority training areas, and inform an annual Victorian Skills Plan to better guide training delivery where it's needed most.

The VSA will develop platforms to make information available to support decisions by industry, providers and students. The VSA will provide a new focus for statewide and local problem solving to support skills supply, strengthen the quality of teaching and training and drive collaborative innovation across the VET sector.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

Increasing the funding of high-quality and accessible training

Contributions for government-subsidised accredited courses delivered by TAFEs and other registered training providers will increase in 2022 to maintain a high-quality training system. This includes subsidy rates, maximum concession contribution rates and non-Free TAFE fee waiver rates.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

More training places for the TAFE and training system

Funding is provided to continue support for eligible students to enhance their skills and employment opportunities by providing subsidised vocational education and training.

Funding is also provided for the Asylum Seeker VET program, which provides eligible asylum seekers with access to subsidised training.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

Skills and Jobs Centre bus for the Mallee

Funding is provided for a pilot Skills and Jobs Centre bus to service communities in the Mallee region, including Charlton, Kerang and Robinvale. This will provide career advice, help with job searching and other supports for job seekers.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

Tackling the digital skills divide to get Victorians into jobs

Funding is provided to increase places in pre-accredited digital literacy and employability skills training courses delivered by Learn Local providers to enhance the employment prospects of educationally disadvantaged Victorians. It will also support the development and implementation of an online core skills assessment tool to better target training pathways for learners in post-compulsory training.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

TAFE reform

Funding is provided to establish the Office of TAFE Coordination and Delivery as a separate business unit in the Department of Education and Training, to lead strategic projects and enhance collaboration across the TAFE network.

Funding will also continue coordination of practical placements for TAFE students, including students in the allied health, individual support and community services, early childhood and education and training sectors.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

Departmental efficiency measures

Base and efficiency review

The Department of Education and Training will reduce portfolio operating expenditure, including by streamlining administrative and policy functions, reducing expenditure on contractors and improving procurement practices.

Asset initiatives

Table 1.9: Asset initiatives – Department of Education and Training ($ million)

	2020-21	2021-22	2022-23	2023-24	2024-25	TEI
Early Childhood Education						
Child Link	..	5.5	..	..	..	5.5
Ready for school: Kinder for every three-year-old	..	..	..	..	44.8	44.8
School Education						
Doctors in Secondary Schools	..	0.4	..	..	..	0.4
Essential maintenance and compliance	..	1.6	56.6	20.8	1.0	80.0
Land acquisition	..	86.7	45.2	144.6	..	276.4
Minor Capital Works Fund	..	6.0	14.0	..	..	20.0
New schools construction	..	181.1	278.8	31.3	0.4	491.6
Relocatable Buildings Program	..	105.3	..	..	..	105.3
School upgrades [(a)]	..	9.2	106.4	204.0	19.8	340.0
School upgrades: growth for 2024 [(a)]	..	2.3	23.2	49.8	9.5	85.0
Victorian Academy of Teaching and Leadership	..	11.6	10.2	..	..	21.8
Support for Students with Disabilities						
Accessible Buildings Program	..	10.0	5.0	..	..	15.0
Inclusive Schools Fund	..	1.0	9.0	..	..	10.0
Planning for schools	..	0.5	0.5	..	..	1.0
Training, Higher Education and Workforce Development						
Building Better TAFEs Fund	..	7.5	33.7	29.4	1.9	72.4
TAFE Equipment and Facilities Fund for apprentices and trainees	..	12.0	..	..	..	12.0
Total asset initiatives [(b)]	**..**	**440.7**	**582.5**	**479.8**	**77.4**	**1 581.2**

Source: Department of Treasury and Finance

Notes:
(a) The TEI includes funding beyond 2024-25.
(b) Table may not add due to rounding.

Early Childhood Education

Child Link

Refer to the output initiative for a description of this initiative.

Ready for school: Kinder for every three-year-old

Refer to the output initiative for a description of this initiative.

School Education

Doctors in Secondary Schools

Refer to the output initiative for a description of this initiative.

Essential maintenance and compliance

Funding is provided to support the Planned Maintenance Program, which responds to the proactive Rolling Facilities Evaluation and is a continuous program of works across the school system. This program ensures issues with asset condition are managed in a planned and ongoing manner.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

Land acquisition

Land will be acquired for new schools in the following municipalities: Cardinia, Casey, Hume, Melton, Mitchell, Port Phillip and Wyndham.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output;
- School Education – Secondary output; and
- Support for Students with Disabilities output.

Minor Capital Works Fund

Funding is provided to continue the Minor Capital Works Fund which provides the opportunity for schools to seek funding for minor capital projects that are a priority for their school.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

New schools construction

The Government will build 13 new schools, contributing to its commitment to open 100 new schools across the state by 2026.

The following 12 new schools will be built to open in 2023:

- Camms Road Primary School (Interim Name);
- Hayes Hill Primary School (Interim Name);
- Holyoake Parade Primary School (Interim Name);
- Lollypop Creek Primary School (Interim Name);
- Merrifield West Secondary School (Interim Name);
- Mount Ridley Special School (Interim Name);
- Officer Rix Road Primary School (Interim Name);
- Riverdale East Primary School (Interim Name);
- Rockbank Murray Road Primary School (Interim Name);

- Tarneit Missen House Primary School (Interim Name);
- Wollert East Secondary School (Interim Name); and
- Wollert West Primary School (Interim Name).

The following new school will be built to open in 2024:

- Truganina North Secondary School (Interim Name)

Additional stages of new schools will also be constructed at three recently-opened schools:

- Cranbourne West Secondary College (at least $15.210 million);
- Elevation Secondary College (at least $25.830 million); and
- Tarneit Senior College (at least $5.806 million).

Funding is also provided for the operating costs associated with the new schools.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output;
- School Education – Secondary output; and
- Support for Students with Disabilities output.

Relocatable Buildings Program

Relocatable buildings will be provided to relieve pressure at schools that are reaching their capacity and to provide additional functional spaces for learning.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

School upgrades

Fifty-two schools across Victoria will receive funding for upgrades. This will improve educational outcomes through the provision of high-quality classrooms and facilities for learning and community use.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

School upgrades

- Aireys Inlet Primary School
- Alamanda K-9 College
- Albert Park College and the Victorian College of the Arts Secondary School
- Ashburton Primary School
- Birralee Primary School
- Brentwood Park Primary School
- California Gully Primary School
- Casterton Primary School
- Chelsea Primary School
- Cobram Primary School
- Croydon Primary School
- Dandenong North Primary School
- Footscray City Primary School
- Forest Street Primary School
- Frankston High School
- Gisborne Secondary College
- Glen Waverley South Primary School
- Goonawarra Primary School
- Huntly Primary School
- Kangaroo Ground Primary School
- Kensington Primary School
- Kerang South Primary School
- Kerrimuir Primary School
- Koo Wee Rup Primary School
- Manchester Primary School
- Montmorency Primary School
- Moonee Ponds Primary School
- Mount Beauty Primary School
- Mullauna Secondary College
- Niddrie Primary School
- Northcote High School
- Orbost regeneration
- Parkwood Green Primary School
- Pascoe Vale Girls Secondary College
- Plenty Parklands Primary School
- Rushworth P-12 College
- Sale College
- St Albans East Primary School
- St Arnaud Secondary College
- Swinburne Senior Secondary College
- Templeton Primary School
- Traralgon (Stockdale Road) Primary School
- Underbool Primary School
- Viewbank Primary School
- Warrandyte High School
- Watsonia North Primary School
- Weeden Heights Primary School
- Wembley Primary School
- Westall Secondary College
- Wheelers Hill Primary School
- Woady Yaloak Primary School
- Yaapeet Primary School

School upgrades: growth for 2024

Funding is provided to expand capacity to meet enrolment demand at six established area schools. The expanded capacity will be ready for the 2024 school year at the following schools:

- Drouin Primary School (at least $22.097 million);
- Glen Eira College (at least $6.577 million);
- Manor Lakes P-12 College (at least $9.402 million);
- Moorabbin Primary School (at least $15.857 million);
- Mount Ridley P-12 College (at least $10.706 million); and
- Newlands Primary School (at least $11.830 million).

Funding is also provided for the operating costs associated with the expanded capacity.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output; and
- School Education – Secondary output.

Victorian Academy of Teaching and Leadership

Refer to the output initiative for a description of this initiative.

Support for Students with Disabilities

Accessible Buildings Program

Funding is provided to improve access to school facilities for students with disabilities and additional needs. Facility modifications may include providing ramps and handrails, alterations to toilet and shower facilities and adjustments for students with vision or hearing impairments.

This initiative contributes to the Department of Education and Training's Support for Students with Disabilities output.

Inclusive Schools Fund

The Inclusive Schools Fund will continue to provide school infrastructure such as playgrounds, outdoor sensory areas and quiet re-engagement spaces.

This initiative contributes to the Department of Education and Training's Support for Students with Disabilities output.

Planning for schools

Funding is provided for planning for a future upgrade of Verney Road School in Shepparton and broader specialist provision across the Shepparton region.

This initiative contributes to the Department of Education and Training's Support for Students with Disabilities output.

Training, Higher Education and Workforce Development

Building Better TAFEs Fund

To complete distribution of the Building Better TAFEs Fund, funding is provided for the following two TAFE redevelopment projects to improve lifelong education pathways:

- Bendigo Kangan Institute's Broadmeadows Campus Redevelopment; and
- GOTAFE's Archer Street Shepparton Campus Redevelopment.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

TAFE Equipment and Facilities Fund for apprentices and trainees

Funding is provided for TAFEs to upgrade facilities and equipment to support training for apprentices and trainees. This aims to build partnerships with industry and ensure apprentices and trainees develop contemporary skills to meet changing industry practice.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

DEPARTMENT OF ENVIRONMENT, LAND, WATER AND PLANNING

Output initiatives

Table 1.10: Output initiatives – Department of Environment, Land, Water and Planning **($ million)**

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*
Climate Change					
Seizing the economic opportunity of a net zero, climate resilient State	..	5.0	5.0	..	..
Effective Water Management and Supply					
Compliance and interceptions: protect reliability of water entitlements and maximise water resources for regional business and communities	..	0.7	0.9	0.9	..
Delivering a sustainable solution for Bendigo's Central Deborah historic mine workings	..	3.2	5.4	..	..
Resilient water markets, regional communities and infrastructure	..	3.6	2.6	2.2	..
Supporting regional communities and economic recovery through healthy waterways	..	8.5	9.0	7.0	..
Energy					
Maintaining essential energy functions	..	16.9	16.8	15.0	14.2
Powerline Bushfire Safety Program	..	1.5	..	..	..
Zero and low emission vehicles: accelerating adoption	..	11.0	15.3	19.8	..
Environment and Biodiversity					
A clean air future for all Victorians	..	0.9	0.9	..	..
EcoCentre redevelopment	..	1.0	1.0	0.8	..
Making public land safe from contamination	..	2.9	..	..	..
More Trees for a Cooler, Greener West	..	5.0	..	..	..
Pest and weed management	..	1.3	1.3	1.3	1.3
Port Phillip Bay Fund	..	2.2	2.2	2.2	2.2
Supporting Trust for Nature	..	1.0	1.0	1.0	1.0
Unique biodiversity protection through community-driven action	..	14.3	13.3	12.2	12.2
Wildlife protection and support package	..	3.3	2.5	..	..
Fire and Emergency Management					
Aviation resources	14.5	..	..	..	..
Bushfire preparedness 2020-21	18.2	..	..	..	..
Emergency management sector reform	..	0.6	0.6	0.6	0.6
Enhanced communications during emergencies	..	53.6	43.7	18.0	18.1
Reducing bushfire risk in a rapidly-changing climate	..	78.6	84.9	87.0	89.1
Management of Public Land and Forests					
COVIDSafe Summer plan 2020-21	1.4	..	..	..	..
Delivering Victoria's Regional Forest Agreement commitments	..	12.9	11.1	7.9	6.0
Great Ocean Road management reforms	..	2.2	2.2	..	..
Protecting regional environments	..	4.0	4.8	..	..
Zoos Victoria Kids Free policy	..	10.0	10.0	..	..

	2020-21	2021-22	2022-23	2023-24	2024-25
Parks Victoria					
Enhancing Parks Victoria operations	..	7.9	8.0	7.9	7.9
Planning, Building and Heritage					
Plan Melbourne implementation	..	3.3	3.3	..	..
Revitalising Central Geelong	..	0.5	0.2	..	..
Streamlining for growth	..	7.0	7.0	..	..
Unlocking new communities and affordable housing	..	7.0	..	..	..
Statutory Activities and Environment Protection					
EPA step-in high-risk waste sites	..	11.8	2.3	..	..
Sustaining the EPA's strengthened regulatory functions	..	42.3	27.3	3.5	3.5
Wildlife Act 1975 review	..	1.5	1.5	..	..
Total output initiatives [(a)]	**34.1**	**325.3**	**284.0**	**187.1**	**156.0**
Base and efficiency review [(b)]	(5.5)	(10.9)	(29.1)	(74.4)	(37.2)

Source: Department of Treasury and Finance

Notes:
(a) Table may not add due to rounding.
(b) These savings acquit whole of government efficiencies announced in the 2019-20 Budget.

Climate Change

Seizing the economic opportunity of a net zero, climate resilient State

Funding is provided to enhance capability to drive progress towards Victoria's emissions reduction targets and support job creation in clean and competitive industries in Victoria.

This initiative contributes to the Department of Environment, Land, Water and Planning's Climate Change output.

Effective Water Management and Supply

Compliance and interceptions: protect reliability of water entitlements and maximise water resources for regional business and communities

Funding is provided to support water compliance activities that will maintain community confidence in the water entitlement framework, prevent water theft and address emerging risks to water availability.

This initiative will be funded from the Environmental Contribution Levy.

This initiative contributes to the Department of Environment, Land, Water and Planning's Effective Water Management and Supply output.

Delivering a sustainable solution for Bendigo's Central Deborah historic mine workings

Funding is provided for the continuation of the groundwater treatment program and investigation of a permanent solution to safeguard Bendigo's urban waterways.

This initiative will be funded from the Environmental Contribution Levy.

This initiative contributes to the Department of Environment, Land, Water and Planning's Effective Water Management and Supply output.

Resilient water markets, regional communities and infrastructure

Funding is provided for community engagement and capacity building to support irrigators and Traditional Owners. This includes grants for infrastructure projects to enable farms to modernise and optimise water efficiency.

This initiative will be funded from the Environmental Contribution Levy.

This initiative contributes to the Department of Environment, Land, Water and Planning's Effective Water Management and Supply output.

Supporting regional communities and economic recovery through healthy waterways

Funding is provided for a package of on-ground environmental works to improve the health of rivers and wetlands. Sites targeted will be of high recreational and tourism importance.

This initiative will be funded from the Environmental Contribution Levy.

This initiative contributes to the Department of Environment, Land, Water and Planning's Effective Water Management and Supply output.

Energy

Maintaining essential energy functions

The Government will continue to meet its responsibilities to maintain a safe, secure and reliable energy system and ensure Victoria can realise the benefits of the rapid rate of growth in renewable energy. Protection for energy consumers will be maintained through the continuation of the Energy Fairness Plan, further growth in renewables, reducing emissions and improving the reliability of the grid.

This initiative will be partly funded from the Sustainability Fund.

This initiative contributes to the Department of Environment, Land, Water and Planning's Energy output.

Powerline Bushfire Safety Program

Funding is provided to continue delivering safer powerlines to the Victorian community, including business case development for future technology-led investment that reduces powerline related bushfire risk.

This initiative contributes to the Department of Environment, Land, Water and Planning's Energy output.

Zero and low emission vehicles: accelerating adoption

Funding is provided to encourage the early adoption of zero emission vehicles by households and businesses through a public subsidy scheme for lower-cost zero emission vehicles.

This is a component of the comprehensive Zero Emissions Vehicles (ZEV) package made possible by a zero and low-emissions vehicle road user charge.

This initiative contributes to the Department of Environment, Land, Water and Planning's Energy output.

Environment and Biodiversity

A clean air future for all Victorians

Funding is provided for actions to support Melbourne's inner-west communities, with a focus on early diagnosis and treatment of childhood asthma to achieve better long-term health outcomes.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

EcoCentre redevelopment

Funding is provided to contribute to the design and construction of a new facility for the Port Phillip EcoCentre in St Kilda. The EcoCentre is a leading community-managed organisation with a dedicated team of scientists, educators and volunteers who design and implement innovative environmental programs.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Making public land safe from contamination

Work will begin to remediate contaminated public land to minimise harm to the community and the environment and provide safe recreation and visitation sites. Contaminated sites to be addressed include Stawell calcine sands, Glenlyon Recreation Reserve, Muckatah Recreation Reserve, Kennett River Recreation Reserve and Princetown Recreation Reserve.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

More Trees for a Cooler, Greener West

Funding is provided to plant trees in Melbourne's west to reduce the risk of heat stress, create access to green spaces and improve overall air quality.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Pest and weed management

Funding is provided to partner with local government authorities for weed and pest management and to continue the Conservation and Pest Management Program to manage invasive species.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Port Phillip Bay Fund

Funding is provided to continue the Port Phillip Bay Fund, which provides grants to local government authorities to rehabilitate Port Phillip Bay ecosystems.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Supporting Trust for Nature

Funding is provided for continued support for Trust for Nature to deliver essential work towards private land conservation.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Unique biodiversity protection through community-driven action

Funding is provided to continue targeted action to improve biodiversity through grants and direct involvement by the community to protect threatened species, improve habitats and reduce threats to biodiversity. This includes continuing the successful Victorian Landcare Program, ensuring that regional Landcare coordinator and facilitator roles are maintained.

In addition, funding is provided to refresh *Biodiversity 2037*, Victoria's long-term plan to stop the decline of native plants and animals and improve the natural environment, in line with legislative obligations under the *Flora and Fauna Guarantee Act 1988*.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Wildlife protection and support package

Funding is provided for a package of initiatives which seek to protect Victorian wildlife through:

- taking action to reduce the risk of extinction for Victoria's iconic endangered faunal emblem species;
- the Wildlife Victoria Hotline, providing community reporting and coordination for wildlife in distress;
- supporting Victorian wildlife centres and shelters, enabling rehabilitation of injured and orphaned wildlife; and
- improving the protection of critical habitats for Victoria's threatened species.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Fire and Emergency Management

Aviation resources

Funding was provided for additional firefighting aviation resources to support the State's firefighting capability during the 2020-21 bushfire season.

This initiative contributes to the Department of Environment, Land, Water and Planning's Fire and Emergency Management output.

Bushfire preparedness 2020-21

Funding was provided for additional preparedness activities for the 2020-21 bushfire season, including additional project firefighters and vehicles.

This initiative contributes to the Department of Environment, Land, Water and Planning's Fire and Emergency Management output.

Emergency management sector reform

Refer to the Department of Justice and Community Safety for a description of this initiative.

Enhanced communications during emergencies

Funding is provided to transition the Department of Environment, Land, Water and Planning's emergency management user base from an analogue radio communication system to an encrypted digital radio system, improving the reliability and interoperability of the communications service to better prepare and respond to emergency events including bushfires.

This initiative contributes to the Department of Environment, Land, Water and Planning's Fire and Emergency Management output.

Reducing bushfire risk in a rapidly-changing climate

Funding is provided to continue the Reducing Bushfire Risk program and Safer Together strategy, which aim to reduce the impact of bushfires on Victorian communities, the economy and the environment. A range of new and existing actions will be delivered, including:

- maintaining the planned burning program;
- increasing mechanical and other non-burn fuel treatments;
- providing for forest firefighter capacity and continuing to build community understanding of risk;
- establishing an Office of Bushfire Risk Management in the Department of Environment, Land, Water and Planning to lead and coordinate the implementation of evidence-based fuel management across all land in Victoria;
- supporting the implementation of the Victorian Traditional Owner Cultural Fire Strategy;
- providing additional firefighter safety equipment; and
- undertaking asset maintenance and replacement, including the strategic road network and regional fire towers to support fire access and response.

This initiative responds to recommendations of the Inspector-General for Emergency Management Inquiry into the 2019-20 Victorian Fire Season.

This initiative contributes to the Department of Environment, Land, Water and Planning's Fire and Emergency Management output.

Management of Public Land and Forests

COVIDSafe Summer plan 2020-21

Funding was provided to assist in reducing the risk of coronavirus (COVID-19) spreading through visitor interactions on public land and waterways across Victoria during the 2020-21 summer.

This initiative contributes to the Department of Environment, Land, Water and Planning's Management of Public Land and Forests output.

Delivering Victoria's Regional Forest Agreement commitments

Funding is provided for a program of investments to deliver on the obligations of the newly modernised Regional Forest Agreements (RFAs) that establish the framework for the sustainable management and conservation of forests. This includes development of community-centred Forest Management Plans, completing the reviews of regulatory and governance instruments as mandated by the RFAs, and empowering Traditional Owners to partner with government and actively manage Country.

This initiative contributes to the Department of Environment, Land, Water and Planning's Management of Public Land and Forests output.

Great Ocean Road management reforms

Funding is provided to transfer public land management to the new Great Ocean Road Coast and Parks Authority, establish sustainable revenue streams and continue to develop a strategic framework plan to ensure a coherent and coordinated approach to the management of the Great Ocean Road and its landscapes. The Department of Environment, Land, Water and Planning and the Authority will support the Eastern Maar and Wadawurrung Traditional Owners to actively participate in the management of traditional lands and develop shared economic benefits.

This initiative contributes to the Department of Environment, Land, Water and Planning's Management of Public Land and Forests output.

Protecting regional environments

Funding is provided for the continued resourcing of the Office of the Conservation Regulator to ensure it can oversee regulatory functions in conservation and environment in Victoria. This includes educating the community about conservation and environment protection in Victoria, providing guidance to support compliance, and undertaking enforcement action when necessary.

This initiative contributes to the Department of Environment, Land, Water and Planning's Management of Public Land and Forests output.

Zoos Victoria Kids Free policy

Funding is provided to allow children under 16 years of age to continue to enjoy free access to Melbourne Zoo, Healesville Sanctuary and Werribee Open Range Zoo on weekends, public holidays and during school holidays.

This initiative contributes to the Department of Environment, Land, Water and Planning's Management of Public Land and Forests output.

Parks Victoria

Enhancing Parks Victoria operations

Funding is provided to ensure priority parks and public spaces remain staffed, maintained, and available to enhance the health and wellbeing of Victorians.

This initiative contributes to the Department of Environment, Land, Water and Planning's Parks Victoria output.

Planning, Building and Heritage

Plan Melbourne implementation

Additional funding is provided to continue to implement and conduct a five-year review of Plan Melbourne, the whole of government strategy that seeks to integrate long-term land use, infrastructure and transport planning to meet the city's future needs.

This initiative contributes to the Department of Environment, Land, Water and Planning's Planning, Building and Heritage output.

Revitalising Central Geelong

Funding is provided to support the Geelong Authority to deliver the Revitalising Central Geelong Action Plan.

This initiative contributes to the Department of Environment, Land, Water and Planning's Planning, Building and Heritage output.

Streamlining for growth

Funding is provided to continue the Streamlining for Growth program administered by the Victorian Planning Authority (VPA) to assist local government authorities to plan and manage growth. This funding includes assistance for reducing capacity constraints on council approval processes, reducing delays associated with utility approvals, and improving guidelines for local government authorities and developers to reduce the uncertainty associated with turning precinct structure plans into subdivision permits.

This initiative contributes to the Department of Environment, Land, Water and Planning's Planning, Building and Heritage output.

Unlocking new communities and affordable housing

Funding is provided to the VPA to continue to support precinct planning for high-priority areas to maintain the pipeline of land supply.

This initiative contributes to the Department of Environment, Land, Water and Planning's Planning, Building and Heritage output.

Statutory Activities and Environment Protection

EPA step-in high-risk waste sites

The Environment Protection Authority (EPA) will continue to remediate two high-risk waste sites located in Kaniva and Campbellfield, to protect the community and the environment. The EPA will pursue the previous site occupiers, owners, company directors and any other relevant parties to recover these costs.

This initiative will be funded from the Municipal and Industrial Landfill Levy.

This initiative contributes to the Department of Environment, Land, Water and Planning's Statutory Activities and Environment Protection output.

Sustaining the EPA's strengthened regulatory functions

Funding is provided for the EPA to ensure it can continue to protect Victoria's environment from pollution and waste and fulfil its obligations under the *Environment Protection Amendment Act 2018*. EPA's Officers for the Protection of the Local Environment program will continue to respond to local reports of noise, odour, dust, waste dumping and storage, litter and water pollution.

This initiative will be funded from the Municipal and Industrial Landfill Levy.

This initiative contributes to the Department of Environment, Land, Water and Planning's Statutory Activities and Environment Protection output.

Wildlife Act 1975 review

The Department of Environment, Land, Water and Planning will conduct a comprehensive first principles review of the *Wildlife Act 1975*, including its scope and purpose, and will consider reform options in consultation with an expert panel.

This initiative contributes to the Department of Environment, Land, Water and Planning's Statutory Activities and Environment Protection output.

Departmental efficiency measures

Base and efficiency review

The Department of Environment, Land, Water and Planning will reduce its operating expenditure through whole of departmental reforms that deliver efficiencies to functions including finance, communications, human resources and information technology. This includes more efficient operating models, leveraging technology to reduce costs and administrative overheads, and simplifying processes and streamlined operations across departmental groups and portfolio entities.

Asset initiatives

Table 1.11: Asset initiatives – Department of Environment, Land, Water and Planning **($ million)**

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*	*TEI*
Fire and Emergency Management						
Reducing bushfire risk in a rapidly-changing climate	..	11.0	11.0	11.0	11.0	44.0
Management of Public Land and Forests						
Mt Baw Baw Alpine Resort wastewater plant	..	3.0	1.0	..	..	4.0
Total asset initiatives [(a)]	**..**	**14.0**	**12.0**	**11.0**	**11.0**	**48.0**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Fire and Emergency Management

Reducing bushfire risk in a rapidly-changing climate

Refer to the output initiative for a description of this initiative.

Management of Public Land and Forests

Mt Baw Baw Alpine Resort wastewater plant

The ageing wastewater plant and sewerage network will be replaced at the Mt Baw Baw Alpine Resort to reduce environmental impacts and ensure amenity at the site is maintained.

This initiative contributes to the Department of Environment, Land, Water and Planning's Management of Public Land and Forests output.

DEPARTMENT OF FAMILIES, FAIRNESS AND HOUSING

Output initiatives

Table 1.12: Output initiatives – Department of Families, Fairness and Housing ($ million)

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*
Child Protection and Family Services					
Early intervention and diversion	..	15.6	25.9	16.5	12.3
Maintaining the foundations of the children and families system	..	263.9	243.0	249.5	247.4
Putting Families First	..	5.3	6.2	6.3	..
Reforming care services	..	53.4	13.2	16.5	18.6
Community Participation					
Building better connected communities	..	1.8	0.4	0.4	0.4
Good Money	..	3.8	3.5	3.6	3.7
Public health and local place-based delivery	..	152.9	..	..	..
Responding to community-based healthcare demand	..	2.2	1.1	1.1	1.1
Disability Services					
Changing Places	..	2.5	..	..	..
Support for regulators and complaints handling bodies	..	12.4	11.0	..	..
Family Violence Service Delivery					
Central Information Point	..	12.9	..	..	..
Family Violence Graduate Program	..	0.5	0.7	..	..
Information sharing and family violence risk assessment and management reform	..	26.9	28.6	23.5	18.0
Intervening early to prevent family violence	..	1.2	1.2	..	..
Perpetrator accountability	..	12.8	1.7	1.8	1.8
Pets in refuges and crisis accommodation	..	0.6	0.2	0.2	0.2
Responses for children and young people impacted by family violence and sexual assault	..	14.1	9.7	10.0	10.3
Support for victim survivors of family violence and sexual assault	..	21.9	9.1	9.3	8.7
Housing Assistance					
Critical additional responses for people experiencing homelessness placed in hotels during the coronavirus (COVID-19) pandemic	19.5	11.5	(11.6)	(2.5)	..
Homelessness services	..	46.7	53.0	46.4	47.6
Paving the Way Forward: pathway to recovery at North Melbourne and Flemington housing estates	..	2.4	3.1	0.5	0.5
Tackling rough sleeping	..	5.9	8.1	10.2	2.0
LGBTIQ+ Equality Policy and Programs					
LGBTIQ+ Grants Program	..	1.0	..	..	..
Melbourne Pride 2021	..	1.0	..	..	..

	2020-21	2021-22	2022-23	2023-24	2024-25
Multicultural Affairs Policy and Programs					
Enhanced engagement approach with culturally and linguistically diverse (CALD) communities and complex families	23.8	..	..	..	..
Multicultural Festivals and Events Program	..	1.1	..	..	..
Multicultural seniors grants	..	2.0	2.0	2.0	2.0
Recovery together: jobs and stimulus initiatives for Victoria's multicultural communities	..	4.4	0.1	..	..
Supporting improved settlement outcomes	..	4.5	1.4	1.4	1.4
Tackling racism in Victoria head-on	..	0.6	0.6	0.3	..
Office for Disability					
Building inclusive and safe communities for Victorians with disability	..	8.1	0.3	0.4	0.4
Seniors Programs and Participation					
Elder abuse primary prevention, health service response and early intervention	..	1.0	..	..	..
Support to Veterans in Victoria					
Shrine of Remembrance	..	3.3	2.7	..	..
Supporting veterans	..	0.8	0.7	0.4	0.4
Women's Policy					
Improving outcomes for women in Victoria: strengthening Victoria's economic recovery through women's participation	..	2.1	2.1	..	..
Youth					
Engaging and supporting at-risk young people	..	9.2	9.2	..	..
Strengthening youth participation and connection	..	3.7	3.2	..	..
Total output initiatives [(a)]	**43.3**	**714.0**	**430.3**	**397.7**	**376.9**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Child Protection and Family Services

Early intervention and diversion

Further funding is provided for a range of early intervention programs to divert more families from involvement in the children and families system and statutory interventions. This includes a trial to embed family services in universal settings such as schools, early years services and community health hubs to provide more accessible services for vulnerable families.

Aboriginal Community Controlled Organisations will continue to receive funding to give 400 Aboriginal families each year access to Koorie Supported Playgroups and In-Home Parent Coaching to support the home learning environments of young Aboriginal children.

Funding is also provided to pilot a new employment program, Frontline Victoria, which will fast-track degree qualified career changers into a career in the children and families sector. This program provides participants with financial support to complete graduate-level qualifications and paid placements with child and family services providers to develop participants' practical skills.

Funding for this initiative is linked to the Early Intervention Investment Framework.

This initiative contributes to the Department of Families, Fairness and Housing's Child Protection and Family Services output.

Maintaining the foundations of the children and families system

Funding is provided to continue the expansion of the child protection workforce and increase out-of-home care placements for children who are unable to live safely with their families.

Funding is also provided for a range of initiatives to improve outcomes for vulnerable families and enhance the quality and safety of the children and families system, including:

- further funding to continue the transfer of case management of Aboriginal child protection and out-of-home care services to Aboriginal Community Controlled Organisations;
- Family Group Conferencing to divert vulnerable children and families from statutory services through a process led by family members to plan and make decisions for a child who is at risk of harm, abuse or neglect;
- additional funding for the settlement of civil claims for historical institutional child abuse and providing additional supports to Victorians in institutional care before 1990;
- continuation of Child FIRST services to connect vulnerable families to services that meet their needs;
- continuation of integrated healthcare in secure welfare services for children and young people while they are in secure care;
- continuation of enhanced cleaning and hygiene requirements in residential care and other settings to limit the spread of coronavirus (COVID-19); and
- continuation of assistance available to ensure the sustainability of community service organisations at risk of financial stress.

This initiative contributes to the Department of Families, Fairness and Housing's Child Protection and Family Services output.

Putting Families First

Funding is provided to implement trials in Brimbank-Melton and Goulburn of a new whole-of-family support model. Interdisciplinary teams led by a family practitioner will work with vulnerable families with multiple health, justice or human services needs to improve their safety, health and wellbeing, and divert them from long-term acute and tertiary service usage.

Funding for this initiative is linked to the Early Intervention Investment Framework.

This initiative contributes to the Department of Families, Fairness and Housing's Child Protection and Family Services output.

Reforming care services

Funding is provided for increased support to home-based carers and children and young people under their care. The package includes:

- an expansion of respite placements to kinship carers;
- an expansion of the training and support Carer KaFE program to permanent carers; and
- an expansion of the Better Futures and HomeStretch programs to assist eligible young people on permanent care orders to either remain in care until they turn 21 years of age or transition to independence.

Funding is also provided to continue the permanent carer helpline and the Keeping Connected Sibling and Placement Support and the Treatment Foster Care Oregon evidence-based models of care.

This initiative contributes to the Department of Families, Fairness and Housing's Child Protection and Family Services output.

Community Participation

Building better connected communities

Funding is provided to continue a hotline operated by the Australian Red Cross that provides emotional support to help people feeling disconnected or lonely to engage with their local communities.

The reimagined Seniors Festival will be continued, providing outreach to isolated older people in aged care facilities through online, video and radio-based entertainment.

The Justice Connect not-for-profit law program will continue to give free and low-cost access to legal information and support, helping volunteers and not-for-profit community organisations to understand the law and achieve good governance.

This initiative contributes to the Department of Families, Fairness and Housing's Community Participation output.

Good Money

Funding is provided for Good Money services to deliver safe and affordable financial services through four shop fronts in Collingwood, Geelong, Dandenong and Morwell. Good Money delivers no interest and low interest loans, low-cost insurance and financial advice to individuals and households facing financial stress.

The funding will also enable the development of telephone and digital services and a continuation of financial wellbeing services in bushfire affected communities.

This initiative contributes to the Department of Families, Fairness and Housing's Community Participation output.

Public health and local place-based delivery

Refer to the Department of Health for a description of this initiative.

Responding to community-based healthcare demand

Refer to the Department of Health for a description of this initiative.

Disability Services

Changing Places

Funding is provided to construct new fully accessible public toilet facilities across Victoria. This builds on previous investment in Changing Places facilities and enables people with disability and high support needs to participate in social, recreational, and cultural activities across Victoria.

This initiative contributes to the Department of Families, Fairness and Housing's Disability Services output.

Support for regulators and complaints handling bodies

Refer to Whole of Government – Mental Health and Wellbeing for a description of this initiative.

Family Violence Service Delivery

Central Information Point

Funding is provided to continue the operation of the statewide Central Information Point which provides information to family safety practitioners in The Orange Door support and safety hubs, allowing them to assess and manage the safety risks of family violence victim survivors.

This initiative contributes to the Department of Families, Fairness and Housing's Family Violence Service Delivery output.

Family Violence Graduate Program

Funding is provided to support up to 80 new graduates to receive training and other development support while working to become specialists in a range of family violence services.

This initiative contributes to the Department of Families, Fairness and Housing's Family Violence Service Delivery output.

Information sharing and family violence risk assessment and management reform

Funding is provided to enable departments and agencies to support Phase Two organisations to meet obligations prescribed under the legislated family violence Multi-Agency Risk Assessment and Management (MARAM) framework and Child and Family Violence Information Sharing Schemes. Support includes workforce training and change management guidance and tools to ensure that organisational policies and practices are consistent with both information sharing schemes and the MARAM framework.

This initiative contributes to the:

- Department of Families, Fairness and Housing's Family Violence Service Delivery output;
- Department of Education and Training's Early Childhood Education output;
- Department of Health's Acute Training and Development output;
- Department of Justice and Community Safety's Policing and Community Safety output; and
- Courts Services Victoria's Courts output.

Intervening early to prevent family violence

Funding is provided to support the development of tools and resources for addressing drivers of sexual violence in young people, and the delivery of youth-focused programs that promote healthy relationships and community understanding of family violence.

This initiative contributes to the Department of Families, Fairness and Housing's Family Violence Service Delivery output.

Perpetrator accountability

Funding is provided to enable family violence specialists to deliver perpetrator interventions and contribute to an increasing evidence base about what works to change behaviour and prevent violence. Funding will enable specialists to work with perpetrators and their families to deliver Men's Behaviour Change programs, and to extend perpetrator responses and accommodation support.

This initiative contributes to the Department of Families, Fairness and Housing's Family Violence Service Delivery output.

Pets in refuges and crisis accommodation

Funding is provided to support victim survivors in family violence situations ensuring the safety of and ongoing connection with their pets. This includes flexible brokerage for family violence refuges to access pet boarding, pet foster care, rehousing programs and fitting out accommodation for the needs of pets. Funding will also support family violence refuge and crisis accommodation providers to develop relationships with animal shelters and local animal welfare agencies.

This initiative contributes to the Department of Families, Fairness and Housing's Family Violence Service Delivery output.

Responses for children and young people impacted by family violence and sexual assault

Funding is provided to continue the statewide expansion of services to adolescents who use violence in the home, extend sexually abusive behaviour treatment services and provide sexual assault support services targeted to children and young people.

This initiative contributes to the Department of Families, Fairness and Housing's Family Violence Service Delivery output.

Support for victim survivors of family violence and sexual assault

Funding is provided to continue case management responses for victim survivors of family violence in emergency accommodation and for victim survivors of sexual assault, to extend family violence supports and services including sexual assault services, statewide 24/7 crisis services, flexible support packages, culturally safe responses for Aboriginal survivors, and case management and brokerage for women on temporary visas. Funding is also provided to build the capacity of the service system to respond to culturally and linguistically diverse communities and faith communities.

This initiative contributes to the Department of Families, Fairness and Housing's Family Violence Service Delivery output.

Housing Assistance

Critical additional responses for people experiencing homelessness placed in hotels during the coronavirus (COVID-19) pandemic

Funding is provided to meet the housing and support needs of people in emergency accommodation. This supports vulnerable Victorians to remain in hotels until their transition into longer-term housing arrangements. Funding is also provided for additional security at hotels.

This initiative contributes to the Department of Families, Fairness and Housing's Housing Assistance output.

Homelessness services

Funding is provided to continue programs that support people who are homeless and at risk of homelessness, including:

- the Private Rental Assistance Program, that provides support to more than 7 000 households annually in establishing or maintaining a private rental tenancy, including an additional outreach initiative and the expansion of the Aboriginal Private Rental Assistance Program;
- an expansion of housing pathways for people exiting prison, to provide support in the period between prison release and access to housing, to prevent them from becoming homeless;
- continuing to deliver assertive outreach and supportive housing teams for rough sleepers;
- on-site delivery of essential health and addiction services at three congregate crisis accommodation facilities, to help treat the underlying complex and diverse causes of people's homelessness, including alcohol and other drug treatment, mental health treatment and chronic health treatment;
- specialist leaving care and youth homelessness services, to support young people leaving care;
- the Kangan Education First Youth Foyer, which supports young people experiencing or at risk of homelessness by providing integrated accommodation and education-focused intervention for young people; and
- the H3 Alliance, to prevent and resolve homelessness in the rapidly expanding Wyndham growth corridor by increasing access to housing supply, providing outreach, transitional, legal and health support, building capacity and addressing issues that lead to housing vulnerability.

This initiative contributes to the Department of Families, Fairness and Housing's Housing Assistance output.

Paving the Way Forward: pathway to recovery at North Melbourne and Flemington housing estates

Funding is provided to continue and enhance community engagement activities undertaken during the coronavirus (COVID-19) shutdown of the North Melbourne and Flemington public housing towers. This initiative includes a new engagement approach and partnerships with residents, allowing them more input into the decisions that impact their homes, neighbourhoods and support services.

The program also responds to recommendations in the Victorian Ombudsman's *Investigation into the detention and treatment of public housing residents arising from a COVID-19 'hard lockdown' in 2020*.

This initiative contributes to the Department of Families, Fairness and Housing's Housing Assistance output.

Tackling rough sleeping

Funding is provided to the Journey to Social Inclusion program, delivered by Sacred Heart Mission, to provide intensive wrap-around support and services including head-leased properties to people facing long-term homelessness. The program also provides clients with support to sustain their housing, gain training and employment and establish stronger social connections.

Funding is also provided to establish a linked dataset to integrate data from departmental and agency systems, with a focus on rough sleeping, and to build a microsimulation model. Microsimulation modelling will help monitor and understand client outcomes and service demand, and improve understanding of risk factors to enable better targeting of early interventions. It will also assist in assessing the effectiveness of interventions and their translation to longer-term avoided costs across government.

Further development of the Community Services and Infrastructure Planning (CommSIP) tool and roll-out to other departments and agencies will support strategic, integrated service planning for rough sleepers engaging with government services.

Funding for this initiative is linked to the Early Intervention Investment Framework.

This initiative contributes to the Department of Families, Fairness and Housing's Housing Assistance output.

LGBTIQ+ Equality Policy and Programs

LGBTIQ+ Grants Program

Funding is provided to continue the LGBTIQ+ organisation grants program and the LGBTIQ+ Leadership Program. This initiative supports recovery for LGBTIQ+ community groups impacted during the coronavirus (COVID-19) pandemic and assists the development of leadership capability in individuals and organisations in the LGBTIQ+ community.

This initiative contributes to the Department of Families, Fairness and Housing's LGBTIQ+ Equality Policy and Programs output.

Melbourne Pride 2021

Funding is provided for Melbourne Pride 2021, a major one-off event to celebrate and support LGBTIQ+ communities. Melbourne Pride 2021 will mark the 40-year anniversary of the decriminalisation of homosexuality by the Victorian Parliament.

This initiative contributes to the Department of Families, Fairness and Housing's LGBTIQ+ Equality Policy and Programs output.

Multicultural Affairs Policy and Programs

Enhanced engagement approach with culturally and linguistically diverse (CALD) communities and complex families

Funding is provided to support the expansion of the prevention and preparedness work of the Culturally and Linguistically Diverse (CALD) Communities Taskforce. The Taskforce works in partnerships with community organisations, multicultural service providers, local government and the Victorian Multicultural Commission to develop community-specific, locally delivered solutions to help slow the spread of coronavirus (COVID-19) including through the promotion and adoption of COVIDSafe behaviours. This includes the provision of emergency relief, outreach supports, tailored health advice and innovative communications activities, including for CALD women and young people.

Local community organisations will be supported to deliver translated content to diverse communities and complex families about coronavirus (COVID-19). This funding will also support implementation of the Family Recovery Program, with a case worker engaging families for three to five months to help them negotiate recovery from the impacts of COVID-19.

This initiative contributes to the Department of Families, Fairness and Housing's:

- Multicultural Affairs Policy and Programs output; and
- Child Protection and Family Services output.

This initiative contributes to the Department of Health's Community Health Care output.

Multicultural Festivals and Events Program

Funding is provided to continue supporting multicultural festivals and events in Victoria. These festivals and events celebrate and promote multicultural diversity and foster social cohesion in the community.

This initiative contributes to the Department of Families, Fairness and Housing's Multicultural Affairs Policy and Programs output.

Multicultural seniors grants

Funding is provided to support multicultural seniors' groups in Victoria, with a focus on helping older Victorians to connect with the community through regular social outings, cultural events and activities and promoting health and wellbeing.

This initiative contributes to the Department of Families, Fairness and Housing's Multicultural Affairs Policy and Programs output.

Recovery together: jobs and stimulus initiatives for Victoria's multicultural communities

Funding is provided to develop a cross-government bicultural worker strategy aimed at recruiting and supporting bicultural workers to assist CALD communities to navigate government services.

Grants will also support multicultural communities to build, upgrade and renovate community infrastructure as they recover after the coronavirus (COVID-19) pandemic.

This initiative contributes to the Department of Families, Fairness and Housing's Multicultural Affairs Policy and Programs output.

Supporting improved settlement outcomes

Funding is provided to achieve improved settlement outcomes for Victoria's humanitarian cohorts and emerging migrant communities. These supports will build community capacity and extend legal support for asylum seekers and temporary visa holders, and continue case management support and information on employment protections for migrant communities across Victoria. Funding will also increase the capacity for Regional Community Hubs to improve services for new migrants, refugees and asylum seekers across Victoria.

This initiative contributes to the Department of Families, Fairness and Housing's Multicultural Affairs Policy and Programs output.

Tackling racism in Victoria head-on

Funding is provided to support the implementation of communication, community engagement and training initiatives to reduce vilification and hate-based conduct. These initiatives are part of the Government's response to the *Parliamentary Inquiry into Anti-Vilification Protections*.

This initiative contributes to the Department of Families, Fairness and Housing's Multicultural Affairs Policy and Programs output.

Office for Disability

Building inclusive and safe communities for Victorians with disability

Funding is provided for accessible emergency communications for people with disability during emergencies, and to increase their capacity to plan ahead of emergencies and support their resilience in recovery periods.

Disability Liaison Officers will also continue to provide support for people with disability, facilitate access to health services and increase inclusiveness. Further funding is also provided to the Victorian Disability Advocacy Program to continue promoting the rights and voices of people with disability.

This initiative contributes to the Department of Families, Fairness and Housing's Office for Disability output.

Seniors Programs and Participation

Elder abuse primary prevention, health service response and early intervention

Funding is provided to continue the Elder Abuse Prevention Networks, which raise awareness of elder abuse and deliver primary prevention activities, and help to meet obligations under the *National Plan to Respond to the Abuse of Older Australians (Elder Abuse) 2019-2023*.

Funding is also provided to continue the Integrated Model of Care in five health services. This model aims to strengthen elder abuse responses within public health services and community partners through workforce training, specialist clinical advice regarding older people and elder abuse, counselling and delivery of primary prevention activities through the Elder Abuse Prevention Networks.

This initiative contributes to the Department of Families, Fairness and Housing's Seniors Programs and Participation output.

Support to Veterans in Victoria

Shrine of Remembrance

Funding is provided to address critical safety and security issues at the Shrine of Remembrance, including upgrades and maintenance to stairs and lighting towers, and installation of security measures and ramps.

This initiative contributes to the Department of Families, Fairness and Housing's Support to Veterans in Victoria output.

Supporting veterans

Funding is provided to extend the Public Sector Veterans Employment Strategy to assist veterans transitioning to the civilian workforce and support veterans to find employment in the Victorian public sector.

Funding is also provided for the commemoration of major events and anniversaries and for an ex-service organisation summit on veterans' welfare in 2022.

This initiative contributes to the Department of Families, Fairness and Housing's Support to Veterans in Victoria output.

Women's Policy

Improving outcomes for women in Victoria: strengthening Victoria's economic recovery through women's participation

Funding is provided to establish a Gender Responsive Budgeting Unit within the Department of Treasury and Finance, working closely with the Office for Women, to ensure outcomes for women are measured and considered as part of budget decision-making processes, embedding gender impact analysis and understanding in the allocation of resources. This initiative supports implementation of the *Gender Equality Act 2020*.

Funding is also provided to deliver targeted economic security programs to support migrant and refugee women into employment. This funding enables community organisations to respond to the specific needs of women at different stages of their employment pathway, providing support, advice and mentoring to build the necessary confidence and skills to pursue employment, establish a small business or access further education.

This initiative contributes to the Department of Families, Fairness and Housing's Women's Policy output.

This initiative contributes to the Department of Treasury and Finance's Budget and Financial Advice output.

Youth

Engaging and supporting at-risk young people

Funding is provided to continue initiatives that support young Victorians at risk of disengagement from the community. These community-led initiatives provide vulnerable young people from African and Pasifika backgrounds with culturally-specific early interventions and increased education and employment opportunities. These initiatives will also support improved community safety outcomes by building protective factors that prevent young people being drawn to various forms of anti-social behaviour.

Funding for this initiative is linked to the Early Intervention Investment Framework.

This initiative contributes to the Department of Families, Fairness and Housing's Youth output.

Strengthening youth participation and connection

Funding is provided to continue initiatives that support young people at risk of disengagement. This includes continuing the Latrobe Youth Space projects and services, the Regional Presence Project across four rural offices, the Marram Nganyin Aboriginal Youth Mentoring Program with Aboriginal organisations, and supporting young people from disadvantaged and culturally diverse communities to participate in Scouts and Girl Guides.

This initiative contributes to the Department of Families, Fairness and Housing's Youth output.

Asset initiatives

Table 1.13: Asset initiatives – Department of Families, Fairness and Housing ($ million)

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*	*TEI*
Child Protection and Family Services						
Maintaining the foundations of the children and families system	..	1.5	1.5	1.6	..	4.6
Total asset initiatives	**..**	**1.5**	**1.5**	**1.6**	**..**	**4.6**

Source: Department of Treasury and Finance

Child Protection and Family Services

Maintaining the foundations of the children and families system

Refer to the output initiative for a description of this initiative.

DEPARTMENT OF HEALTH

Output initiatives

Table 1.14: Output initiatives – Department of Health ($ million)

	2020-21	2021-22	2022-23	2023-24	2024-25
Acute Health Services					
100 000 lives	..	9.6	10.6	13.5	11.9
Boosting our healthcare workforce [(a)]	..	7.9	5.3	..	..
Driving shorter wait lists and better outcomes from elective surgery	..	10.6	10.6	0.2	0.1
Enabling a high-quality, efficient public pathology system	19.3	9.8	10.4	12.4	13.9
Expanding adult emergency departments	..	2.9	2.9	..	..
Health services cybersecurity	..	19.0	..	..	..
Healthshare [(a)]	0.7	35.3	40.2	41.6	32.9
Meeting demand for hospital services [(a)(c)]	..	1 401.9	742.5	761.0	780.1
Mildura Base Hospital planning [(b)]	..	0.8	1.3	..	..
Modernising Victoria's health system through governance reform	..	9.1	7.2	8.8	9.3
Public fertility care services for Victoria [(a)]	..	11.2	19.4	19.5	..
Ageing, Aged and Home Care					
Future provision of public sector residential aged care	..	28.8	..	..	..
Ambulance Services					
Ambulance demand	..	188.5	25.3	25.9	26.6
Ambulance Victoria sustainability	..	53.7	48.3	50.7	51.6
Drug Treatment and Rehabilitation					
Decriminalising public drunkenness	0.9	9.5	..	..	..
Medically supervised injecting rooms	..	18.7	21.4	..	..
Mental Health					
Victorian Fixated Threat Assessment Centre [(a)]	..	17.0	17.4	17.9	18.3
Primary, Community and Dental Health					
Enhanced engagement approach with culturally and linguistically diverse (CALD) communities and complex families	2.0	..	..	..	..
Responding to community-based healthcare demand [(a)]	..	76.1	12.8	1.0	1.1
Sunbury and Cobaw Community Health Hub expansion	..	3.0	..	..	..
Support for asylum seekers	..	3.9	..	..	..
Public Health					
Immunising Victorians against COVID-19: Phase 1A and Phase 1B vaccine rollout [(c)]	328.9	..	..	..	..
Public health and local place-based delivery [(c)]	..	800.7	8.7	8.5	4.7
Total output initiatives [(d)]	**351.8**	**2 716.9**	**982.8**	**961.1**	**950.3**

Source: Department of Treasury and Finance

Notes:

(a) These initiatives contribute to activity that attracts Commonwealth funding under the National Health Reform Agreement. Estimates of the Commonwealth's contribution are included.

(b) This project is funded from the Regional Health Infrastructure Fund and is not included in the total output initiatives figures.

(c) These initiatives contribute to activity that attracts Commonwealth funding under the National Partnership on COVID-19 Response. Estimates of the Commonwealth's contribution are included.

(d) Table may not add due to rounding.

Acute Health Services

100 000 lives

Funding is provided to improve the health and life outcomes of 100 000 Victorians over five years by delivering a program of large scale improvement initiatives which work to reduce preventable hospital admissions, reduce unintended harm, and limit unnecessary medical interventions within Victoria's health system.

Funding for this initiative is linked to the Early Intervention Investment Framework.

This initiative contributes to the Department of Health's Admitted Services output.

Boosting our healthcare workforce

Funding is provided to expand Victoria's healthcare workforce pipeline following significant disruption during the coronavirus (COVID-19) pandemic. This includes the delivery of 200 000 additional student placement days in the public health system and supporting clinicians to undertake training to build their professional skills and competence in student education and supervision.

This initiative contributes to the Department of Health's Acute Training and Development output.

Driving shorter wait lists and better outcomes from elective surgery

Funding is provided to improve elective surgery access and outcomes, reduce elective surgery waiting lists by accelerating the uptake of more efficient same day surgical models and rapidly reassessing patients on wait lists, and piloting the expansion of alternative care pathways for suitable patients. This funding will complement the existing elective surgery wait list blitz and encourage efficient use of existing surgical capacity in health services.

Funding for this initiative is linked to the Early Intervention Investment Framework.

This initiative contributes to the Department of Health's Admitted Services output.

Enabling a high-quality, efficient public pathology system

Victoria's coronavirus (COVID-19) testing capacity will be expanded through the purchase and installation of additional pathology equipment and extra staff in public pathology laboratories. Funding is also provided to consolidate existing public pathology laboratories into networks supported by new laboratory information systems. This will enable greater coordination and efficiency of pathology testing across Victoria, building on the reforms which supported COVID-19 testing.

This initiative contributes to the Department of Health's Admitted Services output.

Expanding adult emergency departments

Funding is provided for service and capital planning to determine the future requirements of adult emergency departments at Maroondah Hospital, Casey Hospital, Northern Hospital, Werribee Mercy Hospital and Austin Hospital.

This initiative contributes to the Department of Health's Admitted Services output.

Health services cybersecurity

Funding is provided to strengthen cyber security measures for Victorian public health services and Ambulance Victoria. This includes support for next generation anti-virus protections, a Security Operations Centre, and a recovery service in the event of a successful cyber attack.

This initiative contributes to the Department of Health's Admitted Services output.

Healthshare

Funding is provided to establish shared procurement structures and supply chains to support Victorian health services. Consolidation of these functions will achieve efficiencies in procurement, reduce unnecessary variation across health services, and allow greater coordination of the State's medical stocks.

This initiative contributes to the Department of Health's Admitted Services output.

Meeting demand for hospital services

Funding is provided to support service delivery levels and performance in Victoria's hospitals, including additional funding for elective surgery, more emergency department staff, additional highly-specialised therapies, and to support new wards as they open.

This initiative contributes to the Department of Health's:

- Admitted Services output;
- Emergency Services output;
- Non-Admitted Services output; and
- Small Rural Services – Acute Health output.

Mildura Base Hospital planning

Funding is provided to undertake service and capital planning to finalise the masterplan and business case for a future redevelopment of the Mildura Base Hospital.

This initiative contributes to the Department of Health's Admitted Services output.

Modernising Victoria's health system through governance reform

Health services will be supported to formalise new shared governance arrangements that commenced as part of Victoria's coronavirus (COVID-19) pandemic response. These changes will continue to support the efficient coordination and collaboration of public and acute health services in response to the pandemic and help deliver better outcomes and more equitable access across Victoria.

This initiative contributes to the Department of Health's Admitted Services output.

Public fertility care services for Victoria

Funding is provided to deliver public fertility care services, implementing the Government's commitment to assist more people to become parents through in vitro fertilisation. This includes providing up to 2 700 treatment cycles annually and a range of other fertility care services. Funding will also be provided for the first public sperm and egg bank in Australia, to ensure Victorians have access to donor sperm and eggs within the public system.

This initiative contributes to the Department of Health's Admitted Services output.

Ageing, Aged and Home Care

Future provision of public sector residential aged care

Additional funding is provided to public sector residential aged care services to continue to provide high-quality care to vulnerable aged persons, including those with mental health issues, and assist in meeting nurse to patient ratios in public sector residential aged care.

This initiative contributes to the Department of Health's Residential Aged Care output.

Ambulance Services

Ambulance demand

Additional funding is provided to respond to growing demand for ambulance services across Victoria and to respond to changing demand patterns following the coronavirus (COVID-19) pandemic. Funding is also provided to plan for the next tranche of ambulance station builds, including in regional growth areas such as Armstrong Creek and Marong.

This initiative contributes to the Department of Health's:

- Ambulance Emergency Services output; and
- Ambulance Non-Emergency Services output.

Ambulance Victoria sustainability

Funding is provided to boost Ambulance Victoria's operational resources, including new funding for 117 paramedics in addition to paramedics and support staff to be recruited as part of the Ambulance Demand initiative, and trialling a telehealth pilot to support patients with complex needs.

This initiative contributes to the Department of Health's:

- Ambulance Emergency Services output; and
- Ambulance Non-Emergency Services output.

Drug Treatment and Rehabilitation

Decriminalising public drunkenness

Funding is provided to establish the foundations for a health-based response to public drunkenness, implementing the Government's commitment to decriminalise public drunkenness. This includes funding for trial sites, including health outreach teams, transport and sobering up services. Funding is also provided for Aboriginal cultural safety initiatives.

This initiative contributes to the Department of Health's Drug Treatment and Rehabilitation output.

This initiative contributes to the Department of Justice and Community Safety's Justice Policy, Services and Law Reform output.

Medically supervised injecting rooms

Funding is provided to support the continued implementation of responses to the review of the supervised injecting room trial, including operating funding for a further two years of service of the supervised injecting room located in North Richmond and funding to establish a second supervised injecting room in the City of Melbourne.

This initiative contributes to the Department of Health's Drug Treatment and Rehabilitation output.

Mental Health

Victorian Fixated Threat Assessment Centre

Funding is provided for the Victorian Fixated Threat Assessment Centre to continue delivering coordinated responses, through co-located police and mental health clinicians, to serious threats of violence posed by people with complex needs.

This initiative contributes to the Department of Health's Clinical Care output.

This initiative contributes to the Department of Justice and Community Safety's Policing and Community Safety output.

Primary, Community and Dental Health

Enhanced engagement approach with culturally and linguistically diverse (CALD) communities and complex families

Refer to the Department of Families, Fairness and Housing for a description of this initiative.

Responding to community-based healthcare demand

Funding is provided to address the impacts of the coronavirus (COVID-19) pandemic on community-based health care. This includes catch-up care for dental services, cancer services and maternal and child health services to ensure clients who were unable to engage over the past 12 months receive the care they need. A proportion of these funds will be allocated to support catch-up care for Aboriginal Victorians. Increases in demand for alcohol and other drugs (AOD) programs will be met by three new residential AOD treatment facilities, additional community-based counselling services and expanded forensic services.

Funding is also provided to 12 women's health services across Victoria to meet growing demand for gender responsive healthcare, including prevention of family violence support services, women's mental health and sexual and reproductive health services.

This initiative will also establish three new women's sexual and reproductive health hubs, and expand the operating hours and scope of services at existing hubs.

Funding is also provided to continue the Pathways program, which provides case management services to sex workers.

This initiative contributes to the Department of Health's:

- Admitted Services output;
- Dental Services output;
- Drug Treatment and Rehabilitation output; and
- Maternal and Child Health and Early Parenting Services output.

This initiative contributes to the Department of Families, Fairness and Housing's:

- Community Participation output; and
- Women's Policy output.

Sunbury and Cobaw Community Health Hub expansion

Funding is provided to expand the community facilities and services at the Sunbury and Cobaw Community Health Hub which provides a range of health, wellbeing and community services for the local area.

This initiative contributes to the Department of Health's Community Health Care output.

Support for asylum seekers

Funding is provided to continue provision of critical mental health supports to people seeking asylum who are ineligible for Medicare and income support, including nurse and GP care, mental health support, basic needs assistance including for food, medication and utilities, homelessness assistance and case coordination.

This initiative contributes to the Department of Health's Health Protection output.

Public Health

Immunising Victorians against COVID-19: Phase 1A and Phase 1B vaccine rollout

Funding is provided to deliver vaccines to Victorians as part of the national coronavirus (COVID-19) vaccination program by establishing and equipping a range of vaccine hubs across the state, training immunisers, and providing booking pathways. Funding is also provided to develop necessary data and information technology systems, engage with the community about the availability and benefits of vaccination, and to safeguard patient safety.

This initiative contributes to the Department of Health's Health Protection output.

Public health and local place-based delivery

Funding is provided to continue the core public health response to the coronavirus (COVID-19) pandemic, investing in capacity to respond to and manage any further spread and support continued easing of public health restrictions in Victoria. This will include continued operation of local public health units, wastewater surveillance and pathology capacity to prevent and protect communities from COVID-19.

Funding is provided to continue critical COVID-19 prevention activities, health promotion and specialised response capability to support Victorians living in public housing, disability accommodation and other high-risk accommodation settings with shared facilities.

This initiative contributes to the Department of Health's:

- Community Health Care output; and
- Health Protection output.

This initiative contributes to the Department of Families, Fairness and Housing's:

- Child Protection and Family Services output;
- Community Participation output;
- Concessions to pensioners and other beneficiaries output;
- Disability Services output; and
- Housing Assistance output.

Asset initiatives

Table 1.15: Asset initiatives – Department of Health **($ million)**

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*	*TEI*
Acute Health Services						
Austin Hospital Central Sterile Services Department	..	7.8	..	..	..	7.8
Building a world-class hospital in Maryborough [(a)]	..	0.5	10.0	41.4	40.9	94.8
Building emergency departments kids and families can count on [(b)]	..	10.8	15.9	66.6	6.3	99.7
Clinical technology refresh	..	18.0	..	..	..	18.0
Delivering more hospital beds for Melbourne's East (Angliss Hospital Expansion Stage 2) [(c)]	..	3.2	7.8	42.4	45.5	98.9
Echuca Wellness Centre	1.2	6.3	0.8	..	..	8.3
Enabling a high-quality, efficient public pathology system	10.5	18.5	38.4	29.7	19.4	116.5
Engineering infrastructure replacement program	..	50.0	..	..	..	50.0
Medical equipment replacement program	..	35.0	..	..	..	35.0
Meeting demand for hospital services [(d)]	..	15.0	..	..	..	15.0
Public fertility care services for Victoria	..	20.0	..	..	..	20.0
Regional Health Infrastructure Fund [(e)]	..	20.0	..	..	..	20.0
Swan Hill District Hospital Emergency Department Upgrade	0.2	2.0	10.0	31.0	5.5	48.7
Ten new community hospitals to give patients the best care [(f)]	..	29.3	277.1	247.7	1.4	555.5
Ageing, Aged and Home Care						
Rural and Regional Public Sector Residential Aged Care Services Revitalisation Strategy Stage 1 [(g)]	..	9.2	3.8	25.5	23.9	65.0
Drug Treatment and Rehabilitation						
Alcohol and other drugs residential rehabilitation treatment expansion	..	0.3	6.0	3.2	..	9.4
Total asset initiatives [(h)]	**11.9**	**230.8**	**369.9**	**487.5**	**143.0**	**1 247.7**

Source: Department of Treasury and Finance

Notes:

(a) The TEI of this initiative is $100 million inclusive of funding provided in previous budgets and includes funding beyond 2024-25.

(b) The TEI of this initiative is $102 million inclusive of funding provided in previous budgets. It includes $40 million funding from the Commonwealth Government and $3.2 million in previous output funding.

(c) The TEI of this initiative is $103 million inclusive of funding provided in previous budgets.

(d) This project is funded from the Regional Health Infrastructure Fund and is not included in the total asset initiatives figures.

(e) This initiative includes planning for the future redevelopment of Mildura Base Hospital and minor capital works to meet demand for hospital services.

(f) The TEI of this initiative is $675 million inclusive of funding provided in previous budgets.

(g) The TEI includes funding beyond 2024-25.

(h) Table may not add due to rounding.

Acute Health Services

Austin Hospital Central Sterile Services Department

Funding is provided to expand capacity of the Central Sterile Services Department at the Austin Hospital by installing four new batch washers and one trolley washer with related infrastructure works. This will increase the performance and capacity for reprocessing surgical instruments to meet surgical demand.

This initiative contributes to the Department of Health's Admitted Services output.

Building a world-class hospital in Maryborough

Funding is provided to construct a new two-level building that will improve patient services, amenity and accessibility with early works to commence in 2022. The new building will include a range of services including day surgery, birthing suites, medical imaging, pathology, ambulatory services and urgent care.

This initiative delivers on the Government's election commitment as published in *Labor's Financial Statement 2018*.

This initiative contributes to the Department of Health's Admitted Services output.

Building emergency departments kids and families can count on

Funding is provided to construct dedicated children's emergency departments at Northern Hospital, Frankston Hospital, Casey Hospital, Maroondah Hospital and University Hospital Geelong. The projects will reconfigure or expand emergency departments to ensure children receive care in a dedicated and appropriate environment.

This initiative delivers on the Government's election commitment as published in *Labor's Financial Statement 2018*.

This initiative contributes to the Department of Health's Admitted Services output.

Clinical technology refresh

Funding is provided to upgrade the network infrastructure needed to support and deliver patient-related services such as pathology, diagnostic imaging and patient management systems. This will improve delivery of information related to patient diagnostics and other clinical services and enhance cybersecurity.

This initiative contributes to the Department of Health's Admitted Services output.

Delivering more hospital beds for Melbourne's East (Angliss Hospital Expansion Stage 2)

Funding is provided to deliver an expansion of the Angliss Hospital including a new in-patient unit.

This initiative delivers on the Government's election commitment as published in *Labor's Financial Statement 2018*.

This initiative contributes to the Department of Health's Admitted Services output.

Echuca Wellness Centre

Funding is provided to build a new purpose-built cancer and wellness centre in Echuca to improve the access, comfort and amenities for patients and provide a more efficient working environment for staff.

This initiative contributes to the Department of Health's Admitted Services output.

Enabling a high-quality, efficient public pathology system

Refer to the output initiative for a description of this initiative.

Engineering infrastructure replacement program

Critical engineering infrastructure will be upgraded and replaced in selected metropolitan, rural and regional hospitals. This covers a range of infrastructure items and can include emergency generators, cooling towers, nurse call systems, electrical or mechanical switchboards and patient lifts to enable continuity of health service delivery and compliance with regulatory requirements.

This initiative contributes to the Department of Health's Admitted Services output.

Medical equipment replacement program

Critical medical equipment in metropolitan, rural and regional health services will continue to be replaced. The equipment supports operating suites, emergency departments, surgical wards, intensive care units, neonatal and maternity services, and specialist areas. This will reduce risks for patients and staff and improve service availability through the introduction of newer, more advanced medical equipment.

This initiative contributes to the Department of Health's Admitted Services output.

Meeting demand for hospital services

Refer to the output initiative for a description of this initiative.

Public fertility care services for Victoria

Refer to the output initiative for a description of this initiative.

Regional Health Infrastructure Fund

A funding boost is provided to the Regional Health Infrastructure Fund to improve the quality and amenity of infrastructure across a range of rural and regional health services. This funding will allow health services to respond to local priorities and maintain and enhance their service delivery capacity.

This initiative contributes to the Department of Health's Admitted Services output.

Swan Hill District Hospital Emergency Department Upgrade

Funding is provided to construct a new Emergency Department including medical imaging at Swan Hill District Hospital to replace the current outdated emergency department. This will increase the capacity and provide contemporary facilities to meet the current and future demand for emergency services in the local community. The initiative includes a $30 million funding contribution from the Commonwealth Government.

This initiative contributes to the Department of Health's Admitted Services output.

Ten new community hospitals to give patients the best care

Funding is provided to construct and expand 10 community hospitals in Craigieburn, Cranbourne, Pakenham, Phillip Island, Sunbury, Torquay, Mernda, Eltham, Point Cook and the inner south of Melbourne. This investment will increase capacity and ensure patient access to high-quality health care services in key growth areas. Construction of the Cranbourne community hospital will start in 2021. Previous funding was provided for land acquisition and design works.

This initiative delivers on the Government's election commitment as published in *Labor's Financial Statement 2018*.

This initiative contributes to the Department of Health's Admitted Services output.

Ageing, Aged and Home Care

Rural and Regional Public Sector Residential Aged Care Services Revitalisation Strategy Stage 1

Funding is provided to rebuild the Glenview Community Care aged care facility in Rutherglen to deliver 50 beds and expanded capacity.

The development will enable improved models of care and will ensure the community has access to safe and high-quality public sector aged care services.

Funding is also provided to undertake detailed planning and design work for the future redevelopment of the Camperdown and Cohuna public sector aged care facilities.

This initiative contributes to the Department of Health's:

- Residential Aged Care output; and
- Clinical Care output.

Drug Treatment and Rehabilitation

Alcohol and other drugs residential rehabilitation treatment expansion

Funding is provided to deliver an additional 10 beds and refurbish support areas at Westside Lodge in Sunshine to provide dual diagnosis and integrated treatment for both mental health and alcohol and other drug clients. This investment will enhance capacity, reduce wait times and improve treatment outcomes.

This initiative contributes to the Department of Health's:

- Drug Treatment and Rehabilitation output; and
- Mental Health Community Support Services output.

DEPARTMENT OF JOBS, PRECINCTS AND REGIONS

Output initiatives

Table 1.16: Output initiatives – Department of Jobs, Precincts and Regions ($ million)

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*
Agriculture					
Accelerating Victoria's agriculture sector response to a changing climate	..	4.9	4.6	4.8	5.7
Animal welfare support	..	1.1	..	..	..
Implementation of the Victorian Forestry Plan	12.0	12.0	..	..	..
Rural Financial Counselling Service	..	1.9	1.9	2.0	..
Support for seasonal agriculture workforce	19.3	..	..	..	..
Transforming traceability	..	3.5	4.1	4.0	..
Victoria's Fruit Fly Strategy	..	1.9	1.7	1.5	1.3
Victorian Rural Women's Network	..	0.3	0.4	0.4	0.3
Business Precincts					
Digital Infrastructure Upgrade: Cremorne	..	1.0	..	..	..
Creative Industries					
Creative State: Creative Neighbourhoods program	..	2.2	1.5	0.4	0.4
Creative State: Cultural and creative organisations support and recovery	5.7	68.6	2.3	2.3	0.2
Creative State: Extending Music Works	..	3.6	3.6	2.6	1.1
Creative State: Increasing audiences and markets	..	0.8	1.5	0.1	0.1
Creative State: Multi-year investment framework for creative industries	..	6.0	6.0	6.0	6.0
Creative State: Regional and outer suburban touring program	..	1.3	1.3	1.0	1.0
Creative State: Revitalising our cultural institutions	..	8.0	8.3	..	..
Creative State: Screen industry strategy 2021-2025	..	24.3	30.1	31.1	35.1
Creative State: Stimulating new and innovative creative products	..	1.3	2.0	1.0	0.3
Creative State: Supporting First Nations, young and diverse talent, festivals and careers	..	1.3	1.0	1.0	0.7
Industry, Innovation, Medical Research and Small Business					
Circuit Breaker Action Business Support Package	147.0	..	..	..	..
Defence Capture Plan	..	2.7	2.7	..	..
Free Wi-Fi in Ballarat and Bendigo central business districts	..	3.6	..	..	..
Medical Research: Generation Victoria and Living Evidence	..	8.5	8.5	0.8	0.3
Melbourne central business district economic package	7.4	50.0	50.0	..	..
Securing and scaling mRNA vaccine manufacturing capability in Victoria: Stage one	..	30.0	20.0	..	..
Small business services and support	..	2.6	1.8	..	..
Supporting industries: COVID Coordination and Recovery	7.5	23.6	..	..	..

	2020-21	2021-22	2022-23	2023-24	2024-25
Jobs					
Getting Victorians Back to Work: Our Plan to minimise the risk and costs of greater inequality	..	7.6	6.7	3.7	3.7
Maximising local jobs and local content	..	11.4	11.2	9.0	9.0
Test Isolation Payments	55.2	..	..	..	..
Local Government and Suburban Development					
Emergency management sector reform: implementation of reviews and inquiries	2.5	0.3	..	..	..
Growing Suburbs Fund	..	50.0	..	..	..
Leadership for women in local government	..	0.6	0.5	0.4	0.3
Public Libraries Funding Program	..	2.7	2.2	2.2	2.2
Roadside Weeds and Pests Program	..	3.0	2.9	2.9	2.9
Rural Roads Support Package	..	0.7	0.7	..	..
Suburban recovery and revitalisation	..	0.5	0.5	..	..
Regional Development					
Addressing opportunities in place: A Thriving Central Goldfields Shire	..	1.0	..	..	..
Addressing opportunities in place: Latrobe Valley transition and transformation	..	10.0	..	..	..
Addressing opportunities in place: Portland Economic Diversification Plan	..	6.2	8.1	2.5	0.7
Ready to grow: supporting regional population growth	..	2.5	2.5	..	..
Seymour revitalisation	..	0.2	1.2	0.2	..
Strengthening Regional and Metropolitan Partnerships	..	8.0	8.0	..	..
Resources					
Resources for Recovery: Securing the Resources for Victoria's economic recovery	..	14.2	14.3	3.6	3.6
Sport, Recreation and Racing					
Backing Victoria's Racing Industry: Increase to VRI POCT payment	..	47.6	48.3	49.5	50.8
Building inclusive sport and recreation communities	..	1.0	1.0	1.0	1.0
Celebrating female sporting icons	..	0.3	..	..	..
Change our Game: Office for Women in Sport and Recreation	..	3.0	2.9	2.9	2.9
Harness Racing Victoria transformation program	..	4.1	..	..	..
Investing in local sports infrastructure	..	55.0	..	..	..
La Trobe University Sports Park	..	45.2	54.4	1.5	..
Sporting Trusts Support	..	48.3	..	..	..
Victorian Institute of Sport	..	8.2	8.2	8.2	..
Tourism and Major Events					
Business Events Program	..	10.2	10.9	10.9	10.9
Emerald Tourist Railway	..	11.2	..	..	..
Regional Travel Voucher Scheme expansion	6.0	..	..	..	..
Visitor Economy: destination marketing	..	27.5	27.5	..	..
Visitor Economy Partnerships	..	2.2	2.2	2.2	2.2

	2020-21	2021-22	2022-23	2023-24	2024-25
Trade and Global Engagement					
International education recovery and growth	..	12.4	12.8	12.8	12.9
Trade facilitation	..	5.0	..	..	..
Victorian Government Trade and Investment Network	..	1.8	0.8	0.8	0.8
Total output initiatives [(a)]	**262.6**	**666.6**	**380.8**	**173.3**	**156.1**
Base and efficiency review [(b)]	(116.0)	(33.0)	(58.2)	(68.1)	(68.7)

Source: Department of Treasury and Finance

Notes:
(a) Table may not add due to rounding.
(b) These savings acquit whole of government efficiencies announced in the 2019-20 Budget.

Agriculture

Accelerating Victoria's agriculture sector response to a changing climate

Funding is provided to deliver the Government's commitment to position Victoria as a leader in low-emissions agriculture, including through accelerating research in emissions reducing technologies, delivering on-farm action plans to measure and reduce emissions, updating the Victorian Land Use Information System and developing an Agricultural Climate Spatial Tool.

The Victorian Agriculture and Climate Change Statement will also be developed, which will be co-designed with industry and regional leaders and create a shared long-term vision about the role about the role of Victoria's agriculture sector in a net zero emissions economy.

This initiative contributes to the Department of Jobs, Precincts and Regions' Agriculture output.

Animal welfare support

Funding is provided for the following projects supporting animal welfare:

- enhanced infrastructure at Edgar's Mission Farm Sanctuary;
- feed and equipment at McIntyre Wildlife Shelter;
- feed, shelters, fencing, training and other items for Winged Horse Equine Welfare;
- treatment equipment for Horse Shepherd Equine Sanctuary;
- medical equipment and veterinary costs for Lamb Care Australia; and
- a virtual fence trial run by Surf Coast Wildlife Rescue.

This initiative contributes to the Department of Jobs, Precincts and Regions' Agriculture output.

Implementation of the Victorian Forestry Plan

Funding is provided for VicForests to deliver a range of forest management services to support implementation of the Victorian Forestry Plan. These activities include Leadbeater possum protection, bushfire management support, road maintenance and the provision of forest data services.

This initiative contributes to the Department of Jobs, Precincts and Regions' Agriculture output.

Rural Financial Counselling Service

Funding is provided for the State's contribution to the Rural Financial Counselling Service so it can continue to offer free and impartial advice to farming and related small businesses suffering financial hardship.

This initiative contributes to the Department of Jobs, Precincts and Regions' Agriculture output.

Support for seasonal agriculture workforce

Funding is provided for a response to the seasonal harvest workforce shortage to attract seasonal workers and ensure farmers have the workers they need. Support includes the seasonal harvest sign-on bonus for jobseekers who take up a harvest job; a co-contribution to quarantine costs for workers under the Commonwealth Government's Pacific mobility schemes; and Seasonal Workforce Industry Support grants.

This initiative contributes to the Department of Jobs, Precincts and Regions' Agriculture output.

Transforming traceability

Agricultural traceability systems will be strengthened to enhance Victoria's reputation for high-quality food and fibre products, driving growth in both local and export market access. This will be achieved by implementing a traceability and product integrity action plan which will provide increased information on traceability systems and improve biosecurity risk management. New traceability technologies will be trialled, building on successful Agriculture Victoria technology trials, and marketing campaigns will be developed to promote Victoria's paddock to plate journey.

This initiative contributes to the Department of Jobs, Precincts and Regions' Agriculture output.

Victoria's Fruit Fly Strategy

Funding is provided for Victoria's Fruit Fly Strategy, which will focus on preparedness and prevention activities, strengthening shared responsibility in the management of the Queensland Fruit Fly. The Strategy will protect jobs tied to strong regional industry and food export growth.

This initiative contributes to the Department of Jobs, Precincts and Regions' Agriculture output.

Victorian Rural Women's Network

Funding is provided to continue the Victorian Rural Women's Network. This program will deliver upskilling, leadership and capability building opportunities, thereby supporting the economic participation and resilience of rural women in Victoria.

Business Precincts

Digital Infrastructure Upgrade: Cremorne

Funding is provided for digital infrastructure upgrades in Cremorne. This will support implementation of the Cremorne Place Implementation Plan and enable innovation and business productivity improvements.

This initiative contributes to the Department of Jobs, Precincts and Regions' Business Precincts output.

Creative Industries

Creative State: Creative Neighbourhoods program

Funding is provided for established and emerging creative neighbourhoods, promoting affordable creative spaces for artists, greater security for creative enterprises and stimulating the growth of local creative industries in metro, regional and outer-urban areas.

Funding for Emporium Creative Hub will expand creative opportunities and experiences for the Bendigo region and its people. Funding for the Brunswick Design District will support development, investment and activation for creative enterprises in the heart of Brunswick.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Access, Development and Innovation output.

Creative State: Cultural and creative organisations support and recovery

Funding is provided to strengthen and support Victoria's cultural and creative agencies impacted by the coronavirus (COVID-19) pandemic. Funding will help keep agencies, performing arts organisations and other cultural institutions such as the Abbotsford Convent open and active, retain their workforces, ensure their immediate solvency and enhance business recovery through to the end of 2021-22.

The Tech Connect program will fund training hubs to build technical capacity, safety and capability in Victoria's regional performing arts centres. Funding is also provided to deliver the Access All Stages program, enabling Arts Centre Melbourne to subsidise venue hire and labour fees to its resident companies (including Melbourne Theatre Company, Melbourne Symphony Orchestra, Opera Australia, Victorian Opera and the Australian Ballet) throughout 2021 and 2022.

Funding is also provided to enhance the visitor experience and operations as work continues on the final stage of the Geelong Arts Centre redevelopment.

This initiative contributes to the Department of Jobs, Precincts and Regions':

- Creative Industries Portfolio Agencies output; and
- Creative Industries Access, Development and Innovation output.

Creative State: Extending Music Works

Funding is provided to extend the Music Works package, which will support musicians, managers, technicians, venues, peak bodies and small to medium industry businesses and organisations to accelerate the recovery and growth of Victoria's contemporary music scene. Funding also builds on the strategic partnership with the Victorian Music Development Office and Music Victoria.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Access, Development and Innovation output.

Creative State: Increasing audiences and markets

Funding is provided to develop audiences and international markets for Victorian creatives through support for flagship events such as Melbourne International Games Week, a new Victorian First Peoples Art and Design Fair and Victoria's role within the Creative Cities Network.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Access, Development and Innovation output.

Creative State: Multi-year investment framework for creative industries

Funding is provided to deliver a sustainable multi-year investment funding framework for non-government creative organisations, generating jobs and opportunities for creative workers. This funding will invest in a broad range of organisations across Victoria contributing to a vibrant creative state, as well as attracting audiences and developing markets through cultural tourism.

This initiative contributes to the Department of Jobs Precincts and Regions' Creative Industries Access, Development and Innovation output.

Creative State: Regional and outer suburban touring program

Funding is provided for content development through to on the road touring and presentations, showcasing the creative talents of regional and outer suburban communities, encouraging cultural tourism and providing equitable access to creative experiences and services.

This initiative contributes to the Department of Jobs Precincts and Regions' Creative Industries Access, Development and Innovation output.

Creative State: Revitalising our cultural institutions

Refer to the asset initiative for a description of this initiative.

Creative State: Screen industry strategy 2021-2025

Funding is provided to help transform Victoria's screen industry by growing jobs and economic activity, building skills and talent, creating homegrown content and intellectual property, and promoting our screen industry to the world. The Assigned Production Investment Program will help increase the volume and scale of Victorian-led screen production and the Victorian Screen Incentive Program will help attract international and interstate screen productions to Victoria. Initiatives such as Imagine Impact and Creators' Lab will also help accelerate development of high-end drama screenplays.

This initiative will also deliver flagship screen events and revitalise the Melbourne International Film Festival to reinforce Melbourne's position as Australia's leading destination for screen industry events.

Film Victoria's Attachment Program will be expanded to include opportunities for technical positions on visual effects productions where shortages exist. Continuation of the Key Talent Placements Program will also provide advanced skills development for writers, directors and other key creatives.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Portfolio Agencies output.

Creative State: Stimulating new and innovative creative products

Funding is provided to support a broad and diverse range of creative workers and organisations to develop bold new works, enhance skills and drive innovation, research and development. This initiative provides funding for the Creators Fund, a commissioning program delivered via Melbourne Fringe and support for collaborative new works through Asia TOPA.

This initiative contributes to the Department of Jobs Precincts and Regions' Creative Industries Access, Development and Innovation output.

Creative State: Supporting First Nations, young and diverse talent, festivals and careers

Funding is provided to develop opportunities and pathways to ensure the next generation of creative practitioners reflect the diversity of Victoria's broader community. Traineeships and better mentoring opportunities ensure job seekers from First Nations, youth and diverse backgrounds are better placed to obtain secure, well-paid work, while leadership programs will support a diverse cohort of mid-career and established creatives.

First Nation festivals and platforms such as Yirramboi, Blak & Bright Literature Festival and the Koori Art Show will facilitate more jobs and markets for artistic content, increasing the opportunity for new industry careers and emerging enterprises.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Access, Development and Innovation output.

Industry, Innovation, Medical Research and Small Business

Circuit Breaker Action Business Support Package

Funding is provided to support Victorian businesses impacted by the five-day circuit breaker action in February, including:

- grant payments through the Business Costs Assistance Program, providing direct financial support to eligible employing and non-employing businesses including in the hospitality, food wholesaling, tourism, events and selected retail industries;
- additional payments of $3 000 per premises for businesses who had previously received grant support through the Licensed Hospitality Venue Fund;
- funding for cancelled regional and metropolitan accommodation bookings through the Victorian Accommodation Support Program; and
- establishment of the Melbourne Travel Voucher Scheme, building on the success of the Regional Travel Voucher Scheme (RTVS), by offering 40 000 vouchers for travel in greater Melbourne, with a further 10 000 RTVS vouchers also provided.

This initiative contributes to the Department of Jobs, Precincts and Regions':

- Industry, Innovation, Medical Research and Small Business output;
- Jobs output; and
- Tourism and Major Events output.

Defence Capture Plan

Victoria's defence industry and supply chains will be supported to secure roles in delivering major defence contracts through advocacy, advisory and capability development activities. These objectives will be delivered through the Victorian Defence Industry Advocate and the operations of the Defence Council of Victoria, the Victorian Defence Alliances and the Defence Science Institute.

This initiative contributes to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Free Wi-Fi in Ballarat and Bendigo central business districts

Funding is provided to continue free public Wi-Fi network services in the Ballarat and Bendigo central business districts for a further seven years. This will continue to support more affordable access to digital services in these locations and deliver benefits including greater digital inclusion, communications resilience and improved visitor experience.

This initiative contributes to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Medical Research: Generation Victoria and Living Evidence

The Murdoch Children's Research Institute will continue to be supported to deliver the Generation Victoria (GenV) initiative, which aims to improve community health by tracking and analysing the health outcomes of a cohort of Victorian children over time. Research enabled by GenV will provide an evidence base to inform government policy, strategies, interventions and investments across a range of policy areas, including health, education and early childhood development.

Funding will also be provided for Living Evidence Phase Two, building on the successful delivery of the world's only Living Guidelines for COVID-19. The Living Evidence Consortium applies continuous surveillance to incorporate new evidence into clinical practice guidelines. This will support better patient outcomes through the development and maintenance of guidelines for five of Australia's high-burden disease groups: stroke, kidney disease, heart disease, diabetes and musculoskeletal conditions.

Melbourne central business district economic package

Funding is provided to stimulate economic activity and rejuvenate the City of Melbourne through the *CBD Dining Experiences Scheme* and the *Melbourne City Revitalisation Fund*. These programs will incentivise the public to return to the central business district and extend selected existing programs funded through the 20/21 *Melbourne City Recovery Fund*.

This initiative contributes to the Department of Jobs, Precincts and Regions':

- Industry, Innovation, Medical Research and Small Business output; and
- Tourism and Major Events output.

Securing and scaling mRNA vaccine manufacturing capability in Victoria: Stage one

Funding is provided to support the establishment of a mRNA vaccine and therapeutic manufacturing capability in Victoria. This will be facilitated through collaboration with the Commonwealth and world-leading experts from Monash University, the University of Melbourne, the Doherty Institute, other leading research institutes and industry partners.

The establishment of local a mRNA manufacturing capability will provide vaccine security, ensure manufacturing can be contracted locally to mitigate global supply chain risks and create a more robust defence against future pandemics.

Small business services and support

The Government will continue supporting small and medium-sized Victorian businesses through business recovery and resilience mentoring services, small business support toolkits, and a Ready for Growth service to support high-growth potential businesses through masterclasses and personalised coaching, including in advanced digital engagement and innovation. Funding will be provided to continue support for implementation of the Victorian Small Business Commission's new case management system.

This initiative contributes to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Supporting industries: COVID Coordination and Recovery

Funding is provided to continue the Government's engagement with Victorian businesses on industry recovery and adaptation guidance and preparedness in response to COVID-19, education programs and COVIDSafe communications and marketing campaigns. The Business Victoria Hotline will continue to be supported and Public Events Framework observers will support the coordination of safe public events.

This initiative contributes to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Jobs

Getting Victorians Back to Work: Our Plan to minimise the risk and costs of greater inequality

Funding is provided to continue the following programs which support a strong and inclusive economy and employment growth in communities and cohorts hit hardest by the coronavirus (COVID-19) pandemic:

- community revitalisation and microenterprise development programs to help address entrenched disadvantage through place-based approaches;
- supporting Victoria's social enterprise sector through the Social Enterprise Network of Victoria and Social Traders, and continued resourcing for the management and monitoring of the Social Procurement Framework;
- Impact 21, which supports employment pathways for people with an intellectual disability, including Down syndrome, by developing work-ready skills and tailoring roles and support in collaboration with employers; and
- establishing the Local Transition Response Service to support workers facing retrenchment through rapid tailored assistance to manage the transition to alternative employment, including brokering local business-to-business solutions to redeploy affected workers.

This initiative contributes to the Department of Jobs, Precincts and Regions' Jobs output.

Maximising local jobs and local content

Funding is provided to ensure that opportunities for local businesses and workers associated with government procurement are maximised. The Office of the Local Jobs First Commissioner and Industry Capability Network Victoria will be resourced to oversee and enforce compliance with the *Local Jobs First Act 2003* and the Local Jobs First Policy.

Funding is provided to support the operation of Ethical Clothing Australia and the accreditation process for the Ethical Supplier Register.

Funding is provided to establish the Fair Jobs Code Unit in the Department of Jobs, Precincts and Regions to support implementation of the Fair Jobs Code, including undertaking education and compliance activities.

This initiative contributes to the Department of Jobs, Precincts and Regions' Jobs output.

Test Isolation Payments

Funding is provided for the delivery of Test Isolation Payments to support people without leave entitlements or existing financial support to self-isolate while awaiting coronavirus (COVID-19) test results or those caring for someone awaiting their test results, reducing risks of community transmission.

This initiative contributes to the Department of Jobs, Precincts and Regions' Jobs output.

Local Government and Suburban Development

Emergency management sector reform: implementation of reviews and inquiries

Refer to the Department of Justice and Community Safety for a description of this initiative.

Growing Suburbs Fund

Funding is provided to extend the Growing Suburbs Fund to deliver critical local infrastructure projects that support economic participation and recovery after the coronavirus (COVID-19) pandemic across Melbourne's interface councils and regional Victoria's peri-urban shires, which are experiencing population growth and changing demographics.

The fund will provide grants for quality local community infrastructure such as libraries, community centres, arts and cultural facilities, parks and reserves, kindergartens/early learning centres and sport and recreation facilities.

This initiative contributes to the Department of Jobs, Precincts and Regions' Local Government and Suburban Development output.

Leadership for women in local government

Funding is provided to run a community leadership training program for 120 women across the local government sector. This will support women's participation across local government and progress towards the *Safe and Strong: A Gender Equality Strategy* target of 50 per cent female mayors and councillors by 2025.

This initiative contributes to the Department of Jobs, Precincts and Regions' Local Government and Suburban Development output.

Public Libraries Funding Program

Funding is provided to public libraries across Victoria to maintain the quality of resources and services. This will ensure that these facilities continue to deliver free and universal access to education, resources and other programs to Victorian communities.

This initiative contributes to the Department of Jobs, Precincts and Regions' Local Government and Suburban Development output.

Roadside Weeds and Pests Program

Funding is provided to regional, rural and interface councils with responsibility for maintaining municipal rural roads to prevent the establishment and spread of weeds and pests. This will reduce the risk of weed infestations on rural roadsides, helping to prevent the spread of fire along road reserves and onto adjacent public and private land, and flow-on benefits for weed and pest management on farming land.

This initiative contributes to the Department of Jobs, Precincts and Regions' Local Government and Suburban Development output.

Rural Roads Support Package

Funding is provided to deliver improvements in road asset management systems, integration and alignment across the 11 small rural shire councils. This will promote consistency in policy setting and road asset management practices over the medium and long term, producing ongoing efficiencies in road maintenance.

This initiative contributes to the Department of Jobs, Precincts and Regions' Local Government and Suburban Development output.

Suburban recovery and revitalisation

Funding is provided for the Springvale Road Boulevard streetscape improvement project in Greater Dandenong. These works will enhance the safety, accessibility and vibrancy of the local shopping strip.

This initiative contributes to the Department of Jobs, Precincts and Regions' Local Government and Suburban Development output.

Regional Development

Addressing opportunities in place: A Thriving Central Goldfields Shire

Funding is provided to renew the Go Goldfields Every Child, Every Chance initiative. The program brings together community, business, government, and not-for-profit partners to ensure every child in the Central Goldfields Shire has the opportunity to grow up safe, healthy, and confident.

This initiative contributes to the Department of Jobs, Precincts and Regions' Regional Development output.

Addressing opportunities in place: Latrobe Valley transition and transformation

Funding is provided to activate the Food Manufacturing Precinct on Alexanders Road in Morwell. This investment will deliver pioneering infrastructure allowing the precinct to manage greater water and energy demands. Activation of the precinct will create employment opportunities by attracting value-adding food businesses to the Latrobe Valley.

This initiative contributes to the Department of Jobs, Precincts and Regions':

- Regional Development output; and
- Industry, Innovation, Medical Research and Small Business output.

Addressing opportunities in place: Portland Economic Diversification Plan

Funding is provided for a Portland Economic Diversification Plan to support economic diversification, growth and resilience in Portland and the broader Glenelg Shire. The Plan will deliver a number of projects including local freight road upgrades, Stage 2 of the Henty Employment Precinct infrastructure upgrades and the Portland Diversification Fund. These projects will be facilitated by the establishment of a Regional and Rural Victoria office in Portland.

This initiative contributes to the Department of Jobs, Precincts and Regions' Regional Development output.

Ready to grow: supporting regional population growth

Funding is provided to continue the Growing Regional Opportunities for Work program and the Regional Community Leadership program. These programs will ensure the impacts of the Government's regional investments are maximised by working with local businesses to create jobs for people who experience barriers to employment and ensuring that strong local leadership skills are fostered and used.

This initiative contributes to the Department of Jobs, Precincts and Regions' Regional Development output.

Seymour revitalisation

Funding is provided to progress the design and construction of enabling infrastructure in the Hilldene Employment Precinct in Seymour. This will address the shortage of readily developable industrial land in the town and support the establishment of new businesses.

This initiative contributes to the Department of Jobs, Precincts and Regions' Regional Development output.

Strengthening Regional and Metropolitan Partnerships

Funding is provided to continue the Regional and Metropolitan Partnerships programs. The Partnerships provide a conduit for businesses, community groups and local government authorities to access State government programs and deliver specific and meaningful projects for their regions.

The Partnerships Development Fund will also be continued and expanded to the Regional Partnerships, providing targeted investments in local community-led projects to boost job creation and community connection.

This initiative contributes to the Department of Jobs, Precincts and Regions':

- Regional Development output; and
- Local Government and Suburban Development output.

Resources

Resources for Recovery: Securing the Resources for Victoria's economic recovery

Funding is provided to support activities that respond to Victoria's extractive resources needs and deliver the Government's Big Build program, following a rise in economic activity throughout the State. Additional resources will assist with meeting a sustained increase in minerals exploration applications and work plan variation requests. Technical geological expertise will also be maintained to support the attraction of ongoing investment in the State's resources sector, underpinning regional jobs and economic activity.

This initiative contributes to the Department of Jobs, Precincts and Regions' Resources output.

Sport, Recreation and Racing

Backing Victoria's Racing Industry: Increase to VRI POCT payment

The Government will lift the amount of net wagering revenue that is returned to the Victorian Racing Industry from 1.5 per cent to 3.5 per cent, from 1 July 2021.

This change is expected to increase the Government's gross annual contributions by around $50 million per year, although the net benefit to the racing industry is lower. This higher Government contribution will help bridge the gap between the New South Wales and Victorian racing industry funding frameworks, and help Victoria remain Australia's pre-eminent racing state.

Building inclusive sport and recreation communities

Funding is provided for the continued delivery of Reclink's ActiVIC program. This program supports diversity and inclusion by providing more equitable access to sport and active recreation for people with a disability, those from culturally and linguistically diverse backgrounds, Aboriginal Victorians and economically disadvantaged Victorians.

This initiative contributes to the Department of Jobs, Precincts and Regions' Sport, Recreation and Racing output.

Celebrating female sporting icons

Funding is provided to design and erect a statue of an iconic female netball identity at John Cain Arena.

This initiative contributes to the Department of Jobs, Precincts and Regions' Sport, Recreation and Racing output.

Change our Game: Office for Women in Sport and Recreation

Funding is provided to continue the Office for Women in Sport and Recreation and delivery of Change our Game initiatives supporting female participation and gender equality in sport. This includes the delivery of Community Activation and Scholarship grants.

This initiative contributes to the Department of Jobs, Precincts and Regions' Sport, Recreation and Racing output.

Harness Racing Victoria transformation program

Funding is provided for Harness Racing Victoria's transformation program. The transformation program will increase investment in the code by encouraging greater participation, reducing barriers to entry, and leveraging the strength of the industry in regional Victoria.

This initiative contributes to the Department of Jobs, Precincts and Regions' Sport, Recreation and Racing output.

Investing in local sports infrastructure

Funding is provided for grants programs that deliver new and upgraded community sport and recreation infrastructure, increasing participation opportunities and improving accessibility for the community. This will include strategically identified projects, such as large-scale or regionally significant sporting infrastructure and competitive grant funding. Sport specific facilities will also be delivered to assist the elite and sports development programs of state sporting associations.

Female Friendly Facilities funding will also be extended to provide grants to deliver community pavilions, change rooms, playing grounds, and courts, to ensure women and girls can access appropriate community sporting facilities.

This initiative contributes to the Department of Jobs, Precincts and Regions' Sport, Recreation and Racing output.

La Trobe University Sports Park

Funding is provided towards delivering professional standard football facilities for the Home of the Matildas and a future home for Football Victoria. Funding is also provided for a Rugby Centre of Excellence. Both the Home of the Matildas and the Rugby Centre of Excellence will support greater participation in football and rugby, particularly for women and girls and disadvantaged groups.

This initiative contributes to the Department of Jobs, Precincts and Regions' Sport, Recreation and Racing output.

Sporting Trusts Support

Funding is provided to support the operations of the Melbourne and Olympic Parks Trust, the State Sport Centres Trust and the Kardinia Park Stadium Trust which have been affected by public health restrictions during the coronavirus (COVID-19) pandemic.

This initiative contributes to the Department of Jobs, Precincts and Regions' Sport, Recreation and Racing output.

Victorian Institute of Sport

Funding is provided to the Victorian Institute of Sport to increase the number of Victorians categorised as elite athletes supported in the lead up to the Paris 2024 Olympic Games and to expand programs and support services for elite athletes.

This initiative contributes to the Department of Jobs, Precincts and Regions' Sport, Recreation and Racing output.

Tourism and Major Events

Business Events Program

Funding is provided to continue to attract a strong pipeline of business events to Melbourne and regional Victoria. As a high-yielding sector of the visitor economy, business events provide a pipeline of visitors during the off-peak and shoulder seasons and will continue to support the State's economic recovery.

This initiative contributes to the Department of Jobs, Precincts and Regions' Tourism and Major Events output.

Emerald Tourist Railway

Funding is provided to support the operation of the Emerald Tourist Railway.

This initiative contributes to the Department of Jobs, Precincts and Regions' Tourism and Major Events output.

Regional Travel Voucher Scheme expansion

Funding is provided to expand the Regional Travel Voucher Scheme through an additional 30 000 vouchers to encourage Victorian residents to travel within regional Victoria. Coupled with the additional vouchers provided in the Circuit Breaker Action Business Support Package, this initiative delivers an immediate demand stimulus for the tourism industry, supporting jobs and economic activity.

This initiative contributes to the Department of Jobs, Precincts and Regions' Tourism and Major Events output.

Visitor Economy: destination marketing

Funding is provided to support Victoria's visitor economy through targeted drive, short-haul flight, long-haul flight and growth marketing campaigns to encourage tourism visitation. These initiatives will continue to assist in rebuilding the Victorian visitor economy brand in response to the impact of the coronavirus (COVID-19) pandemic.

This initiative contributes to the Department of Jobs, Precincts and Regions' Tourism and Major Events output.

Visitor Economy Partnerships

Funding is provided for the continued transition of Regional Tourism Boards to Visitor Economy Partnerships, in line with the recommendations of the Regional Tourism Review. This will build capability, improve collaboration between the Government, regional councils and industry, and position regional Victoria to attract higher rates of visitation.

This initiative contributes to the Department of Jobs, Precincts and Regions' Tourism and Major Events output.

Trade and Global Engagement

International education recovery and growth

Funding is provided to continue programs that will assist the recovery and growth of Victoria's international education sector. This includes continuing the Study Melbourne brand, Study Melbourne Student Centre, and the Study Melbourne Inclusion and Empowered Programs. This initiative also continues delivery of the Global Education Network and Study Melbourne Hubs.

This initiative contributes to the Department of Jobs, Precincts and Regions' Trade and Global Engagement output.

Trade facilitation

Funding is provided for the Trade Mission Program to support exporters and strengthen business connections to international markets. This will be complemented by campaigns to promote Victorian industry capability locally and internationally.

This initiative contributes to the Department of Jobs, Precincts and Regions' Trade and Global Engagement output.

Victorian Government Trade and Investment Network

The continued operations of the Victorian Government Trade and Investment Network will be supported. The appointment of new investment professionals in strategic markets will also stimulate foreign direct investment flows and investment attraction in key sectors of the Victorian economy. This will assist the trade sector to recover from the impacts of the coronavirus (COVID-19) pandemic and support the State's longer-term economic recovery.

This initiative contributes to the Department of Jobs, Precincts and Regions' Trade and Global Engagement output.

This initiative contributes to the Department of Treasury and Finance's Invest Victoria output.

Departmental efficiency measures

Base and efficiency review

The Department of Jobs, Precincts and Regions will reduce its operating expenditure, including through opportunities to streamline administrative and policy functions including grants administration. This includes savings identified subsequent to the original base review process.

Asset initiatives

Table 1.17: Asset initiatives – Department of Jobs, Precincts and Regions ($ million)

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*	*TEI*
Business Precincts						
Fishermans Bend Innovation Precinct at the former General Motors Holden site	..	23.4	81.6	74.5	..	179.4
Creative Industries						
Creative State: Revitalising our cultural institutions	..	17.2	..	..	..	17.2
Total asset initiatives [(a)]	**..**	**40.6**	**81.6**	**74.5**	**..**	**196.6**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Business Precincts

Fishermans Bend Innovation Precinct at the former General Motors Holden site

Funding is provided to commence development of the former General Motors Holden site at Fishermans Bend into a centre of innovation in advanced manufacturing, engineering and design. This includes commencement of remediation works, installation of essential utility services and establishment of road access to the University of Melbourne's future School of Engineering campus scheduled to open in 2024.

This initiative contributes to the Department of Jobs, Precincts and Regions' Business Precincts output.

Creative Industries

Creative State: Revitalising our cultural institutions

Funding is provided to renew the exhibition offerings and visitor experience of the Melbourne Museum including a new Triceratops Gallery showcasing the recent acquisition of the most complete Triceratops fossil skeleton ever found, Gondwana Garden that will expand the Pauline Gandel Children's Gallery to create an outdoor exhibition experience featuring the megafauna of ice age Australia, and a rotating range of immersive digital experiences.

Funding is also provided to increase storage space and improve storage methods to help fulfil Melbourne Museum's custodial responsibilities to protect and create capacity to further develop cultural and scientific collections.

A concept design and business case will also be developed for future redevelopment of Scienceworks to expand its capacity to cater for growing demand.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Cultural Infrastructure and Facilities output.

DEPARTMENT OF JUSTICE AND COMMUNITY SAFETY

Output initiatives

Table 1.18: Output initiatives – Department of Justice and Community Safety ($ million)

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*
Advocacy, Human Rights and Victim Support					
Civil response to prohibit change or suppression practices	..	0.5	0.8	0.8	0.7
Implementing the Optional Protocol to the Convention against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment	..	0.5	..	..	..
Justice system response to family violence	..	5.4	5.0	2.8	0.5
Restorative Engagement and Redress Scheme for Victoria Police employees	3.4	15.5	15.6	7.7	..
Supporting victims of crime	..	12.1	13.4	12.4	9.1
Supporting vulnerable Victorians	0.1	6.8	3.8	2.2	2.2
Community-Based Offender Supervision					
Improved oversight and support of offenders	..	12.3	0.9	0.9	..
Community Crime Prevention					
Crime Prevention initiatives	..	14.7	1.7	1.7	1.7
Emergency Management Capability					
Country Fire Authority digital radio upgrade [(a)]	..	7.3	8.7	23.9	31.3
Critical service delivery for Victoria's emergency services	..	58.7	11.9	..	..
Emergency management sector reform: implementation of reviews and inquiries	11.2	24.1	9.7	3.5	1.9
Emergency service organisations infrastructure	..	9.4	7.6	1.6	0.1
Fiskville Off-site Remediation and Redress Scheme development	..	6.5	13.3	..	..
High consequence chemical response	..	0.9	0.4	0.7	1.7
High-Risk Industries: Engagement and Enforcement Operation	49.7	50.0	..	..	..
Initiatives to fast-track Victoria's recovery from the 2019-2020 Victorian bushfires	..	60.5	34.2	5.6	4.1
Victorian fire season and water safety communications strategy and campaigns	..	7.6	7.9	6.7	6.7
Water safety and flood awareness campaigns	2.0	..	..	..	..
Gambling and Liquor Regulation					
Royal Commission into the Casino Operator and Licence	10.0	..	..	..	..

	2020-21	2021-22	2022-23	2023-24	2024-25
Justice Policy, Services and Law Reform					
Decriminalising public drunkenness	0.3	..	..	..	..
Implementing the Legislated Spent Convictions Scheme	..	1.0	1.5	..	..
Royal Commission into the Management of Police Informants	4.6	23.8	21.8	5.6	5.1
Supporting the State's forensic capability	2.6	12.2	12.3	12.8	12.9
Policing and Community Safety					
Drug tests on our roads	..	6.7	6.4	..	..
Embedded Youth Outreach Program	..	1.5	1.6	1.6	1.6
Initiatives to counter violent extremism	..	5.9	4.2	3.2	3.2
Victorian Fixated Threat Assessment Centre	..	2.8	2.9	3.3	3.1
Prisoner Supervision and Support					
Responding to critical needs in the prison system	..	8.7	16.2	16.6	..
Protection of Children, Personal Identity and Screening Services					
Disability Advice and Response Team for the Children's Court	..	0.7	1.0	1.2	1.0
Working with Children Check and National Disability Insurance Scheme worker screening	4.0	9.0	9.3	5.9	5.0
Public Prosecutions and Legal Assistance					
Increasing justice system capacity and service availability	..	17.7	14.4	12.5	10.8
Justice recovery	12.5	..	..	..	..
Legal assistance and critical early intervention support services		10.1	9.3	9.5	2.2
Sustainable delivery of prosecution services	..	12.6	12.8	13.0	13.3
Public Sector Information Management, Privacy and Integrity					
Safeguarding human rights and accountability in the information age	..	0.6	0.4	0.3	0.3
Regulation of the Victorian Consumer Marketplace					
Professional Engineers Registration Scheme	..	2.7	4.9	..	..
Residential Tenancies Dispute Resolution Scheme	4.7	..	..	..	..
Youth Justice					
Community based diversionary services and opening Cherry Creek	0.1	73.4	47.7	21.7	22.3
Youth Justice COVID-19 response	1.4	..	..	..	..
Total output initiatives [(b)]	**106.6**	**482.2**	**301.5**	**177.8**	**140.8**
Base and efficiency review [(c)]	(3.7)	(27.4)	(53.2)	(100.1)	(137.4)

Source: Department of Treasury and Finance

Notes:

(a) Additional funding of $33.8 million in 2025-26 and $33.8 million in 2026-27 is beyond the forward estimates.

(b) Table may not add due to rounding.

(c) These savings acquit whole of government efficiencies announced in the 2019-20 Budget.

Advocacy, Human Rights and Victim Support

Civil response to prohibit change or suppression practices

Funding is provided to establish a civil response scheme in the Victorian Equal Opportunity and Human Rights Commission to support the recent *Change or Suppression (Conversion) Practices Prohibition Act 2021*.

This initiative contributes to the Department of Justice and Community Safety's Advocacy, Human Rights and Victim Support output.

Implementing the Optional Protocol to the Convention against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment

Funding is provided to begin giving improved assurance and oversight of the treatment of persons deprived of liberty. This will assist Victoria to work towards meeting obligations under the Optional Protocol to the Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment, as ratified by Australia in December 2017.

This initiative contributes to the Department of Justice and Community Safety's Advocacy, Human Rights and Victim Support output.

Justice system response to family violence

Funding is provided to further strengthen, integrate and embed the justice system's response to family violence through:

- establishing legal services in The Orange Door network;
- continuing counselling and trauma programs to support women in prison;
- continuing family violence training and implementation of the Multi-Agency Risk Assessment and Management (MARAM) framework across the justice portfolio supported by specialist family violence practice leads embedded in Corrections Victoria and Youth Justice;
- building family violence capacity through dedicated research and evaluation functions; and
- better identification of perpetrators and continuation of tailored intervention programs to support behaviour change and help break the cycle of family violence.

This initiative contributes to the Department of Justice and Community Safety's Advocacy, Human Rights and Victim Support output.

Restorative Engagement and Redress Scheme for Victoria Police employees

Funding is provided to implement the redress and restorative engagement scheme for victims of workplace sexual harassment and sexual assault at Victoria Police.

This initiative contributes to the Department of Justice and Community Safety's Advocacy, Human Rights and Victim Support output.

Supporting victims of crime

Funding is provided to start transformation of the victim service system through establishing the foundations for a new Financial Assistance Scheme for victims of crime. Funding is also provided to continue the intermediaries program and provide a new victims legal service.

This initiative contributes to the Department of Justice and Community Safety's Advocacy, Human Rights and Victim Support output.

This initiative contributes to the Court Services Victoria's Courts output.

Supporting vulnerable Victorians

Funding is provided to recruit new honorary justices to address demand through Honorary Justice Services Support and to continue the Youth Referral and Independent Persons Program for young people and the guardianship, investigation and Independent Third Persons programs at the Office of the Public Advocate.

This initiative contributes to the Department of Justice and Community Safety's Advocacy, Human Rights and Victim Support output.

Community-Based Offender Supervision

Improved oversight and support of offenders

Funding is provided to improve community safety through strengthened oversight and rehabilitative support of offenders including those on Community Correction Orders. This includes establishing a central specialised team to provide case management oversight of high-risk, complex offenders on Community Correction Orders.

This initiative contributes to the Department of Justice and Community Safety's Community-Based Offender Supervision output.

Community Crime Prevention

Crime Prevention initiatives

Funding is provided for initiatives to keep Victorian communities safe by addressing the root causes of crime, including the provision of Youth Crime Prevention Grants and other initiatives as well as partnerships with National Motor Vehicle Theft Reduction, Crime Stoppers and Neighbourhood Watch.

Funding for this initiative is linked to the Early Intervention Investment Framework.

This initiative contributes to the Department of Justice and Community Safety's Community Crime Prevention output.

Emergency Management Capability

Country Fire Authority digital radio upgrade

Funding is provided to the Country Fire Authority (CFA) to replace CFA's digital radios, to ensure continued reliability and interoperability with other emergency services agencies, to further improve responsiveness to emergency events.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Critical service delivery for Victoria's emergency services

Funding is provided for critical programs and increased demand for the Emergency Services Telecommunication Authority, Life Saving Victoria, State Control Centre, and Emergency Management Victoria.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Emergency management sector reform: implementation of reviews and inquiries

Funding is provided for immediate actions and the next phase of critical work to strengthen Victoria's emergency management arrangements and implementation of actions from the Government's response to recent inquiries undertaken by the Inspector-General for Emergency Management and the Commonwealth Government's Royal Commission into National Natural Disaster Management.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

This initiative contributes to the Department of Environment, Land, Water and Planning's Fire and Emergency Management output.

This initiative contributes to the Department of Jobs, Precincts and Regions' Local Government and Suburban Development output.

This initiative contributes to the Department of Transport's Transport Safety and Security output.

Emergency service organisations infrastructure

Refer to the asset initiative for a description of this initiative.

Fiskville Off-site Remediation and Redress Scheme development

Funding is provided to clean up contaminated sites neighbouring the former Country Fire Authority (CFA) Training College at Fiskville and to undertake initial design and engagement on a Redress Scheme for affected persons.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

High consequence chemical response

Refer to the asset initiative for a description of this initiative.

High-Risk Industries: Engagement and Enforcement Operation

Funding is provided for the High-Risk Industries Engagement and Enforcement Operation to ensure that designated high-risk and at-risk industries are compliant with Chief Health Officer directions and public health restrictions in response to the coronavirus (COVID-19) pandemic.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Initiatives to fast-track Victoria's recovery from the 2019-2020 Victorian bushfires

Funding is provided for initiatives in communities impacted by the 2019-2020 Victorian bushfires including case management, financial counselling, mental health support, legal aid, business support, restoration of waterways, reconstruction and rebuilding, replacement of visitor assets, wildlife welfare, and supports for schools and early childhood services.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Victorian fire season and water safety communications strategy and campaigns

Funding is provided for an overarching communication strategy to guide the approach to hazards preparation and response, including the Victorian Fire Season Campaign and Water Safety Campaign.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Water safety and flood awareness campaigns

Funding is provided to Life Saving Victoria and the Victorian State Emergency Service to deliver urgent water safety measures and a Community Safety Flood Awareness campaign.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Gambling and Liquor Regulation

Royal Commission into the Casino Operator and Licence

Funding is provided to establish a Royal Commission into Crown Melbourne Limited's suitability to hold its Victorian casino licence and the suitability of its associates, including Crown Resorts Ltd.

This initiative contributes to the Department of Justice and Community Safety's Gambling and Liquor Regulation output.

Justice Policy, Services and Law Reform

Decriminalising public drunkenness

Refer to the Department of Health for a description of this initiative.

Implementing the Legislated Spent Convictions Scheme

Funding is provided to establish the Spent Convictions Scheme, which will be administered by Victoria Police and provide a framework for controlled disclosure of certain criminal records after periods without serious reoffending.

This initiative contributes to the Department of Justice and Community Safety's Justice Policy, Services and Law Reform output.

Royal Commission into the Management of Police Informants

Funding is provided to support the Government's response to the Royal Commission into the Management of Police Informants, including:

- establishing a Special Investigator, a Human Source Auditor and an independent Implementation Monitor;
- operational costs to the State and the Independent Broad-based Anti-Corruption Commission in responding to the Royal Commission;
- additional resources for Victoria Legal Aid and for a dedicated Office of Public Prosecutions response team;
- enhanced Victoria Police governance and operational procedures for management of human sources, including provision of education and training for police on disclosure obligations and continuation of the information management platform; and
- additional support staff in appeal courts.

This initiative contributes to the Department of Justice and Community Safety's:

- Justice Policy, Services and Law Reform; and
- Policing and Community Safety output.

This initiative contributes to the Court Services Victoria's Courts output.

This initiative contributes to Parliament's Public Sector Integrity output.

Supporting the State's forensic capability

Funding is provided to continue the delivery of key forensic services at the Victorian Institute of Forensic Medicine, and facility upgrades to enhance the forensic capability of the Institute. This includes the addition of magnetic resonance imaging technology, lab equipment, structural upgrades, and new case management systems. Funding is also provided to support the Donor Tissue Bank of Victoria.

This initiative contributes to the Department of Justice and Community Safety's Justice Policy, Services and Law Reform output.

Policing and Community Safety

Drug tests on our roads

Funding is provided to Victoria Police to continue its program of additional drug tests on our roads. The continuation of the drug driving program will help police get dangerous drivers off the State's roads and avoid the risk of serious road injuries and casualties associated with driving under the influence of drugs.

This initiative contributes to the Department of Justice and Community Safety's Policing and Community Safety output.

Embedded Youth Outreach Program

Funding is provided to continue the embedded Youth Outreach Program in the existing locations of Werribee and Dandenong, where police officers and youth workers are paired to provide assessment, initial support and referral for vulnerable young people and prevent possible future reoffending.

This initiative contributes to the Department of Justice and Community Safety's Policing and Community Safety output.

Initiatives to counter violent extremism

Funding is provided to continue funding key responses to countering violent extremism, including diversion and disengagement initiatives in youth and adult justice, and the establishment of a multi-agency panel to assist with case management across multiple services.

This initiative contributes to the Department of Justice and Community Safety's:

- Policing and Community Safety output;
- Community Crime Prevention output;
- Prisoner Supervision and Support output; and
- Youth Justice Custodial Service output.

Victorian Fixated Threat Assessment Centre

Refer to the Department of Health for a description of this initiative.

Prisoner Supervision and Support

Responding to critical needs in the prison system

Funding is provided to address immediate needs in the prison system through continuation of Vocational Education and Training across the prison system and the ATLAS psycho-educational and wellbeing support for prisoners on remand, and extension of the Disability and Complex Needs Service program for women being piloted at the Dame Phyllis Frost Centre.

This initiative contributes to the Department of Justice and Community Safety's Prisoner Supervision and Support output.

Protection of Children, Personal Identity and Screening Services

Disability Advice and Response Team for the Children's Court

Funding is provided for a team to support young people with disability who have matters before the Children's Court.

This will lead to a clear pathway for young people to access disability support in a timely manner, helping to reduce the burden on the courts and reducing the time to hear a matter.

This initiative contributes to the Department of Justice and Community Safety's Protection of Children, Personal Identity and Screening Services output.

Working with Children Check and National Disability Insurance Scheme worker screening

Funding is provided to support the Working with Children Check unit, and for the operation of a National Disability Insurance Scheme (NDIS) worker screening unit that checks to confirm that existing or prospective NDIS workers do not pose a risk to people with disability.

This initiative contributes to the Department of Justice and Community Safety's Protection of Children, Personal Identity and Screening Services output.

This initiative contributes to the Court Services Victoria's Courts output.

Public Prosecutions and Legal Assistance

Increasing justice system capacity and service availability

Funding is provided to improve the justice system's service availability and capacity to respond to the increasing volume of matters moving through the courts, and to reduce delays caused by the coronavirus (COVID-19) public health restrictions.

This initiative contributes to the Department of Justice and Community Safety's:

- Public Prosecutions and Legal Assistance output;
- Prisoner Supervision and Support output; and
- Policing and Community Safety output.

Justice recovery

Funding is provided to increase the justice system's capacity to reduce delays caused by the coronavirus (COVID-19) public health restrictions, build a stronger and more accessible justice system and improve the safety of family violence victims. The funding will:

- expand the specialist family violence legal services model which focuses on early legal advice, helping to resolve family violence matters outside of court;
- introduce a Victoria Legal Aid Help Before Court service, to assist people prepare online before their court date;
- expand legal service for regional Aboriginal Victorians; and
- provide additional legal assistance for vulnerable women experiencing or at risk of family violence while pregnant or with young children.

Funding for Justice recovery is also described under Court Services Victoria.

This initiative contributes to the Department of Justice and Community Safety's:

- Public Prosecutions and Legal Assistance output; and
- Policing and Community Safety output.

Legal assistance and critical early intervention support services

Funding is provided to continue critical legal services and improve access to justice for Victorians who need support through:

- continuing grant payments to Community Legal Centres;
- expanding the Mabels family violence service;
- continuing the WestJustice Mortgage Stress Service which delivers a combination of legal, social, health and financial assistance to prevent the repossession of homes and reduce mortgage stress;
- supporting the Federation of Community Legal Centres;
- supporting the Victorian Law Reform Commission's reference on stalking, harassment and similar conduct, and the use of Personal Safety Intervention Orders;
- continuing Victoria Legal Aid's (VLA) Independent Advocacy and Support service;
- employing additional VLA lawyers and support staff to represent and assist parents and children in child protection legal proceedings;
- delivering the Coronial Council review into improving the experiences of bereaved families in the coronial process;
- providing specialist legal services to the LGBTIQ+ community;
- supplementing Victoria's contribution to the Community Legal Assistance Service System; and
- supporting the Victorian Equal Opportunity and Human Rights Commission and reduce its dispute resolution service backlog.

Funding for this initiative is linked to the Early Intervention Investment Framework.

This initiative contributes to the Department of Justice and Community Safety's Public Prosecutions and Legal Assistance output.

Sustainable delivery of prosecution services

Funding is provided for the Office of Public Prosecutions to continue to prosecute offenders effectively, to provide support for victims and witnesses, increase the use of digital evidence, and provide a strong focus on family violence.

This initiative contributes to the Department of Justice and Community Safety's Public Prosecutions and Legal Assistance output.

Public Sector Information Management, Privacy and Integrity

Safeguarding human rights and accountability in the information age

Funding is provided for the Office of the Victorian Information Commissioner to fulfil its legislated obligations under the *Integrity and Accountability Legislation Amendment (Public Interest Disclosures, Oversight and Independence) Act 2019*, which came into effect on 31 December 2019.

This initiative contributes to the Department of Justice and Community Safety's Public Sector Information Management, Privacy and Integrity output.

Regulation of the Victorian Consumer Marketplace

Professional Engineers Registration Scheme

Funding is provided for the operation of a mandatory statutory professional engineers registration scheme in Victoria, promoting a qualified and experienced workforce that allows Victorian engineers to compete in national and international markets.

This initiative contributes to the Department of Justice and Community Safety's Regulation of the Victorian Consumer Marketplace output.

This initiative contributes to the Court Services Victoria's Courts output.

Residential Tenancies Dispute Resolution Scheme

Funding is provided to support Consumer Affairs Victoria and the Dispute Settlement Centre of Victoria to administer and operate the Residential Tenancies Dispute Resolution Scheme, assisting landlords and tenants to negotiate reduced rent or rent payment plans.

This initiative contributes to the Department of Justice and Community Safety's Regulation of the Victorian Consumer Marketplace output.

Youth Justice

Community based diversionary services and opening Cherry Creek

Funding is provided for core youth justice programs, ongoing investment in diversionary programs, and establishing a new custodial operating model at Cherry Creek.

This initiative contributes to the Department of Justice and Community Safety's:

- Youth Justice Community-Based Services output; and
- Youth Justice Custodial Services output.

Youth Justice COVID-19 response

Funding is provided to strengthen and support the Youth Justice response to the coronavirus (COVID-19) pandemic in Victoria's Youth Justice Centres.

This initiative contributes to the Department of Justice and Community Safety's Youth Justice Custodial Services output.

Departmental efficiency measures

Base and efficiency review

The Department of Justice and Community Safety will reduce its operating expenditure by streamlining administrative functions, improving procurement arrangements and increasing its efficiency through innovative work practices and productivity enhancing reforms.

Asset initiatives

Table 1.19: Asset initiatives – Department of Justice and Community Safety ($ million)

	2020-21	2021-22	2022-23	2023-24	2024-25	TEI
Advocacy, Human Rights and Victim Support						
Supporting victims of crime	..	7.6	..	..	..	7.6
Supporting vulnerable Victorians	..	1.0	0.5	..	..	1.5
Community-Based Offender Supervision						
Improved oversight and support of offenders	..	0.3	..	..	..	0.3
Emergency Management Capability						
Emergency management sector reform: implementation of reviews and inquiries	1.3	..	..	..	..	1.3
Emergency service organisations infrastructure	..	3.2	3.1	0.1	3.0	9.4
High consequence chemical response	..	..	4.7	1.4	..	6.1
High-Risk Industries: Engagement and Enforcement Operation	5.1	2.4	..	..	..	7.5
Justice Policy, Services and Law Reform						
Royal Commission into the Management of Police Informants	..	6.5	1.3	1.3	..	9.1
Supporting the State's forensic capability	..	33.0	7.2	..	..	40.2
Policing and Community Safety						
Delivering new police station infrastructure	..	17.0	19.0	7.5	0.1	43.5
Total asset initiatives [(a)]	**6.4**	**70.9**	**35.8**	**10.3**	**3.1**	**126.5**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Advocacy, Human Rights and Victim Support

Supporting victims of crime

Refer to the output initiative for a description of this initiative.

Supporting vulnerable Victorians

Refer to the output initiative for a description of this initiative.

Community-Based Offender Supervision

Improved oversight and support of offenders

Refer to the output initiative for a description of this initiative.

Emergency Management Capability

Emergency management sector reform: implementation of reviews and inquiries

Refer to the output initiative for a description of this initiative.

Emergency service organisations infrastructure

Funding is provided to enhance the facilities of emergency service organisations to provide modern, fit-for-purpose infrastructure, including refurbishment of the Country Fire Authority station at Doreen, replacement of stations at Serpentine, Metcalfe, Irymple, and information, communication and technology upgrades at the Edithvale station. A new Port Fairy Victorian State Emergency Services facility will be developed and co-located with the local Country Fire Authority unit. Funding is also provided to redevelop Life Saving Victoria's Wonthaggi clubhouse, Williamstown clubhouse, and Point Lonsdale beach base.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

High consequence chemical response

Funding is provided to Fire Rescue Victoria to increase the agency's capability to effectively contain and mitigate transportable High Consequence Chemical (HCCs) incidents.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

High-Risk Industries: Engagement and Enforcement Operation

Refer to the output initiative for a description of this initiative.

Justice Policy, Services and Law Reform

Royal Commission into the Management of Police Informants

Refer to the output initiative for a description of this initiative.

Supporting the State's forensic capability

Refer to the output initiative for a description of this initiative.

Policing and Community Safety

Delivering new police station infrastructure

Funding is provided to deliver new and upgraded police station infrastructure, including new land for new station developments and the replacement of Benalla Police Station.

This initiative contributes to the Department of Justice and Community Safety's Policing and Community Safety output.

DEPARTMENT OF PREMIER AND CABINET

Output initiatives

Table 1.20: Output initiatives – Department of Premier and Cabinet ($ million)

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*
Digital Government and Communications					
Better customer experiences through insightful design	..	1.8	1.8	1.8	1.8
Commercial passenger vehicles quick response code solution	0.9	..	..	..	..
Cyber Safe Victoria 2021+	..	13.4	13.3	12.3	11.8
Enhancing customer experience with more digital services for Victorians	..	25.0	25.7	..	..
Planning for government shared services infrastructure evolution	3.7	12.0	..	..	..
Single Digital Presence	..	14.6	14.6	..	..
Victoria Together	..	2.5	..	..	..
Victoria's Open Data Program	..	1.8	1.7	1.8	1.8
Government-wide Leadership, Reform and Implementation					
Extending public sector behavioural science capability	..	1.5	1.5	1.5	1.5
Insights Victoria	7.9	7.9	..	..	..
Securing Victoria's international interests	..	2.3	2.1	0.3	..
Suburban workplace hubs	8.3	5.9	5.9	..	..
Industrial Relations					
Better supports for on-demand or gig workers in Victoria	..	5.1	0.2	..	..
Maintaining Positive Public Sector Industrial Relations	..	1.2	1.2	1.2	1.2
Management of Victoria's Public Records					
Public Record Office Victoria: Asset Maintenance and Renewal Program	0.8	..	..	..	..
Total output initiatives [(a)]	**21.5**	**94.9**	**67.9**	**18.8**	**18.0**
Base and efficiency review [(b)]	0.5	(10.3)	(14.9)	(21.3)	(21.3)

Source: Department of Treasury and Finance

Notes:
(a) Table may not add due to rounding.
(b) These savings acquit whole of government efficiencies announced in the 2019-20 Budget.

Digital Government and Communications

Better customer experiences through insightful design

Funding is provided for the continuation of the three streams - Business Insights, Service Design and Public Engagement - of the Centralised Public Engagement Capability program. This program improves the experience of those interacting with government and provides community insights that inform improvements to government services and programs.

This initiative contributes to the Department of Premier and Cabinet's Digital Government and Communications output.

Commercial passenger vehicles quick response code solution

Funding is provided to expand the whole of government quick response (QR) code contact tracing system to commercial passenger vehicles. Expansion of the system will enable drivers and passengers to use a fit for purpose contact tracing system.

This initiative contributes to the Department of Premier and Cabinet's Digital Government and Communications output.

Cyber Safe Victoria 2021+

Funding is provided to continue Victoria's program to protect public services from cyber attacks through improvements to government cybersecurity controls and early detection of cyber risks. World-class technology and software tools will be deployed on public sector networks to defend against malicious software and provide targeted reporting.

This initiative contributes to the Department of Premier and Cabinet's Digital Government and Communications output.

Enhancing customer experience with more digital services for Victorians

Funding is provided to continue Service Victoria's operations and improve public access to services by creating new channels for simple, faster, high-volume transactions such as grant applications and permit approvals.

This initiative contributes to the Department of Premier and Cabinet's Digital Government and Communications output.

Planning for government shared services infrastructure evolution

Funding is provided to plan for the evolution of shared services technology infrastructure to further improve operational efficiency, capacity and flexibility.

This initiative contributes to the Department of Premier and Cabinet's Digital Government and Communications output.

Single Digital Presence

Funding is provided to support a common digital publishing platform to manage and consolidate a range of government websites to give a consistent user experience and easier access to online information and services.

This initiative contributes to the Department of Premier and Cabinet's Digital Government and Communications output.

Victoria Together

Funding is provided to continue Victoria Together, an online platform delivering enhanced online experiences to Victorians during and after the coronavirus (COVID-19) pandemic. Victoria Together also shares a range of online content that supports the wellbeing and connection of disadvantaged and isolated Victorians.

This initiative contributes to the Department of Premier and Cabinet's Digital Government and Communications output.

Victoria's Open Data Program

Funding is provided for the Open Data Program, which supports greater public access to Victorian data. Maintaining and continuing the development of DataVic – Victoria's existing open data portal – will promote innovation, increase public trust in government, and empower citizens by supporting businesses, entrepreneurs and communities to access and use data to create innovative products or improve the quality of services.

This initiative contributes to the Department of Premier and Cabinet's Digital Government and Communications output.

Government-wide Leadership, Reform and Implementation

Extending public sector behavioural science capability

Funding is provided for the continuation of the Behavioural Insights Unit, which provides analysis and advice to government departments and agencies including as part of the Government's coronavirus (COVID-19) pandemic response and recovery.

This initiative contributes to the Department of Premier and Cabinet's Government-wide Leadership, Reform and Implementation output.

Insights Victoria

Funding is provided to extend the Insights Victoria platform, which supports continued monitoring and reporting of public health and mobility and use of cross-portfolio data and analytics to track the rollout and progress of key economic recovery initiatives. This information will inform targeted policies and programs, and support public communications and campaigns as part of the Government's coronavirus (COVID-19) pandemic response and recovery.

This initiative contributes to the Department of Premier and Cabinet's Government-wide Leadership, Reform and Implementation output.

Securing Victoria's international interests

Funding is provided to strengthen Victoria's international engagement efforts. This includes identification of emerging economic opportunities in overseas markets, renewed memberships with the Asia Society and the Australia India Institute.

This initiative contributes to the Department of Premier and Cabinet's Government-wide Leadership, Reform and Implementation output.

Suburban workplace hubs

Funding is provided to trial five workplace hubs in suburban Melbourne to support work location flexibility for up to 2 380 public servants each week. This will support local economic activity in the suburbs with more foot traffic and spending at local traders. It will also assist with the COVIDSafe return of employees to CBD offices by alleviating accommodation pressures and reducing public health risks in commuting daily on public transport.

This initiative contributes to the Department of Premier and Cabinet's Government-wide Leadership, Reform and Implementation output.

Industrial Relations

Better supports for on-demand or gig workers in Victoria

Funding is provided for a project establishment team to start implementing the Government's response to the Inquiry into the Victorian On-Demand Workforce. This includes the development of standards to encourage fair conduct and accountability by platform businesses and to improve transparency between these businesses and the workers they engage.

Funding is provided to commence work to establish a support service or agency to assist on-demand workers.

This initiative contributes to the Department of Premier and Cabinet's Industrial Relations output.

Maintaining Positive Public Sector Industrial Relations

Funding is provided for the continued operations of the Public Sector Industrial Relations Unit, which oversees the enterprise bargaining processes across the public sector and provides industrial relations services to the Government.

This initiative contributes to the Department of Premier and Cabinet's Industrial Relations output.

Management of Victoria's Public Records

Public Record Office Victoria: Asset Maintenance and Renewal Program

Refer to the asset initiative for a description of this initiative.

Departmental efficiency measures

Base and efficiency review

The Department of Premier and Cabinet will reduce its operating expenditure, including through opportunities to streamline administrative and policy functions, improve procurement efficiency and reduce its consultancy expenditure.

Asset initiatives

Table 1.21: Asset initiatives – Department of Premier and Cabinet ($ million)

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*	*TEI*
Digital Government and Communications						
Enhancing customer experience with more digital services for Victorians	..	8.1	8.1	..	..	16.2
Government-wide Leadership, Reform and Implementation						
Alternative Quarantine Accommodation Hub: Planning	10.0	5.0	..	..	..	15.0
Management of Victoria's Public Records						
Public Record Office Victoria: Asset Maintenance and Renewal Program	..	0.5	0.2	..	..	0.7
Total asset initiatives [(a)]	**10.0**	**13.6**	**8.3**	**..**	**..**	**31.9**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Digital Government and Communications

Enhancing customer experience with more digital services for Victorians

Refer to the output initiative for a description of this initiative.

Government-wide Leadership, Reform and Implementation

Alternative Quarantine Accommodation Hub: Planning

Funding is provided for planning and design works for a new purpose-built quarantine accommodation hub.

This initiative contributes to the Department of Premier and Cabinet's Government-wide Leadership, Reform and Implementation output.

Management of Victoria's Public Records

Public Record Office Victoria: Asset Maintenance and Renewal Program

Funding is provided to maintain and renew essential building infrastructure at the Victorian Archives Centre in North Melbourne to protect the public records collection from environmental damage.

This initiative contributes to the Department of Premier and Cabinet's Management of Victoria's Public Records output.

DEPARTMENT OF TRANSPORT

Output initiatives

Table 1.22: Output initiatives – Department of Transport ($ million)

	2020-21	2021-22	2022-23	2023-24	2024-25
Accommodation and workplace modernisation strategy	0.5	0.5	2.6	2.6	2.6
Coronavirus (COVID-19) impacts on the transport network	296.2	..	..	..	..
Maintenance and management of new assets	4.5	49.3	6.5	6.4	5.2
Bus Services					
Bus service improvements and reform	..	11.9	18.8	14.7	15.2
Fishing and Boating					
Better boating facilities [(a)]	..	6.3	6.3	3.3	3.3
Fisheries investment plan [(b)]	..	2.6	2.7	2.7	2.8
Ports and Freight					
Mode Shift Incentive Scheme	..	3.6	..	..	..
Sustainable local ports	..	4.1	1.7	..	..
Regulation of Commercial Passenger Vehicle Services					
Multi-Purpose Taxi Program	..	5.0	5.0	5.0	5.0
Road Asset Management					
Murray River bridge crossing upgrades	..	5.2	5.9	4.8	..
Road Operations					
A more productive road network for freight	..	0.9	0.6	0.7	..
Active transport	..	1.8	1.2	1.1	1.1
Bulla Bypass	..	13.5	..	..	..
Ison Road – Rail Overpass	..	1.8	1.8	..	..
Metropolitan Road Upgrades	..	14.7	5.0	0.1	0.4
Regional Road Upgrades	..	6.7	3.9	0.2	0.2
Road Safety Strategy [(c)]	2.1	8.1	14.8	18.5	12.3
School crossing supervisor program	..	20.3	20.8	..	..
Zero and low emission vehicles: commercial sector	..	4.0	1.0	..	..
Train services					
Caulfield rationalisation works [(d)]	..	..	..	0.0	0.0
Caulfield Station Interchange Project: planning	..	2.0	..	..	..
Regional rail sustainability	..	100.4	48.1	..	..
RideSpace	7.5	1.9	..	..	..
Rolling stock maintenance and disposal programs	2.4	17.7	7.8	4.0	1.6
South Dynon train maintenance facility	..	0.3	2.0	7.7	7.9
Tram Services					
Tram infrastructure upgrades	..	0.2	0.2	0.2	0.2
Tram performance	..	4.1	..	..	1.6

	2020-21	2021-22	2022-23	2023-24	2024-25
Transport Infrastructure					
Capacity improvements to Wyndham Vale and Melton	..	22.0	..	..	..
Fitzroy Gasworks Sports Centre	..	0.2	0.2	0.2	..
Improving transport connections to Fishermans Bend	..	6.0	9.0	..	..
Public transport accessibility and amenity upgrades	..	7.3	2.6	..	..
Transport Safety and Security					
Emergency Management Sector Reform	4.4	11.8	9.2	1.5	1.5
Total output initiatives [e]	**317.6**	**334.3**	**177.6**	**73.7**	**61.0**
Base and efficiency review [f]	(8.5)	(81.9)	(128.8)	(112.0)	(111.8)

Source: Department of Treasury and Finance

Notes:

(a) This initiative will be funded from the Better Boating Fund.
(b) This initiative includes $0.4 million of funding from the Recreational Fishing License Trust.
(c) This initiative includes funding from the Transport Accident Commission.
(d) Funding represented as 0.0 due to rounding.
(e) Table may not add due to rounding.
(f) These savings acquit whole of government efficiencies announced in the 2019-20 Budget.

Accommodation and workplace modernisation strategy

Refer to the asset initiative for a description of this initiative.

Coronavirus (COVID-19) impacts on the transport network

Funding is provided to address the impacts of the coronavirus (COVID-19) pandemic on the transport network. This includes offsetting the impact of lower revenue for train, tram and bus operators to continue service delivery, additional cleaning to support public health and ensure that users are safe using public transport, providing traffic management at road and border checkpoints and compliance and monitoring of the commercial passenger vehicle industry.

This initiative contributes to the Department of Transport's:

- Bus Services – Statewide output;
- Regulation of Commercial Passenger Vehicle Services output;
- Road Network Performance output;
- Train Services – Metropolitan output;
- Train Services – Regional output;
- Train Services – Statewide output; and
- Tram Services output.

Maintenance and management of new assets

Funding is provided for operating and maintenance works on metropolitan and regional public transport assets that have begun or will begin operations before June 2022. This will facilitate delivery of public transport services, provide additional frontline staff at stations, and maintain new assets that give greater amenity and security.

This initiative contributes to the Department of Transport's:

- Road Asset Management output;
- Train Services – Metropolitan output;
- Train Services – Regional output;
- Train Services – Statewide output; and
- Tram Services output.

Bus Services

Bus service improvements and reform

Funding is provided to progress bus network reform and for the delivery of service changes and extensions across Victoria including:

- route adjustments and extensions to complement Big Build projects;
- school special services in Shepparton and Horsham;
- new and extended routes in Clyde, Clyde North and Tarneit North;
- network changes in the Yarra Valley and Broadmeadows;
- additional services between Moonee Ponds and Melbourne University;
- upgrades and improvements to the Sunbury bus interchange;
- service uplifts for bus routes between Fishermans Bend and the Melbourne central business district;
- improvements to the bus interchange near the former General Motors Holden site; and
- operational improvements at Southern Cross Station to improve the reliability of existing bus services.

Funding is also provided to continue the Westgate Punt ferry service across the Yarra River between Fishermans Bend and Spotswood.

This initiative contributes to the Department of Transport's:

- Bus Services – Metropolitan;
- Bus Services – Statewide output; and
- Transport Infrastructure output.

Fishing and Boating

Better boating facilities

Critical boating infrastructure will be upgraded at Warrnambool and Lake Bullen Merri. This will improve local boating facilities and increase accessibility for users, while supporting tourism and employment in the greater Warrnambool and Colac regions.

The Government will continue working with local councils and land managers to remove boat ramp parking and launching fees at Victoria's public boat ramps.

This initiative delivers on the Government's election commitment as published in *Labor's Financial Statement 2018*.

This initiative contributes to the Department of Transport's Fishing and Boating output.

Fisheries investment plan

Operational funding is provided for the fish hatchery in Shepparton. It will produce up to 1.6 million additional fish stock in Victorian waters every year, promote recreational fishing and support new jobs in the Shepparton region. The Victorian Fisheries Authority will strengthen its fishing crime enforcement and get a new ocean patrol vehicle to support its operations.

This initiative contributes to the Department of Transport's Fishing and Boating output.

Ports and Freight

Mode Shift Incentive Scheme

The Mode Shift Incentive Scheme will be continued, encouraging the transfer of freight from road to rail, reducing congestion and improving safety for all road users.

This initiative contributes to the Department of Transport's Ports and Freight output.

Sustainable local ports

Critical works will be undertaken on the breakwater in Apollo Bay and local port infrastructure at Lakes Entrance. These will improve user safety and accessibility to these facilities, while supporting local businesses and employment.

A new strategy and framework will be developed to guide future Government investment in Victoria's local port network.

This initiative contributes to the Department of Transport's Ports and Freight output.

Regulation of Commercial Passenger Vehicle Services

Multi-Purpose Taxi Program

The Multi-Purpose Taxi Program lifting fee and wheelchair accessible vehicle subsidy will continue to incentivise the supply of wheelchair-accessible vehicles and services for people with mobility needs.

This initiative contributes to the Department of Transport's Regulation of Commercial Passenger Vehicle Services output.

Road Asset Management

Murray River bridge crossing upgrades

Funding is provided to the road maintenance program for road surface replacement and bridge structure renewals at crossings along the Murray River. This work will address road asset deterioration and reduce road user exposure to safety hazards.

This initiative contributes to the Department of Transport's Road Asset Management output.

Road Operations

A more productive road network for freight

Refer to the asset initiative for a description of this initiative.

Active transport

Refer to the asset initiative for a description of this initiative.

Bulla Bypass

Funding is provided to progress planning for a bypass of Bulla, to relieve pressure on the Sunbury to Bulla Road and improve transport connections in Melbourne's growing north.

This initiative contributes to the Department of Transport's:

- Road Operations output; and
- Transport Infrastructure output.

Ison Road – Rail Overpass

Refer to the asset initiative for a description of this initiative.

Metropolitan Road Upgrades

Refer to the asset initiative for a description of this initiative.

Regional Road Upgrades

Refer to the asset initiative for a description of this initiative.

Road Safety Strategy

Refer to the asset initiative for a description of this initiative.

School crossing supervisor program

Local government authorities will receive funding to enhance school crossing supervision and increase road safety around schools.

This initiative contributes to the Department of Transport's Road Safety output.

Zero and low emission vehicles: commercial sector

Funding is provided for a new innovation fund to encourage the early adoption of zero and low emission vehicles by the commercial sector, including the commercial passenger vehicle, freight and construction sectors. This initiative will invite proposals from industries that support transition towards zero and low emission technologies.

This is a component of the comprehensive Zero Emissions Vehicles (ZEV) package made possible by a zero and low-emissions vehicle road user charge.

This initiative contributes to the Department of Transport's:

- Ports and Freight output;
- Regulation of Commercial Passenger Vehicle Services output; and
- Road Network Performance output.

Train Services

Caulfield rationalisation works

Refer to the asset initiative for a description of this initiative.

Caulfield Station Interchange Project: planning

Funding is provided to plan for future upgrades at Caulfield Station to improve customer amenity and passenger flows, noting that an increase in platform-to-platform interchange movements is expected at the station after the opening of the Metro Tunnel.

This initiative contributes to the Department of Transport's:

- Train Services – Metropolitan output; and
- Transport Infrastructure output.

Regional rail sustainability

Refer to the asset initiative for a description of this initiative.

RideSpace

Real-time passenger crowding information is being provided for metropolitan trains, stations and platforms through the RideSpace online tool launched in January 2021. Access to real-time information will help passengers to make decisions about which train services they are comfortable using.

This initiative contributes to the Department of Transport's Train Services – Statewide output.

Rolling stock maintenance and disposal programs

Refer to the asset initiative for a description of this initiative.

South Dynon train maintenance facility

Refer to the asset initiative for a description of this initiative.

Tram Services

Tram infrastructure upgrades

Refer to the asset initiative for a description of this initiative.

Tram performance

Refer to the asset initiative for a description of this initiative.

Transport Infrastructure

Capacity improvements to Wyndham Vale and Melton

Refer to the asset initiative for a description of this initiative.

Fitzroy Gasworks Sports Centre

Refer to the asset initiative for a description of this initiative.

Improving transport connections to Fishermans Bend

The Government will continue planning development and protection for transit corridors within Fishermans Bend. This includes planning for land acquisition and corridor protection in the precinct, as well as further investigation of the feasibility of high capacity transport options.

This initiative contributes to the Department of Transport's Transport Infrastructure output.

Public transport accessibility and amenity upgrades

Refer to the asset initiative for a description of this initiative.

Transport Safety and Security

Emergency Management Sector Reform

Refer to the Department of Justice and Community Safety for a description of this initiative.

Departmental efficiency measures

Base and efficiency review

The Department of Transport will reduce portfolio operating expenditure by streamlining administrative and policy functions, including through reducing functional overlaps, program consolidation, the implementation of new technologies and improvements to business processes.

Asset initiatives

Table 1.23: Asset initiatives – Department of Transport **($ million)**

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*	*TEI*
Accommodation and workplace modernisation strategy	..	4.7	4.5	..	..	9.1
Bus Services						
Bus service improvements and reform	..	8.2	5.4	..	..	13.7
Safer public transport	..	1.9	1.2	..	..	3.1
Fishing and Boating						
Fisheries investment plan [(a)]	..	0.7	..	..	..	0.7
Ports and Freight						
Sustainable local ports	..	1.6	..	..	..	1.6
Road Operations						
A more productive road network for freight	..	19.3	7.8	6.7	5.6	39.4
Active transport	..	5.2	10.7	..	..	15.9
Improving the Calder Freeway [(b)]	2.0	12.0	85.8	0.2	..	100.0
Ison Road – Rail Overpass [(c)]	..	10.3	..	..	..	tbc
Metropolitan Road Upgrades	..	2.4	6.4	15.4	6.6	30.8
Mickleham Road Upgrade Stage 1 [(d)]	..	14.9	..	..	..	tbc
Regional Road Upgrades	..	4.1	12.7	..	..	16.7
Road Safety Strategy [(e)(f)]	226.4	56.6	10.7	15.7	20.7	330.0
Train Services						
Caulfield rationalisation works [(g)]	0.3	46.8	123.2	38.6	5.9	240.1
Lydiard Street Level Crossing Upgrade	..	4.2	6.3	..	..	10.5
New metropolitan trains [(g)(h)]	tbc	tbc	tbc	tbc	tbc	985.8
Regional rail sustainability	..	133.0	107.9	110.5	113.2	464.6
Rolling stock maintenance and disposal programs [(g)]	..	44.5	65.3	9.1	5.5	125.1
South Dynon train maintenance facility [(i)]	tbc	tbc	tbc	tbc	tbc	tbc
Tram Services						
Tram infrastructure upgrades [(g)]	..	0.5	25.7	124.0	138.6	367.6
Tram performance [(j)]	..	9.1	12.6	15.0	..	36.7
Transport Infrastructure						
Capacity improvements to Wyndham Vale and Melton	..	50.7	20.9	..	..	71.6
Central Pier Docklands redevelopment	..	3.0	..	..	..	3.0
Fitzroy Gasworks Sports Centre [(k)]	..	4.8	42.5	7.1	..	54.5
Public transport accessibility and amenity upgrades	..	14.1	1.4	..	..	15.5
Total asset initiatives [(l)]	**228.7**	**680.9**	**766.9**	**548.0**	**534.2**	**3 082.9**

Source: Department of Treasury and Finance

Notes:

(a) This project will be funded from the Recreational Fishing License Trust.
(b) This project includes Commonwealth funding of $50 million.
(c) The State has committed $10.3 million for early works. The TEI and estimated completion date will be disclosed following funding consideration of future work packages.
(d) Includes funding of $7.3 million sourced from the Metropolitan Road and Intersection Upgrades project. The State has committed $14.9 million for early works. The TEI and estimated completion date will be disclosed following funding consideration of future works packages.
(e) This project includes funding from the Transport Accident Commission.
(f) This project includes Commonwealth funding of $183.3 million.
(g) The TEI includes funding beyond 2024-25.
(h) Funding allocation is not reported at this time due to the commercial sensitivity of the procurement process.
(i) The TEI will be disclosed following further project planning and development.

Notes (continued):
(j) This project includes funding of $1.0 million from the City of Melbourne.
(k) This project includes funding contribution from the City of Yarra.
(l) Table may not add due to rounding. Totals include expenditure for initiatives with 'tbc'.

Accommodation and workplace modernisation strategy

Funding is provided to optimise the Department of Transport's use of office space, undertake critical works, and uplift productivity through new flexible working arrangements.

This initiative contributes to all outputs of the Department of Transport.

Bus Services

Bus service improvements and reform

Refer to the output initiative for a description of this initiative.

Safer public transport

Toughened glass safety screens will be installed on 450 Victorian buses to improve safety and security for bus drivers. Handrails will also be replaced across the tram fleet to improve safety for passengers.

This initiative contributes to the Department of Transport's:

- Bus Services – Metropolitan output; and
- Tram Services output.

Fishing and Boating

Fisheries investment plan

Refer to the output initiative for a description of this initiative.

Ports and Freight

Sustainable local ports

Refer to the output initiative for a description of this initiative.

Road Operations

A more productive road network for freight

A new automated road assessment and permit system will be developed to allow heavy vehicles to access the road network in a faster and more efficient way. Pre-approved heavy vehicle types and mapping of key routes will be expanded to support safer and more reliable heavy freight movements.

Funding is also provided for a program of priority bridge upgrades and renewal works to improve safety and productivity across the State's road network.

This initiative contributes to the Department of Transport's:

- Road Asset Management output;
- Road Network Performance output; and
- Road Safety output.

Active transport

A package of priority projects will be funded to promote Victoria's walking and cycling network safety and usage, including:

- early works for a new shared trail between Eltham and Greensborough;
- a bridge structure with shared bike and walking lanes along the Kew to Highett Strategic Cycling Corridor at Toorak Road, as part of the Anniversary Trail; and
- pedestrian infrastructure at the intersection of Highbury Road, Seven Oaks Road and Newhaven Road in eastern metropolitan Melbourne.

Active Transport Victoria will continue to plan and deliver active transport commitments across Victoria's walking and cycling network.

This initiative contributes to the Department of Transport's:

- Road Network Performance output; and
- Transport Infrastructure output.

Improving the Calder Freeway

Funding is provided to progress planning of targeted upgrades, including improvements to safety and capacity at Calder Park Interchange, along the Calder Freeway between Gap Road in Sunbury and the M80 Ring Road. This initiative is supported by co-funding from the Commonwealth Government.

This initiative contributes to the Department of Transport's:

- Road Network Performance output; and
- Transport Infrastructure output.

Ison Road – Rail Overpass

Funding is provided to progress early works for the construction of a bridge over the Geelong-Melbourne rail line to connect Ison Road through Wyndham West and the Princes Freeway corridor. Once completed, this will allow for direct travel between developing residential areas in Melbourne's west and employment and education precincts.

Funding is also provided to develop a business case for upgrades to the Werribee Main Road/Princes Freeway interchange.

This initiative contributes to the Department of Transport's Road Network Performance output.

Metropolitan Road Upgrades

Funding is provided for a number of upgrades on metropolitan roads to improve safety and travel times, and to develop high-priority projects for future upgrades, at locations including:

- Springvale Road and Virginia Street intersection, Springvale;
- Canterbury Road and Heathmont Road intersection, Heathmont;
- Bulla Road and Tullamarine Freeway Interchange;
- Somerton Road, Mickleham Road to Roxburgh Park Drive;
- Craigieburn Road East, Hume Freeway Overpass to Epping Road;
- York Road between Swansea Road and Monbulk Road, Mount Evelyn;
- Derrimut Road, Hopkins Road and Boundary Road in Tarneit; and
- Punt Road, Princes Highway East to Swan Street, Richmond.

This initiative contributes to the Department of Transport's:

- Road Network Performance output; and
- Road Safety output.

Mickleham Road Upgrade Stage 1

Funding is provided to progress early works for the upgrade of Mickleham Road between Somerton Road and Dellamore Boulevard, Greenvale to improve transport connections in Melbourne's growing north.

This initiative contributes to the Department of Transport's:

- Road Network Performance output; and
- Transport Infrastructure output.

Regional Road Upgrades

Funding is provided for a number of upgrades on regional roads to improve network efficiency and road safety, and to develop high-priority projects, at locations including:

- Western Freeway and Learmonth Road intersection;
- Corridor Improvements, Surf Coast Highway;
- Corridor Improvements, Bellarine Link Stage 1, Geelong;
- Bunurong Road, Cape Paterson;
- Traffic Controllers, Barwon Heads; and
- Black Forest Drive, Woodend.

Funding is also provided for the Heavy Vehicle Safety and Productivity Program and Bridges Renewal Program.

This initiative contributes to the Department of Transport's:

- Road Network Performance output; and
- Road Safety output.

Road Safety Strategy

Initiatives under the new Road Safety Strategy 2021-2030 and first Action Plan will be delivered. These initiatives will support research and development into new safety technologies, identify strategies to increase public awareness and compliance, and promote road safety for vulnerable road users, including food-delivery riders and older drivers.

Additional cameras will be installed across Victoria's road network to reduce the risk of speeding related fatalities and serious injuries. The Department of Transport will review drink-driving and other policies, and enforcement options to detect mobile telephone related driving offences.

Further road safety infrastructure will be delivered, with co-funding from the Commonwealth, across metropolitan and regional Victoria, including road sealing, traffic signal upgrades, signage and safety barrier installation.

This initiative contributes to the Department of Transport's Road Safety output.

Train services

Caulfield rationalisation works

Track infrastructure at Caulfield Junction will be upgraded to allow for increased train speeds and improved service plans. Funding will also be provided for additional traction power feeders and security fencing upgrades to improve reliability.

This initiative contributes to the Department of Transport's:

- Train Services – Metropolitan output; and
- Transport Infrastructure output.

Lydiard Street Level Crossing Upgrade

Funding is provided to upgrade and reopen the Lydiard Street Level Crossing, relinking both sections of Lydiard Street and improving access to the station and businesses in the Ballarat activity centre.

This initiative contributes to the Department of Transport's:

- Train Services output; and
- Transport Infrastructure output.

New metropolitan trains

The Government will buy 25 new trains to improve reliability, accessibility, and passenger experience on the metropolitan network.

The new trains will be manufactured in Victoria, supporting a significant number of local manufacturing and supply chain jobs. These new trains will allow replacement of the Comeng fleet to continue and support Victoria's compliance with Commonwealth accessibility standards and rail safety regulations.

Funding is also provided to upgrade the Craigieburn train maintenance facility to support the delivery and operation of new trains.

This initiative contributes to the Department of Transport's Train Services – Metropolitan output.

Regional rail sustainability

V/Line will receive funding certainty to support train reliability and punctuality standards. A program of works, including major periodic maintenance and routine maintenance will be delivered across the regional rail network.

This initiative contributes to the Department of Transport's Train Services – Regional output.

Rolling stock maintenance and disposal programs

Life extension and sustainability programs for the Comeng/Classic fleet and A and Z-Class trams will be implemented to continue safe and reliable operations on the network.

Funding is also provided to progress the disposal of decommissioned Comeng trains, which will free up stabling capacity on the metropolitan network.

This initiative contributes to the Department of Transport's:

- Train Services – Metropolitan output;
- Train Services – Regional output; and
- Tram Services output.

South Dynon train maintenance facility

The South Dynon train maintenance facility will be upgraded to provide additional maintenance capacity for the regional VLocity fleet.

These works will ensure new VLocity trains can be maintained and support service uplifts on the regional network.

This initiative contributes to the Department of Transport's Train Services – Regional output.

Tram Services

Tram infrastructure upgrades

Funding is provided to deliver enabling infrastructure to support the deployment of Next Generation Trams including construction of a new tram maintenance facility in Melbourne's north-west, upgrades to Southbank Depot and land acquisition for new power substations.

This initiative contributes to the Department of Transport's Tram Services output.

Tram performance

The performance of the tram network will be enhanced through the installation of non-mountable tram kerbs in six Melbourne central business district locations to better separate trams and road traffic to prevent collisions, improve safety and reduce travel disruptions. St Kilda Road corridor tram services to accommodate the impact of Melbourne Metro Tunnel construction traffic disruptions will also continue.

Funding is also provided to sustain the tram Automatic Vehicle Monitoring system which manages and monitors tram services. This investment will mitigate the risk of major tram service disruptions and ensure the system can continue to operate while a replacement system is developed.

This initiative contributes to the Department of Transport's Tram Services output.

Transport Infrastructure

Capacity improvements to Wyndham Vale and Melton

Infrastructure upgrades will be delivered along the Wyndham Vale and Melton corridors to enable the future operation of higher capacity trains.

Funding is also provided to undertake development work for a new commuter train, as a future replacement for the existing classic fleet currently operating on regional lines.

This initiative contributes to the Department of Transport's Transport Infrastructure output.

Central Pier Docklands redevelopment

Funding is provided to develop the concept design and business case for demolition and redevelopment of Central Pier at Docklands.

This initiative contributes to the Department of Transport's Transport Infrastructure output.

Fitzroy Gasworks Sports Centre

A multi-purpose sports centre will be built in the Fitzroy Gasworks Precinct. The centre will be located adjacent to the new Fitzroy Gasworks Senior Campus and include four indoor courts, an additional rooftop court and a gym.

This initiative contributes to the Department of Transport's Transport Infrastructure output.

Public transport accessibility and amenity upgrades

Funding is provided for a package of works to deliver accessibility and amenity improvements across the public transport network including:

- preparation of a public transport accessibility strategy that will set out a pathway for realising universal accessibility across the public transport network;
- design and development for level-access upgrades to seven tram stop pairs critical to tram service reconfigurations after the Metro Tunnel opening;
- minor accessibility, amenity and safety improvements through the installation of braille plates at 1 200 trams stops; tactile ground surface indicators at 1 027 tram stops; concrete hardstands at 203 tram stops; and better lighting, weather protection and road markings at 42 high-priority tram stops;
- completion of the Mills Street tram stop upgrade in Middle Park;
- amenity and safety upgrades at metropolitan train stations, including Aspendale; Burnley; North Richmond; and Ruthven station; as well as planning for an upgrade of the Windsor station southern platform second entrance; and
- accessibility, amenity and safety upgrades to nine bus stops around Greensborough Station as part of precinct improvements being delivered in conjunction with the Hurstbridge Line Upgrade.

This initiative contributes to the Department of Transport's:

- Transport Infrastructure output;
- Transport Safety and Security output; and
- Train Services output.

DEPARTMENT OF TREASURY AND FINANCE

Output initiatives

Table 1.24: Output initiatives – Department of Treasury and Finance ($ million)

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*
Budget and Financial Advice					
Improving expenditure advice, oversight and accountability	..	4.5	4.0	4.0	4.0
Commercial and Infrastructure Advice					
Acquisition of Bendigo GovHub	..	0.6	..	..	..
Boosting efficiency in infrastructure procurement: resourcing the Construction Supplier and Residential Cladding Rectification Registers	..	1.5	1.3	1.3	1.1
Demolition works at 80-90 Champion Road, Newport	9.0	..	..	..	..
Demolition works at the former Energy Brix Australia Corporation site, Morwell	10.2	..	..	..	..
Monitoring and assurance of the state capital program	..	5.3	4.7	3.1	3.1
Economic and Policy Advice					
Embedding early intervention in government service delivery	..	4.1	3.8	3.8	3.8
Partnerships Addressing Disadvantage	..	6.3	6.2	6.6	6.6
Economic Regulatory Services					
Expansion of regulatory activities of the Essential Services Commission [(a)]	..	0.6	0.5	0.5	0.5
Support for the expansion of the Victorian Energy Upgrades program	0.2	1.7	1.7	1.5	1.5
Invest Victoria					
Victorian Government Trade and Investment Network	..	1.2	..	..	..
Revenue Management and Administrative Services to Government					
Distillery door grant	..	0.1	5.0	5.0	..
State Revenue Office Advanced Revenue Management Program	..	16.6	16.8	17.7	18.6
Services to Government					
Centralised Accommodation Management	0.8	1.6	1.6	..	..
Zero and low emission vehicles: government fleet	..	3.2	11.8	..	..
Total output initiatives [(b)]	**20.2**	**47.2**	**57.3**	**43.4**	**39.1**
Base and efficiency review [(c)]	..	(5.0)	(12.5)	(17.5)	(20.0)

Source: Department of Treasury and Finance

Notes:

(a) Includes $2.0 million to be held in contingency to be allocated to the Economic Regulatory Services output as required.

(b) Table may not add due to rounding.

(c) These savings acquit whole of government efficiencies announced in the 2019-20 Budget.

Budget and Financial Advice

Improving expenditure advice, oversight and accountability

Funding is provided to increase the Department of Treasury and Finance's budget and finance analytical and monitoring capabilities, and reform the whole of government Departmental Funding Model to increase financial oversight, better support effective and efficient program delivery and improved performance measurement.

This initiative contributes to the Department of Treasury and Finance's Budget and Financial Advice output.

Commercial and Infrastructure Advice

Acquisition of Bendigo GovHub

Refer to the asset initiative for a description of this initiative.

Boosting efficiency in infrastructure procurement: resourcing the Construction Supplier and Residential Cladding Rectification Registers

Funding is provided to boost the resilience, capacity and use of the Construction Supplier Register and Residential Cladding Rectification Register. The registers improve procurement efficiency by simplifying and streamlining procurement processes by pre-qualifying suppliers.

This initiative contributes to the Department of Treasury and Finance's Commercial and Infrastructure Advice output.

Demolition works at 80-90 Champion Road, Newport

Funding is provided to demolish the former TAFE buildings and warehouses at the Champion Road site to reduce ongoing site maintenance costs and the risks associated with unauthorised persons entering the premises.

This initiative contributes to the Department of Treasury and Finance's Commercial and Infrastructure Advice output.

Demolition works at the former Energy Brix Australia Corporation site, Morwell

Funding is provided to conduct demolition works, asbestos disposal and remediation at the former Energy Brix Australia Corporation site.

This initiative contributes to the Department of Treasury and Finance's Commercial and Infrastructure Advice output.

Monitoring and assurance of the state capital program

Funding is provided to strengthen the Department of Treasury and Finance's monitoring of the State's infrastructure pipeline and undertake capital project assurance reviews. This includes funding for the Office of Projects Victoria to identify and remove barriers to construction efficiency. The Gateway Review Process will also be improved to better identify risks and manage potential cost pressures.

This initiative contributes to the Department of Treasury and Finance's Commercial and Infrastructure Advice output.

Economic and Policy Advice

Embedding early intervention in government service delivery

Funding is provided to lead and implement an early intervention framework across government to support reforms that invest early for better and fairer outcomes.

This initiative contributes to the Department of Treasury and Finance's Economic and Policy Advice output.

Partnerships Addressing Disadvantage

Funding is provided to expand the Partnerships Addressing Disadvantage (PAD) initiative through a fifth program that will directly target and address pervasive social issues to support vulnerable Victorians. Resources will also be provided to streamline the current PAD process and to deliver robust monitoring and evaluation outcomes. This PAD will be focused on solutions to address homelessness.

This initiative contributes to the Department of Treasury and Finance's Economic and Policy Advice output.

Economic Regulatory Services

Expansion of regulatory activities of the Essential Services Commission

Funding is provided to the Essential Services Commission (ESC) to support trials of innovative energy products and services, such as microgrids and virtual power plants, which are not currently permitted under energy rules. This will encourage new jobs and integrate more large-scale renewables and distributed energy resources in Victoria. The ESC will also report on the outcomes of these trials and make recommendations to the Government on ways to further reduce red tape for the energy sector.

This initiative contributes to the Department of Treasury and Finance's Economic Regulatory Services output.

Support for the expansion of the Victorian Energy Upgrades program

Funding is provided to the ESC to support the recent expansion of targets to the Victorian Energy Upgrades program. This includes upgrades to the ESC's information technology system to give expanded services to program participants.

This initiative contributes to the Department of Treasury and Finance's Economic Regulatory Services output.

Invest Victoria

Victorian Government Trade and Investment Network

Refer to the Department of Jobs, Precincts and Regions for a description of this initiative.

Revenue Management and Administrative Services to Government

Distillery door grant

A distillery door grant capped at $5 million a year for two years will be introduced from 2021-22. Eligible claims will be paid to producers at the capped rate of $25 per litre of alcohol in eligible product sales sold through the 'distillery door'. If the scheme is over-subscribed, the rebate per litre of alcohol will be reduced equally for all the eligible applicants. The State Revenue Office will administer the claims from 2021-22. This scheme is designed to support and enhance Victoria's distillery industry.

This initiative contributes to the Department of Treasury and Finance's Revenue Management and Administrative Services to Government output.

State Revenue Office Advanced Revenue Management Program

Refer to the asset initiative for a description of this initiative.

Services to Government

Centralised Accommodation Management

Refer to the asset initiative for a description of this initiative.

Zero and low emission vehicles: government fleet

Funding is provided to encourage zero emission vehicle uptake across the government fleet through direct procurement and infrastructure upgrades to government owned and leased buildings. This is a component of the comprehensive Zero Emissions Vehicles (ZEV) package made possible by a zero and low-emissions vehicle road user charge.

This initiative contributes to the Department of Treasury and Finance's Services to Government output.

Departmental efficiency measures

Base and efficiency review

The Department of Treasury and Finance will reduce its operating expenditure through efficiencies generated by streamlining internal processes and corporate functions and reducing expenditure on consultants.

Asset initiatives

Table 1.25: Asset initiatives – Department of Treasury and Finance ($ million)

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*	*TEI*
Commercial and Infrastructure Advice						
Acquisition of Bendigo GovHub	..	120.8	..	..	..	120.8
Boosting efficiency in infrastructure procurement: resourcing the Construction Supplier and Residential Cladding Rectification Registers	..	0.1	1.0	..	..	1.0
Economic Regulatory Services						
Support for the expansion of the Victorian Energy Upgrades program	..	0.5	0.1	..	..	0.6
Revenue Management and Administrative Services to Government						
State Revenue Office Advanced Revenue Management Program	0.3	6.6	5.9	5.9	5.9	24.4
Services to Government						
Centralised Accommodation Management	..	9.2	0.7	..	..	9.8
Total asset initiatives [(a)]	**0.3**	**137.1**	**7.6**	**5.9**	**5.9**	**156.6**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Commercial and Infrastructure Advice

Acquisition of Bendigo GovHub

Funding was provided to acquire the Bendigo GovHub, located at the site of the City of Greater Bendigo offices, to provide office accommodation for local and state government workers.

This initiative contributes to the Department of Treasury and Finance's Commercial and Infrastructure Advice output.

Boosting efficiency in infrastructure procurement: resourcing the Construction Supplier and Residential Cladding Rectification Registers

Refer to the output initiative for a description of this initiative.

Economic Regulatory Services

Support for the expansion of the Victorian Energy Upgrades program

Refer to the output initiative for a description of this initiative.

Revenue Management and Administrative Services to Government

State Revenue Office Advanced Revenue Management Program

Funding is provided to the State Revenue Office (SRO) to modernise its Revenue Management System. This will provide a better customer experience and increase the SRO's efficiency and effectiveness in collecting a range of State taxes, duties and levies, as well as broader administration of a range of programs.

This initiative contributes to the Department of Treasury and Finance's Revenue Management and Administrative Services to Government output.

Services to Government

Centralised Accommodation Management

Funding is provided for additional resources to implement the Accommodation Management Efficiency Program, a core component of Centralised Accommodation Management that aims to generate savings in the State's managed office accommodation portfolio.

This initiative contributes to the Department of Treasury and Finance's Services to Government output.

PARLIAMENT

Output initiatives

Table 1.26: Output initiatives – Parliament **($ million)**

	2020-21	2021-22	2022-23	2023-24	2024-25
Legislative Council					
Legislative Council Standing Committees	..	0.9	0.9	..	..
Parliamentary Budget Office					
PBO: Funding for 2022 general election costs	..	..	0.9	..	..
Parliamentary Services					
Cybersecurity upgrades	..	2.0	2.1	2.2	2.3
Implementation of Victorian Independent Remuneration Tribunal and Improving Parliamentary Standards Act	..	2.2	..	..	..
Increase in Members of Parliament electorate office and communication budgets	..	0.1	0.2	0.2	0.2
Parliamentary Investigatory Committees					
Performance audit of Independent Broad-based Anti-corruption Commission	..	0.4	..	..	..
Public Sector Integrity					
IBAC: Enhancing Complainant Experience and IBAC's Compliance Capability	..	0.9	0.8	..	..
IBAC: Enhancing support provided to the Victorian public sector to prevent corruption and police misconduct [(a)]	..	1.3	1.6	1.0	..
IBAC: Information Technology Strategy [(a)]	0.6	1.5	0.8	0.3	0.3
Royal Commission into the Management of Police Informants	..	0.5	1.4	1.4	1.3
VO: Sustainable base funding for the Victorian Ombudsman	..	1.8	2.5	3.0	3.5
Total output initiatives [(b)]	**0.6**	**11.6**	**11.1**	**8.2**	**7.6**

Source: Department of Treasury and Finance

Notes:

(a) A Treasurer's Advance of $7 million in 2021-22 will also be approved for urgent additional investigative, prevention, review and communications activities. IBAC has agreed to undertake a base review of its operations over the next 12 months, which the Government will use to inform any need for further resourcing in the future.

(b) Table may not add due to rounding.

Legislative Council

Legislative Council Standing Committees

Funding is provided to Parliament to support the Infrastructure, Environment and Planning, Legal and Social Issues Legislative Council Standing Committees.

This initiative contributes to Parliament's Legislative Council output.

Parliamentary Budget Office

PBO: Funding for 2022 general election costs

Funding is provided to the Parliamentary Budget Office to provide additional independent and policy costing and advisory services to Members of Parliament in the lead up to and following the 2022 general election.

This initiative contributes to the Parliament's Parliamentary Budget Office output.

Parliamentary Services

Cybersecurity upgrades

Funding is provided to implement cybersecurity systems testing, training and awareness programs, improve incident response mechanisms, embed 24-hour cyber event logging and upgrade existing information and communication technology security systems. This will improve Parliament's ability to prevent and respond to cybersecurity threats.

This initiative contributes to Parliament's Parliamentary Services output.

Implementation of Victorian Independent Remuneration Tribunal and Improving Parliamentary Standards Act

Funding is provided to enable the Department of Parliamentary Services to meet the reporting requirements of the *Victorian Independent Remuneration Tribunal and Improving Parliamentary Standards Act 2019* (VIRTIPS Act) for the Parliament of Victoria.

This initiative contributes to Parliament's:

- Legislative Assembly output;
- Legislative Council output; and
- Parliamentary Services output.

Increase in Members of Parliament electorate office and communication budgets

The electorate office and communication budgets for Members of Parliament are calculated based on the number of voters enrolled in their electorate as at the last day of February of the previous financial year as per the determination of the Victorian Independent Remuneration Tribunal. In accordance with the most recent determination of the Tribunal, Parliament will receive additional funding for electorate office and communication budgets.

This initiative contributes to Parliament's Parliamentary Services output.

Parliamentary Investigatory Committees

Performance audit of Independent Broad-based Anti-corruption Commission

Funding is provided to procure the services of an independent auditor to assess the performance of the Independent Broad-based Anti-corruption Commission (IBAC). The audit's objectives are to determine whether IBAC is achieving its objectives effectively, economically and efficiently, as required under the *Independent Broad-based Anti-Corruption Commission Act 2011* (Vic).

This initiative contributes to Parliament's Parliamentary Investigatory Committees output.

Public Sector Integrity

IBAC: Enhancing Complainant Experience and IBAC's Compliance Capability

Funding is provided for IBAC to meet its legislative obligations under amendments introduced in 2020 to the *Public Interest Disclosure (PID) Act 2012*. Additional resources will allow IBAC to implement the PID scheme and ensure timeliness and responsiveness when resolving PID matters.

This initiative contributes to Parliament's Public Sector Integrity output.

IBAC: Enhancing support provided to the Victorian public sector to prevent corruption and police misconduct

Funding is provided to IBAC to support its ability to prevent Victorian public sector corruption and police misconduct through a program of research, engagement and communications. A new website will also be developed together with resources tailored to culturally and linguistically diverse communities.

This initiative contributes to Parliament's Public Sector Integrity output.

IBAC: Information Technology Strategy

Funding is provided to IBAC to implement its Information Technology Strategy, which will support a capability uplift and modernise its technology to enable its staff to work securely and effectively from any location across Victoria. This will also facilitate the utilisation of advanced analytics while ensuring critical security obligations are met.

This initiative contributes to Parliament's Public Sector Integrity output.

Royal Commission into the Management of Police Informants

Refer to the Department of Justice and Community Safety for a description of this initiative.

VO: Sustainable base funding for the Victorian Ombudsman

Funding is provided to enable the Ombudsman to meet new and ongoing legislative requirements, respond to cost pressures in their operations, and support the transition to budget independence.

This additional funding will result in the Ombudsman being funded at a level equivalent to $75.70 per Victorian public servant in 2021-22. This is higher than New South Wales – which provided its equivalent agency with $73.32 per public servant in 2019-20 and also exceeds respective funding levels in Queensland, Western Australia and South Australia in that period.

This initiative contributes to Parliament's Public Sector Integrity output.

Asset initiatives

Table 1.27: Asset initiatives – Parliament **($ million)**

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*	*TEI*
Parliamentary Services						
Cybersecurity upgrades	..	0.1	0.2	0.2	0.1	0.5
Public Sector Integrity						
Royal Commission into the Management of Police Informants	..	0.3	..	..	..	0.3
Total asset initiatives [(a)]	**..**	**0.4**	**0.2**	**0.2**	**0.1**	**0.8**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Parliamentary Services

Cybersecurity upgrades

Refer to the output initiative for a description of this initiative.

Public Sector Integrity

Royal Commission into the Management of Police Informants

Refer to the Department of Justice and Community Safety for a description of this initiative.

COURT SERVICES VICTORIA

Output initiatives

Table 1.28: Output initiatives – Court Services Victoria **($ million)**

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*
Courts					
Establishing an Early Intervention Fast-Track model in the Industrial Division of the Magistrates' Court	..	1.7	2.6	2.6	2.7
Justice recovery	10.4	..	..	..	..
New Victorian Civil and Administrative Tribunal accommodation	..	1.5	..	..	..
Online Magistrates' Court	..	7.8	8.0	7.7	7.2
Professional Engineers Registration Scheme [(a)]	..	0.1	0.0	0.0	0.0
Responding to increasing pressure on Victoria's justice system		11.0	7.5	7.4	7.5
Royal Commission into the Management of Police Informants	..	3.0	3.0	3.0	3.0
Securing the proven benefits of innovation and service delivery reform	..	10.5	7.5	4.7	0.3
Specialist family violence integrated court response	..	10.1	11.6	10.7	10.2
Supporting victims of crime	..	0.2	0.2	0.2	0.2
Victorian Civil and Administrative Tribunal digital service transformation	..	10.5	11.4	4.3	1.6
Working with Children Check and National Disability Insurance Scheme worker screening [(a)]	..	0.1	0.0	0.0	0.0
Total output initiatives [(b)]	**10.4**	**56.2**	**51.9**	**40.7**	**32.7**

Source: Department of Treasury and Finance

Notes:
(a) Funding represented as 0.0 due to rounding.
(b) Table may not add due to rounding.

Courts

Establishing an Early Intervention Fast-Track model in the Industrial Division of the Magistrates' Court

Funding is provided to deliver the Government's election commitment to establish an Early Intervention Fast-Track model in the Industrial Division of the Magistrates' Court. The new model will facilitate the early resolution of unpaid wage claims and simplify court processes to make it faster, cheaper and easier for employees to recover the money they are owed through the Magistrates' Court.

This initiative contributes to Court Services Victoria's Courts output.

Justice recovery

Funding is provided to expand the Online Magistrates' Court, establish an online case management team in the Children's Court and employ additional audio-visual link technology support staff. This will increase court capacity to hear more matters remotely and address court delays caused by the coronavirus (COVID-19) public health restrictions.

Funding is also provided for a Coroners Court special investigation into the deaths of aged care residents arising from the coronavirus (COVID-19) pandemic, and additional Victorian Civil and Administrative Tribunal (VCAT) staff to reduce wait times for Guardianship List matters.

Funding for Justice recovery is also described under the Department of Justice and Community Safety.

This initiative contributes to Court Services Victoria's Courts output.

New Victorian Civil and Administrative Tribunal accommodation

Funding is provided to support VCAT identify new accommodation options.

This initiative contributes to Court Services Victoria's Courts output.

Online Magistrates' Court

Funding is provided to continue and expand the successful Online Magistrates' Court program, increasing the Magistrates' Court's capacity to hear more matters remotely, and improving access to justice, the court-user experience and court productivity.

This initiative contributes to Court Services Victoria's Courts output.

Professional Engineers Registration Scheme

Refer to the Department of Justice and Community Safety for a description of this initiative.

Responding to increasing pressure on Victoria's justice system

To ensure Victoria's courts continue to operate effectively and efficiently, funding is provided for:

- COVIDSafe initiatives across the court jurisdictions, including cleaning and personal protective equipment, that enable the courts to continue operating safely;
- additional County Court staff to address delays caused by the coronavirus (COVID-19) public health restrictions;
- additional judges for the County Court's Criminal Division to address the court backlog;
- additional support staff for new coroners, and funding to support the transportation of deceased persons to and from the coronial mortuaries across Victoria;

- the continuation of the Children's Court's online case management pilot, to increase the Children's Court's capacity to hear more matters virtually – improving the user experience and court productivity;
- additional resources for the Children's Court Clinic, to ensure the timely provision of psychological and psychiatric assessments of children and families, and reduce the cost of children spending unnecessary time in custody due to report delays;
- the continuation of the self-represented litigant support service provided by Justice Connect;
- Magistrates' Court health and wellbeing programs, including mental health first-aid training, and psycho-social risk assessment training; and
- Coroners Court support and counselling initiatives.

This initiative contributes to Court Services Victoria's Courts output.

Royal Commission into the Management of Police Informants

Refer to the Department of Justice and Community Safety for a description of this initiative.

Securing the proven benefits of innovation and service delivery reform

Funding is provided to continue existing court programs, including the:

- Youth Control Order program, which provides the Children's Court with an intensive and targeted supervision sentencing option;
- Intensive Bail Order program, which provides a supervision and support service for young people awaiting trial;
- Cubby House program, to provide a supportive and safe haven for children and young people dealing with traumatic family situations in the Broadmeadows and Melbourne Children's Courts;
- Shepparton Family Drug Treatment Court, to assist parents reduce their alcohol and drug dependence and regain custody of their children from out-of-home care, improving outcomes for at-risk children;
- active case management at the County and Supreme Courts to resolve more cases sooner and reduce judicial workload pressures; and
- VCAT's Knowledge Management System, to improve the quality and efficiency of VCAT's administrative services through digital and other service enhancements.

Funding is also provided to support the Judicial Commission of Victoria in its role investigating complaints about judicial officers and VCAT members, and increase the capacity of the Victims of Crime Assistance Tribunal to assist victims recover from a crime by providing financial assistance for expenses incurred.

This initiative contributes to Court Services Victoria's Courts output.

Specialist family violence integrated court response

Funding is provided to establish specialist family violence courts at the remaining Magistrates' Court headquarter courts to ensure they have the functions of Family Violence Court Division courts, further acquitting the recommendations of the Royal Commission into Family Violence. Funding is also provided to:

- undertake works at seven Magistrates' Court headquarter courts to ensure user safety and accessibility;
- continue the successful family violence remote hearing service, which will enable victim survivors and witnesses to give testimony remotely and safely;
- expand the Court Mandated Counselling Order Program to eight new locations across the State to hold perpetrators to account and drive behaviour change; and
- deliver statewide practitioner programs.

This initiative contributes to Court Services Victoria's Courts output.

Supporting victims of crime

Refer to the Department of Justice and Community Safety for a description of this initiative.

Victorian Civil and Administrative Tribunal digital service transformation

Funding is provided to VCAT to upgrade digital services infrastructure including the case management system and increase process automation, to deliver more accessible and timely provision of justice to citizens and businesses.

This initiative contributes to Court Services Victoria's Courts output.

Working with Children Check and National Disability Insurance Scheme worker screening

Refer to the Department of Justice and Community Safety for a description of this initiative.

Asset initiatives

Table 1.29: Asset initiatives – Court Services Victoria **($ million)**

	2020-21	*2021-22*	*2022-23*	*2023-24*	*2024-25*	*TEI*
Courts						
County Court Accommodation and Services Renewal	..	5.4	2.8	4.0	..	12.3
Justice recovery	0.2	..	..	..	..	0.2
Online Magistrates' Court	..	8.1	2.1	..	..	10.2
Responding to increasing pressure on Victoria's justice system	..	1.4	..	..	..	1.4
Royal Commission into the Management of Police Informants	..	1.0	..	..	..	1.0
Specialist family violence integrated court response	..	10.0	10.0	10.0	5.0	35.0
Victorian Civil and Administrative Tribunal digital service transformation	..	15.4	11.8	1.7	..	29.0
Total asset initiatives [(a)]	**0.2**	**41.3**	**26.8**	**15.7**	**5.0**	**89.0**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Courts

County Court Accommodation and Services Renewal

Funding is provided to enhance the County Court building to increase the availability of criminal court rooms, upgrade existing infrastructure and develop spaces to increase the safety and useability of the facilities for staff and people accessing court services consistent with a contemporary court facility.

This initiative contributes to Court Services Victoria's Courts output.

Justice recovery

Refer to the output initiative for a description of this initiative.

Online Magistrates' Court

Refer to the output initiative for a description of this initiative.

Responding to increasing pressure on Victoria's justice system

Refer to the output initiative for a description of this initiative.

Royal Commission into the Management of Police Informants

Refer to the Department of Justice and Community Safety for a description of this initiative.

Specialist family violence integrated court response

Refer to the output initiative for a description of this initiative.

Victorian Civil and Administrative Tribunal digital service transformation

Refer to the output initiative for a description of this initiative.

REVENUE INITIATIVES

Table 1.30: Revenue initiatives **($ million)**

	2020-21	2021-22	2022-23	2023-24	2024-25
Revenue measures					
Backing Victoria's Racing Industry: increased wagering and betting tax	..	47.6	48.3	49.5	50.8
Extend the point of consumption framework to keno tax	..	1.0	4.4	5.2	6.2
Increase land tax rates for high-value landholdings	..	335.9	368.0	397.2	433.3
Increase the tax-free threshold for land tax	..	(22.3)	(24.5)	(26.4)	(28.8)
Increased penalty unit value	..	60.7	62.5	63.4	65.0
Premium duty rate on land transfer duty for high-value properties	..	136.7	184.1	210.5	229.7
Removal of land tax exemption for private gender-exclusive clubs	..	0.1	0.1	0.2	0.2
Windfall gains tax for high-value landholdings	..	..	38.7	41.0	43.9
Economic Support and Recovery					
Bring forward increases in the payroll tax-free threshold to $700 000	..	(27.9)	..	..	..
Bring forward the regional employer payroll tax rate of 1.2125 per cent	..	(29.9)	..	..	..
Temporary increase in the eligibility threshold for the off-the-plan duty concession	..	(0.2)	(0.5)	(0.8)	(1.9)
Temporary land transfer duty concession for new residential property within the Melbourne local government area	(0.1)	(33.2)	(9.0)	(4.3)	(2.7)
Vacant residential land tax exemption for new developments	..	..	(0.6)	(0.6)	(0.6)
Total revenue initiatives [(a)]	**(0.1)**	**468.5**	**671.4**	**735.0**	**795.0**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding

Backing Victoria's Racing Industry: increased wagering and betting tax

Wagering and betting tax will increase from 8 per cent to 10 per cent of net wagering revenue from 1 July 2021, bringing Victoria into line with the rate that applies in New South Wales, and remaining below the rate that applies in other states. The new tax rate will enable the Government to lift the amount of net wagering revenue that is returned to the Victorian Racing Industry from 1.5 per cent to 3.5 per cent, protecting Victorian jobs.

The balance of revenue from the tax will continue to be distributed to the Hospitals and Charities Fund and the ANZAC Day Proceeds Fund.

Extend the point of consumption framework to keno tax

The Government will extend the point of consumption framework to keno tax from 15 April 2022 to ensure all companies supplying keno to Victorian customers pay their fair share. All licensed keno service providers will be liable to pay tax on expenditure of customers located in Victoria, regardless of where the service provider is located or licensed, at the prevailing rate.

Increase land tax rates for high-value landholdings

From 1 January 2022, the land tax rate for taxpayers with larger property holdings will increase by:

- 0.25 percentage points for taxable landholdings exceeding $1.8 million; and
- 0.3 percentage points for taxable landholdings exceeding $3 million.

This change will apply to both the general and trust surcharge rates, and support additional investment in the services and infrastructure the community relies on.

Increase the tax-free threshold for land tax

From 1 January 2022, the tax-free threshold for general land tax rates will increase from $250 000 to $300 000. This means for land not held on trust, land tax will only be payable if the total taxable value of Victorian land is equal to or exceeds $300 000. The trust rate scale will remain unchanged.

This initiative will benefit an estimated 61 000 taxpayers with taxable holdings below $300 000.

Increased penalty unit value

Following a freeze in 2020-21, the penalty unit value will increase by 10 per cent from 1 July 2021. The price increases apply to fines indexed under the *Monetary Units Act 2004,* which include traffic infringement fines and court-imposed penalties. This measure will contribute to budget repair while supporting community safety objectives.

Premium duty rate on land transfer duty for high-value properties

For contracts entered into from 1 July 2021, a new land transfer duty threshold for high-value property transactions will be introduced. For property transactions with a dutiable value above $2 million, the land transfer duty payable will increase to $110 000 plus 6.5 per cent of the dutiable value in excess of $2 million.

This change will support additional investment in the services and infrastructure the community relies on.

Removal of land tax exemption for private gender-exclusive clubs

From 1 January 2022, private gender-exclusive clubs will no longer be eligible for the land tax exemption for societies, clubs or associations. This initiative is expected to result in increased tax payable from private gender-exclusive clubs with high-value landholdings that currently receive a land tax exemption.

Windfall gains tax for high-value landholdings

From 1 July 2022, a tax will apply to large windfall gains associated with planning decisions to rezone land, ensuring that all Victorians receive a fair share of these windfall gains.

The total value uplift from a rezoning decision will be taxed at 50 per cent for windfalls above $500 000, with the tax phasing in from $100 000 – ensuring the vast majority of land holders will not be affected.

The tax is payable on rezonings across Victoria except on rezonings to and from the Urban Growth Zone within existing Growth and Infrastructure Contribution areas, and rezonings to Public Land Zones. The tax applies to rezonings between zone types rather than between zone sub-categories.

This initiative will help ensure developers and landholders who benefit from planning decisions pay their fair share.

Economic Support and Recovery

Bring forward increases in the payroll tax-free threshold to $700 000

To support Victorian jobs the Government will bring forward increases in the payroll tax-free threshold, which will increase from $650 000 to $700 000 from 1 July 2021.

Approximately 500 businesses will no longer be liable for payroll tax in 2021-22 due to the increase in the tax-free threshold and a further 42 000 businesses will pay less tax.

Bring forward the regional employer payroll tax rate of 1.2125 per cent

To support regional Victorian jobs the Government will bring forward reductions in the regional employer rate of payroll tax. The regional employer rate will reduce from 2.02 per cent to 1.2125 per cent from 1 July 2021.

Approximately 4 000 regional businesses will benefit from the reduced regional employer rate.

Temporary increase in the eligibility threshold for the off-the-plan duty concession

For contracts entered into from 1 July 2021 to 30 June 2023, the threshold for the off-the-plan concession for land transfer duty will increase to $1 million for all home buyers. Consistent with existing eligibility requirements, the property must be the principal place of residence for at least one of the purchasers.

This increase will mean that in order to be eligible for the off-the-plan duty concession, the dutiable value of the property (the contract price minus the construction costs incurred on or after the contract date) can be up to $1 million.

This initiative will support the residential construction sector and protect Victorian jobs.

Temporary land transfer duty concession for new residential property within the Melbourne local government area

A concession of up to 100 per cent of the land transfer duty payable will be provided on the purchase of new residential property, in the Melbourne local government area, with a dutiable value of up to $1 million.

For new residential property that has been unsold for less than 12 months since completion, a 50 per cent concession will be provided. Purchases of a new property that has been unsold for 12 months or more since completion will be exempt from duty. The exemption/concession will apply to the duty otherwise payable (excluding any foreign purchaser additional duty).

The 50 per cent concession will be in place for contracts entered into from 1 July 2021 to 30 June 2022, and the 100 per cent concession will be in place for contracts entered into from 21 May 2021 to 30 June 2022 (inclusive).

This measure supports housing affordability for buyers and renters of inner-city dwellings and will support new construction activity and protect Victorian jobs.

Vacant residential land tax exemption for new developments

From 1 January 2022, the vacant residential land tax exemption for new developments will be extended to apply for up to two years. This measure supports the construction sector by providing an exemption for at least two tax years following the completion of a newly constructed dwelling before the vacant residential land tax may apply.

SAVINGS

Table 1.31: Savings **($ million)**

	2020-21	2021-22	2022-23	2023-24	2024-25
More efficient and effective government	..	98.7	167.9	690.3	925.0

Source: Department of Treasury and Finance

More efficient and effective government

Expenditure will be redirected to ensure the continued efficient and effective delivery of government priorities. Expenditure will also be reviewed on an ongoing basis to ensure lower value spending is reprioritised and invested in priority areas.

In recognition of lower than previously forecast inflation, indexation applied to departments' base funding will be revised with differentiated rates provided for wage and non-wage components. Non-wage indexation will be guided by the Government's consumer price index forecasts. Wage indexation will be aligned to the Government's rebalanced wages policy, with impacts to be phased in from 1 January 2022.

This initiative is part of the Government's comprehensive strategy to return to an operating surplus in the medium term.

CHAPTER 2 – DEPARTMENT PERFORMANCE STATEMENTS

This chapter presents departmental performance statements that describe the objectives and associated performance indicators departments seek to achieve over the medium term. This chapter also describes the outputs (goods and services) that departments are funded to deliver to achieve these objectives.

Budget Paper No. 3, Chapter 1 *Service Delivery* describes the new initiatives that will be funded in 2021-22 and makes links with the base funding departments receive for ongoing programs. The departmental performance statements published in this chapter describe the services provided by the Government and, where relevant, have been updated to reflect the new initiatives in Chapter 1.

Performance measures for each output are divided into Quality, Quantity, Timeliness and Cost categories. The performance measures collectively describe the goods and services delivered, and how they are measured. The 2021-22 targets represent what the Government seeks or expects to achieve in the coming year. For each measure, targets and expected outcomes from 2020-21 allow a comparison of departmental performance from the previous year. Due to the timing of the *2020-21 Budget*, performance statements included the 2019-20 actual outcomes. As these outcomes have already been reported, the *2021-22 Budget* excludes 2019-20 performance information.

The Government is continuing to improve its performance reporting framework to provide more meaningful specification of the outputs delivered by departments, measures of successful delivery of these outputs, and a clear alignment with departmental objectives.

Output movements as a result of machinery of government changes

A range of machinery of government changes were implemented in 2020-21, including the creation of the new department; the Department of Families, Fairness and Housing. The departmental performance statements published in this chapter are organised according to the new structure of the Victorian public service.

Footnotes for outputs and performance measures that have moved as a result of the machinery of government changes indicate which department was previously responsible for delivering the service described.

The table below provides an overview of the movement of outputs between departments, including outputs split between departments.

Table 2.1: Movement of outputs as a result of machinery of government changes in 2020-21

Outputs	*Old department*	*New department*
Entire outputs moved between departments		
Acute Health Services [(a)] Ambulance Services [(a)] Drug Services [(a)] Mental Health [(a)] Primary, Community and Dental Health [(a)] Public Health [(a)] Small Rural Services [(a)]	Department of Health and Human Services	Department of Health
Child Protection and Family Services Concessions to Pensioners and Beneficiaries Disability Services Empowering Individuals and Communities [(a)] Family Violence Service Delivery Housing Assistance	Department of Health and Human Services	Department of Families, Fairness and Housing [(b)]
LGBTIQ+ equality policy and programs Multicultural affairs policy and programs Support to veterans in Victoria Women's policy Youth	Department of Premier and Cabinet	Department of Families, Fairness and Housing
Outputs split between departments		
Ageing, Aged and Home Care	Department of Health and Human Services	Department of Health Department of Families, Fairness and Housing [(c)]

Source: Department of Treasury and Finance

Notes:

(a) Includes all sub-outputs.

(b) As a consequence of the machinery of government transfers, there were some additional administrative transfers between the Departments of Health, and Families, Fairness and Housing, the Office of Disability and Community Participation outputs.

(c) Respite and support services was transferred to the Department of Families, Fairness and Housing's Seniors Programs and Participation output.

Other matters to note

Appendix A *Output performance measures for review by the Public Accounts and Estimates Committee* identifies performance measures that are proposed to be substantially changed or discontinued in 2021-22.

Situations where it is appropriate to substantially change or discontinue a performance measure include:

- a current measure can be replaced by a more appropriate measure and the new measure will provide more meaningful information to the Parliament and the public;
- it is no longer relevant due to a change in policies or priorities of the Government and/or departmental objectives;
- milestones, projects or programs have been completed, substantially changed, or discontinued; and
- funding is not provided in the current budget for the continuation of initiatives.

Changed or discontinued measures have been amended or replaced by new measures in instances where they can provide a stronger basis for evaluating the outcomes of performance of services to the community.

When reading the performance statements, 'nm' refers to a new performance measure and 'na' refers to measures that are either not applicable in the specified year or data is not available. Where a department has included a new measure in 2021-22, historical performance data has been provided, where available, to assist with analysis of the department's performance over time.

The impact of the coronavirus (COVID-19) pandemic on 2021-22 performance statements

In the *2020-21 Budget*, performance targets were set for what was considered a standard year. For many measures, this meant rolling forward targets from 2019-20 into 2020-21. This approach allows this budget to show the full anticipated impact of the coronavirus (COVID-19) pandemic on government performance through the 2020-21 expected outcomes.

In 2021-22, it is expected that some government services will be impacted by the ongoing effects of the COVID-19 pandemic. Similar to last year, the *2021-22 Budget* will set performance targets for a standard year. That is, where performance measures and targets have been changed or measures have been updated it is due to:

- annual routine movements which exclude the impact of the COVID-19 pandemic (e.g. target adjustments that are dependent on output costs); or
- new performance measures being added, and targets being revised, to reflect new initiatives in Chapter 1 *Output, asset investment, savings and revenue initiatives*.

Where new measures have been added because of funding decisions in 2021-22, the targets have similarly been set at what would be considered a standard year.

The standard year approach remains the most efficient and transparent way to set performance targets and measures in a COVID-19 setting. Estimating the impact of COVID-19 on performance targets remains difficult in 2021-22. The standard year approach will demonstrate the full impact of COVID-19 on government activities in the 2021-22 financial year, which will be reported in future budgets.

Removal of the Capital Assets Charge from output costs

The Capital Assets Charge (CAC) policy is discontinued from the *2021-22 Budget* and the CAC has been removed from all output costs in the *2021-22 Budget Paper No. 3*. In previous years, the CAC has been used to demonstrate the opportunity costs of utilising government assets.

While the inclusion of the CAC was reflected in the output cost it did not reflect the real distribution of funds to departments and public sector agencies. This is because departments were funded from the budget for their CAC expense, and departments then immediately paid the same amount back into the Consolidated Fund.

Removing the CAC does not disadvantage departments.

Rather, it creates more meaningful departmental financial information, generates administrative efficiency, and brings Victoria in line with budgeting practices of other Australian jurisdictions.

The removal of the CAC reduces departmental appropriations and output costs by the same amount. The restatement of output costs in this chapter provides a like-for-like basis for comparative purposes.

DEPARTMENT OF EDUCATION AND TRAINING

Ministerial portfolios

The Department supports the ministerial portfolios of early childhood, education, higher education, and training and skills.

Departmental mission statement

The Department of Education and Training's mission is captured within its statement of strategic intent:

> 'Together we give every Victorian the best learning and development experience, making our state a smarter, fairer and more prosperous place.'

As part of this vision, we want Victoria to be a place where:

- children and young people are confident, optimistic, healthy and resilient;
- students reach their potential, regardless of background, place, circumstance or abilities;
- Victorians develop knowledge, skills and attributes needed now and for the jobs of the future; and
- the Department's workforce is high performing, empowered, valued and supported.

The Department contributes to the Government's commitment to building the Education State by ensuring that every Victorian has access to the best learning and development experience.

Departmental objectives

Achievement

Raise standards of learning and development achieved by Victorians using education, training, and early childhood education services.

Engagement

Increase the number of Victorians actively participating in education, training, and early childhood education services.

Wellbeing

Increase the contribution education, training, and early childhood education services make to good health and quality of life for all Victorians, particularly children and young people.

Productivity

Increase the productivity of our services.

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ millions)

	2020-21 budget	*2020-21 expected outcome*	*2021-22 budget*	*Variation [(a)] %*
Strategy, Review and Regulation	117.6	118.6	117.8	0.2
Early Childhood Education	843.7	815.1	973.4	15.4
School Education – Primary	5 448.9	5 476.3	5 765.9	5.8
School Education – Secondary	4 447.5	4 471.4	4 713.1	6.0
Training, Higher Education and Workforce Development	2 579.5	2 575.6	2 599.8	0.8
Support Services Delivery	387.4	389.1	389.1	0.4
Support for Students with Disabilities	1 172.0	1 160.0	1 363.6	16.4
Total [(b)(c)]	**14 996.7**	**15 006.0**	**15 922.8**	**6.2**

Source: Department of Education and Training

Notes:

(a) Variation between the 2020-21 budget and the 2021-22 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant output cost.

(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget *and CAC impacts are therefore excluded from the figures. Refer to individual output sections for comparative output costs inclusive of CAC.*

(c) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.2 outlines the Department's income from transactions and Table 2.3 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.2: Income from transactions **($ million)**

	2019-20 actual	*2020-21 budget*	*2020-21 revised*	*2021-22 budget [(a)]*
Output appropriations [(b)]	14 887.5	16 273.6	16 261.2	15 120.5
Special appropriations	8.0	6.0	6.2	6.2
Interest	19.7	17.6	17.6	14.8
Sale of goods and services	761.5	694.4	694.4	872.4
Grants	139.8	44.5	60.2	33.2
Other income	433.8	364.7	364.7	409.9
Total income from transactions [(c)]	**16 250.3**	**17 400.8**	**17 404.3**	**16 456.9**

Source: Department of Education and Training

Notes:

(a) Includes an estimated $1.3 billion of non-public account contributions in 2021-22.

(b) The Capital Assets Charge policy is discontinued from the 2021-22 Budget*.*

(c) Table may not add due to rounding.

Table 2.3: Parliamentary authority for resources **($ million)**

	2020-21 budget	*2020-21 revised*	*2021-22 budget*
Annual appropriations	**16 710.7**	**16 339.2**	**15 883.9**
Provision of outputs [(a)]	15 565.8	15 558.4	14 473.9
Additions to the net asset base	1 144.9	780.9	1 409.9
Payments made on behalf of the State	..	..	..
Receipts credited to appropriations	**657.9**	**672.0**	**615.4**
Unapplied previous years appropriation	**215.0**	**215.0**	**31.2**
Provision of outputs	57.5	57.5	31.2
Additions to the net asset base	157.5	157.5	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**17 583.5**	**17 226.2**	**16 530.4**
Special appropriations	**6.0**	**6.2**	**6.2**
Trust funds	**3 872.2**	**3 931.0**	**4 221.9**
State Grants (School Funding Reform framework) Non-government programs [(b)]	3 833.8	3 880.9	4 197.3
Other [(c)]	38.4	50.1	24.6
Total parliamentary authority [(d)]	**21 461.7**	**21 163.4**	**20 758.5**

Source: Department of Education and Training

Notes:

(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget*.*

(b) The purpose of this trust primarily relates to recurrent Commonwealth funding provided to the non-government school sector under the School Funding Reform framework as part of the Australian Education Act *2013.*

(c) Includes inter-departmental transfers.

(d) Table may not add due to rounding.

Departmental performance statement

Strategy Review and Regulation

The Strategy Review and Regulation output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 4: Productivity

The departmental objective indicators are:

- $ per primary school student per year[(a)];
- $ per secondary school student per year[(a)]; and
- $ per vocational education and training (VET) student contact hour.

Note:
(a) These indicators refer to government and non-government schools.

Outputs

Strategy Review and Regulation (2021-22: $117.8 million)

This output develops, plans and monitors strategic policy settings across all stages of learning. It also includes inter-governmental negotiations as well as research, data and performance evaluations. This output also supports regulation that ensures quality education and training is delivered.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of Registered Training Organisation (RTO) quality audits and school reviews undertaken annually	number	102	97	102
Quality				
Education peak bodies that rate the Victorian Registration and Qualifications Authority (VRQA) effective or highly effective in performing its regulatory function *This performance measure relates to the calendar year.*	per cent	90	94	90
Regulated schools and RTOs that rate the VRQA effective or highly effective in performing its regulatory function *This performance measure relates to the calendar year.*	per cent	90	94	90
Percentage of government schools where an enrolment audit is conducted *This performance measure relates to the calendar year. The 2020-21 expected outcome is lower than the 2020-21 target due to a lower number of approved audits in response to coronavirus (COVID-19) and associated disruption to schools.*	per cent	32.5	11.3	32.5
Cost				
Total output cost	$ million	117.8	118.6	117.6
Total output cost including the CAC *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from* the 2021-22 Budget.	*$ million*	*118.6*	*119.3*	*118.4*

Source: Department of Education and Training

Early Childhood Education

The Early Childhood Education output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 1: Achievement

The departmental objective indicators are:

- Children developmentally 'on track' on the Australian Early Development Census[(a)] (AEDC) in the language and cognitive skills domains; and
- Proportion of early childhood services meeting or exceeding National Quality Standard Area 1 (NQSA1 – Educational program and practice).

Objective 2: Engagement

The departmental objective indicators are:

- Participation in a kindergarten service in the year before school; and
- Proportion of early childhood education and care services meeting or exceeding National Quality Standard Area 6 (NQSA6 – Collaborative partnerships with families and communities).

Objective 3: Wellbeing

The departmental objective indicators are:

- Proportion of children who have no behavioural issues on entry into Prep;
- Proportion of children who have no general development issues on entry into Prep; and
- Children developmentally 'on track' on the AEDC social competence and emotional maturity domains[(a)].

Objective 4: Productivity

The departmental objective indicator is:

- $ per kindergarten student per year.

Note:

(a) These indicators refer to government and non-government schools.

Early Childhood Education (2021-22: $973.4 million)

This output involves the provision of kindergarten and children's services. Services include the monitoring of education and care services and specialist services to improve access to kindergartens for disadvantaged children. This output provides early intervention and parenting support. It also includes a range of services and support for children with a developmental delay or disability and their families.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Children funded to participate in kindergarten in the year before school	number	80 000	79 850	81 000
This performance measure relates to the calendar year. This performance measure includes first and second year kindergarten participants. *The lower 2021-22 target reflects the forecast population of children in the year before school in 2021.*				
Aboriginal children funded to participate in kindergarten in the year before school	number	1 550	1 653	1 350
This performance measure relates to the calendar year. This performance measure includes first and second year Aboriginal kindergarten participants. *The 2020-21 expected outcome is higher than the 2020-21 target due to the higher than previously estimated Aboriginal population in the year before school, and increased service participation within this group.* *The higher 2021-22 target reflects recent performance and better alignment with the forecast Aboriginal population in the year before school in 2021.*				
Kindergarten participation rate in the year before school	per cent	96.0	89.1	96.0
This performance measure relates to the calendar year and excludes children who participate in a second year of the four year-old kindergarten program. *The 2020-21 expected outcome is lower than the 2020-21 target due in part to the impact of COVID-19 on the number of children enrolling after the kindergarten year has commenced, with very few children enrolling from Term 2 onwards compared to previous years.*				
Kindergarten participation rate for Aboriginal children in the year before school	per cent	96.0	100.0	90.0
This performance measure relates to the calendar year. This performance measure excludes children who participate in a second year of the four-year-old kindergarten program. *The 2020-21 expected outcome is higher than the 2020-21 target due to the continued success of initiatives to increase participation for Aboriginal children, including the Koorie Kids Shine at Kindergarten campaign.* *The higher 2021-22 target reflects recent performance and better alignment with the participation target for all children.*				
Children funded to participate in kindergarten in the year two years before school	number	5 000	2 673	2 300
This performance measure relates to the calendar year. This performance measure includes children in Early Start Kindergarten (ESK) and the phased rollout of three-year-old kindergarten. *The 2020-21 expected outcome is higher than the 2020-21 target due to an increase in ESK uptake among children known to child protection. This reflects targeted interventions aimed at increasing participation of vulnerable children in funded kindergarten, including Early Childhood LOOKOUT, supporting children in out-of-home care.* *The higher 2021-22 target reflects an increase in ESK enrolments as a result of broadening of eligibility criteria and the phased rollout of three-year-old kindergarten program.*				
Children funded to participate in Early Start Kindergarten or Access to Early Learning in the year two years before school	number	3 000	nm	nm
New performance measure for 2021-22 to reflect the sustained focus on initiatives to improve early learning participation, such as the Early Years Compact, Koorie Kids Shine at Kindergarten, and the Early Childhood Agreement for Children in Out-of-Home Care. This performance measure relates to the calendar year. This performance measure includes Aboriginal kindergarten participants.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Average number of inspections per service	number	0.85	0.60	0.85
This performance measure relates to the calendar year. *The 2020-21 expected outcome is lower than the 2020-21 target due to fewer compliance inspections and quality audits being conducted in the first half of 2020 in light of COVID-19 restrictions.*				
Number of Early Years Management funded services	number	1 000	nm	nm
New performance measure for 2021-22 to reflect support for the ongoing provision of community-based kindergarten services for local families as a foundation for the provision of both three- and four-year-old kindergarten. This performance measure relates to the calendar year.				
Proportion of approved eligible services assessed and rated	per cent	25.0	5.8	25.0
This performance measure relates to the calendar year. *The 2020-21 expected outcome is lower than the 2020-21 target because the assessment and rating process was suspended for most of 2020 due to COVID-19 restrictions.*				
Quality				
Education and care services offering a funded kindergarten program assessed as exceeding the National Quality Standard	per cent	46	43	46
This performance measure relates to the calendar year. *The 2020-21 expected outcome is lower than the 2020-21 target due to the higher than usual number of long day care services that were newly funded to deliver a kindergarten program in 2020 assessed as 'meeting' (or below) the National Quality Standard, as well as the impact of changes made to the requirements to be assessed as 'exceeding'.*				
Education and care services offering a funded kindergarten program assessed as meeting or exceeding the National Quality Standard	per cent	91	91	91
This performance measure relates to the calendar year.				
Parent satisfaction with kindergarten services	per cent	90	na	90
This performance measure relates to the calendar year. The performance measure includes funded kindergarten providers. *No outcome has been reported in 2020-21 because the underlying data collection from the kindergarten satisfaction survey was cancelled in light of COVID-19.*				
Cost				
Total output cost	$ million	973.4	815.1	843.7
Total output cost including the CAC	*$ million*	987.9	829.0	857.6
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget*.* *The CAC is discontinued from* the 2021-22 Budget*.* *The higher 2021-22 target primarily reflects new funding announced as part of the* 2021-22 Budget*, a higher 2021-22 funding profile from previous budget decisions and indexation.*				

Source: Department of Education and Training

School Education – Primary

The School Education – Primary output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 1: Achievement

The departmental objective indicators are:

- Primary students meeting the expected standard in national and international literacy and numeracy assessment[(a)]; and
- Percentage of positive responses to teacher collaboration within primary schools[(b)].

Objective 2: Engagement

The departmental objective indicators are:

- Mean number of primary student absent days per full-time equivalent (FTE) a year[(c)];
- Mean number of unapproved student absence days per FTE per year in primary schools[(c)]; and
- Primary students with a positive opinion about their school providing a stimulating learning environment[(c)].

Objective 3: Wellbeing

The departmental objective indicators are:

- Primary students feeling connected to their school[(c)]; and
- Primary students with a positive opinion about their school providing a safe and orderly environment for learning[(c)].

Objective 4: Productivity

The departmental objective indicator is:

- $ per primary school student per year[(c)].

Notes:

(a) This indicator refers to government schools for the national assessments and both government and non-government schools for the international assessments.

(b) These indicators refer to government schools.

(c) These indicators refer to government and non-government schools.

School Education – Primary (2021-22: $5 765.9 million)

The School Education – Primary output provides services to develop essential skills and learning experiences to engage young minds and improve the quality of learning of students in Prep to Year 6 in government and non-government schools.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Investment in non-government schools (primary)	$ million	524.6	484.0	485.2
The higher 2021-22 target primarily reflects the funding profile for the non-government school capital grants, additional enrolment-based funding and indexation.				
Percentage of government primary school students receiving equity funding	per cent	25	25	26
This performance measure relates to the calendar year. This performance measure refers to government schools only. The lower 2021-22 target reflects the expected impact of demographic changes on student eligibility.				
Number of teachers participating in the Primary Mathematics and Science Specialist initiative	number	200	200	200
This performance measure relates to the calendar year. This performance measure refers to government schools only. This performance measure renames the 2020-21 performance measure 'Number of teachers who completed professional development as Mathematics and Science Specialists'. The measure continues to report on the same activity, however the title has been amended to more accurately reflect the counting methodology and use of funding.				
Number of assistant principals participating in leadership development programs	number	700	388	700
This performance measure relates to the calendar year. This performance measure refers to government schools only. This performance measure renames the 2020-21 performance measure 'Number of assistant principals participating in leadership development programs, including the Aspiring Principals Program'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity. The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 on onsite operations.				
Number of principals participating in leadership development programs	number	1 100	671	1 100
This performance measure relates to the calendar year. This performance measure refers to government schools only. This performance measure renames the 2020-21 performance measure 'Number of principals participating in leadership development programs, including the Expert Leaders of Education Program'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity. The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 on onsite operations.				
Number of school staff who are not principals or assistant principals participating in leadership development programs	number	3 000	2 470	3 000
This performance measure relates to the calendar year. This performance measure refers to government schools only. This performance measure includes all school staff (teaching and education support). This performance measure renames the 2020-21 performance measure 'Number of school staff who are not principals or assistant principals participating in leadership development programs, including the Aspiring Principals Program and the Local Leaders Program'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity. The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 on onsite operations.				
Number of teachers completing mentoring training	number	900	835	900
The performance measure relates to the calendar year. This performance measure includes early childhood teachers. The 2020-21 expected outcome is lower than the 2020-21 target due to a small number of participants that cancelled or postponed their attendance in response to COVID-19 and the move to remote and flexible learning in Term 2 2020.				
Number of Victorian schools participating as a 'lead school' for the Respectful Relationships initiative	number	382	382	382
This performance measure relates to primary and secondary schools.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Number of school-based staff who have participated in the whole-school Respectful Relationships professional learning initiative *This performance measure relates to the calendar year. This performance measure relates to primary and secondary schools.* *The higher 2021-22 target reflects the expected number of staff participating in Respectful Relationships training in 2021.*	number	35 000	30 000	30 000
Number of schools able to access the Digital Assessment Library *This performance measure relates to the calendar year.*	number	2 413	2 413	2 413
Number of Digital Assessment Library items developed *This performance measure relates to the calendar year.* *The 2020-21 expected outcome is higher than the 2020-21 target due to a greater than expected amount of content becoming available within the library for construction of tests.*	number	1 590	1 887	1 590
Number of schools supported with strategic business and financial support *This performance measure relates to the calendar year. This performance measure refers to government schools only.* *The 2020-21 expected outcome is higher than the 2020-21 target due to greater uptake of support services by schools and greater demand for online training than was anticipated.* *The higher 2021-22 target reflects greater school uptake of support services.*	number	700	859	400
Number of school staff attending strategic business and financial support training *This performance measure relates to the calendar year. This performance measure refers to government schools only.* *The 2020-21 expected outcome is lower than the 2020-21 target due to a number of scheduled training sessions not being delivered during 2020 due to COVID-19 restrictions.*	number	2 500	1 167	2 500
Proportion of eligible schools in receipt of funding for the Swimming in Schools program *This performance measure relates to the calendar year. This performance measure refers to government schools only.*	per cent	100	100	100
Units of service provided by Data and Evidence Coaches *This performance measure relates to the calendar year. This performance measure refers to government schools only.* *The 2020-21 expected outcome is lower than the 2020-21 target with COVID-19 affecting onsite service delivery to schools.*	number	1 140	934	1 140
Number of schools utilising the Local Administrative Bureau *New performance measure for 2021-22 to reflect expanded supports to relieve the administrative burden on schools and Senior Education Improvement Leaders. This performance measure relates to the calendar year. This performance measure refers to government schools only.*	number	88	nm	nm
Number of schools working with School-wide Positive Behaviour Support *New performance measure for 2021-22 to reflect the achievement of positive climates for learning through effective behaviour support. This performance measure relates to the calendar year. This performance measure refers to government schools only.*	number	400	nm	nm
Utilisation of annual hours allocated to schools for onsite IT technical support *New performance measure for 2021-22 to reflect the maintenance of onsite technical support service levels to schools through the Technical Support to Schools program. This performance measure relates to the calendar year. This performance measure refers to government schools only.*	per cent	99	nm	nm
Quality				
Average days lost due to absence at Year 5 *This performance measure relates to the calendar year. This performance measure refers to government schools only.* *The 2020-21 expected outcome is lower than the 2020-21 target, with the impact of COVID-19 and the move to remote and flexible learning during 2020 resulting in fewer overall absences for illness and family holidays.*	number	14.1	13.6	14.1
Average days lost due to absence at Year 6 *This performance measure relates to the calendar year. This performance measure refers to government schools only.* *The 2020-21 expected outcome is lower than the 2020-21 target, with the impact of COVID-19 and the move to remote and flexible learning during 2020 resulting in fewer overall absences for illness and family holidays.*	number	14.5	13.8	14.5

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Average days lost due to absence for Aboriginal students in Years Prep to 6	number	24.0	26.7	24.0
This performance measure relates to the calendar year. This performance measure refers to government schools only. The 2020-21 expected outcome is higher than the 2020-21 target. This is likely to be due to the impact of COVID-19 and the move to remote and flexible learning during 2020, with parent choice on student attendance reflecting the particular characteristics of and risks for Koorie families. The rate covers all absences, including those due to illness and parent choice. This cohort is small and data is subject to volatility.				
Proportion of positive responses to school satisfaction by parents of government primary school students	per cent	85	85	85
This performance measure relates to the calendar year. This performance measure refers to government schools only.				
Percentage of government schools compliant with the Child Safety Standards three months after review	per cent	100	82	100
This performance measure relates to the calendar year. This performance measure refers to government schools only. The 2020-21 expected outcome is lower than the 2020-21 target due to COVID-19 related delays in the 2020 assessment cycle.				
Percentage of Aboriginal students above the bottom three bands for numeracy in Year 3 (National Assessment Program Literacy and Numeracy – NAPLAN testing)	per cent	46.7	na	46.7
This performance measure relates to the calendar year. Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.				
Percentage of Aboriginal students above the bottom three bands for numeracy in Year 5 (NAPLAN testing)	per cent	35.2	na	35.2
This performance measure relates to the calendar year. Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.				
Percentage of Aboriginal students above the bottom three bands for reading in Year 3 (NAPLAN testing)	per cent	58.2	na	58.2
This performance measure relates to the calendar year. Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.				
Percentage of Aboriginal students above the bottom three bands for reading in Year 5 (NAPLAN testing)	per cent	44.6	na	44.6
This performance measure relates to the calendar year. Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.				
Percentage of students above the bottom three bands for numeracy in Year 3 (NAPLAN testing)	per cent	73.8	na	73.8
This performance measure relates to the calendar year. Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.				
Percentage of students above the bottom three bands for numeracy in Year 5 (NAPLAN testing)	per cent	66.0	na	66.0
This performance measure relates to the calendar year. Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.				
Percentage of students above the bottom three bands for reading in Year 3 (NAPLAN testing)	per cent	82.0	na	82.0
This performance measure relates to the calendar year. Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.				
Percentage of students above the bottom three bands for reading in Year 5 (NAPLAN testing)	per cent	72.5	na	72.5
This performance measure relates to the calendar year. Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Percentage of students in the top two bands for numeracy in Year 3 (NAPLAN testing)	per cent	46.7	na	46.7
This performance measure relates to the calendar year. *Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.*				
Percentage of students in the top two bands for numeracy in Year 5 (NAPLAN testing)	per cent	35.3	na	35.3
This performance measure relates to the calendar year. *Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.*				
Percentage of students in the top two bands for reading in Year 3 (NAPLAN testing)	per cent	60.7	na	60.7
This performance measure relates to the calendar year. *Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.*				
Percentage of students in the top two bands for reading in Year 5 (NAPLAN testing)	per cent	45.1	na	45.1
This performance measure relates to the calendar year. *Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.*				
Years 5–6 students' opinion of their connectedness with the school	number (1-5)	4.4	4.1	4.4
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The 2020-21 expected outcome is likely to be lower than the 2020-21 target due to the impact of changes to survey timing and structure to account for remote learning. This combined with the reduced response rate in 2020 has reduced the comparability of results for 2020.*				
Proportion of identified schools that subsequently improved their performance	per cent	67.0	na	60.0
This performance measure relates to the calendar year. This performance measure refers to government schools only. *Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020 21.* *The higher 2021-22 target reflects increased support to schools to improve performance.*				
Proportion of participants rating the impact of the Victorian Academy of Teaching and Leadership's professional learning on their own development and practice as 'significant' or above (all programs)	per cent	78.0	78.0	78.0
This performance measure relates to the calendar year. *This performance measure renames the 2020-21 performance measure 'Proportion of participants rating (at or above 'significant') the impact of the Bastow Institute of Educational Leadership's professional learning on their own development and practice'. The new measure reports on the same activity as the previous measure however has been amended to reflect the establishment of the Victorian Academy of Teaching and Leadership.*				
Proportion of participants who are satisfied with the Victorian Academy of Teaching and Leadership's professional learning and development training (all programs)	per cent	82.0	82.0	82.0
This performance measure relates to the calendar year. *This performance measure renames the 2020-21 performance measure 'Proportion of participants who are satisfied with the Bastow Institute of Educational Leadership's professional learning and development training'. The new measure reports on the same activity as the previous measure however has been amended to reflect the establishment of the Victorian Academy of Teaching and Leadership.*				
Cost				
Total output cost	$ million	5 765.9	5 476.3	5 448.9
Total output cost including the CAC	*$ million*	*6 792.4*	*6 458.9*	*6 431.3*
The higher 2021-22 target primarily reflects new funding announced as part of the 2021-22 Budget*, funding approved after the release of the* 2020-21 Budget *and indexation* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from* the 2021-22 Budget.				

Source: Department of Education and Training

School Education – Secondary

The School Education – Secondary output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 1: Achievement

The departmental objective indicators are:

- Secondary students meeting the expected standard in national and international literacy and numeracy assessment[(a)];
- Percentage of positive responses to teacher collaboration within secondary schools[(b)];
- Average score in science (Programme for International Student Assessment (PISA) 15-year-olds) in Victoria compared to global top performers[(a)]; and
- Year 12 or equivalent completion rates of young people[(b)].

Objective 2: Engagement

The departmental objective indicators are:

- Mean number of secondary student absent days per FTE per year[(b)];
- Mean number of unapproved student absence days per FTE per year in secondary schools[(b)]; and
- Secondary students with a positive opinion about their school providing a stimulating learning environment[(b)].

Objective 3: Wellbeing

The departmental objective indicators are:

- Secondary students feeling connected to their school[(b)]; and
- Secondary students with a positive opinion about their school providing a safe and orderly environment for learning[(b)].

Objective 4: Productivity

The departmental objective indicator is:

- $ per secondary school student per year[(c)].

Notes:

(a) This indicator refers to government schools for the national assessments and both government and non-government schools for the international assessments.

(b) These indicators refer to government schools.

(c) These indicators refer to government and non-government schools.

School Education – Secondary (2021-22: $4 713.1 million)

The School Education – Secondary output involves provision of education and support services designed to improve student learning, development and wellbeing in Years 7 to 12 in government and non-government schools. These seek to consolidate literacy and numeracy competencies including creative and critical thinking, as well as physical, social, emotional and intellectual development in adolescence. It also covers the provision of services to improve pathways to further education, training and employment.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Investment in non-government schools (secondary)	$ million	541.2	497.5	500.5
The higher 2021-22 target primarily reflects the funding profile for non-government school capital grants, additional enrolment-based funding and indexation.				
Number of school students enrolled in the Victorian Certificate of Applied Learning (VCAL)	number	21 650	22 888	20 600
The performance measure relates to the calendar year. *The 2020-21 expected outcome is higher than the 2020-21 target due to greater than anticipated demand for the qualification.* *The higher 2021-22 target reflects the expected continuation of this trend.*				
Number of school students participating in accredited vocational programs	number	48 500	48 561	48 000
This performance measure relates to the calendar year. *The higher 2021-22 target reflects recent increases in the number of students participating in accredited vocational programs.*				
Number of school-based apprentices/trainees	number	3 700	3 520	3 700
This performance measure relates to the calendar year.				
Proportion of all secondary schools offering vocational options to students as part of their secondary school certificate	per cent	96.0	94.5	96.0
This performance measure relates to the calendar year.				
Number of students for which government secondary schools are funded to 'catch up'	number	10 700	10 700	11 100
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The lower 2021-22 target reflects the number of students eligible for 'catch-up funding' in 2021.*				
Percentage of government secondary school students receiving equity funding	per cent	30.5	31.0	32.0
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The lower 2021-22 target reflects the expected impact of demographic changes on student eligibility.*				
Number of students participating in the Victorian Young Leaders program	number	325	360	430
The 2020-21 expected outcome is lower than the 2020-21 target due to travel restrictions and the impact of national statutory changes on delivery of the program. *The lower 2021-22 target reflects the expected demand for this program.*				
Number of partner secondary schools accessing a Tech School	number	160	168	130
This performance measure relates to the calendar year. This performance measure refers to government and non-government schools who are partners to a Tech School. *The 2020-21 expected outcome is higher than the 2020-21 target due to an increase in the number of eligible schools (new schools opening in service areas), and a higher proportion of partner schools accessing Tech School programs and support during the remote learning period.* *The higher 2021-22 target reflects the expected level of demand in 2021.*				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Proportion of employment-based pathways-qualified teachers retained in Victorian government school workforce (within two years) after completing the pathway	per cent	65	nm	nm
New performance measure for 2021-22 reflects measures to increase the supply of teachers in hard to staff subjects and schools, including those in disadvantaged communities. This performance measure relates to the calendar year.				
Quality				
Average days lost due to absence in Years 11 and 12	number	16.1	14.8	16.1
This performance measure relates to the calendar year. This performance measure refers to government schools only. The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 and the move to remote and flexible learning during 2020. A lower figure is more desirable, as it indicates that students are having fewer days away from school. The rate covers all absences, including those due to illness and parent choice.				
Average days lost due to absence in Years 7–10	number	19.0	18.9	19.0
This performance measure relates to the calendar year. This performance measure refers to government schools only.				
Average days lost due to absence for Aboriginal students in Years 7 to 12	number	35.0	37.0	35.0
This performance measure relates to the calendar year. This performance measure refers to government schools only. The 2020-21 expected outcome is higher than the 2020-21 target. This is likely to be due to the impact of COVID-19 and the move to remote and flexible learning during 2020, with parent choice on student attendance reflecting the particular characteristics of and risks for Koorie families. The rate covers all absences, including those due to illness and parent choice. This cohort is small and data is subject to volatility.				
Median VCE study score	number	29	29	29
This performance measure relates to the calendar year. This performance measure refers to government schools only.				
Proportion of positive responses to school satisfaction by parents of government secondary school students	per cent	80	81	80
This performance measure relates to the calendar year. This performance measure refers to government schools only.				
Percentage of Aboriginal students above the bottom three bands for numeracy in Year 7 (NAPLAN testing)	per cent	29.7	na	29.7
This performance measure relates to the calendar year. Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.				
Percentage of Aboriginal students above the bottom three bands for numeracy in Year 9 (NAPLAN testing)	per cent	27.9	na	27.9
This performance measure relates to the calendar year. Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.				
Percentage of Aboriginal students above the bottom three bands for reading in Year 7 (NAPLAN testing)	per cent	29.2	na	29.2
This performance measure relates to the calendar year. Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.				
Percentage of Aboriginal students above the bottom three bands for reading in Year 9 (NAPLAN testing)	per cent	26.3	na	26.3
This performance measure relates to the calendar year. Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.				
Percentage of school leavers completing a VCE VET program in a school progressing to further education, training or work	per cent	95.0	92.2	95.0
This performance measure relates to the calendar year.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Percentage of school leavers completing an intermediate or senior VCAL in a school progressing to further education, training or work	per cent	85.0	79.5	85.0
This performance measure relates to the calendar year. *The 2020-21 expected outcome is lower than the 2020-21 target due to a significant proportion of students deferring further education and training in 2020 in light of COVID-19, challenges relating to online program delivery and reductions in employment opportunities associated with the impacts of COVID-19.*				
Percentage of students above the bottom three bands for numeracy in Year 7 (NAPLAN testing)	per cent	64.7	na	64.7
This performance measure relates to the calendar year. *Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.*				
Percentage of students above the bottom three bands for numeracy in Year 9 (NAPLAN testing)	per cent	57.9	na	57.9
This performance measure relates to the calendar year. *Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.*				
Percentage of students above the bottom three bands for reading in Year 7 (NAPLAN testing)	per cent	61.1	na	61.1
This performance measure relates to the calendar year. *Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.*				
Percentage of students above the bottom three bands for reading in Year 9 (NAPLAN testing)	per cent	53.3	na	53.3
This performance measure relates to the calendar year. *Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.*				
Percentage of students in the top two bands for numeracy in Year 7 (NAPLAN testing)	per cent	36.7	na	36.7
This performance measure relates to the calendar year. Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.				
Percentage of students in the top two bands for numeracy in Year 9 (NAPLAN testing)	per cent	27.6	na	27.6
This performance measure relates to the calendar year. *Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.*				
Percentage of students in the top two bands for reading in Year 7 (NAPLAN testing)	per cent	31.2	na	31.2
This performance measure relates to the calendar year. *Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.*				
Percentage of students in the top two bands for reading in Year 9 (NAPLAN testing)	per cent	23.0	na	23.0
This performance measure relates to the calendar year. *Due to the cancellation of 2020 NAPLAN, no outcome has been reported in 2020-21.*				
Percentage of students who remain at school from Year 7 to Year 12	per cent	93.0	91.0	93.0
This performance measure relates to the calendar year.				
Percentage of VCAL certificates satisfactorily completed by school students	per cent	77.0	74.5	77.0
This performance measure relates to the calendar year.				
Years 7–9 students' opinion of their connectedness with the school	number (1-5)	3.7	3.6	3.7
This performance measure relates to the calendar year. This performance measure refers to government schools only.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Percentage of students in out-of-home care receiving targeted supports in school (LOOKOUT Education Support Centres)	per cent	85.0	80.0	85.0
This performance measure relates to the calendar year. *The 2020-21 expected outcome is lower than the 2020-21 target due to limitations on the ability of LOOKOUT Centres to work with schools in 2020 due to COVID-19 restrictions, including indirect impacts from reduced training and other related school processes.*				
Proportion of Navigator program participants re-engaged in schooling	per cent	70.0	64.0	70.0
This performance measure relates to the calendar year. *The 2020-21 expected outcome is lower than the 2020-21 target, despite an increase in program participation numbers as a result of the expansion of the program into three new areas. Re-engagement in the program is generally calculated over the course of 18 months.*				
Percentage of Year 9 students in government schools that complete an online assessment using a career diagnostic tool	per cent	86.0	nm	nm
New performance measure for 2021-22 to better reflect support provided for career education and planning in schools. *This performance measure relates to the calendar year. This performance measure refers to government schools only.*				
Proportion of Year 10-12 students with a Career Action Plan	per cent	86.0	nm	nm
New performance measure for 2021-22 to better reflect support provided for career education and planning in schools. *This performance measure relates to the calendar year. This performance measure refers to government schools only.*				
Cost				
Total output cost	$ million	4 713.1	4 471.4	4 447.5
Total output cost including the CAC	*$ million*	*5 456.4*	*5 182.9*	*5 158.9*
The higher 2021-22 target primarily reflects new funding announced as part of the 2021-22 Budget*, funding approved after the release of the* 2020-21 Budget *and indexation.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from* the 2021-22 Budget.				

Source: Department of Education and Training

Training, Higher Education and Workforce Development

The Training, Higher Education and Workforce Development output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 1: Achievement

The departmental objective indicators are:

- VET course completions;
- Certificate III or above completions; and
- Proportion of graduates with improved employment status after training.

Objective 2: Engagement

The departmental objective indicators are:

- VET enrolments by age and gender;
- VET enrolments by administrative regions;
- VET enrolments by skills shortage category courses;
- VET enrolments by specialised category courses;
- VET participation by learners facing barriers;
- VET participation by unemployed learners; and
- Proportion of VET students satisfied with the teaching in their course.

Objective 3: Wellbeing

The departmental objective indicator is:

- Level of student satisfaction with VET.

Objective 4: Productivity

The departmental objective indicator is:

- $ per VET student contact hour.

Training, Higher Education and Workforce Development

(2021-22: $2 599.8 million)

The Training, Higher Education and Workforce Development output supports Victorians to gain the skills and capabilities essential for success in employment and further training or study. The Department works with the TAFE and training sector to deliver quality training that strongly supports industry to meet the evolving needs of the economy, promotes equity and addresses disadvantage, with an emphasis on growth sectors of the economy. This output includes the functions of training system design, industry engagement, stakeholder information, contracting and monitoring of quality and training services including accredited and pre-accredited vocational education and training through to adult community education.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of government subsidised course enrolments	number	317 500	297 253	317 500
This performance measure relates to the calendar year. *The 2020-21 expected outcome is lower than the 2020-21 target due to travel restrictions, business constraints and training limitations in light of COVID-19 restrictions.*				
Number of government subsidised course enrolments in the TAFE Network	number	145 000	146 843	145 000
This performance measure relates to the calendar year.				
Number of government subsidised pre-accredited module enrolments funded through the Adult Community and Further Education (ACFE) Board	number	48 400	35 774	45 000
This performance measure relates to the calendar year. *The 2020-21 expected outcome is lower than the 2020-21 target due to travel restrictions, business constraints and training limitations in light of COVID-19 restrictions.* *The higher 2021-22 target reflects the additional 1 000 places funded in the* 2020-21 Budget *and another 2 400 places in the* 2021-22 Budget.				
Number of government subsidised apprenticeship course enrolments	number	49 900	47 153	49 900
This performance measure relates to the calendar year. *The 2020-21 expected outcome is lower than the 2020-21 target due to reduced employment opportunities (and subsequent enrolments) for apprentices in 2020 in light of COVID-19 restrictions.*				
Proportion of government subsidised enrolments related to qualifications that will lead to jobs and economic growth	per cent	83.0	87.1	83.0
This performance measure relates to the calendar year.				
Number of government subsidised course enrolments by students living in regional Victoria	number	81 300	77 758	81 300
This performance measure relates to the calendar year.				
Number of students without Year 12, or Certificate II or above, enrolled in a government subsidised course at Certificate III or above	number	58 000	53 291	58 000
This performance measure relates to the calendar year. *The 2020-21 expected outcome is lower than the 2020-21 target due to travel restrictions, business constraints and training limitations in light of COVID-19 restrictions.*				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Number of government subsidised foundation module enrolments	number	150 000	123 515	190 000
This performance measure relates to the calendar year. *The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 and substitution from accredited foundation training to other types of training.* *The lower 2021-22 target reflects the expectation that substitution from accredited foundation training to other types of training will continue.*				
Number of government subsidised course enrolments by students eligible for fee concession	number	67 500	55 940	67 500
This performance measure relates to the calendar year. *The 2020-21 expected outcome is lower than the 2020-21 target due to travel restrictions, business constraints and training limitations in light of COVID-19 restrictions.*				
Number of enrolments in the Free TAFE for priority courses initiative	number	50 000	nm	nm
New performance measure for 2021-22 enables assessment of the take-up of the Free TAFE for priority courses initiative. *This performance measure relates to the calendar year.*				
Quality				
Proportion of employers of apprentices and trainees who are satisfied with training	per cent	78.1	79.1	77.6
This performance measure relates to the calendar year. *Data for 2020-21 outcomes relate to the 2020 Victorian Employer Satisfaction Survey of 2019 training experiences.* *The higher 2021-22 target reflects the improved outcomes achieved in 2020-21.*				
Proportion of VET completers who are satisfied with their training	per cent	85.7	86.7	84.6
This performance measure relates to the calendar year. *Data for 2020-21 outcomes relate to the 2020 Victorian Student Satisfaction Survey of 2019 training experiences. The higher 2021-22 target reflects the improved outcomes achieved in 2020-21.*				
Proportion of VET completers with an improved employment status after training	per cent	54.4	55.4	51.8
This performance measure relates to the calendar year. *Data for 2020-21 outcomes relate to the 2020 Victorian Student Satisfaction Survey of 2019 training experiences. The 2020-21 expected outcome is higher than the 2020-21 target, however a change in survey methodology for this measure means it is difficult to compare 2020 results to the 2020 target or 2019 results. The higher 2021-22 target reflects the revised survey methodology.*				
Proportion of VET completers who achieved their main reason for training	per cent	84.1	85.1	83.4
This performance measure relates to the calendar year. *Data for 2020-21 outcomes relate to the 2020 Victorian Student Satisfaction Survey of 2019 training experiences. The higher 2021-22 target reflects the improved outcomes achieved in 2020-21.*				
Two-year completion rate for non-apprentice commencements in government subsidised Australian Qualifications Framework (AQF) qualifications	per cent	46.3	48.4	46.3
This performance measure relates to the calendar year. *Data for the 2020-21 outcome is the proportion of enrolments which commenced in 2019 that completed at the end of 2020.*				
Six-year completion rate for apprentice commencements in government subsidised AQF qualifications	per cent	58	nm	nm
New performance measure for 2021-22 enables the assessment of the completion rate of apprentice students in government subsidised AQF qualifications. This performance measure relates to the calendar year. *Target for 2021-22 relates to the proportion of enrolments which commenced in 2016 that complete by the end of 2021.*				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Cost				
Total output cost	$ million	2 599.8	2 575.6	2 579.5
Total output cost including the CAC	*$ million*	*2 816.5*	*2 792.2*	*2 796.2*

The 2020-21 and 2021-22 targets include funding for selected public sector workforce training and development initiatives, reflecting their contribution to outcomes and government priorities related to this output.
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.

Source: Department of Education and Training

Support Services Delivery

The Support Services Delivery output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 4: Productivity

The departmental objective indicators are:

- $ per primary school student per year[(a)]; and
- $ per secondary school student per year[(a)].

Note:
(a) These indicators refer to government and non-government schools.

Support Services Delivery (2021-22: $389.1 million)

The Support Services Delivery output primarily provides student welfare and support, student transport (excluding transport for special needs students) and health services.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Eligible primary school students in receipt of Camps, Sports and Excursions Fund *This performance measure relates to the calendar year.* *The 2020-21 expected outcome is lower than the 2020-21 target due to reduced number of applications from parents.*	number	135 400	127 876	135 400
Eligible secondary school students in receipt of Camps, Sports and Excursions Fund *This performance measure relates to the calendar year.*	number	91 800	95 700	91 800
Investment in student welfare and support *The 2020-21 target has been revised to reflect the exclusion of the CAC from output costs in the* 2021-22 Budget.	$ million	343.2	344.2	342.2
Investment in travelling allowances and transport support (not including special needs students) *The 2020-21 target has been revised to reflect the exclusion of the CAC from output costs in the* 2021-22 Budget.	$ million	45.9	45.0	45.2
Health assessments of prep-aged students by school nurses *This performance measure relates to the calendar year.* *The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 restricting school nursing operations.*	number	70 500	54 138	70 500
School students (government) supported by conveyance allowance *This performance measure relates to the calendar year.* *The higher 2021-22 target reflects an anticipated increase in the number of eligible applicants due to new schools opening.*	number	9 255	8 655	8 750
School students (non-government) supported by conveyance allowance *This performance measure relates to the calendar year.* *The higher 2021-22 target reflects an anticipated increase in the number of eligible applicants due to new schools opening.*	number	28 922	28 636	27 700
Schools allocated a nurse through the Secondary School Nursing Program *This performance measure relates to the calendar year. This performance measure refers to government schools only.*	number	198	196	198
Schools funded for primary welfare officers *This performance measure relates to the calendar year. This performance measure refers to government schools only.* *The higher 2021-22 target reflects an increase in net school openings.*	number	803	800	799

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quality				
School satisfaction with student support services	per cent	80.0	75.0	80.0
This performance measure relates to the calendar year. This performance measure refers to government schools only. The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 and remote learning requirements which changed the nature of student support services delivery to schools throughout 2020.				
Cost				
Total output cost	$ million	389.1	389.1	387.4
Total output cost including the CAC	*$ million*	*389.5*	*389.4*	*387.7*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from* the 2021-22 Budget.				

Source: Department of Education and Training

Support for Students with Disabilities

The Support for Students with Disabilities output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 4: Productivity

The departmental objective indicators are:

- $ per primary school student per year[(a)]; and
- $ per secondary school student per year[(a)].

Note:
(a) These indicators refer to government and non-government schools.

Support for Students with Disabilities (2021-22: $1 363.6 million)

The Support for Students with Disabilities output covers programs and funding to support students with disabilities as well as transport, welfare and support services for students with special needs.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Eligible special school students provided with appropriate travel	number	8 925	8 895	9 050
This performance measure relates to the calendar year. The lower 2021-22 target reflects expected demand in the eligible student population.				
Proportion of government school students who receive adjustments to support their access and participation in learning because of disability as defined in the *Disability Discrimination Act 1992* (Cth)	per cent	17.0	nm	nm
New performance measure for 2021-22 to reflect the phased roll out of Disability Inclusion (a new disability funding and support model). This performance measure relates to the calendar year. This performance measure refers to government schools only.				
Proportion of total government schools resourced through the Disability Inclusion funding and support model	per cent	30.0	nm	nm
New performance measure for 2021-22 to reflect the phased roll out of Disability Inclusion (a new disability funding and support model). This performance measure relates to the calendar year. This performance measure refers to government schools only.				
Proportion of positive responses to school satisfaction by parents of government special school students	per cent	85	84	85
This performance measure relates to the calendar year. This performance measure refers to government schools only.				
Cost				
Total output cost	$ million	1 363.6	1 160.0	1 172.0
Total output cost including the CAC	*$ million*	*1 437.4*	*1 230.6*	*1 242.6*
The higher 2021-22 target primarily reflects new funding announced as part of the 2021-22 Budget*, a higher 2021-22 funding profile from previous budget decisions and indexation. The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget*. The CAC is discontinued from* the 2021-22 Budget*.*				

Source: Department of Education and Training

DEPARTMENT OF ENVIRONMENT, LAND, WATER AND PLANNING

Ministerial portfolios

The Department supports the ministerial portfolios of Energy, Environment and Climate Change, Solar Homes, Water, and Planning.

Departmental mission statement

The Department of Environment, Land, Water and Planning's mission is to shape and support liveable, inclusive and sustainable communities, and thriving natural environments across Victoria by:

- listening, working alongside and partnering with the community in everything we do;
- leveraging the connectivity between our portfolios to respond to the impacts of climate change in a productive, collaborative and coordinated way;
- maximising opportunities for attracting investment and jobs through supporting the development of new, environmentally sustainable industries; and
- protecting, enhancing and strengthening the State's liveability and protecting our natural environment, infrastructure and heritage for future generations.

The Department contributes to the Government's commitment to a stronger, fairer, better Victoria by supporting our natural and built environment, to ensure economic growth and liveable, sustainable and inclusive communities that are resilient to the impacts of climate change.

Departmental objectives

Net zero emission, climate-ready economy and community

The Department leads the Government's response to climate change, in line with the *Climate Change Act 2017*. The Government's response includes reducing greenhouse gas emissions, adapting to the impacts of climate change, and supporting the economic and social transition to a net zero emissions and climate-resilient future.

The Climate Change output contributes to this objective by leading the development and implementation of strategic, whole of government climate change policy and programs that contribute to Victoria's 2050 target of net zero greenhouse gas emissions and build the State's resilience to climate change.

Healthy, resilient and biodiverse environment

The Department leads the development and implementation of strategic regulation and investment in environmental and natural resource programs across Victoria.

The Environment and Biodiversity output contributes to this objective by developing and implementing environmental policy and delivering investment, regulatory and research functions.

The Waste and Recycling output delivers investment into reducing waste, transforming recycling services and increasing value from recycled materials. These activities support industry, innovation, research and development and clean technologies to create new markets and business opportunities for recycled materials.

The Statutory Activities and Environment Protection output protects the environment and people by preventing and reducing harm from pollution and waste through better regulation, conducting research and gathering intelligence to inform compliance and enforcement activities, collaboration and the provision of advice.

Reliable, sustainable and affordable energy services

The Department delivers programs on renewable energy, improving energy efficiency and productivity, and provides policy advice to government on the delivery of reliable, sustainable and affordable energy services to households and business consumers.

The Energy output contributes to this objective through state-based energy programs, including renewable energy development, energy efficiency and affordability improvements, and facilitation of new investment.

Victoria is transitioning to a lower emissions future, reducing fossil fuel usage and air pollution, and allowing independence from conventional energy supplies. The Solar Homes output will, over 10 years, provide 778 500 households with either solar panel energy systems, solar hot water systems, or battery storage for homes with existing solar energy systems. The program also provides solar panels rebates for small businesses and financial subsidies to vulnerable and low-income households to upgrade heating and install high-efficiency reverse cycle air conditioners.

Productive and effective land management

The Department delivers effective management and governance of Victoria's public land to protect its social, economic and environmental values and maximise its use by all Victorians.

The Land Use Victoria output delivers high quality and authoritative land administration and property information services, including the registration of land titles under the Torrens system, survey, valuation and land information services. Land Use Victoria also incorporates the State's foundational spatial data services and government land policies.

The Management of Public Land and Forests output contributes to this objective by providing stewardship of Victoria's forests, coasts and Crown land reserves, to ensure that natural, built and historic assets are managed responsibly.

The Parks Victoria output contributes to this objective by managing the development and protection of Victoria's natural, cultural and community assets.

Safe and sustainable water resources

The Department increases the efficiency of supply and use of water in cities and towns, and improves environmental conditions of waterways to ensure that Victoria has safe and sustainable water resources to meet future urban, rural and environmental needs.

The Effective Water Management and Supply output contributes to this objective by developing policies, providing strategic advice and overseeing regulatory systems and institutional arrangements to effectively manage Victoria's water resources.

A safe and quality built environment

The Department plans for the future growth and transformation of Victoria's cities and regions, and provides leadership and advice on heritage protection and the built environment.

The Planning, Building and Heritage output contributes to this objective by delivering programs to address the future growth and transformation of cities and regions.

Reduced impact of major bushfires and other emergencies on people, property and the environment

The Department delivers an integrated approach to reducing the risk of bushfires and other emergencies to protect people, property and the environment.

The Fire and Emergency Management output contributes to this objective by planning and delivering integrated bushfire management, and the provision of emergency response.

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2020-21 budget	*2020-21 expected outcome*	*2021-22 budget*	*Variation [(a)] %*
Net zero emission, climate-ready economy and community				
Climate Change	42.9	44.0	32.9	(23.3)
Healthy, resilient and biodiverse environment				
Environment and Biodiversity	183.2	191.1	162.3	(11.4)
Statutory Activities and Environment Protection	272.7	272.1	236.5	(13.3)
Waste and Recycling	58.3	41.8	55.9	(4.1)
Reliable, sustainable and affordable energy services				
Energy	337.0	529.1	278.3	(17.4)
Solar Homes	424.4	412.6	322.2	(24.1)
Productive and effective land management				
Land Use Victoria	262.6	272.9	255.4	(2.7)
Management of Public Land and Forests	299.8	301.8	294.0	(1.9)
Parks Victoria	191.7	193.4	207.6	8.3
Safe and sustainable water resources				
Effective Water Management and Supply	327.1	354.5	317.7	(2.9)
A safe and quality built environment				
Planning, Building and Heritage	434.5	420.8	321.1	(26.1)
Reduced impact of major bushfires and other emergencies on people, property and the environment				
Fire and Emergency Management	390.2	457.3	406.4	4.2
Total [(b)(c)]	**3 224.2**	**3 491.4**	**2 890.2**	**(10.4)**

Source: Department of Environment, Land, Water and Planning

Notes:

(a) Variation between 2020-21 budget and 2021-22 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant outputs.

(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget *and CAC impacts are therefore excluded from the figures. Refer to individual output sections for comparative output costs inclusive of CAC.*

(c) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.4 outlines the Department's income from transactions and Table 2.5 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.4: Income from transactions **($ million)**

	2019-20 actual	*2020-21 budget*	*2020-21 revised*	*2021-22 budget*
Output appropriations [(a)]	2 017.1	2 279.8	2 498.2	2 081.1
Special appropriations	151.9	139.9	139.9	181.7
Interest	10.7	20.6	18.4	21.6
Sale of goods and services	117.6	80.6	89.7	81.2
Grants	25.8	33.9	81.8	6.1
Other income	470.7	416.6	368.2	515.1
Total income from transactions [(b)]	**2 793.8**	**2 971.4**	**3 196.2**	**2 886.8**

Source: Department of Environment, Lands, Water and Planning

Notes:

(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget.

(b) Table may not add due to rounding.

Table 2.5: Parliamentary authority for resources **($ million)**

	2020-21 budget	*2020-21 revised*	*2021-22 budget*
Annual appropriations	**3 049.1**	**3 204.7**	**2 802.1**
Provision of outputs [(a)]	2 092.1	2 265.0	1 879.4
Additions to the net asset base	271.9	256.5	238.5
Payments made on behalf of the State [(b)]	685.1	683.1	684.2
Receipts credited to appropriations	**222.0**	**267.4**	**240.9**
Unapplied previous years appropriation	**18.3**	**18.3**	**..**
Provision of outputs	16.0	16.0	..
Additions to the net asset base	2.3	2.3	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**3 289.4**	**3 490.4**	**3 042.9**
Special appropriations	**164.8**	**161.6**	**201.9**
Trust funds	**929.6**	**962.0**	**1 068.5**
Municipal and Industrial Landfill Levy Trust [(c)]	187.9	187.9	374.5
Parks and Reserves Trust [(d)]	200.5	200.5	208.5
Other [(e)]	541.1	573.6	485.6
Total parliamentary authority [(f)]	**4 383.8**	**4 614.0**	**4 313.4**

Source: Department of Environment, Lands, Water and Planning

Notes:

(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget*.*

(b) Includes contributions by the state under agreements pursuant to section 25 of the Murray Darling Basin Act 1993*.*

(c) The purpose of this trust primarily relates to the collection and distribution of the General Landfill Levy as required under section 70E of the Environment Protection and Sustainability Victoria Amendment Act 2014*.*

(d) The purpose of this trust primarily holds the park charge collected to support ongoing core operations of Parks Victoria throughout the metropolitan area, the Royal Botanic Gardens, Zoos Victoria and the Shrine of Remembrance.

(e) Includes inter-departmental transfers.

(f) Table may not add due to rounding.

Departmental performance statement

Objective 1: Net zero emission, climate-ready economy and community

This objective involves leading a whole of government response to climate change, including reducing greenhouse gas emissions, adapting to the impacts of a changing climate, and supporting the economic and social transition to a net zero emissions and climate resilient future.

The Department leads the modernisation of legislative, regulatory and governance arrangements in the environment portfolio, and uses economic, research and scientific expertise to develop policy responses to harness Victoria's current and emerging opportunities, in the context of climate change.

The foundation for the Department's work on these issues is the *Climate Change Act 2017*.

The departmental objective indicators are:

- reduction in emissions from government operations;
- percentage reduction in Victoria's greenhouse gas emissions relative to 2005; and
- reduction in annual energy costs for Victorian schools participating in the ResourceSmart Schools program.

Outputs

Climate Change (2021-22: $32.9 million)

This output leads the development and implementation of strategic, whole of government climate change policy and programs that contribute to Victoria's 2050 target of net zero greenhouse gas emissions and building the State's resilience to climate change.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Victorian schools participating in the ResourceSmart Schools program	number	700	700	700
Annual energy saved by Victorian schools participating in the ResourceSmart Schools program	kWh	8 500 000	12 000 000	8 500 000
The 2020-21 expected outcome is higher than the 2020-21 target due to reduced energy consumption during periods of remote teaching and learning in response to coronavirus (COVID-19).				
Quality				
Stakeholder satisfaction with climate change engagement events	per cent	75	nm	nm
This new performance measure replaces the 2020-21 measure 'Departmental stakeholder satisfaction with engagement in completed policy projects' to better reflect the service being delivered.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Timeliness				
Delivery of agreed milestones for climate change policy, advice and research within agreed timeframes	per cent	80	80	80
This performance measure renames the 2020-21 performance measure 'Delivery of policy, advice and research on climate change within agreed timeframes'. This measure reports on the same activity as the previous measure, however it has been amended for increased clarity.				
Completion of Annual Greenhouse Gas Emissions Report	date	Oct 2021	nm	nm
New performance measure for 2021-22 to reflect the annual delivery of a core requirement of the Climate Change Act 2017 *to publicly report on Victoria's greenhouse gas emissions.*				
Cost				
Total output cost	$ million	32.9	44.0	42.9
Total output cost including the CAC	*$ million*	*32.9*	*44.0*	*42.9*
The lower 2021-22 target predominantly reflects the funding profile for Sustainability funded programs: Statewide coastal program and Climate change community action. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from* the 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Environment, Land, Water and Planning

Objective 2: Healthy, resilient and biodiverse environment

This objective involves leading the development and implementation of strategic regulation and investment in environmental and natural resource programs across Victoria.

The Department works with portfolio partners, local communities and external stakeholders to develop effective, evidence-based policies, programs and regulatory responses for: environment protection; waste resource recovery and recycling; ecosystem resilience; native vegetation management; threatened species; and land management practices.

The departmental objective indicators are:

- participation in community-based environmental programs;
- reduction in pollutants from priority hotspots; and
- reduction in waste generation per person.

Outputs

Environment and Biodiversity (2021-22: $162.3 million)

This output leads the development and implementation of strategic, whole of government environmental policy and delivers investment, regulatory and research functions that support Victoria's diverse and resilient ecosystems.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Hours volunteered across all government-funded environmental volunteering programs	number	965 350	nm	nm
This new performance measure replaces the 2020-21 measure 'Victorian Landcare Groups supported by a facilitator' to reflect expansion of environmental volunteering under the Victorians Volunteering for Nature – Environmental Volunteering Plan.				
New permanently protected native vegetation on private land	hectares	800	800	600
The 2020-21 expected outcome and 2021-22 target are higher than the 2020-21 target due to additional funding provided since 2017-18 creating a pipeline of covenants that are coming to fruition through registration on title.				
Hectares of weed control in priority locations	hectares	140 000	100 000	140 000
The 2020-21 expected outcome is lower than the 2020-21 target due to COVID-19 restrictions impacting on the area of weed control undertaken.				
Hectares of pest predator control in priority locations	hectares	400 000	400 000	400 000
Hectares of pest herbivore control in priority locations	hectares	500 000	500 000	300 000
The 2020-21 expected outcome and 2021-22 target are higher than the 2020-21 target due to increased funding for pest control under bushfire recovery programs, enabling additional herbivore control work to be undertaken.				
Hectares of revegetation in priority locations for habitat connectivity	hectares	1 000	1 000	1 000
Strategic compliance operations implemented by the Conservation Regulator	number	6	nm	nm
New performance measure for 2021-22 to reflect the strategic priorities of the Conservation Regulator.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quality				
Presentations made and scientific publications in peer reviewed journals	number	60	70	60
The 2020-21 expected outcome is higher than the 2020-21 target as COVID-19 restrictions on scientific fieldwork enabled staff to instead produce a higher number of peer-reviewed journal articles.				
Annual Arthur Rylah Institute Client Survey respondents rank the level of overall satisfaction with ARI's research as good, very good or excellent	per cent	95	nm	nm
New performance measure for 2021-22 to reflect client satisfaction with the science rigour, quality of outputs, level of impact, communication and understanding of the client's needs.				
Portfolio entity annual reports including financial statements produced in line with the *Financial Management Act 1994* and free from material errors	per cent	100	100	100
Preharvest surveys of areas planned for timber harvesting completed	per cent	80	95	80
This performance measure has been transferred from the Management of Public Land and Forests output as this measure is better aligned to the achievement of a healthy, resilient and biodiverse environment. *The 2020-21 expected outcome is higher than the 2020-21 target due to $1 million in funding being brought forward from 2021-22 to ensure surveys could be conducted well in advance of proposed harvest dates.*				
Timeliness				
Native Vegetation Credit Extracts processed within 10 days	per cent	95	95	95
Planning referrals relating to native vegetation processed within statutory timeframes	per cent	80	83	80
Wildlife Licence renewals processed by target dates	per cent	96	96	96
Cost				
Total output cost	$ million	162.3	191.1	183.2
Total output cost including the CAC	*$ million*	*165.2*	*194.0*	*186.1*
The lower 2021-22 target predominantly reflects the funding profile for Immediate recovery work submissions; Biodiversity bushfire response and recovery and core environmental and Traditional Owner programs initiatives. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from* the 2021-22 Budget.				

Source: Department of Environment, Land, Water and Planning

Statutory Activities and Environment Protection (2021-22: $236.5 million)

This output involves protecting the environment and people by preventing and reducing harm from pollution and waste through better regulation, conducting research and gathering intelligence to inform compliance and enforcement activities, collaboration and the provision of advice. These activities support a liveable and prosperous state by leveraging good environmental performance and a shared responsibility among all Victorians to maintain clean air, water and land, and minimal disturbance from noise and odour.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Inspections that assess compliance, including permissioned activities, where operations represent a significant risk to the environment and human health	number	400-450	300	250-300
This performance measure renames the 2020-21 performance measure 'Inspections that assess premises compliance, including licenced premises, whose operations represent a significant risk to the environment and human health'. This measure reports on the same activity as the previous measure, however it has been amended for increased clarity and alignment to the amended Environment Protection Act 2017. *The higher 2021-22 target reflects anticipated improvements in capacity and capability to support the amended* Environment Protection Act 2017 *with increased focus on regulatory activities with a proactive, preventative focus.*				
Events and activities that engage business and community in environment protection	number	60-65	nm	nm
This new performance measure replaces the 2020-21 measures 'Events that engage business and community in environment protection' and 'Activities that support business to comply with environmental obligations' reflecting improvements to the EPA's engagement approach including newer and more flexible methods for engagement and increased government focus on working with community and business to help them understand their environment and their duty in protecting it.				
Environment condition notifications provided to Victorians via digital channels	number	> 1 000	1 000	900-1 000
The higher 2021-22 target reflects an increasing trend over previous years.				
Quality				
EPA prosecutions are selected using a risk-based approach, focused on environmental outcomes and are successful	per cent	90	90	70
The 2020-21 expected outcome is higher than the 2020-21 target due to the EPA achieving successful outcomes in all prosecutions completed in the first three quarters of the year. The number of completed prosecutions is less than normal due to the COVID-19 pandemic impacting on the courts' timetabling. *The higher 2021-22 target reflects the EPA's focus on using prosecution as a key tool to drive compliance outcomes.*				
Environmental audits reviewed to ensure compliance with statutory requirements and guidelines	per cent	90	94	90
Remedial notices complied with by due date or escalated in line with EPA's Compliance and Enforcement policy	per cent	90	93	90

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Timeliness				
Pollution reporters requesting follow up by EPA receive contact within three working days	per cent	85	98	85
The 2020-21 expected outcome is higher than the 2020-21 target due to process improvements in line with customer expectations and additional staff via an outsourced contact centre.				
Applications for permissions completed within statutory timelines	per cent	96	96	96
This performance measure renames the 2020-21 performance measure 'Works approvals and licences completed within required statutory timelines'. This measure reports on the same activity as the previous measure, however it has been amended for increased clarity and alignment to the amended Environment Protection Act 2017 *regarding permissions including licences, permits and registrations.*				
Planning matters responded to within agreed timeframes	per cent	80	nm	nm
New performance measure for 2021-22 to reflect the EPA's role in responding to strategic land use planning and mining regulation matters.				
Applications for internal review of remedial notices completed within statutory timeframes	per cent	90	nm	nm
New performance measure for 2021-22 reflecting the timeliness of the EPA in performing reviews of remedial notices according to the requirements of the amended Environment Protection Act 2017.				
EPA provides technical advice to lead agencies within agreed timelines during emergency incidents	per cent	90	90	90
EPA responds within one day of notification to waste crime incidents identified for priority response	per cent	90	nm	nm
New performance measure for 2021-22 to reflect EPA focus on waste outcomes in line with the Government's Recycling Victoria policy and the EPA's legislative purpose.				
Cost				
Total output cost	$ million	236.5	272.1	272.7
Total output cost including the CAC	*$ million*	*236.5*	*272.1*	*272.7*
The lower 2021-22 target predominantly relates to the funding profile for initiatives funded from the Sustainability and Municipal and Industrial Landfill Levy funds: Implementing the Environment Protection Authority's strengthened regulatory functions, Bringing our Environment Protection Authority into the modern era and Timber plantation establishment. This is partially offset by funding for the new 2021-22 Budget *initiatives: Sustaining the Environment Protection Authority's strengthened regulatory functions and EPA step-in high risk waste sites.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from* the 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Environment, Land, Water and Planning

Waste and Recycling (2021-22: $55.9 million)

This output delivers investment into reducing waste, transforming recycling services and increasing value from recycled materials. These activities support industry, innovation, research and development and clean technologies to create new markets and business opportunities for recycled materials.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Proportion of waste diverted away from landfill	per cent	70	70	70
Proportion of Victorian households with access to organic food and garden waste recycling services	per cent	16	13	13
This performance measure renames the 2020-21 measure 'Proportion of Victorian households with access to organic food and garden waste recycling or local composting services' to better reflect increased access to a broader range of service through kerbside reform. *The higher 2021-22 target reflects progress towards Victoria's target of all households having access to organic food and garden waste recycling services by 2030.*				
Proportion of Victorian households with access to separated glass recycling services	per cent	11	nm	nm
New performance measure for 2021-22 to reflect progress towards Victoria's target of all households having access to kerbside glass recycling services by 2027.				
Victorian local council sites supported to upgrade infrastructure to safely collect and sort e-waste for recovery	number	140	110	110
The higher 2021-22 target reflects the expectation for continued strong local government engagement with the program.				
Quality				
Cumulative increase in the capacity of Victoria's resource recovery infrastructure	tonnes	1 000 000	850 000	900 000
The 2020-21 expected outcome is lower than the 2020-21 target as some projects originally scheduled to be completed in 2020-21 have been rescheduled to 2021-22 in response to the COVID-19 pandemic, impacting on workplace restrictions, and logistics and supply chains. *The higher 2021-22 target reflects the cumulative nature of this measure.*				
Timeliness				
Average assessment time (calendar days) for major investment grants from application closure to recommendation	days	60	nm	nm
New performance measure for 2021-22 to reflect support for investment in waste and recycling facilities and initiatives through timely assessment of grant applications.				
Cost				
Total output cost	$ million	55.9	41.8	58.3
Total output cost including the CAC	*$ million*	*55.9*	*41.8*	*58.3*
The 2020-21 expected outcome is lower than the 2020-21 target predominantly due to a rephase of funding for the Recycling Victoria initiative. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from* the 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Environment, Land, Water and Planning

Objective 3: Reliable, sustainable and affordable energy services

This objective is focused on delivering a comprehensive suite of energy programs that will improve energy efficiency, strengthen consumer protections and improve affordability. The Department also provides policy advice to government on how to deliver clean, reliable, sustainable and affordable energy services to Victorians.

The Department works with a range of stakeholders to provide energy services to consumers, attract investment in renewable energy and low emissions technologies, and support local jobs and communities as Victoria's energy system transitions.

The Department also provides a 10-year program for households to install solar energy technologies.

The departmental objective indicators are:

- relative share of Victoria's energy sourced from renewables;
- percentage of surveyed users of the Victorian Energy Compare website who report that they plan to switch offers after using the website; and
- electricity generating capacity installed under the Solar Homes program; and
- solar systems installed under the Solar Homes program.[(a)]

Note:
(a) New objective indicator to reflect the cumulative number of Solar systems installed under the Solar Homes Program

Outputs

Energy (2021-22: $278.3 million)

This output advocates for the provision of reliable, sustainable and affordable energy services through state-based energy programs, including renewable energy development, energy efficiency and affordability improvements, and facilitation of new investment.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Certificates surrendered to meet energy saving targets under the Victorian Energy Upgrades program.	million certificates	6.5	6.5	6.5
Solar energy purchases sufficient to meet annual Melbourne tram network demand	per cent	100	100	100
Share of Victoria's electricity generation from renewable sources	per cent	31	27	25
The 2020-21 expected outcome and 2021-22 target are higher than the 2020-21 target, due to the successful achievement of Victoria's renewable energy policies to drive growth in renewables.				
Large-scale Generation Certificates procured under the Renewable Certificate Purchasing Initiative sufficient to meet annual electricity demand of participating government sites	per cent	100	100	100
Cumulative renewable electricity generation capacity under the Victorian Renewable Energy Target 2017 Auction	MW	650	650	650

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
New Energy Jobs Fund projects completed	number	15	4	4
The higher 2021-22 target reflects the number of projects scheduled for completion in 2021-22.				
Government-supported events that engage business and supply chains regarding the energy sector	number	10	10	10
Vulnerable Victorian energy consumers reached through consumer support programs	number	10 000	10 000	2 500
The 2020-21 expected outcome and the 2021-22 target are higher than the 2020-21 target due to the Victorian Government's $250 Power Saving Bonus, which includes a significant community outreach program.				
Quality				
Relative reduction in statewide powerline-related bushfire risk	per cent	45	45	45
The 2021-22 target remains at 45 per cent as this measure is only calculated every two years, in line with the completion of major capital works. The next calculation will occur in the second half of 2022.				
Users of the Victorian Energy Compare website who report a better understanding of their usage costs after using the website.	per cent	65	65	65
Victoria is represented at each Energy Ministers' meeting	per cent	100	100	100
Timeliness				
Delivery of key Australian Energy Market Commission funding milestones, in line with funding agreements and agreed project deliverables	per cent	100	100	100
Cost				
Total output cost	$ million	278.3	529.1	337.0
Total output cost including the CAC	*$ million*	*278.3*	*529.1*	*337.0*
The 2020-21 expected outcome is higher than the 2020-21 target due to an increase in funding for energy reliability and sustainability initiatives.				
The lower 2021-22 target predominantly relates to the funding profile of energy reliability and sustainability initiatives.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget*.*				
The CAC is discontinued from the 2021-22 Budget*.*				
This output did not have a provision for CAC in previous budgets.				

Source: Department of Environment, Land, Water and Planning

Solar Homes (2021-22: $322.2 million)

This output will, over 10 years, provide 778 500 households with either solar panel energy systems, solar hot water systems, or battery storage for homes with existing solar energy systems, as Victoria transitions to a lower emissions future, reducing fossil fuel usage and air pollution, and allowing independence from conventional energy supplies.

The program also includes solar photovoltaic panels rebates for small businesses and provides financial subsidies to vulnerable and low-income households to upgrade heating and install high-efficiency reverse-cycle air conditioners.

Through this output, Solar Victoria supports investment in household energy technology innovation to find new and improved ways to meet future energy demand.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Applications for Solar PV rebates for owner-occupied and rental households approved	number	75 000	65 420	65 420
The higher 2021-22 target reflects additional funding provided in the 2020-21 Budget.				
Applications for home battery rebates approved	number	7 000	4 150	7 000
The 2020-21 expected outcome is lower than the 2020-21 target due to lower than anticipated uptake of the increase in home battery rebates available through the 2020-21 Budget. *In addition, 2 000 battery rebates were set aside in 2020-21 to support consumers' participation in battery aggregation opportunities as part of the Solar Homes Aggregation Program. It is expected that demand for battery rebates will increase as solar businesses respond to the increased availability of solar battery rebates and reduction in rebate values.* *The 2021-22 target reflects the number of solar battery rebates provided in the* 2020-21 Budget.				
Applications for solar hot water rebates approved	number	6 000	1 000	6 000
The 2020-21 expected outcome is lower than the 2020-21 target due to lower than expected demand for Solar Hot Water unit rebates.				
Applications for Solar PV rebates for small businesses approved	number	5 000	100	5 000
The 2020-21 expected outcome is lower than the 2020-21 target due to the program delivery being delayed to allow for detailed implementation planning.				
Applications for Home Heating and Cooling Upgrade rebates for reverse cycle air conditioning units to replace inefficient heating systems approved	number	70 000	nm	nm
New performance measure for 2021-22 to reflect funding provided in the 2020-21 Budget *to support 250 000 households to upgrade their heater and install a high efficiency reverse cycle air conditioner.*				
Quality				
Rebated installations audited by the Solar Homes Audit Program to be conducted in accordance with the Solar Homes Assurance Framework plan	per cent	5	5	5
Timeliness				
Average number of weeks to process completed eligibility applications	weeks	4	3	4
The 2020-21 expected outcome is better than the 2020-21 target due to Solar Homes application portal enhancements implemented early 2020 which improved manual processing and the online application experience for customers.				
Cost				
Total output cost	$ million	322.2	412.6	424.4
Total output cost including the CAC	*$ million*	*322.2*	*412.6*	*424.4*
The lower 2021-22 target predominantly reflects the funding profile for the Energy efficiency upgrades for homes and Solar Homes initiatives. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Environment, Land, Water and Planning

Objective 4: Productive and effective land management

This objective delivers effective management and governance of Victoria's public land to protect its social, economic and environmental values and maximise its use by all Victorians.

The Department works with statutory agencies, committees and local governments to ensure that: land is productive and is used in a sustainable manner; infrastructure on public land and in coastal environments is appropriate and well managed; the condition of marine, coastal and estuarine environments is protected, maintained and improved; and key biodiversity assets, priority habitats and ecological processes are healthy and secure.

The Department also provides quality land information services, including comprehensive and accessible spatial information, to support integrated planning and decision making and ensure confidence in the integrity and efficiency of the property system. The Department provides policy advice to government on the best use of government land. The Department also provides assurance on the integrity, impartiality and accountability of Government land transactions by analysing each transaction and working with agencies to ensure land is transacted in accordance with legislation, policy and probity standards.

The departmental objective indicators are:

- efficient provision of timely and authoritative land administration and property information services;
- number of visits to the public land estate managed by the Department's portfolio agencies (Parks Victoria);
- bay and park assets rated in average to excellent condition~~;~~
- consistent and timely provision of government land transaction approvals and advice; and
- Traditional Owner satisfaction with progress on the Pupangarli Marnmarnepu Implementation Action Plan endorsed by the statewide Caring for Country Partnership Forum[(a)].

Note:

(a) New objective indicator for 2021-22 to reflect the Department's commitment to Aboriginal self-determination.

Outputs

Land Use Victoria (2021-22: $255.4 million)

This output delivers high-quality and authoritative land administration and property information services, including the registration of land titles under the Torrens system, survey, valuation and land information services. Land Use Victoria also incorporates the State's foundational spatial data services and government land policies. The probity of the Government's property transactions is overseen by the Government Land Monitor.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Property transfers, discharge of mortgages and registration of new mortgages	number (thousand)	850	840	850
Rapid land use assessments completed	number	40	50	40
The 2020-21 expected outcome is higher than the target due to additional ministerial requests for rapid land use assessments and the reallocation of staff resources towards this activity due to a lower volume of strategic land use assessments in 2020-21.				
Quality				
Audited Vicmap digital map base not requiring correction	per cent	98	99	98
Government-owned properties sold, bought or leased within 10 per cent of valuation	per cent	80	80	80
Timeliness				
Delivery of updated Vicmap Foundation Data within one week	per cent	98	100	98
Land dealings registered within five days	per cent	99	99.5	99
New titles (subdivisions) created within three weeks	per cent	95	85	95
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 pandemic and an increase in the number of lodgements received.				
Update transactions for the Vicmap digital map base processed within the required timeframes	per cent	98	99	98
Cost				
Total output cost	$ million	255.4	272.9	262.6
Total output cost including the CAC	*$ million*	*256.2*	*273.8*	*263.4*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Environment, Land, Water and Planning

Management of Public Land and Forests (2021-22: $294.0 million)

This output provides for the improved stewardship of Victoria's forests, coasts and Crown land reserves. Through this output, the Department manages the natural, built and historic assets on public land responsibly, and incorporates management of public land in partnership with statutory agencies, committees of management and local government.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Crown land leases directly managed by the Department	number	720	720	720
Crown land licenses directly managed by the Department	number	45 000	45 000	45 000
Native Title and Traditional Owner Settlement Act 2010 negotiations the Department supports with data and information services	number	4	4	2
The 2020-21 expected outcome and the 2021-22 target are higher than the 2020-21 target due to two existing negotiations continuing longer than expected, in addition to two new negotiations that DELWP is supporting.				
Native Title and Traditional Owner Settlement Act 2010 agreements being implemented by the Department	number	6	6	7
The 2020-21 expected outcome and the 2021-22 target are lower than the 2020-21 target due to the timing for finalisation of agreements under negotiation.				
Participants in Coastcare activities	number	10 000	2 350	10 000
The 2020-21 expected outcome is lower than the 2020-21 target due to COVID-19 restrictions shifting activities to online delivery methods and a mild summer season.				
Visitors to the Royal Botanic Gardens in Melbourne and Cranbourne	number (million)	2.0-2.2	1.7	1.6-2.0
The higher 2021-22 target reflects planned activities to increase visitation and build new audiences for programs, events and tours.				
Specimens curated in the State Botanical Collection	number	30 000	20 000	30 000
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 restrictions on fieldwork to collect specimens and on-site curation.				
Visitors to Zoos Victoria at Melbourne, Werribee and Healesville	number (million)	2.85	1.7	2.85
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 restrictions causing zoo closures, and limits on visitation numbers.				
Beaches renourished in Port Phillip Bay	number	3	7	7
The lower 2021-22 target reflects the number of projects scheduled for completion.				
Contaminated Crown land sites assessed/prepared for remediation	number	5	4	2
The 2020-21 expected outcome is higher than the 2020-21 target due to additional sites being selected for remediation by the EPA and additional resourcing to complete assessments/preparations. *The higher 2021-22 target has been increased to reflect this.*				
Suburban dog parks and pocket parks under development	number	43	43	20
The 2020-21 expected outcome and the 2021-22 target are higher than the 2020-21 target reflecting progress in implementing successfully funded round two projects.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quality				
Publicly elected Committees of Management that have a current statutory appointment	per cent	90	90	90
Recreational facilities in state forests with a life expectancy greater than five years	per cent	75	78	75
Timeliness				
Rent reviews of Department-managed Crown land leases undertaken within specified time frames	per cent	95	95	95
Investigations of alleged non-compliance with the Code of Practice for Timber Production 2014 and other relevant laws are completed within the statute of limitations of two years	per cent	100	nm	nm
This new performance measure replaces the 2020-21 performance measure 'Investigations of alleged non-compliance with the Code of Practice for Timber Production undertaken in accordance with the Environment Compliance Policy and associated procedures'. The new measure more effectively captures a key accountability of the Timber Harvesting Compliance program regarding the completion of investigations and provides greater public transparency about the investigations conducted by the Conservation Regulator.				
Cost				
Total output cost	$ million	294.0	301.8	299.8
Total output cost including the CAC	*$ million*	*313.5*	*321.1*	*319.2*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Environment, Land, Water and Planning

Parks Victoria (2021-22: $207.6 million)

This output provides for the improved stewardship of Victoria's parks. Through this output, Parks Victoria manages the development and protection of natural, cultural and community assets for safe enjoyment and sustainable use by all Victorians. Parks Victoria works to ensure the State's park assets are managed efficiently and effectively.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Area treated to minimise the impact of pest plants, pest animals and over abundant native animals in parks managed by Parks Victoria	hectares (000)	2 200	2 200	2 200
Visits to national, state, urban and other terrestrial parks	number (million)	80	86.4	80
The 2020-21 expected outcome is higher than the 2020-21 target as current analysis indicates that COVID-19 restrictions increased visitation to local parks in metropolitan Melbourne.				
Visits to piers and jetties	number (million)	35	31.8	35
The 2020-21 expected outcome is lower than the 2020-21 target as current analysis indicates that COVID-19 restrictions on the movement of Melbourne residents impacted on visits to Victoria's piers and jetties.				
Total area of estate managed by Parks Victoria	hectares (000)	4 120	4 120	4 117
The higher 2021-22 target reflects additions to the estate in 2020-21.				
Quality				
Significant built bay assets managed by Parks Victoria rated in average to excellent condition	per cent	80	70	80
The 2020-21 expected outcome is lower than the 2020-21 target due to the decline of maritime assets from age and storm impacts. However, works undertaken during 2020-21 have resulted in higher overall asset condition since 2019-20.				
Significant built park assets managed by Parks Victoria rated in average to excellent condition	per cent	88	88	88
Cost				
Total output cost	$ million	207.6	193.4	191.7
Total output cost including the CAC	*$ million*	*207.6*	*193.4*	*191.7*
The higher 2021-22 target predominantly reflects funding for the new 2021-22 Budget *initiative Enhancing Parks Victoria operations.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Environment, Land, Water and Planning

Objective 5: Safe and sustainable water resources

This objective increases the security of supply and the efficient use of water in cities and towns, and improves the environmental condition of waterways to ensure Victoria has safe and sustainable water resources to meet future urban, rural and environmental needs.

The Department works in partnership with water corporations, catchment management authorities, government agencies, industry, traditional owners and the community to balance the economic, environmental and social values of water. This helps to deliver secure water supplies, greener and liveable cities and towns, and healthy waterways and aquifers.

The departmental objective indicators are:

- proportion of intended properties (or equivalent) in the Goulburn Murray, Macalister, Werribee and Bacchus Marsh irrigation districts connected to a modernised irrigation delivery system; and
- number of river reaches/wetlands with maintained or improved environmental condition.

Outputs

Effective Water Management and Supply (2021-22: $317.7 million)

This output develops policies, provides strategic advice and oversees regulatory systems and institutional arrangements to effectively manage Victoria's water resources. Through this output, the Department delivers on-ground environmental programs to improve the health of waterways; water industry reform, governance and performance oversight; integrated water management; sustainable irrigation programs; and makes water resource information accessible to enable informed decision making.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Area of waterway vegetation works undertaken to improve the health and resilience of waterways	hectares	9 000	8 986	9 000
Cumulative water savings (permanent reduction in irrigation distribution system delivery losses) realised through water recovery projects	megalitres	909 902	909 896	909 902
Climate and hydrology research activities underway that focus specifically on Victoria	number	1	1	1
This performance measure renames the 2020-21 measure 'Climate research activities commissioned and received that focus specifically on Victoria' to better reflect the long-term nature of the research, as most research activities will not be commissioned and received within a 12-month timeframe.				
Long-term water monitoring sites maintained	number	1 167	1 167	1 205
Interactions with Water Markets reporting and transparency information, including visits to the Water Markets insights webpage and other digital information, per month	number	2 000	1 500	1 500
The higher 2021-22 target reflects expected increased interactions as a result of the creation of new information products that meet community interest.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Schools signed up to Schools Water Efficiency Program (SWEP)	number	1 500	1 300	1 200
The 2020-21 expected outcome is higher than the 2020-21 target due to targeted recruitment of schools through the Department of Education and Training, Catholic Education Victoria, and other activities resulting in increased enrolments to SWEP. *The higher 2021-22 target reflects the cumulative nature of the measure.*				
Place-based plans and actions underway for healthier communities and environments that encompass multiple values (Aboriginal, social, environmental and economic)	number	8	8	8
Households or community housing assisted in the Community Rebate and Housing Retrofit Program	number	1 555	1 580	1 580
The lower 2021-22 target reflects funding provided in the 2020-21 Budget.				
Area of active stewardship for catchment health and resilience	hectares	12 000	3 678	5 000
The 2020-21 expected outcome is lower than the 2020-21 target due to the refocusing of effort toward regional catchment strategy development and project planning, as a result of COVID-19 impacts on on-ground activities. *The higher 2021-22 target reflects the focus of Catchment Management Authorities increasing delivery of on-ground catchment stewardship projects in 2021-22, reflecting the phased program delivery for this second year of the program.*				
New flood studies underway to ensure communities understand flood risk and to inform investment in flood warning and mitigation measures	number	6	6	6
Environmental watering actions achieved at planned sites	per cent	90	95	60
The 2020-21 expected outcome is higher than the 2020-21 target due to the expectation that there will be sufficient water available to meet environmental watering demands, wetter than average conditions in most systems, water allocations, carryover and coordinated use of environmental water held by multiple environmental water holders. *The higher 2021-22 target reflects the anticipated achievement of completed watering events based on activities over 2016-2020. The environmental water planning framework is seasonally adaptive, so planned watering events align with the amount of environmental water available.*				
Quality				
Compliance with the salinity management actions agreed in the Murray Darling Basin Agreement	per cent	100	100	100
Victorian Water Register system availability per annum	per cent	95.8	95	95
The higher 2021-22 target reflects anticipated improvements from updates to the Victorian Water Register.				
Waterway and catchment health priority projects delivered involving community and sector partners	per cent	90	70	70
The higher 2021-22 target reflects an increase in program delivery, as the focus of delivery partners transitions from project planning to implementation and delivery.				
Timeliness				
Waterway licenses and permits processed within statutory timeframes	per cent	90	94	75
The 2020-21 expected outcome is higher than the 2020-21 target due to delivery partners prioritising core statutory functions. *The higher 2021-22 target reflects the expectation that this level of delivery will continue into 2021-22.*				
Cost				
Total output cost	$ million	317.7	354.5	327.1
Total output cost including the CAC	*$ million*	*319.3*	*356.1*	*328.8*
The 2020-21 expected outcome is higher than the target predominately due to additional Commonwealth funding for new water efficiency programs. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Environment, Land, Water and Planning

Objective 6: A safe and quality built environment

This objective plans for the future growth and transformation of cities and regions, and provides leadership and advice on heritage protection and the built environment. It delivers streamlined, fair and transparent planning, building and heritage systems.

The department recognises the link between the natural and built environment in the quality of our lives and works to accommodate population growth while maintaining world-class liveability and protecting our heritage for future generations.

The departmental objective indicators are:

- improved liveability, sustainability and inclusiveness of public spaces and neighbourhoods; and
- effective protection of cultural and natural heritage.

Outputs

Planning, Building and Heritage (2021-22: $321.1 million)

This output delivers programs to address the future growth and transformation of cities and regions through: strategic and integrated land use planning; urban development, design and renewal; land supply; heritage conservation and management; and regulatory reform. Through this output, the Department administers the statutory responsibilities of the Minister for Planning and provides for fair and transparent planning, building and heritage systems.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Local governments undertaking work to support strategic planning for coastal settlements and areas	number	15	15	15
Places or objects assessed for the Victorian Heritage Register	number	40	40	45
The 2020-21 expected outcome is lower than the 2020-21 target due to restrictions to access places and objects for assessment due to the COVID-19 pandemic and the increased complexity of assessments for nominated places and objects. The lower 2021-22 target reflects increased complexity of assessments for places and objects including, for example, industrial sites and landscapes.				
Conservation projects funded for 'at risk' State significant heritage places and objects	number	20	15	15
The higher 2021-22 target reflects increased funding provided for the competitive Community Heritage Grants program.				
Projects approved through the Streamlining for Growth program that benefit councils	number	30	30	30
Planning projects initiated in regional cities and towns to unlock and deliver zoned land supply	number	3	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding the Affordable by Supply program.				
Planning projects initiated to deliver zoned land supply for new 20-minute neighbourhoods in Greenfields Melbourne	number	3	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding the Affordable by Supply program.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Building inspections undertaken by the Victoria Building Authority to identify use of noncompliant cladding materials	number	480	nm	nm
New performance measure for 2021-22 to quantify the number of inspections completed in relation to the identification of noncompliant cladding material, providing greater visibility and accountability on progress in the stages of delivery of the Cladding Rectification Program.				
Building audits undertaken by the Victoria Building Authority to identify use of noncompliant cladding materials	number	350	300	480
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to COVID-19 restrictions limiting onsite meetings and inspections, plus the reduced availability of Fire Rescue Victoria staff. *The lower 2021-22 target reflects the expectation that reduced FRV staff availability will continue into 2021-22.*				
Building permits inspected by the Victorian Building Authority	per cent	10	10	10
In-scope government buildings that have commenced cladding rectification works	number	7	nm	nm
This new performance measure replaces the 2020-21 performance measure 'Government buildings identified as high priority that have commenced cladding rectification'. The new measure provides increased clarity to reflect the commencement of cladding rectification works on government buildings as demonstrated by when a construction contract has been awarded and rectification works have commenced on site.				
In-scope government buildings that have completed cladding rectification works	number	31	nm	nm
This new performance measure replaces the 2020-21 performance measure 'Government buildings identified as high priority that have commenced cladding rectification'. The new measure provides increased clarity to reflect the completion of cladding rectification works on government buildings as demonstrated by the project reaching practical completion.				
In-scope privately owned residential buildings that have commenced cladding rectification works	number	150	nm	nm
New performance measure for 2021-22 to reflect the commencement of cladding rectification works on privately-owned residential buildings as demonstrated by when a Design and Construct contract has been awarded and the final design of the rectification works has commenced to enable the physical works to begin on site.				
In-scope privately-owned residential buildings that have completed cladding rectification works	number	150	nm	nm
New performance measure for 2021-22 to reflect the completion of cladding rectification works on privately-owned residential buildings as demonstrated by the project reaching practical completion.				
Quality				
Environment effects statements, referrals and assessments are completed effectively and within the timeframes necessary to meet targets in the Ministerial Guidelines	per cent	70	65	70
The 2020-21 expected outcome is lower than the 2020-21 target due to a significant increase in Environment Effects Statement referrals and assessments.				
Proportion of planning applications that proceed through the VicSmart process within 10 days	per cent	16	16	16
Planning Scheme Amendments that are correct upon submission for approval	per cent	80	70	80
The 2020-21 expected outcome is lower than the 2020-21 target due to Planning Scheme Amendments that have been submitted with missing or incorrect information. System enhancements are being explored and considered to improve the quality and completeness of amendments submitted for approval.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Timeliness				
Average number of days to issue an archaeological consent	days	20	20	20
Average number of days to issue heritage certificates	days	7	7	7
Heritage permits issued within initial 60-day statutory timeframes	per cent	90	80	90
The 2020-21 expected outcome is lower than the 2020-21 target due to COVID-19 restrictions on access to places requiring assessment and an increase in permit applications for high-level development of heritage places.				
Median number of days taken by the Department to assess a planning scheme amendment	days	35	70	25
The 2020-21 expected outcome is higher than the 2020-21 target due to a high number of prescribed and ministerial amendments adding to the overall number of amendments for processing and disruptions associated with the COVID-19 pandemic. *The higher 2021-22 target better reflects the appropriate length of time required by department planners to assess and make recommendations on exhibited planning scheme amendments, and enables effective discussions with councils and other proponents to refine and improve the quality of amendments.*				
Urban Development Program Report on analysis of supply, consumption and adequacy of residential and industrial land completed	date	June 2022	June 2021	Jun 2021
State population projections completed to inform State Budget delivery	date	Feb 2022	Mar 2021	Feb 2021
The 2020-21 expected outcome is later than the 2020-21 target as input to the 2021-22 Budget *was not required until March 2021. The one-month delay enabled state population projections to incorporate the latest population estimates from the Australian Bureau of Statistics.*				
Victoria in Future population projection data to support infrastructure and service delivery planning completed	date	Jun 2022	Jun 2021	Jun 2021
Planning permit applications for new renewable energy facilities (excluding call ins) prepared for determination within 45 days after completion of public notice and receipt of council response to public notice	per cent	70	60	70
The 2020-21 expected outcome is lower than the 2020-21 target due to increased workload from the expansion of the Minister for Planning's permit responsibilities from wind farms only, to now include solar farms and all renewables, large scale batteries, and power lines.				
Cost				
Total output cost	$ million	321.1	420.8	434.5
Total output cost including the Capital Assets Charge (CAC)	*$ million*	*337.5*	*437.3*	*450.9*
The lower 2021-22 target predominately reflects the funding profile for initiatives funded through the Growth Areas Infrastructure Contribution Fund: Merinda Park railway station, Cranbourne station car park and pedestrian amenity upgrade, Cranbourne rail corridor duplication shared user path; fire stations in Wyndham Vale, Truganina Station and Clyde North; new ambulance stations in Melton, Melton South, Werribee and Hillside. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Environment, Land, Water and Planning

Objective 7: Reduced impact of major bushfires and other emergencies on people, property and the environment

This objective delivers an integrated approach to reducing the risk of bushfires and other emergencies to protect people, property and the environment.

The Department works together with land and fire managers and with the community to plan and deliver bushfire management across public and private land, and uses world-leading science to manage fire and ecosystems.

The departmental objective indicators are:

- percentage of bushfires contained at first attack and/or under five hectares to suppress bushfires promptly, keep bushfires small and minimise loss;
- area treated through planned burning and other treatments to maintain the statewide bushfire risk at or below 70 per cent;
- percentage of agreed departmental emergency management obligations met on time and to standard; and
- the economic impact of fire prevention and preparedness investment.

Output

Fire and Emergency Management (2021-22: $406.4 million)

This output plans and delivers integrated bushfire management. Through this output, the Department works with land and fire managers to plan and deliver bushfire management across public and private land; involves local communities in decision-making, drawing on local values and insights to promote resilience; invests in science and partnerships to build knowledge of the relationship between fire and the environment to better manage risk; monitors and assesses the impact and effectiveness of fire management operations; ensures its workforce is effectively trained and prepared; and maintains a strategic road network to facilitate fire and emergency related activities and provide access for the community, timber and tourism industries.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Strategic fuel breaks built or upgraded	km	963	484	484
The higher 2021-22 target reflects the phased program delivery for this year.				
Strategic fire access roads improved	km	2 000	2 200	2 000
The 2020-21 expected outcome is higher than the 2020-21 target due to a number of road improvements being less complex, allowing a greater number of kilometres to be addressed.				
Bridges or crossings on the strategic fire access road network replaced or upgraded	number	10	21	10
The 2020-21 expected outcome is higher than the 2020-21 target due to a number of low complexity crossing upgrades being delivered, allowing a greater number of bridges or crossings to be addressed.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Personnel with accreditation in a fire and emergency management role	number	2 400	2 420	2 200
The 2020-21 expected outcome is higher than the 2020-21 target due to the addition of new emergency management roles. The new roles are State Agency Controller and Regional Agency Controller. The higher target for 2021-22 reflects this change.				
State forests roads (Category 1) and bridges (on Category 1 roads) with documented inspections and/or maintenance programs to meet regulatory obligations	per cent	100	100	100
Statewide bushfire risk is maintained at or below the target	per cent	70	64	70
The 2020-21 expected outcome is lower than the 2020-21 target due to significant amount of high priority burns completed in spring 2020 and further burns expected for autumn 2021.				
Stakeholder and community forums on bushfire management and planned burning held	number	12	12	12
Quality				
Fires contained at less than five hectares to suppress fires before they become established, minimising impact	per cent	80	97.5	80
The 2020-21 expected outcome is higher than the 2020-21 target due to significant amount of high priority burns completed in spring 2020 and further burns expected for autumn 2021.				
Personnel accredited to serve in a senior capacity (level 2 or 3) in a fire and emergency management role	number	330	380	315
The 2020-21 expected outcome is higher than the 2020-21 target due to additional roles included in the figures. The new roles are State Agency Controller and Regional Agency Controller. The higher target for 2021-22 reflects this change.				
Proportion of Community-Based Bushfire Management partnerships rated as high functioning	per cent	80	80	80
Timeliness				
Assessment of model of cover completed to assess resource requirements and availability	date	Dec 2021	Dec 2020	Dec 2020
Joint Fuel Management Program plans completed	date	Sep 2021	Sep 2020	Sep 2020
This performance measure renames the 2020-21 measure 'Joint Fuel Management Plans completed' to reflect the new name of the program.				
Fires contained at first attack to suppress fires before they become established, minimising impact	per cent	80	97	80
The 2020-21 expected outcome is higher than the 2020-21 target due to significant amount of high-priority burns completed in spring 2020 and further burns expected for autumn 2021.				
Readiness and response plans completed prior to the upcoming fire season	date	Oct 2021	Oct 2020	Oct 2020
Cost				
Total output cost	$ million	406.4	457.3	390.2
Total output cost including the CAC	*$ million*	*461.0*	*512.2*	*445.1*
The 2020-21 expected outcome is higher than the 2020-21 target is predominantly due to additional funding provided to augment Victoria's aviation firefighting fleet, support necessary bushfire emergency management preparation activities and undertake bushfire recovery activities.				
The higher 2021-22 target predominantly relates to additional funding announced as part of the 2021-22 Budget. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Environment, Land, Water and Planning

DEPARTMENT OF FAMILIES, FAIRNESS AND HOUSING

Ministerial portfolios

The Department supports the ministerial portfolios of Housing, Disability, Ageing and Carers, Child Protection, Equality, Multicultural Affairs, Veterans, Women, Youth and the Prevention of Family Violence.

Departmental mission statement

The Department of Families, Fairness and Housing's vision is to achieve the best health, wellbeing and safety of all Victorians so that they can live a life they value.

The Department contributes to the Government's commitment to a stronger, fairer, better Victoria by developing and delivering policies, programs and services that support, protect and enhance the health, wellbeing and safety of all Victorians.

The Department supports the Victorian Government's commitment to a stronger, fairer, better Victoria by promoting excellence in government service delivery and reform.

Departmental objectives

The Department is focused on delivering the following outcomes:

Victorians are safe and secure

- Victorians live free from abuse and violence; and
- have suitable and stable housing.

Victorians have the capabilities to participate

- Victorians participate in learning and education;
- Victorians participate in and contribute to the economy; and
- Victorians have financial security.

Victorians are connected to culture and community

- Victorians are socially engaged and live in inclusive communities; and
- Victorians can safely identify and connect with their culture and identity.

Engaged citizens

- Support and promote full participation in strong and vibrant communities;
- Empower citizens to participate in policy making and service design; and
- Ensure a holistic approach to social policy and service delivery.

The Department will deliver services that are person-centred and sustainable. Our services will:

- be appropriate and available in the right place, at the right time;
- respond to choice, culture, identity, circumstances and goals;
- be efficient and sustainable; and
- be safe, high quality and provide a positive experience.

Changes to the output structure

The Department has made changes to its output structure for 2021-22 as shown in the table below.

2020-21 outputs	*Reason*	*2021-22 outputs*
Women's Policy	This output has been updated to appropriately reflect the output of activities undertaken under the Women's portfolio. Primary Prevention of Family Violence activities are now reported under the 'Primary prevention of family violence' output.	Women's Policy Primary Prevention of Family Violence

Source: Department of Families, Fairness and Housing

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2020-21 budget	*2020-21 revised*	*2021-22 budget*	*Variation [(a)] %*
Victorians are safe and secure				
Child Protection and Family Services	1 665.1	1 666.2	1 811.4	8.8
Housing Assistance	1 416.2	1 400.6	1 019.6	(28.0)
Family Violence Service Delivery	435.7	418.7	555.1	27.4
Victorians have the capabilities to participate				
Concessions to Pensioners and Beneficiaries	621.1	621.2	625.6	0.7
Disability Services	487.1	506.2	458.1	(6.0)
Victorian Contribution to National Disability Insurance Scheme [(b)]	1 651.9	1 651.9	1 693.3	2.5
Victorians are connected to culture and community				
Community Participation	103.3	132.9	108.7	5.2
Office for Disability	13.3	10.2	15.6	16.7
Engaged citizens				
Seniors Programs and Participation	24.2	26.0	27.4	13.3
Support to veterans in Victoria	9.0	8.6	12.6	40.0
LGBTIQ+ equality policy and programs	7.6	9.3	5.7	(24.9)
Women's policy	11.9	11.4	15.7	32.5
Primary Prevention of Family Violence	25.7	24.1	27.5	7.0
Youth	34.7	34.3	33.7	(2.9)
Multicultural affairs policy and programs	90.6	105.4	54.7	(39.6)
Total [(c)(d)]	**6 597.5**	**6 627.2**	**6 464.7**	**(2.0)**

Source: Department of Families, Fairness and Housing

Notes:

(a) Variation between the 2020-21 budget and the 2021-22 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant outputs.

(b) The output cost does not include contributions to the NDIS from other areas of the Victorian Government.

(c) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget *and CAC impacts are therefore excluded from the figures. Refer to individual output sections for comparative output costs inclusive of CAC.*

(d) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.6 outlines the Department's income from transactions and Table 2.7 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.6: Income from transactions **($ million)**

	2019-20 actual	*2020-21 budget*	*2020-21 revised*	*2021-22 budget*
Output appropriations [(a)]	..	..	2 454.5	6 478.1
Special appropriations	..	..	26.6	63.9
Grants	..	..	73.5	84.8
Total income from transactions [(b)]	**..**	**..**	**2 554.2**	**6 626.8**

Source: Department of Families, Fairness and Housing

Notes:
(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget.
(b) Table may not add due to rounding.

Table 2.7: Parliamentary authority for resources **($ million)**

	2020-21 budget	*2020-21 revised*	*2021-22 budget*
Annual appropriations	**..**	**2 485.4**	**6 222.6**
Provision of outputs [(a)]	..	2 252.5	6 012.6
Additions to the net asset base	..	216.1	140.9
Payments made on behalf of the State	..	16.7	69.1
Receipts credited to appropriations	**..**	**210.7**	**492.6**
Unapplied previous years appropriation	**..**	**..**	**..**
Provision of outputs	..	..	..
Additions to the net asset base	..	..	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**..**	**2 696.0**	**6 715.2**
Special appropriations	**..**	**34.2**	**65.4**
Trust funds	**..**	**463.6**	**850.1**
Total parliamentary authority [(b)]	**..**	**3 193.8**	**7 630.6**

Source: Department of Families, Fairness and Housing

Notes:
(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget.
(b) Table may not add due to rounding.

Departmental performance statement

Objective 1: Victorians are safe and secure

This objective aims for Victorians to live free from abuse and violence and for Victorians to have suitable and stable housing.

The departmental objective indicators are:

- reduce the abuse and neglect of children and young people;
- reduce the rate of growth in out-of-home care – especially for Aboriginal children;
- reduce the number of children in out-of-home care who live in residential care;
- reduce the level of continuing risk for victims of family violence;
- identify and respond to bullying, assault and inappropriate behaviour in departmental and public health services to reduce occurrence; and
- reduce the proportion of the population experiencing homelessness – especially victims of family violence, and young people.

Outputs

Child Protection and Family Services (2021-22: $1 811.4 million)

The Child Protection and Family Services output, through the funding of statutory child protection services, family support and parenting services, adoption and placement care services and specialist support services, aims to ensure the safety and wellbeing of adolescents and children at risk of harm, abuse and neglect. This output aims to make a positive difference to Victorians experiencing disadvantage by providing excellent community services to meet clients' needs.

This output provides:

- child protection services to ensure the safety and wellbeing of children and young people at risk of harm, abuse and neglect;
- specialist support and placement services to ensure the safety and wellbeing of children and young people who require support to remain with their family or are placed in out-of-home care; and
- a range of early intervention and support services to ensure the safety and wellbeing of children, young people and families.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Daily average number of children in care placements	number	9 801	9 145	10 712
The 2020-21 expected outcome is lower than the 2020-21 target due to updated projections of demand. *The lower 2021-22 target reflects the updated projections of demand.*				
Daily average number of children in foster care placements	number	1 681	1 646	1 769
The 2020-21 expected outcome is lower than the 2020-21 target due to updated projections of demand. *The lower 2021-22 target reflects the updated projections of demand.*				
Daily average number of children in residential care placements	number	455	446	520
The 2020-21 expected outcome is lower than the 2020-21 target due to updated projections of demand. *The lower 2021-22 target reflects the updated projections of demand.*				
Daily average number of children in kinship care placements	number	7 665	7 053	8 423
The 2020-21 expected outcome is lower than the 2020-21 target due to updated projections of demand. *The 2021-22 target has been reduced in line with this projection.*				
Daily average number of children subject to permanent care orders	number	3 225	3 092	3 538
The 2020-21 expected outcome is lower than the 2020-21 target due to updated projections of demand. *The lower 2021-22 target reflects the updated projections of demand.*				
Number of Child FIRST assessments and interventions undertaken outside of The Orange Door	number	6 815	17 443	8 064
The 2020-21 expected outcome is higher than the 2020-21 target due to high demand and shows Child FIRST responsiveness to vulnerable families. *The lower 2021-22 target reflects the transfer of services to The Orange Door.* *This performance measure renames the 2020-21 performance measure 'Number of Child FIRST assessments and interventions'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.*				
Number of families receiving an intensive support service	number	2 361	2 361	2 361
Number of investigations from reports to Child Protection Services about the wellbeing and safety of children	number	39 100	35 806	39 100
The 2020-21 expected outcome is lower than the 2020-21 target due to strengthened early support and intervention services reaching vulnerable children. The result is also likely to have been impacted by coronavirus (COVID-19) with fewer reports having been received in some months.				
Number of family services cases provided to Aboriginal families	number	3 281	3 140	3 231
The higher 2021-22 target reflects funding provided in the 2021-22 Budget.				
Reports to Child Protection Services about the wellbeing and safety of children	number	136 677	121 029	136 677
The 2020-21 expected outcome is lower than the 2020-21 target due to increased performance in Child FIRST / Family Services and The Orange Doors, which is providing referral pathways for vulnerable children and families to community-based earlier intervention and supports, rather than being reported to Child Protection. It also reflects the impact of COVID-19.				
Total number of family services cases provided	number	32 486	39 777	33 235
The 2020-21 expected outcome is higher than the 2020-21 target due to high demand and shows Child FIRST responsiveness to vulnerable families. *The lower 2021-22 target reflects the transfer of services to The Orange Door, partly offset by the impact of funding provided in the* 2021-22 Budget.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quality				
Children and young people in care who have had two or less placements in the past 12 months (not including placements at home)	per cent	90	93.7	90.0
Children and young people who were the subject of a substantiated report within 12 months of the closure of a previous substantiated report	per cent	17.5	19.3	17.5
The 2020-21 expected outcome is higher than the 2020-21 target due to a range of factors which may include the impact of COVID-19, that new or cumulative evidence has subsequently become available or that a deterioration in family circumstances has occurred between subsequent investigations.				
Children and young people who were the subject of an investigation which led to a decision not to substantiate, who were subsequently the subject of a substantiation within three months of case closure	per cent	3	3.1	3
Organisations that have successfully completed a certification review (family and community services)	per cent	95	95	95
Organisations that have successfully completed a certification review (specialist support and placement services)	per cent	95	95	95
Proportion of Aboriginal children placed with relatives/kin, other Aboriginal carers or in Aboriginal residential care	per cent	75	73.7	75
Timeliness				
Percentage of child protection investigations assessed as urgent, that were visited, or where attempts were made to visit, within two days of receipt of the report	per cent	97	92.6	97
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19.				
Cost				
Total output cost	$ million	1 811.4	1 666.2	1 665.1
Total output cost including the CAC	*$ million*	*1 827.1*	*1 680.8*	*1 679.7*
The higher 2021-22 target primarily reflects funding provided for Government policy commitments. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Families, Fairness and Housing

Housing Assistance (2021-22: $1 019.6 million)

The Housing Assistance output, through the provision of homelessness services, crisis and transitional accommodation and long-term adequate, affordable and accessible housing assistance, coordinated with support services where required, home renovation assistance and the management of the home loan portfolio, aims to make a positive difference for Victorians experiencing disadvantage by providing excellent housing and community services to meet clients' needs.

This output provides:

- housing assistance for low-income families, older people, singles, youth and other households. It responds to the needs of clients through the provision of appropriate accommodation, including short-term and long-term properties that assist in reducing and preventing homelessness; and
- housing support services to people who are homeless or at risk of homelessness, in short-term housing or crisis situations. Support will assist clients in accessing and maintaining tenancies in appropriate accommodation. Services provided will assist in the prevention and overall reduction of homelessness.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of bonds issued to low-income Victorians to assist access to the private rental market	number	10 000	5 973	10 000
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the economic impact of the COVID-19 pandemic on the private rental market.				
Number of clients assisted to address and prevent homelessness	number	107 000	111 850	123 000
The 2020-21 expected outcome is lower than the 2020-21 target due to lower than anticipated demand for homelessness services due to the COVID-19 pandemic. *The lower 2021-22 target reflects a return to pre-pandemic levels. This measure does not include people seeking homelessness assistance through family violence intake services.*				
Number of clients provided with accommodation	number	30 000	31 750	30 000
The 2020-21 expected outcome is higher than the 2020-21 target due to the impact of funding provided in response to the COVID-19 pandemic.				
Number of households assisted with long-term social housing (public, Aboriginal and community long-term tenancies at end of year)	number	77 900	77 900	77 900
Proportion of homelessness services clients that engage with support services and access or maintain housing	per cent	72	68.6	72
Number of public housing dwellings upgraded during year	number	2 665	2 665	2 665
Total number of social housing dwellings	number	87 515	86 000	86 000
The higher 2021-22 target reflects the planned acquisition of additional housing.				
Total social housing dwellings acquired during the year	number	1 901	2 169	2 284
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 pandemic restricting access to sites and reduction of permitted personnel on site. *The 2021-22 target has been reduced to reflect the temporary impact of 2020-21 funding in response to the COVID-19 pandemic. This measure does not reflect building commencements under the Big Housing Build. Big Housing Build completions will be included in the 2022-23 acquisition target.*				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Number of family violence victims who receive a refuge response	number	1 061	824	1 061
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 public health response on face-to-face services and roll-out of the refuge redevelopment.				
Number of nights of refuge accommodation provided to victims of family violence	number	54 109	42 893	54 109
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 public health response on face-to-face services and roll-out of the refuge redevelopment.				
Number of calls responded to by the statewide 24/7 family violence victim survivor crisis service	number	60 000	62 134	60 000
Number of clients assisted to address and prevent homelessness due to family violence	number	49 000	52 244	62 000
The 2020-21 expected outcome is lower than the 2020-21 target due to lower than anticipated demand for homelessness services due to the COVID-19 pandemic. *The lower 2021-22 target reflects a return to pre-pandemic levels. This measure does not include people seeking homelessness assistance through family violence intake services.*				
Quality				
Social housing tenants satisfied with completed urgent maintenance works	per cent	85	87.5	85
Social housing tenants satisfied with completed non-urgent maintenance works	per cent	80	73	80
The 2020-21 expected outcome is lower than the 2020-21 target due to non-urgent jobs placed on hold for a lengthy period to minimise tenant-contractor interaction during the COVID-19 pandemic.				
Timeliness				
Average waiting time for public rental housing for those clients who have received priority access housing allocation or a priority transfer	months	10.5	12.5	10.5
The 2020-21 expected outcome is higher than the 2020-21 target due to a decrease in tenants moving out of public housing which has provided fewer opportunities for allocations of properties to people on the register.				
Average waiting time for public rental housing for clients who have received a priority access housing or priority transfer allocation due to family violence	months	10.5	10.8	10.5
Proportion of clients where support to sustain housing tenure was provided or referred	per cent	85	89.8	85
The 2020-21 expected outcome is higher than the 2020-21 target due to the impact of funding in response to the COVID-19 pandemic.				
Cost				
Total output cost	$ million	1 019.6	1 400.6	1 416.2
Total output cost including the CAC	*$ million*	*1 019.6*	*1 400.6*	*1 416.2*
The lower 2021-22 target primarily reflects completion of a number of government policy commitments related to the COVID-19 response in 2020-21; partly offset by additional funding provided for Government policy commitments. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Families, Fairness and Housing

Family Violence Service Delivery (2021-22: $555.1 million)

This output will lead and coordinate whole of government family violence policy and implement and deliver the Government's family violence reform agenda. This will include establishing and operating Support and Safety Hubs, implementing information sharing legislation, and delivery of risk assessment and management programs.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Workers trained in the information sharing and family violence risk assessment and risk management reforms	number	10 000	10 000	10 000
This performance measure renames the 2020-21 performance measure 'Workers trained in the Family Violence Risk Assessment and Risk Management Framework' to reflect the current implementation of reforms. The measure is otherwise unchanged.				
Support and Safety Hubs established	number	14	8	8
The higher 2021-22 target reflects the expected implementation schedule as new The Orange Door sites open in 2021-22.				
Total assessments undertaken at the Support and Safety Hubs	number	34 839	25 406	22 536
The 2020-21 expected outcome is higher than the 2020-21 target due to the opening of two new The Orange Door sites in 2020-21. *The higher 2021-22 target reflects the services delivered at each new The Orange Door site that is scheduled to open in 2021-22.*				
Total assessments undertaken for children in the Support and Safety Hubs/The Orange Door	number	10 453	nm	nm
New performance measure for 2021-22 to maintain visibility of service delivery for children as The Orange Door Network is rolled out across the State. This performance measure is proposed as a sub-measure to the measure, 'Total assessments undertaken at the Support and Safety Hubs' and reflects the incorporation of Child FIRST service delivery into The Orange Door as each new site is implemented.				
Number of clients assisted by a Risk Assessment and Management Panel	number	650	448	650
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 public health response, during which time the number of referrals to RAMPs decreased significantly. In part, lower than expected referral volume is due to specialist family violence services being able to successfully manage family violence risk and needs in the context of their COVID-19 operating practice modifications.				
Number of children who receive a Sexually Abusive Behaviours Treatment Service response	number	1 182	1 150	1 150
The higher 2021-22 target reflects additional funding provided in the 2021-22 Budget.				
Number of episodes of support provided to adolescents using violence in the home	number	800	nm	nm
New performance measure for 2021-22 to reflect services provided to this cohort. The measure also reflects additional funding provided in the 2021-22 Budget.				
Number of calls responded to by the statewide telephone help line for men regarding family violence	number	6 000	8 826	6 000
The 2020-21 expected outcome is higher than the 2020-21 target due to the impact of the COVID-19 pandemic on demand.				
Number of men participating in the Men's Behaviour Change program	number	4 400	2 808	4 000
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 pandemic on activities. *The higher 2021-22 target reflects additional funding provided in the* 2021-22 Budget.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Number of case management responses provided to perpetrators of family violence including those that require individualised support	number	1 300	1 170	1 300
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 pandemic on activities.				
Quality				
Satisfaction of workers with the information sharing and family violence risk assessment and risk management training	per cent	80	80	80
This performance measure replaces the 2020-21 performance measure 'Satisfaction of workers with family violence training'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.				
Satisfaction of clients with Support and Safety Hubs services	per cent	80	80	80
Timeliness				
Assessments undertaken within seven days	per cent	80	60	80
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 pandemic on activities and increasing client complexity leading to longer timeframes for assessments completion.				
Sexual assault support services clients receiving an initial response within five working days of referral	per cent	98	98	98
Number of sexual assault services provided to adults, children and young people	number	14 890	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding support for victim survivors of sexual assault.				
Cost				
Total output cost	$ million	555.1	418.7	435.7
Total output cost including the CAC	*$ million*	*558.6*	*418.7*	*439.2*
The higher 2021-22 target primarily reflects funding provided for government policy commitments. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Families, Fairness and Housing

Objective 2: Victorians have the capabilities to participate

This objective aims for Victorians to participate in learning, education and employment, benefit economically from strong health and human services sectors, and participate in the economy and have financial security.

The departmental objective indicators are:

- increase educational engagement and achievement by children and young people in contact with departmental services – especially those in out-of-home care;
- increase participation in three and four-year-old kindergarten by children known to child protection;
- increase the health and wellbeing of those who care voluntarily for people with a disability; people with mental illness; people with chronic illness; older people with care needs; and children in out-of-home care; and
- increase labour market participation by women, people with disability; people with mental illness; carers and people living in specified locations and communities.

Outputs

Concessions to Pensioners and Beneficiaries (2021-22: $625.6 million)[a]

The Concessions to Pensioners and Beneficiaries output, through the development and coordination of the delivery of concessions and relief grants to eligible consumers and concession card holders, aims to make a positive difference for Victorians experiencing disadvantage by providing excellent community services to meet clients' needs.

This output provides reductions in the price of energy, water, and municipal rates to eligible consumers and concession card holders. It also provides trustee services for people on a low income or those who are subject to an order by the Victorian Civil and Administrative Tribunal, and other social and community services, including the provision of emergency relief for individuals or families who are experiencing immediate and personal distress due to a financial or domestic crisis.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Households receiving mains electricity concessions	number	1 006 929	1 006 929	925 281
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities. *The higher 2021-22 target reflects the most current data regarding uptake of concessions in Victoria.*				
Households receiving mains gas concessions	number	679 823	679 823	693 146
The lower 2021-22 target reflects the most current data regarding uptake of concessions in Victoria.				
Households receiving non-mains energy concessions	number	24 123	24 123	23 535
The higher 2021-22 target reflects the most current data regarding uptake of concessions in Victoria.				
Households receiving pensioner concessions for municipal rates and charges	number	432 143	432 143	436 866
The lower 2021-22 target reflects the most current data regarding uptake of concessions in Victoria.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Households receiving water and sewerage concessions	number	709 495	709 495	687 642
The higher 2021-22 target reflects the most current data regarding uptake of concessions in Victoria.				
Number of Utility Relief Grants granted to households	number	72 421	72 421	52 232
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities. *The higher 2021-22 target reflects the most current data regarding uptake of concessions in Victoria.*				
Quality				
Percentage of customers satisfied with State Trustees Limited services	per cent	75	75	75
Percentage of Community Service Agreement performance targets that have been achieved by State Trustees	per cent	90	92	90
Percentage of customer requests answered by State Trustees within the timelines set in the Community Service Agreement	per cent	90	90	90
Cost				
Total output cost	$ million	625.6	621.2	621.1
Total output cost including the CAC	*$ million*	*625.6*	*621.3*	*621.1*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Families, Fairness and Housing

Note:
(a) This excludes funding for transport concessions transferred to the Department of Transport

Disability Services (2021-22: $458.1 million)

The Disability Services output, through the provision of continuing care and support services for people with disabilities, their carers and their families, aims to make a positive difference for Victorians experiencing disadvantage and provide excellent community services to meet clients' needs.

This output provides:

- specialised support for people with a disability and resources and programs that build capacity to respond to the needs of people with a disability; and
- bed and facility-based services characterised by the bundling of accommodation services and disability support.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Clients receiving forensic disability service	number	750	785	750
Quality				
Forensic disability Target Group Assessments completed within six weeks	per cent	80	50	80
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 pandemic on activities.				
Forensic disability residents participating in community reintegration activities	per cent	80	80	80
Organisations that have successfully completed a certification review (accommodation supports)	per cent	95	95	95
Organisations that have successfully completed a certification review (client services and capacity)	per cent	95	95	95
Organisations that have successfully completed a certification review (individualised supports)	per cent	95	95	95
Cost				
Total output cost	$ million	458.1	506.2	487.1
Total output cost including the CAC	*$ million*	*501.1*	*546.2*	*527.1*
The lower 2021-22 target primarily reflects cessation of one-off funding in 2020-21 by Government for COVID-19 and to support the transfer of departmental services to non-government organisations.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Department of Families, Fairness and Housing

Victorian Contribution to National Disability Insurance Scheme

(2021-22: $1 693.3 million)

This is the Department's contribution to Australia's National Disability Insurance Scheme. The scheme ensures that people with severe or profound disabilities can access the necessary supports they need to live the life they want and achieve their goals and aspirations.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
National Disability Insurance Scheme participants	number	109 592	108 786	108 786
The higher 2021-22 target reflects the number of NDIS participants Victoria is expected to jointly fund with the Commonwealth under the bilateral Agreement.				
Cost				
Total output cost	$ million	1 693.3	1 651.9	1 651.9
Total output cost including the CAC	*$ million*	*1 693.3*	*1 651.9*	*1 651.9*

The output cost does not include contributions to the NDIS from other areas of the Victorian Government.
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.
This output did not have a provision for CAC in previous budgets.

Source: Department of Families, Fairness and Housing

Objective 3: Victorians are connected to culture and community

This objective aims for Victorians to be socially engaged and live in inclusive communities, and able to safely identify and connect with their culture and identity.

The departmental objective indicators are:

- increase rates of community engagement, especially for Aboriginal children and young people; and
- increase cultural connection for children in out-of-home care – especially Aboriginal children.

Outputs

Community Participation (2021-22: $108.7 million)

Community participation programs include the Neighbourhood House Coordination Program, Men's Sheds, Community Support and Community Finance initiatives. These programs support the social and economic participation of Victorian communities, particularly vulnerable populations.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Hours of coordination funding provided to Neighbourhood Houses	number (thousand)	561 896	554 872	561 896
Timeliness				
Grants acquitted within the timeframe specified in the terms and conditions of the funding agreement	per cent	92	92	92
Cost				
Total output cost	$ million	108.7	132.9	103.3
Total output cost including the CAC	*$ million*	*108.7*	*132.9*	*103.3*

The 2020-21 expected outcome is higher than the 2020-21 target primarily due to increased funding for Government policy commitments related to the COVID-19 response for the Human Services Readiness & Response Centre; and machinery of government transfers from the Department of Health.
The higher 2021-22 target primarily reflects funding provided for Government policy commitments, partly offset by the completion of a number of government policy commitments related to the COVID-19 response in 2020-21.
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.
This output did not have a provision for CAC in previous budgets.

Source: Department of Families, Fairness and Housing

Office for Disability (2021-22: $15.6 million)

The Office for Disability leads and coordinates whole of government policy, disability action planning and funding, and support to disability advocacy and self-advocacy organisations so that people with a disability experience reduced disadvantage, can fully participate in the community and have their rights upheld.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of Disability Advocacy clients	number	2 500	2 300	2 000
The 2020-21 expected outcome is higher than the 2020-21 target due to the impact of COVID-19 on demand for advocacy services. *The higher 2021-22 target reflects funding provided in the* 2021-22 Budget.				
Timeliness				
Annual reporting against the State disability plan within agreed timeframes	per cent	100	0	100
The 2020-21 expected outcome is lower than the 2020-21 target due to public reporting on the State disability plan being paused to focus on the COVID-19 public health response.				
Cost				
Total output cost	$ million	15.6	10.2	13.3
Total output cost including the CAC	*$ million*	*15.6*	*10.2*	*13.3*
The 2020-21 expected outcome is lower than the 2020-21 target due to machinery of government changes to reflect the transfer of funding to support location of Disability Liaison Officers within Health Programs for 2020-21. *The higher 2021-22 target primarily reflects funding provided for Government policy commitments; partly offset by the completion of a number of government policy commitments related to the COVID-19 response in 2020-21.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Families, Fairness and Housing

Objective 4: Engaged citizens

This objective supports and promotes full participation in strong, resilient and vibrant communities. It empowers citizens to participate in policy making and service design. It ensures a holistic approach to social policy and service delivery.

The departmental objective indicator is:

- increased opportunities for participation by members of the Victorian community in the social, cultural, economic and democratic life of Victoria.

Outputs

Seniors Programs and Participation (2021-22: $27.4 million)

Support broader community planning processes to facilitate an integrated community planning and response approach aimed at enabling older Victorians to fully participate and engage in the community.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
New University of the Third Age membership growth	per cent	5	0.5	5
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 pandemic on activities and restrictions on face-to-face meetings.				
Open rates for Seniors Card eNewsletters	per cent	48	48	48
Individuals provided with respite and support services	number	13 250	13 250	13 250
This performance measure has been transferred directly from the 'Aged Support Services' output to reflect the impact of machinery of government changes.				
Number of hours of respite and support services	number	261 250	261 250	261 250
This performance measure has been transferred directly from the 'Aged Support Services' output to reflect the impact of machinery of government changes.				
Quality				
Eligible seniors in the Seniors Card program	per cent	90	89.5	90
Senior satisfaction with Victorian Seniors Festival events	per cent	90	100	90
The 2020-21 expected outcome is higher than the 2020-21 target due to increased participant satisfaction.				
Cost				
Total output cost	$ million	27.4	26.0	24.2
Total output cost including the CAC	*$ million*	*27.4*	*26.0*	*24.2*
The 2020-21 expected outcome is higher than the 2020-21 target due to additional funding for Government policy commitments and funding for Bushfire Recovery Victoria. *The higher 2021-22 target primarily reflects funding provided for government policy commitments; and rephasing of budget from 2020-21 to align with program delivery.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Families, Fairness and Housing

Support to veterans in Victoria (2021-22: $12.6 million)

This output provides coordination of veteran-related issues at a state level, especially in relation to commemoration, education programs, grant programs, research and veteran welfare. This output supports the Shrine of Remembrance and the Victorian Veterans Council.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Entries received – Premier's Spirit of Anzac Prize	number	250	200	250
The 2020-21 expected outcome is lower than the 2020-21 target as entries are expected to be lower due to the impact of the COVID-19 pandemic.				
Community engagement – Shrine ceremonial activities, public and student education programs, tours and general visitation	number	750 000	735 000	750 000
Number of veterans employed in the Victorian Public Sector	number	750	750	750
Number of ex-service organisation training and/or information sessions delivered	number	4	4	4
Quality				
Commemorative and educative projects meet agreed project objectives	per cent	100	100	100
Timeliness				
Deliver an annual program of grants within agreed, published timelines	per cent	100	100	100
Cost				
Total output cost	$ million	12.6	8.6	9.0
Total output cost including the CAC	*$ million*	*12.6*	*8.6*	*9.0*
The higher 2021-22 target primarily reflects funding provided for Government policy commitments for Shrine of Remembrance and Supporting veterans initiatives.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				
This output did not have a provision for CAC in previous budgets.				

Source: Department of Families, Fairness and Housing

LGBTIQ+ equality policy and programs (2021-22: $5.7 million)

This output provides programs and services to promote equality for LGBTIQ+ Victorians and to support these communities' economic, social and civic participation.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of people who have attended government-supported pride events and festivals	number	90 000	nm	nm
New measure for 2021-22 on the number of people who have attended LGBTIQ+ events and festivals funded through the Equality portfolio.				
Number of organisations engaged through the establishment of a Trans and Gender Diverse Peer Support Program	number	10	10	10
This performance measure renames the 2020-21 performance measure 'Number of organisations engaged through the establishment of a TGD Peer Support Program'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.				
Proportion of LGBTIQ+ grant program recipients who are located in regional and rural areas	per cent	30	40	30
The 2020-21 expected outcome is higher than the 2020-21 target due to the higher than anticipated engagement with regional and rural areas due to the flexibility of grant activities to be delivered online in 2020-21.				
Number of community leaders completing the LGBTIQ+ Leadership Program	number	25	30	25
The 2020-21 expected outcome is higher than the 2020-21 target due to higher than anticipated engagement with LGBTIQ+ community leaders due to the online delivery of the LGBTIQ+ Leadership Program in 2020.				
Quality				
Payments for events made in accordance with department milestones	per cent	100	100	100
This performance measure renames the 2020-21 performance measure 'Payments for events made in accordance with DPC milestones'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.				
Cost				
Total output cost	$ million	5.7	9.3	7.6
Total output cost including the CAC	*$ million*	*5.7*	*9.3*	*7.6*
The 2020-21 expected outcome is higher than the 2020-21 target due to funding provided for Government policy commitments, partially offset by the impact of COVID-19. *The lower 2021-22 target primarily reflects completion of Government policy commitments related to one off economic recovery grants.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Families, Fairness and Housing

Women's policy (2021-22: $15.7 million)

This new output is a disaggregation of the *2020-21 Budget* Women's policy output. This output provides initiatives that support gender equality and better outcomes for women across all areas of their lives including economic security, safety, leadership, health and wellbeing.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of people participating in funded gender equality programs	number	3 400	nm	nm
New measure for 2021-22 to reflect Government priorities regarding activities undertaken under the Women's portfolio. This measure replaces the disaggregated measure proposed for discontinuation 'Number of people participating in funded primary prevention and gender equality programs.' Primary prevention activities are now reported under the new 'Primary prevention of family violence' output.				
Percentage of women on Victorian Government boards	per cent	50	55	50
The 2020-21 expected outcome is higher than the 2020-21 target due to Government's continued efforts to deliver the Women on Boards commitment.				
Quality				
Gender equality grant recipients who met or exceeded contractually agreed outcomes	per cent	95	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding the output of activities undertaken under the Women's portfolio. This measure replaces the disaggregated measure proposed for discontinuation 'Gender equality and prevention of family violence grant recipients who met or exceeded contractually agreed outcomes.' Primary prevention activities are now reported under the new 'Primary prevention of family violence' output.				
Timeliness				
Women's Portfolio projects and programs delivered on time	per cent	100	nm	nm
New measure for 2021-22 reflecting the output of activities undertaken under the Women's portfolio. This measure replaces the disaggregated measure proposed for discontinuation 'Women's and the Prevention of Family Violence projects and programs delivered on time.' Primary prevention activities are now reported under the new 'Primary prevention of family violence' output.				
Tools, resources and guidelines to support the *Gender Equality Act 2020* implementation are completed within agreed timeframes	per cent	100	100	100
Cost				
Total output cost	$ million	15.7	11.4	11.9
Total output cost including the CAC	*$ million*	*15.7*	*11.4*	*11.9*
The higher 2021-22 target primarily reflects funding provided for Government policy commitments.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				
This output did not have a provision for CAC in previous budgets.				

Source: Department of Families, Fairness and Housing

Primary Prevention of Family Violence (2021-22: $27.5 million)

This new output is a disaggregation of the *2020-21 Budget* Women's policy output. This output provides initiatives that support primary prevention of family violence and violence against women.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Number of people participating in funded primary prevention programs	number	3 400	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding activities undertaken under the Primary Prevention of Family Violence output. This measure replaces the disaggregated measure proposed for discontinuation 'Number of people participating in funded primary prevention and gender equality programs'. Women's portfolio activities are reported under the 'Women's Policy' output.				
Quality				
Prevention of family violence grant recipients who met or exceeded contractually agreed outcomes	per cent	95	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding activities undertaken under the Primary Prevention of Family Violence output. This measure replaces the disaggregated measure proposed for discontinuation 'Gender equality and prevention of family violence grant recipients who met or exceeded contractually agreed outcomes.' Women's portfolio activities are reported under the 'Women's Policy' output.				
Timeliness				
Prevention of family violence projects and programs delivered on time	per cent	100	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding the activities undertaken under the Women's portfolio. This measure replaces the disaggregated measure proposed for discontinuation 'Women's and the Prevention of Family Violence projects and programs delivered on time.' Women's portfolio activities are reported under the 'Women's Policy' output.				
Cost				
Total output cost	$ million	27.5	24.1	25.7
Total output cost including the CAC	*$ million*	*27.5*	*24.1*	*25.7*
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19.				
The higher 2021-22 target reflects funding provided for Government policy initiatives for advancing women's economic security, preventing family violence during the COVID-19 pandemic and preventing family violence by early intervention.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				
This output did not have a provision for CAC in previous budgets.				

Source: Department of Families, Fairness and Housing

Youth (2021-22: $33.7 million)

This output leads and coordinates whole of government policy advice and delivers a range of initiatives for young people aged between 12 and 25 years to gain a range of skills and experiences and to actively participate in their local communities.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Participation by young people in programs that provide opportunities to be involved in social and economic life in their communities	number	240 000	247 877	240 000
Participation by young people in programs that support young people to be involved in decision making in their community	number	2 300	2 877	2 300
The 2020-21 expected outcome is higher than the 2020-21 target due to Victorian Youth Week 2020 being delayed to 2020-21 due to the COVID-19 pandemic. This has resulted in two annual events occurring in one financial year. Victorian Youth Week is a key contributor to achievement of this performance measure.				
Number of Scout Hall Capital Projects Completed	number	2	6	2
The 2020-21 expected outcome is higher than the 2020-21 target due to an acceleration in completed projects from year one following completion of the project planning stages. This is the second year of a four-year capital works program.				
Quality				
Participants reporting development of transferrable skills supporting positive outcomes for young people	per cent	75	93	75
The 2020-21 expected outcome is higher than the 2020-21 target due to more young people participating in programs reporting transferrable skills than originally estimated.				
Timeliness				
Percentage of programs delivered within agreed timeframes	per cent	90	99.5	90
The 2020-21 expected outcome is higher than the 2020-21 target due to strong engagement with funded providers across Youth portfolio programs to ensure delivery within agreed timeframes.				
Cost				
Total output cost	$ million	33.7	34.3	34.7
Total output cost including the CAC	*$ million*	*33.7*	*34.3*	*34.7*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the 2021-22 Budget. This output did not have a provision for CAC in previous budgets.*				

Source: Department of Families, Fairness and Housing

Multicultural affairs policy and programs (2021-22: $54.7 million)

This output provides policy advice on multicultural affairs and social cohesion in Victoria, including settlement coordination for newly arrived migrants and refugees and delivers a range of programs to directly support Victoria's multicultural communities. It also supports Victoria's whole of government approach to multiculturalism. The output includes monitoring of government departments' responsiveness to Victorians from culturally, linguistically and religiously diverse backgrounds.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Consultations with communities on issues relevant to culturally and linguistically diverse (CALD) communities	number	75	100	100
The lower 2021-22 target reflects the reduced total funding for the multicultural affairs policy and programs output. The reduction is primarily due to a time-limited increase in funding in 2020-21 to respond to the COVID-19 pandemic to support multicultural communities and to provide targeted support for economic recovery.				
Number of projects delivered in partnerships with CALD communities	number	30	37	30
The 2020-21 expected outcome is higher than the 2020-21 target due to a larger number of projects undertaken in partnership with communities in response to the COVID-19 pandemic.				
Community participation in multicultural events (attendance at Multicultural Affairs events)	number (millions)	1.3	nm	nm
New measure for 2021-22 to reflect recent community attendance figures in Multicultural Affairs events.				
Attendance at Cultural Diversity Week flagship event, Victoria's Multicultural Festival	number	55 000	na	55 000
The 2020-21 expected outcome is not recorded due to the flagship event for Cultural Diversity Week not proceeding in 2020 due to the COVID-19 pandemic. This event is planned to be reintroduced in 2022. Cultural Diversity Week will be highlighted through alternative online seminars and a range of smaller events in 2021.				
Quality				
Proportion of approved grant funding provided to organisations in regional/rural areas	per cent	20	15	20
The 2020-21 expected outcome is lower than the 2020-21 target due to a large proportion of funding through the Multicultural Affairs portfolio in 2020-21 allocated in response to emerging risks related to the COVID-19 pandemic. The majority of this funding has been allocated to metropolitan LGAs linked to COVID-19 cases, with fewer cases in regional and rural Victoria.				
Cost				
Total output cost	$ million	54.7	105.4	90.6
Total output cost including the CAC	$ million	*54.7*	*105.4*	*90.6*
The 2020-21 expected outcome is higher than the 2020-21 target due to funding provided for Government policy commitments, partially offset by the impact of COVID-19. *The lower 2021-22 target primarily reflects completion of a number of government policy commitments related to the COVID-19 response in 2020-21 that supported collaboration with multicultural communities and provided targeted support for economic recovery.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget*.* *The CAC is discontinued from the* 2021-22 Budget*.* *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Families, Fairness and Housing

DEPARTMENT OF HEALTH

Ministerial portfolios

The Department supports the ministerial portfolios of Health, Ambulance Services, Disability, Ageing and Carers, and Mental Health.

Departmental mission statement

The Department of Health's mission is to achieve the best health, wellbeing and safety of all Victorians so that they can live a life they value.

The Department contributes to the Government's commitment to a stronger, fairer, better Victoria by developing and delivering policies, programs and services that support, protect and enhance the health, wellbeing and safety of all Victorians.

Departmental objectives

The Department is focused on delivering the following outcomes:

- Victorians are healthy and well;
- Victorians have good physical health;
- Victorians have good mental health; and
- Victorians act to protect and promote health.

The Department will deliver services that are person centred and sustainable. Our services will:

- be appropriate and available in the right place, at the right time;
- respond to choice, culture, identity, circumstances and goals;
- be efficient and sustainable; and
- be safe, high quality and provide a positive experience.

Changes to the output structure

The Department has made changes to its output structure for 2021-22 as shown in the table below.

2020-21 outputs	*Reason*	*2021-22 outputs*
Acute Health Services	Disaggregation of output group to better align with standard output practice across government	Admitted Services Non-Admitted Services Emergency Services Acute Training and Development
Ageing, Aged and Home Care	Disaggregation of output group to better align with standard output practice across government	Aged Care Assessment Aged Support Services Home and Community Care Program for Younger People
Ambulance Services	Disaggregation of output group to better align with standard output practice across government	Ambulance Emergency Services Ambulance Non-Emergency Services
Drug Services	Disaggregation of output group to better align with standard output practice across government	Drug Prevention and Control Drug Treatment and Rehabilitation
Mental Health	Disaggregation of output group to better align with standard output practice across government	Mental Health Clinical Care Mental Health Community Support Services
Primary, Community and Dental Health	Disaggregation of output group to better align with standard output practice across government	Community Health Care Dental Services Maternal and Child Health and Early Parenting Services
Public Health	Disaggregation of output group to better align with standard output practice across government	Health Protection Health Advancement Emergency Management
Small Rural Services	Disaggregation of output group to better align with standard output practice across government	Small Rural Services – Acute Health Small Rural Services – Aged Care Small Rural Services – Home and Community Care Services Small Rural Services – Primary Health
Clinical Care (sub-output)	Renamed to clarify given elimination of output groups in the department	Mental Health Clinical Care

Source: Department of Health

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2020-21 budget	*2020-21 expected outcome*	*2021-22 budget*	*Variation [(a)] %*
Victorians are healthy and well				
Admitted Services	12 796.1	13 185.2	12 903.4	0.8
Non-Admitted Services	2 050.3	2 008.2	2 208.8	7.7
Emergency Services	773.9	771.3	838.3	8.3
Acute Training and Development	322.8	342.6	352.3	9.1
Residential Aged Care	423.3	421.8	436.1	3.0
Aged Care Assessment	60.8	59.8	59.6	(2.0)
Aged Support Services	120.4	119.2	108.8	(9.6)
Home and Community Care Program for Younger People	203.3	203.6	202.2	(0.5)
Ambulance Emergency Services	1 082.9	1 086.7	1 166.5	7.7
Ambulance Non-Emergency Services	166.1	168.1	196.9	18.6
Drug Prevention and Control	43.2	45.8	44.8	3.7
Drug Treatment and Rehabilitation	264.8	260.5	285.4	7.8
Mental Health Clinical Care	1 911.2	1 893.5	2 177.0	13.9
Mental Health Community Support Services	124.1	125.5	166.3	34.0
Community Health Care	333.6	337.8	381.0	14.2
Dental Services	310.1	297.7	351.9	13.5
Maternal and Child Health and Early Parenting Services	134.4	137.5	150.6	12.1
Health Protection	1 083.8	1 435.8	555.0	(48.8)
Health Advancement	80.8	81.8	81.5	0.9
Emergency Management	12.6	19.5	15.0	19.0
Small Rural Services – Acute Health	416.9	420.2	431.5	3.5
Small Rural Services – Aged Care	238.8	238.8	243.9	2.1
Small Rural Services – Home and Community Care Services	5.3	5.3	5.3	0.0
Small Rural Services – Primary Health	25.2	24.1	24.5	(2.8)
Total [(b)(c)]	**22 984.5**	**23 690.0**	**23 386.6**	**1.7**

Source: Department of Health

Notes:

(a) Variation between the 2020-21 budget and the 2021 22 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant output cost.

(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget *and CAC impacts are therefore excluded from the figures. Refer to individual output sections for comparative output costs inclusive of CAC.*

(c) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.8 outlines the Department's income from transactions and Table 2.9 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.8: Income from transactions **($ million)**

	2019-20 actual	*2020-21 budget*	*2020-21 revised*	*2021-22 budget [(a)]*
Output appropriations [(b)]	17 600.0	20 206.9	18 408.5	12 095.3
Special appropriations	1 371.9	1 100.0	1 116.8	1 989.8
Interest	33.0	46.3	19.5	47.4
Sale of goods and services	1 778.4	1 876.8	1 813.9	1 923.8
Grants	8 735.1	8 408.9	9 056.0	8 181.4
Fair value of assets and services received free of charge or for nominal consideration	0.6	..	37.3	..
Other income	688.3	755.9	736.8	774.8
Total income from transactions [(c)]	**30 207.4**	**32 394.7**	**31 188.8**	**25 012.5**

Source: Department of Health

Notes:
(a) Includes an estimated $9.6 billion of non-public account contributions in 2021-22.
(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget.
(c) Table may not add due to rounding.

Table 2.9: Parliamentary authority for resources **($ million)**

	2020-21 budget	*2020-21 revised*	*2021-22 budget*
Annual appropriations	**19 940.8**	**18 132.1**	**11 826.0**
Provision of outputs [(a)]	19 262.4	17 704.6	11 670.9
Additions to the net asset base	611.7	377.5	155.1
Payments made on behalf of the State	66.8	50.1	..
Receipts credited to appropriations	**923.9**	**681.4**	**426.8**
Unapplied previous years appropriation	**44.7**	**44.7**	**49.1**
Provision of outputs	44.7	44.7	49.1
Additions to the net asset base	..	..	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**20 909.5**	**18 858.2**	**12 301.9**
Special appropriations	**1 282.1**	**1 282.3**	**2 077.5**
Trust funds	**7 567.0**	**7 770.0**	**6 661.0**
National Health Funding Pool – Victorian State Pool Account [(b)]	6 692.2	7 309.5	6 526.9
Other [(c)]	874.8	460.5	134.2
Total parliamentary authority [(d)]	**29 758.6**	**27 910.4**	**21 040.4**

Source: Department of Health

Notes:
(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget.
(a) The purpose of this trust primarily relates to receiving all Commonwealth public hospital funding under the National Health Reform Agreement.
(c) Includes inter-departmental transfers.
(d) Table may not add due to rounding.

Departmental performance statement

Objective: Victorians are healthy and well

This objective aims for Victorians to have good physical health, good mental health and act to protect and promote health.

The departmental objective indicators are:

- reduce obesity and increase physical activity across Victoria;
- increase the proportion of children with healthy birth weight – with a focus on reducing smoking during pregnancy;
- reduce infant mortality;
- reduce inequalities in premature death;
- reduce the suicide rate;
- improve rates of self reported health and wellbeing;
- reduce deaths resulting from misuse of prescription medicine; and
- increase immunisation coverage rates at two years of age and at school entry.

Outputs

Admitted Services (2021-22: $12 903.4 million)

Acute and sub-acute patient services (elective and non-elective) provided at Victorian metropolitan and rural public hospitals.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Palliative separations	number	7 700	7 700	7 700
Sub-acute care separations	number	39 600	37 400	39 600
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the coronavirus (COVID-19) pandemic on activities.				
Total separations – all hospitals	number (thousand)	2 034	1 860	2 034
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
NWAU funded separations – all hospitals except small rural health services	number (thousand)	1 840	1 702	1 840
This measure has been renamed from 'WIES funded separations – all hospitals except small rural health services'. Victoria is moving to a new National Funding Model, and Weighted Inlier Equivalent Separations will no longer apply to funding. The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
Perinatal mortality rate per 1 000 of babies of Aboriginal mothers, using rolling 3-year average	rate per 1 000	8.7	12.6	11
The 2020-21 expected outcome is higher than the 2020-21 target. The Consultative Council on Obstetric and Paediatric Mortality and Morbidity has made specific recommendations over the years targeting Aboriginal women's maternal and perinatal health and wellbeing. The 2021-22 target has been reduced to reflect a purposeful intent to close the gap.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Number of patients admitted from the elective surgery waiting list	number	208 800	174 000	203 020
The 2020-21 expected outcome is lower than the 2020-21 target mostly due to the impact of the COVID-19 pandemic on activities. *The higher 2021-22 target reflects the impact of funding provided in the* 2021-22 Budget*.*				
NWAU funded emergency separations – all hospitals	number (thousand)	759	634	759
This measure has been renamed from 'WIES funded emergency separations – all hospitals'. Victoria is moving to a new National Funding Model, and Weighted Inlier Equivalent Separations will no longer apply to funding. *The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID 19 pandemic on activities.*				
Quality				
Eligible newborns screened for hearing deficit before one month of age	per cent	98	98.4	97
The higher 2021-22 target reflects historical performance.				
Hand hygiene compliance	per cent	85	88	85
Healthcare worker immunisation – influenza	per cent	92	93	90
The higher 2021-22 target reflects the purposeful trajectory to 95 per cent in future years.				
Intensive Care Unit central line associated blood stream infections (CLABSI) per 1 000 device days	rate	0	0.5	0
The 2020-21 expected outcome is higher than the 2020-21 target. Health services continue to strive for a zero rate of infections and are required to review each central line infection for avoidable contributing factors.				
Major trauma patients transferred to a major trauma service	per cent	88	90	85
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to improved clinical triage and care. *The higher 2021-22 target reflects historical performance.*				
Percentage of patients who reported positive experiences of their hospital stay	per cent	95	92	95
Perinatal and child mortality reports received, reviewed and classified	per cent	100	95	95
The higher 2021-22 target reflects historical performance and desired outcome.				
Public hospitals accredited	per cent	100	100	100
Patient reported hospital cleanliness	per cent	70	71	70
Staphylococcus aureus bacteraemias (SAB) infections per 10 000 patient days	rate	1	1	1
Unplanned readmission after treatment for acute myocardial infarction	per cent	4	nm	nm
New performance measure for 2021-22 that replaces 'Unplanned/unexpected readmission for acute myocardial infarction'. This new measure employs an improved case capture methodology that identifies readmissions previously out of scope. The new approach enables a more accurate assessment of the effectiveness of care across multiple health services.				
Unplanned readmission after treatment for heart failure	per cent	11.3	nm	nm
New performance measure for 2021-22 that replaces 'Unplanned/unexpected readmission for heart failure'. This new measure employs an improved case capture methodology that identifies readmissions previously out of scope. The new approach enables a more accurate assessment of the effectiveness of care across multiple health services.				
Unplanned readmission after hip replacement surgery	per cent	6.0	nm	nm
New performance measure for 2021-22 that replaces 'Unplanned/unexpected readmission for hip replacement'. This new measure employs an improved case capture methodology that identifies readmissions previously out of scope. The new approach enables a more accurate assessment of the effectiveness of care across multiple health services.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Unplanned readmission after paediatric tonsillectomy and adenoidectomy	per cent	3.7	nm	nm
New performance measure for 2021-22 that replaces 'Unplanned/unexpected readmission for paediatric tonsillectomy and adenoidectomy'. This new measure employs an improved case capture methodology that identifies readmissions previously out of scope. The new approach enables a more accurate assessment of the effectiveness of care across multiple health services.				
Unplanned readmission after knee replacement surgery	per cent	5.5	nm	nm
New performance measure for 2021-22 that replaces 'Unplanned/unexpected readmission for knee replacement' This new measure employs an improved case capture methodology that identifies readmissions previously out of scope. The new approach enables a more accurate assessment of the effectiveness of care across multiple health services.				
Timeliness				
Non-urgent (Category 3) elective surgery patients admitted within 365 days	per cent	95	78.5	95
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID 19 pandemic on activities.				
Semi-urgent (Category 2) elective surgery patients admitted within 90 days	per cent	83	76	83
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
Urgent (Category 1) elective surgery patients admitted within 30 days	per cent	100	100	100
Cost				
Total output cost	$ million	12 903.4	13 185.2	12 796.1
Total output cost including the CAC	*$ million*	*14 117.0*	*14 281.5*	*13 892.4*
The higher 2021-22 target reflects funding provided for government policy commitments. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Health

Non-Admitted Services (2021-22: $2 208.8 million)

Acute and sub-acute services provided at Victorian metropolitan and rural public hospitals. Access to high-quality services allows the right care to be delivered at the right time in the right location. Non-Admitted sub-acute services improve consumer access to services closer to home by providing models of integrated community care, which significantly reduces the demand for hospital beds and supports the transition from hospital to home in a safe and timely manner. The services improve health outcomes, particularly for older people and people with complex care needs.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Health Independence program direct contacts	number (thousand)	1 599	1 500	1 599
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities. Services have continued to prioritise care to the most urgent patients.				
Patients treated in Specialist Outpatient Clinics – unweighted	number (thousand)	1 975	1 700	1 975
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
Quality				
Post-acute clients not readmitted to acute hospital	per cent	90	90	90
Timeliness				
Health Independence program clients contacted within three days of referral	per cent	85	90	85
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to a shift in hospital practices during COVID-19 to free up inpatient beds and minimise infection risk. The Health Independence program focused on early follow up and review of treatment options. This is a positive result.				
Cost				
Total output cost	$ million	2 208.8	2 008.2	2 050.3
Total output cost including the CAC	*$ million*	*2 221.5*	*2 020.6*	*2 062.7*
The higher 2021-22 target reflects funding provided for government policy commitments. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Health

Emergency Services (2021-22: $838.3 million)

This output relates to emergency presentations at reporting hospitals with emergency departments. It aims to provide high-quality, accessible health and community services, specifically in improving waiting times for emergency services.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Emergency presentations	number (thousand)	1 944	1 775	1 944
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID 19 pandemic on activities.				
Emergency patients that did not wait for treatment	per cent	<5	4	<5
Emergency patients re-presenting to the emergency department within 48 hours of previous presentation	per cent	<6	5	<6
Patients' experience of emergency department care	per cent	85	85	85
Timeliness				
Emergency Category 1 treated immediately	per cent	100	100	100
Emergency patients treated within clinically recommended 'time to treatment'	per cent	80	70	80
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to higher ambulance demand, a higher proportion of complex patients, and heightened infection control practices during the COVID-19 pandemic.				
Emergency patients with a length of stay of less than four hours	per cent	75	67	75
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to higher ambulance demand, a higher proportion of complex patients, and heightened infection control practices during the COVID-19 pandemic.				
Proportion of ambulance patient transfers within 40 minutes	per cent	90	76	90
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to higher ambulance demand, a higher proportion of complex patients, and heightened infection control practices during the COVID-19 pandemic.				
Cost				
Total output cost	$ million	838.3	771.3	773.9
Total output cost including the CAC	*$ million*	*852.2*	*784.2*	*786.8*
The higher 2021-22 target reflects funding provided for government policy commitments.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Department of Health

Acute Training and Development (2021-22: $352.3 million)

Provision of grants to hospitals for the training and accreditation of health workers. These outputs aim to provide career opportunities and contribute towards a stable and accredited workforce in the health sector in Victoria.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Additional student clinical placement days	number	80 000	nm	nm
New performance measure for 2021-22 to reflect funding in the 2021-22 Budget. *This measure is separated from other clinical placement days due to distinct funding as part of the* Boosting our healthcare workforce *initiative.*				
Clinical placement student days (medicine)	number	385 000	385 000	385 000
Clinical placement student days (nursing and midwifery)	number	385 000	385 000	385 000
Clinical placement student days (allied health)	number	160 000	160 000	160 000
Health workers trained in information sharing and family violence risk assessment and risk management	number	12 000	nm	nm
New performance measure for 2021-22 to reflect funding in the 2021-22 Budget *and Government investment in information sharing and family violence risk assessment and risk management.*				
Number of filled rural generalist GP procedural positions	number	15	15	15
Funded post graduate nursing and midwifery places at Diploma and Certificate level	number	954	954	954
Total funded FTE (early graduate) allied health positions in public system	number	700	700	700
Total funded FTE (early graduate) medical positions in public system	number	1 525	1 525	1 525
Total funded FTE (early graduate) nursing and midwifery positions in public system	number	1 889	1 800	1 889
Quality				
Learner satisfaction about their feeling of safety and wellbeing while undertaking their program of study at health services	per cent	80	80	80
Cost				
Total output cost	$ million	352.3	342.6	322.8
Total output cost including the CAC	*$ million*	*352.9*	*343.1*	*323.3*
The 2020-21 expected outcome is higher than the 2020-21 target due to funding provided for government policy initiatives and to align with Commonwealth funding under the National Health Reform Agreement. *The higher 2021-22 target reflects funding provided for government policy commitments.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Health

Residential Aged Care (2021-22: $436.1 million)

This output includes delivery of services for older Victorians requiring ongoing care and support in a residential aged care setting.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Available bed days	days	1 153 718	1 138 757	1 153 718
Quality				
Residential care services accredited	per cent	100	100	100
Cost				
Total output cost	$ million	436.1	421.8	423.3
Total output cost including the CAC	*$ million*	*466.1*	*448.1*	*449.6*

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.

Source: Department of Health

Aged Care Assessment (2021-22: $59.6 million)

This output includes delivery of comprehensive assessment of older Victorians' requirements for treatment and residential aged care services.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Aged care assessments	number	59 000	52 000	59 000
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
Timeliness				
Average waiting time (calendar days) from referral to assessment	days	16	16	16
Percentage of high-priority clients assessed within the appropriate time in all settings	per cent	90	90	90
Percentage of low priority clients assessed within the appropriate time in all settings	per cent	90	90	90
Percentage of medium priority clients assessed within the appropriate time in all settings	per cent	90	90	90
Cost				
Total output cost	$ million	59.6	59.8	60.8
Total output cost including the CAC	*$ million*	*64.8*	*65.0*	*66.0*

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.

Source: Department of Health

Aged Support Services (2021-22: $108.8 million)

This output includes delivery of a range of community services that support older Victorians, such as, eye care services, Personal Alert Victoria services, and pension-level Supported Residential Services.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Pension-level beds available in assisted Supported Residential Services facilities	number	1 736	1 736	1 795
The 2021-22 target has been reduced due to the closure of beds in privately-owned businesses.				
Pension-level Supported Residential Services residents provided with service coordination and support/brokerage services	number	775	775	775
Personal alert units allocated	number	29 121	29 121	29 121
Victorian Eye Care Service (occasions of service)	number	75 800	75 800	75 800
Clients accessing aids and equipment	number	22 658	22 000	15 000
The 2020-21 expected outcome is higher than the 2020-21 target as more clients accessed low-cost items.				
The higher 2021-22 target reflects historical performance.				
Quality				
Funded research and service development projects for which satisfactory reports have been received	per cent	100	100	100
Clients satisfied with the aids and equipment services system	per cent	90	85	85
The higher 2021-22 target reflects historical performance.				
Timeliness				
Applications for aids and equipment acknowledged in writing within 10 working days	per cent	90	90	90
Cost				
Total output cost	$ million	108.8	119.2	120.4
Total output cost including the CAC	*$ million*	*122.3*	*132.7*	*133.8*
The lower 2021-22 target primarily reflects machinery of government transfers of funding and Aged Support Services functions to the Department of Families, Fairness and Housing.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Department of Health

Home and Community Care Programs for Younger people

(2021-22: $202.2 million)

This output includes delivery of a range of community-based nursing, allied health and support services enabling younger people to maintain their independence in the community. This includes Home and Community Care program for Younger People services.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Home and Community Care for Younger People – number of clients receiving a service	number	60 000	60 000	60 000
Home and Community Care for Younger People – hours of service delivery	hours (thousand)	1 000	1 000	1 000
Cost				
Total output cost	$ million	202.2	203.6	203.3
Total output cost including the CAC	*$ million*	*218.2*	*219.6*	*219.3*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Health

Ambulance Emergency Services

(2021-22: $1 166.5 million)

Emergency road, rotary and fixed air wing patient treatment and transport services provide timely and high-quality emergency ambulance services. Timely and high-quality emergency ambulance services contribute to high-quality, accessible health and community services for all Victorians.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Community Service Obligation emergency road and air transports	number	283 447	288 159	270 480
The 2020-21 expected outcome is higher than the 2020-21 target primarily due increased demand on services. The higher 2021-22 target reflects the impact of funding provided in the 2021-22 Budget.				
Statewide emergency air transports	number	5 071	4 257	4 829
The 2020-21 expected outcome is lower than the 2020-21 target due to air activity being entirely demand driven, with the result representing a reduced demand for air services, which has been significantly impacted by the Government's response to COVID-19. The 2021-22 target has been increased to reflect the impact of funding provided in the 2021-22 Budget.				
Statewide emergency road transports	number	506 828	508 938	482 597
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to increased demand on services. The higher 2021-22 target reflects the impact of funding provided in the 2021-22 Budget.				
Treatment without transport	number	88 587	84 629	84 087
The higher 2021-22 target reflects the impact of funding provided in the 2021-22 Budget.				
Quality				
Audited cases attended by Community Emergency Response Teams (CERT) meeting clinical practice standards	per cent	90	90	90
Audited cases statewide meeting clinical practice standards	per cent	95	95	95

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Proportion of adult patients suspected of having a stroke who were transported to a stroke unit with thrombolysis facilities within 60 minutes	per cent	95	90	90
The higher 2021-22 target reflects desired clinical performance goal.				
Proportion of patients experiencing severe cardiac or traumatic pain whose level of pain is reduced significantly	per cent	90	90	90
Proportion of patients very satisfied or satisfied with overall services delivered by paramedics	per cent	95	95	95
Timeliness				
Proportion of emergency (Code 1) incidents responded to within 15 minutes – statewide	per cent	85	81	85
Proportion of emergency (Code 1) incidents responded to within 15 minutes in centres with more than 7 500 population	per cent	90	87	90
Cost				
Total output cost	$ million	1 166.5	1 086.7	1 082.9
Total output cost including the CAC	*$ million*	*1 198.8*	*1 113.8*	*1 109.9*
The higher 2021-22 target reflects funding provided for government policy commitments. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Health

Ambulance Non-Emergency Services (2021-22: $196.9 million)

Non-emergency road, rotary and fixed air wing patient treatment and transport services provide access to timely, high-quality non-emergency ambulance services. High-quality non-emergency ambulance services contribute to high-quality, accessible health and community services for all Victorians. The output supports departmental priorities through provision of patient transport officers to service non-emergency, pre and post hospital patients.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Community Service Obligation non-emergency road and air transports	number	240 569	236 129	229 943
The higher 2021-22 target reflects the impact of funding provided in the 2021-22 Budget.				
Statewide non-emergency air transports	number	2 538	2 349	2 434
The 2021-22 target has been increased to reflect the impact of funding provided in the 2021-22 Budget.				
Statewide non-emergency road transports	number	295 925	310 134	281 733
The 2020-21 expected outcome is higher than the 2020-21 target due to increased demand, partly driven by the impact of the COVID-19 pandemic on activities. *The higher 2021-22 target reflects the impact of funding provided in the* 2021-22 Budget.				
Quality				
Audited cases statewide meeting clinical practice standards	per cent	95	95	95

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Cost				
Total output cost	$ million	196.9	168.1	166.1
Total output cost including the CAC	*$ million*	197.3	*168.4*	*166.4*
The higher 2021-22 target reflects funding provided for government policy commitments. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Health

Drug Prevention and Control (2021-22: $44.8 million)

Encourages all Victorians to minimise the harmful effects of alcohol and other drugs by providing a comprehensive range of strategies, which focus on enhanced community and professional education, targeted prevention and early intervention programs, community and residential treatment services, and the use of effective regulation.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Number of phone contacts from family members seeking support	number	10 682	10 682	10 682
Needles and syringes provided through the Needle and Syringe program	number (thousand)	10 170	10 170	10 170
Number of telephone, email, website contacts and requests for information on alcohol and other drugs	number (thousand)	4 200	5 796	4 200
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
Quality				
Pharmacotherapy permits processed within designated timeframe	per cent	100	100	100
Timeliness				
Percentage of new licences and permits issued to health services or businesses for the manufacture, use or supply of drugs and poisons within six weeks following receipt of full information	per cent	100	100	100
Percentage of treatment permits for medical practitioners or nurse practitioners to prescribe Schedule 8 drugs assessed within four weeks	per cent	80	100	75
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to improvements in processing. *The higher 2021-22 target reflects desired clinical performance.*				
Cost				
Total output cost	$ million	44.8	45.8	43.2
Total output cost including the CAC	*$ million*	*44.8*	*45.8*	*43.2*
The 2020-21 expected outcome is higher than the 2020-21 target due to an output realignment from Drug Treatment and Rehabilitation to Drug Prevention and Control. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Health

Drug Treatment and Rehabilitation (2021-22: $285.4 million)

Assists the community and individuals to control and reduce the harmful effects of illicit and licit drugs, including alcohol, in Victoria through the provision of community-based non-residential and residential treatment services, education and training, and support services.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Clients on the Pharmacotherapy program	number	14 000	14 000	14 000
Commenced courses of treatment – community-based drug treatment services	number	10 189	11 885	8 489
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities. *The higher 2021-22 target reflects historical performance.*				
Number of drug treatment activity units – residential services	number	78 535	55 201	78 535
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
Number of drug treatment activity units – community-based services	number	97 855	72 260	90 325
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities. *The higher 2021-22 target reflects the impact of funding provided in the* 2021-22 Budget.				
Workers complying with Alcohol and Other Drug Minimum Qualification Strategy requirements	per cent	85	85	85
Quality				
Percentage of new clients to existing clients	per cent	50	50	50
Percentage of residential rehabilitation clients remaining in treatment for 10 days or more	per cent	80	80	80
Successful courses of treatment (episodes of care) – community-based drug treatment services	number	7 385	10 339	7 385
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
Percentage of residential withdrawal clients remaining in treatment for two days or more	per cent	80	80	80
Timeliness				
Median wait time between intake and assessment	days	10	10	10
Median wait time between assessment and commencement of treatment	days	20	20	20
Cost				
Total output cost	$ million	285.4	260.5	264.8
Total output cost including the CAC	*$ million*	292.1	267.3	271.6
The higher 2021-22 target primarily reflects funding provided for government policy commitments; and to align with Commonwealth funding under the National Health Reform Agreement. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Health

Mental Health Clinical Care (2021-22: $2 177.0 million)

This output renames the *2020-21 Budget* output 'Clinical Care'. This output provides a range of inpatient residential and community-based clinical services to people with mental illness, and their families so that those experiencing mental health problems can access timely, high-quality care and support to recover and live successfully in the community.

New and updated measures will be introduced ahead of the 2022-23 budget to reflect the priorities outlined in the Government's response to the Final Report of the Royal Commission into Victoria's Mental Health System.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Clinical inpatient separations	number	28 747	27 008	27 488
The higher 2021-22 target reflects funding provided in the 2021-22 Budget.				
Total community service hours (child and adolescent)	number (thousand)	266	219	219
The higher 2021-22 target reflects the impact of funding provided in the 2021-22 Budget.				
Total community service hours (adult)	number (thousand)	1 185	1 103	1 103
The higher 2021-22 target reflects the impact of funding provided in the 2021-22 Budget.				
Total community service hours (aged)	number (thousand)	154	126	126
The higher 2021-22 target reflects the impact of funding provided in the 2021-22 Budget.				
New case index	per cent	50	50	50
Registered community clients	number	85 863	77 221	77 221
The higher 2021-22 target reflects the impact of funding provided in the 2021-22 Budget.				
Occupied residential bed days	number	153 574	151 948	153 574
Occupied sub-acute bed days	number	186 771	188 132	186 771
Quality				
Clients readmitted (unplanned) within 28 days	per cent	14	15.6	14
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
New client index	per cent	45	45	45
Number of designated mental health services achieving or maintaining accreditation under the National Safety and Quality in Health Service Standards	number	18	18	18
Post-discharge community care (child and adolescent)	per cent	88	88	88
Post-discharge community care (adult)	per cent	88	88	88
Post-discharge community care (aged)	per cent	88	88	88
Pre-admission community care	per cent	61	64.9	61
The 2020-21 expected outcome is higher than the 2020-21 target showing increased planned admission.				
Seclusions per 1 000 occupied bed days	number	8	9.3	8
The 2020-21 expected outcome is higher than the 2020-21 target. It is primarily explained by more events for a small number of adult patients with challenging behaviours, and the limited number of metropolitan adolescent units providing statewide services.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Timeliness				
Emergency patients admitted to a mental health bed within eight hours	per cent	80	54.1	80
The 2020-21 expected outcome is lower than the 2020-21 target due to an increasing number of people presenting directly to emergency departments. The creation of 144 new acute public beds and 35 private beds for public patients, as recommended by the Royal Commission into Victoria's Mental Health System, is an explicit response to this issue.				
Cost				
Total output cost	$ million	2 177.0	1 893.5	1 911.2
Total output cost including the CAC	*$ million*	*2 261.6*	*1 975.6*	*1 993.2*
The higher 2021-22 target reflects funding provided for government policy commitments, and to align to Commonwealth funding under the National Health Reform Agreement. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Health

Mental Health Community Support Services (2021-22: $166.3 million)

A range of rehabilitation and support services provided to youth and adults with a psychiatric disability, and their families and carers, so that those experiencing mental health problems can access timely, high-quality care and support to recover and reintegrate into the community.

New and updated measures will be introduced ahead of the 2022-23 budget to reflect the priorities outlined in the Government's response to the Final Report of the Royal Commission into Victoria's Mental Health System.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Bed days	number	62 744	45 086	60 115
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities. *The higher 2021-22 target reflects the impact of funding provided in the* 2021-22 Budget.				
Client Support Units	number	44 157	22 589	37 279
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities. *The higher 2021-22 target reflects the impact of funding provided in the* 2021-22 Budget.				
Clients receiving community mental health support services	number	1 800	1 800	1 800
Quality				
Proportion of major agencies accredited	per cent	100	100	100
Cost				
Total output cost	$ million	166.3	125.5	124.1
Total output cost including the CAC	*$ million*	*169.0*	*128.3*	*126.9*
The higher 2021-22 target reflects funding provided for government policy commitments. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Health

Community Health Care (2021-22: $381.0 million)

This output includes delivery of a range of community care and support services, including counselling, allied health and nursing, that enable people to continue to live independently in the community.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Rate of admissions for ambulatory care sensitive chronic conditions for Aboriginal Victorians	rate per 1 000	14.4	14.4	14.4
Number of referrals made using secure electronic referral systems	number	75 000	75 000	75 000
Primary Care Partnerships with reviewed and updated Strategic Plans	per cent	100	100	100
Service delivery hours in community health care	number (thousand)	1 060	1 060	1 060
Quality				
Agencies with an Integrated Health Promotion plan that meets the stipulated planning requirements	per cent	95	95	95
Cost				
Total output cost	$ million	381.0	337.8	333.6
Total output cost including the CAC	*$ million*	*403.8*	*358.0*	*353.8*

The higher 2021-22 target reflects funding provided for government policy commitments.
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.

Source: Department of Health

Dental Services (2021-22: $351.9 million)

This output includes delivery of a range of dental health services to support health and wellbeing in the community.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Persons treated	number	376 150	264 500	332 150
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities. *he higher 2021-22 target reflects the impact of funding provided in the* 2021-22 Budget.				
Priority and emergency clients treated	number	249 100	212 500	249 100
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
Children participating in the Smiles 4 Miles oral health promotion program	number	49 000	34 000	34 000
The 2021-22 target has been increased to reflect the planned use of held-over funds from prior years in 2021-22.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Timeliness				
Waiting time for dentures	months	22	21.1	22
Percentage of Dental Emergency Triage Category 1 clients treated within 24 hours	per cent	90	93	85
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to a higher percentage of people requiring emergency care being treated within the appropriate time period.				
The higher 2021-22 target reflects desired clinical performance.				
Waiting time for general dental care	months	23	22.1	23
Cost				
Total output cost	$ million	351.9	297.7	310.1
Total output cost including the CAC	*$ million*	*360.8*	*306.6*	*319.0*
The higher 2021-22 target reflects funding provided for government policy commitments.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Department of Health

Maternal and Child Health and Early Parenting Services (2021-22: $150.6 million)

This output involves the provision of community-based maternal and child health services available to all families with children.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Hours of additional support delivered through the Enhanced Maternal and Child Health program	number	248 000	248 000	248 000
Total number of Maternal and Child Health Service clients (aged 0 to 1 year)	number	80 000	80 000	80 000
Timeliness				
Children aged 0 to 1 month enrolled at maternal and child health services from birth notifications	per cent	99	99	99
Cost				
Total output cost	$ million	150.6	137.5	134.4
Total output cost including the CAC	*$ million*	*150.6*	*137.5*	*134.4*
The higher 2021-22 target reflects funding provided for government policy commitments.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				
This output did not have a provision for CAC in previous budgets.				

Source: Department of Health

Health Protection (2021-22: $555.0 million)

Protects the health of Victorians through a range of prevention programs including regulation, surveillance and the provision of statutory services.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Inspections of cooling towers	number	1 300	700	1 300
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
Inspections of radiation safety management licences	number	480	200	480
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
Percentage of Aboriginal children fully immunised at 60 months	per cent	97	95	95
The higher 2021-22 target reflects historic and desired clinical performance.				
Number of available HIV rapid test trial appointments used	number	2 875	1 435	2 875
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic. Full peer rapid HIV testing recommenced in January 2021.				
Women screened for breast cancer by BreastScreen Victoria	number	267 000	255 000	267 000
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic.				
Number of persons participating in newborn bloodspot or maternal serum screening	number	80 000	76 222	80 000
Persons screened for prevention and early detection of health conditions – pulmonary tuberculosis screening	number	2 000	2 000	2 000
Smoking cessation of Aboriginal mothers	per cent	25.2	25.2	25.2
Quality				
Calls to food safety hotlines that are answered	per cent	97	97	97
Immunisation coverage – adolescent (Year 7) students fully immunised for DTPa (diphtheria, tetanus and pertussis)	per cent	90	85	90
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities and accessibility to schools/students.				
Immunisation coverage – At school entry	per cent	95	95	95
Immunisation coverage – At two years of age	per cent	95	94	95
Public health emergency response calls dealt with within designated plans and procedure timelines	per cent	100	100	100
Timeliness				
Percentage of food recalls acted upon within 24 hours of notification	per cent	97	97	97
Infectious disease outbreaks responded to within 24 hours	per cent	100	100	100
Participation rate of women in target age range screened for breast cancer	per cent	54	51	54
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Cost				
Total output cost	$ million	555.0	1 435.8	1 083.8
Total output cost including the CAC	*$ million*	*557.4*	*1 437.2*	*1 085.3*
The 2020-21 expected outcome is higher than the 2020-21 target due to funding provided for government policy commitments related to the COVID-19 response. *The lower 2021-22 target primarily reflects full year funding for a number of government policy commitments related to the COVID-19 response in 2020-21.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Health

Health Advancement (2021-22: $81.5 million)

Improves the general health and wellbeing of Victorians through the provision of community information and the fostering of healthy behaviours.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Persons completing the Life! – Diabetes and Cardiovascular Disease Prevention program	number	5 616	3 600	5 616
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
Number of training courses for health professionals on sexual and reproductive health	number	50	50	50
Number of education or monitoring visits of tobacco or e-cigarette retailers	number	1 500	nm	nm
New performance measure for 2021-22 replaces in part, 'Workplaces and pubs and clubs complying with smoke free environment laws', as it better reflects compliance and enforcement of the Tobacco Act 1987. *It does not include cigarette sales to minors.*				
Number of sales to minors test purchases undertaken	number	3 000	nm	nm
New performance measure for 2021-22 replaces in part, 'Workplaces and pubs and clubs complying with smoke free environment laws', as it better reflects compliance and enforcement of the Tobacco Act 1987.				
Number of education or monitoring visits of smoke-free areas	number	3 500	nm	nm
New performance measure for 2021-22 replaces in part, 'Workplaces and pubs and clubs complying with smoke-free environment laws', as it better reflects compliance and enforcement of the Tobacco Act 1987. *It covers eating and drinking establishments, outdoor locations, enclosed workplaces, and public hospitals.*				
Quality				
Local Government Authorities with Municipal Public Health and Wellbeing Plans	per cent	100	95	100
The 2020-21 expected outcome is lower than the 2020-21 target as councils are required (by the Public Health and Wellbeing Act 2008*) to develop a municipal public health and wellbeing plan 12 months after elections (as is the case for the state level public health and wellbeing plan). Three councils did not have elections in 2019 and it is not yet known if those councils will continue with their existing plan or develop a new plan.*				
Cost				
Total output cost	$ million	81.5	81.8	80.8
Total output cost including the CAC	*$ million*	*81.5*	*81.8*	*80.8*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Health

Emergency Management (2021-22: $15.0 million)

Training in emergency management preparedness, planning, response, relief and recovery.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Number of people trained in emergency management	number	2 000	1 500	2 000
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID-19 pandemic on activities.				
Cost				
Total output cost	$ million	15.0	19.5	12.6
Total output cost including the CAC	*$ million*	*16.0*	*20.5*	*13.6*
The 2020-21 expected outcome is higher than the 2020-21 target due to machinery of government transfers from the Department of Jobs, Precinct and Regions.				
The higher 2021-22 budget primarily reflects machinery of government transfers from the Department of Jobs, Precincts and Regions.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Department of Health

Small Rural Services – Acute Health (2021-22: $431.5 million)

Admitted and non-admitted services delivered by small rural services, including elective and non-elective surgical and medical care, accident and emergency services, and maternity services.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Separations	number (thousand)	35.8	30.0	35.8
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID 19 pandemic on activities.				
Small rural weighted activity unit	number (thousand)	350 000	300 000	350 000
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the COVID 19 pandemic on activities.				
Quality				
Percentage of health services accredited	per cent	100	100	100
Cost				
Total output cost	$ million	431.5	420.2	416.9
Total output cost including the CAC	*$ million*	*458.4*	*447.1*	*443.7*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Department of Health

Small Rural Services – Aged Care (2021-22: $243.9 million)

This output includes delivery of in home, community-based and residential care services for older people, delivered in small rural towns.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Small rural available bed days	number (thousand)	701 143	701 143	701 143
Quality				
Residential care services accredited	per cent	100	100	100
Cost				
Total output cost	$ million	243.9	238.8	238.8
Total output cost including the CAC	*$ million*	*253.6*	*247.8*	*247.8*

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.

Source: Department of Health

Small Rural Services – Home and Community Care Services (2021-22: $5.3 million)

This output includes delivery of in home, community-based care services for older people, and younger people with disabilities delivered by small rural services.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Home & Community Care for Younger People – hours of service delivery	hours	55 000	55 000	55 000
Cost				
Total output cost	$ million	5.3	5.3	5.3
Total output cost including the CAC	*$ million*	*5.3*	*5.3*	*5.3*

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.
This output did not have a provision for CAC in previous budgets.

Source: Department of Health

Small Rural Services – Primary Health (2021-22: $24.5 million)

This output includes delivery of in home, community-based and primary health services delivered by small rural services and designed to promote health and wellbeing and prevent the onset of more serious illness.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected*	*2020-21 target*
Quantity				
Service delivery hours in community health care	number	91 500	107 000	91 500
The 2020-21 expected outcome is higher than the 2020-21 target due to the permissible use of funds from other outputs to provide community health services according to local need.				
Cost				
Total output cost	$ million	24.5	24.1	25.2
Total output cost including the CAC	*$ million*	*24.5*	*24.1*	*25.2*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Health

DEPARTMENT OF JOBS, PRECINCTS AND REGIONS

Ministerial portfolios

The Department of Jobs, Precincts and Regions supports the ministerial portfolios of Agriculture; Business Precincts; Community Sport; Creative Industries; Employment; Industry Support and Recovery; Local Government; Trade; Innovation, Medical Research and the Digital Economy; Racing; Regional Development (and Cross Border Coordination); Resources; Small Business; Suburban Development; and Tourism, Sport and Major Events.

Departmental mission statement

The Department is focused on growing our State's economy and ensuring it benefits all Victorians – by creating more jobs for more people, building thriving places and regions, and supporting inclusive communities.

- More jobs for more people: the Department is helping to grow the economy by working with businesses to create and maintain jobs so more people have meaningful work that is safe and secure. It supports workers, develops and grows our industries, and assists industries in transition. It is creating jobs by leveraging and securing our natural assets and regional strengths, along with fostering our visitor economy, creativity and innovation. It is also connecting Victoria to the world by attracting investment and talent, and helping Victorian businesses successfully trade into global markets.
- Thriving places and regions: the Department is building vibrant, prosperous precincts and regions that drive economic growth and opportunities. It is supporting businesses to establish and grow, and its geographic focus on innovation and sector activity is helping attract investment. It is also cementing Victoria's position as Australia's leading cultural, sport, tourism and events destination.
- Inclusive communities: the Department is working to create opportunities for all Victorians in communities that are well connected, culturally diverse and economically resilient. It is doing this by taking a collaborative approach – working across government and with communities to understand how to share the benefits of economic prosperity, address entrenched disadvantage and support a stronger and fairer society.

Departmental objectives

Create and maintain jobs

This objective seeks to secure a growing, sustainable and equitable jobs market for all Victorians by working with businesses to increase job opportunities, support people into meaningful employment, and attract the investment and talent needed to foster job growth.

The Jobs output contributes to this objective by supporting existing workers and businesses by connecting Victorians experiencing disadvantage to job opportunities, supporting Aboriginal economic inclusion, working with the community to create and support social enterprises; as well as attracting new investment and talent into Victoria to grow the economy and share the benefits of economic prosperity.

Foster a competitive business environment

This objective seeks to grow Victorian industries and businesses by working with priority industry sectors, supporting growth and innovation opportunities for industry, supporting startups and small businesses, and assisting industries in transition.

The Industry, Innovation, Medical Research and Small Business output contributes to this objective by providing access to information and connections and building the capability of Victorian businesses and industry to develop and effectively use new practices and technologies, advocating for a fair and competitive business environment, and supporting small businesses.

Be a globally connected economy

This objective seeks to connect Victoria to the world by helping Victorian businesses successfully trade into global markets and grow Victoria's proportion of international student enrolments in Australia.

The Trade and Global Engagement output contributes to this objective by developing the skills and knowledge of current and potential exporters, connecting organisations to global business opportunities, establishing and deepening strategic commercial international partnerships, and increasing the proportion of international students.

Build prosperous and liveable regions and precincts

This objective seeks to ensure that Victoria's precincts, suburbs and regions are developed to create places where all Victorians have an opportunity to participate in growing communities that are well-connected, prosperous, vibrant and diverse.

The Business Precincts output delivers activities to build vibrant and prosperous precincts that drive economic growth and opportunities. The Department works collaboratively with government, industry and community stakeholders to identify opportunities for the development and delivery of initiatives to strengthen our economy, create jobs and improve liveability for all Victorians.

The Local Government and Suburban Development output delivers activities in partnership with the local government sector to support effective and efficient local governance, leadership, infrastructure and service provision. The Department also works collaboratively to develop Melbourne's suburbs through the Suburban Revitalisation Program and the six Metropolitan Partnerships and improve suburban liveability. Through this output, the Department administers programs to support local governments to increase accountability and provides support to the Victorian Local Government Grants Commission.

The Regional Development output contributes to this objective by working with industry and communities to identify opportunities to support job growth and new investment in regional Victoria, strengthening community capability, and engaging with industry and communities to deliver regional priorities.

Grow vibrant, active and creative communities

This objective seeks to increase the economic, social and cultural value of the creative, sport and recreation industries to Victoria, grow the number and yield of visitors, position Victoria as a major events destination, and ensure the best cultural and sporting experiences are accessible to everyone.

The Creative Industries Access, Development and Innovation output contributes to this objective through developing more opportunities for the creation and presentation of new work, building industry capability and growth, stimulating innovation and wider impacts, engaging more Victorians and building international engagement.

The Creative Industries Portfolio Agencies output contributes to this objective through supporting creative industries agencies to promote access and participation, to increase visitor numbers and to manage the State's cultural collections.

The Cultural Infrastructure and Facilities output contributes to this objective through undertaking maintenance activities and developing infrastructure projects to ensure state-owned cultural venues are available to the public.

The Sport, Recreation and Racing output contributes to this objective by providing strategic leadership and investment in the sport, recreation and racing industries through innovation, sector and industry development and funding support. It supports community participation and inclusion in the sport, recreation and racing sectors by strengthening the capacity of sport and recreation organisations to deliver participation opportunities, improving community sport and recreation facilities across the State and guiding the development and management of state-level sporting facilities and events, to encourage participation by all Victorians. This output also supports the development of the Victorian racing industry through strategic investment in world-class racing and training infrastructure, the promotion of animal welfare and integrity initiatives and encourages participation and investment in the breeding industry to cement Victoria's position as Australia's premier racing state.

The Tourism and Major Events output contributes to this objective through increasing the number of visitors to Victoria, boosting expenditure from these visitors, and continuing to strengthen Victoria's major events program.

Promote productive and sustainably used natural resources

This objective supports a more productive, globally competitive, sustainable and jobs-rich agriculture, food and fibre, and resources sectors. The Department delivers the objective in collaboration with partners, local communities and industry to deliver outcomes that provide benefits to all Victorians.

The Agriculture output contributes to increasing the productivity, competitiveness and sustainability of food and fibre industries and creates the conditions to grow the natural resources economy. This includes protecting and enhancing market access and management of biosecurity risks, increasing the use of new technologies, improving farm practices and supply chain efficiency, building the resilience of the sector to manage risks and emergencies, and ensuring forestry and game resources are sustainably allocated and used for both recreational and commercial purposes.

The Resources output contributes to this objective by aiming to achieve a growing and sustainable earth resources sector through effective policy, programs and regulation.

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2020-21 budget	*2020-21 revised*	*2021-22 budget*	*Variation [(a)] %*
Create and maintain jobs				
Jobs	2 885.0	2 839.7	310.0	(89.3)
Foster a competitive business environment				
Industry, Innovation, Medical Research and Small Business	504.3	664.3	251.2	(50.2)
Be a globally connected economy				
Trade and Global Engagement	105.9	105.9	39.2	(63.0)
Build prosperous and liveable regions and precincts				
Business Precincts	20.0	22.5	16.6	(17.0)
Local Government and Suburban Development	178.6	183.8	145.4	(18.6)
Regional Development	538.7	539.2	256.0	(52.5)
Grow vibrant, active and creative communities				
Creative Industries Access, Development and Innovation	69.1	81.9	54.8	(20.7)
Creative Industries Portfolio Agencies	425.1	467.0	393.7	(7.4)
Cultural Infrastructure and Facilities	81.9	63.0	65.3	(20.3)
Sport, Recreation and Racing	776.6	744.7	497.4	(36.0)
Tourism and Major Events	354.1	478.0	197.9	(44.1)
Promote productive and sustainably used natural resources				
Agriculture	526.0	590.1	464.7	(11.7)
Resources	72.3	72.3	66.2	(8.4)
Total [(b)(c)]	**6 537.6**	**6 852.5**	**2 758.3**	**(57.8)**

Source: Department of Jobs, Precincts and Regions

Notes:

(a) Variation between the 2020-21 budget and the 2021-22 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant outputs.

(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget *and CAC impacts are therefore excluded from the figures. Refer to individual output sections for comparative output costs inclusive of CAC.*

(c) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.10 outlines the Department's income from transactions and Table 2.11 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.10: Income from transactions **($ million)**

	2019-20 actual	*2020-21 budget*	*2020-21 revised*	*2021-22 budget [(a)]*
Output appropriations [(b)]	3 051.8	6 366.7	6 555.1	2 534.1
Special appropriations	1.8	..	..	..
Interest	12.0	9.4	9.8	10.9
Sale of goods and services	128.0	114.5	113.5	126.4
Grants	188.7	34.4	160.2	12.5
Fair value of assets and services received free of charge or for nominal consideration	1.4	0.5	0.5	0.5
Other income	31.6	28.6	28.6	27.8
Total income from transactions [(c)]	**3 415.3**	**6 554.1**	**6 867.7**	**2 712.2**

Source: Department of Jobs, Precincts and Regions

Notes:
(a) Includes an estimated $137.8 million of non-public account contributions in 2021-22.
(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget*.*
(c) Table may not add due to rounding.

Table 2.11: Parliamentary authority for resources **($ million)**

	2020-21 budget	*2020-21 revised*	*2020-21 budget*
Annual appropriations	**6 597.7**	**6 787.3**	**2 696.7**
Provision of outputs [(a)]	6 253.2	6 421.0	2 433.5
Additions to the net asset base	270.1	291.9	186.5
Payments made on behalf of the State	74.5	74.5	76.7
Receipts credited to appropriations	**108.7**	**129.3**	**100.6**
Unapplied previous years appropriation	**17.5**	**17.5**	**..**
Provision of outputs	4.8	4.8	..
Additions to the net asset base	12.7	12.7	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**6 723.9**	**6 934.1**	**2 797.3**
Special appropriations	**28.8**	**28.8**	**..**
Trust funds	**363.4**	**489.5**	**679.2**
Commonwealth Local Government Grants Trust [(b)]	302.6	302.6	636.3
Other [(c)]	60.8	186.9	42.9
Total parliamentary authority [(d)]	**7 116.0**	**7 452.5**	**3 476.6**

Source: Department of Jobs, Precincts and Regions

Notes:
(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget*.*
(b) The purpose of this trust primarily relates to the issuing of grants pursuant to the Commonwealth allocation to the state for on-passing to local government.
(c) Includes inter-departmental transfers.
(d) Table may not add due to rounding.

Departmental performance statement

Objective 1: Create and maintain jobs

This objective seeks to secure a growing, sustainable and equitable jobs market for all Victorians by working with businesses to increase job opportunities, support people into meaningful employment, and attract the investment and talent needed to foster job growth.

The departmental objective indicator is:

- people employed in Victoria.

Outputs

Jobs (2021-22: $310.0 million)

This output includes initiatives to support existing workers and businesses by connecting Victorians experiencing disadvantage to job opportunities, supporting Aboriginal economic inclusion, working with the community to create and support social enterprises; as well as attracting new investment and talent into Victoria to grow the economy and share the benefits of economic prosperity.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Disadvantaged jobseekers who achieve sustainable employment (minimum number of 26 weeks) with the support of Jobs Victoria Services	number	4 000	6 177	6 069
This performance measure renames the 2020-21 performance measure 'Disadvantaged jobseekers who achieve sustainable employment (minimum number of 26 weeks)'. The new performance measure reports on the same activity however has been amended for clarity. *The lower 2021-22 target reflects the impact of the lapsing Working for Victoria initiative.*				
Disadvantaged jobseekers who gain employment with the support of Jobs Victoria Services	number	12 500	2 314	11 200
This performance measure renames the 2020-21 performance measure 'Jobseekers who gain employment with the support of Jobs Victoria'. The new performance measure reports on the same activity however has been amended for clarity. *The 2020-21 expected outcome is lower than the 2020-21 target due to the impacts of coronavirus (COVID-19). The service will be fully operational in 2021-22.* *The higher 2021-22 target reflects the expectation that services will be fully operational and able to achieve greater outcomes in the 2021-22 year.*				
Firms assisted from industry growth programs	number	100	25	25
The higher 2021-2022 target is due to the timing of the launch of the Industry Recovery and Growth Fund (IRGF) and various Manufacturing and Industry Development Fund (MIDF) program streams. In 2020-21, the majority of assistance will be to recipients of a smaller number of larger value IRGF and MIDF grants. A larger number of firms will be assisted in 2021-22.				
Government Youth Employment Scheme traineeships commenced	number	280	150	280
The 2020-21 expected outcome is lower than the 2020-21 target due to the impacts of COVID-19.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Industry stakeholders engaged with the Local Jobs First Policy	number	600	800	500
The 2020-21 expected outcome is higher than the 2020-21 target due to both a larger than expected increase in businesses interested in engaging in government contracts related to the COVID-19 response and a larger than expected volume of contracts being released to the market, including as a result of the Building Works stimulus package. *The higher 2021-22 target reflects new funding in the* 2021-22 Budget *for Maximising Local Jobs and Local Content which will continue to drive activities to engage industry with government projects and the ongoing volume of contracts being released to the market.*				
Jobs created from industry growth programs	number	1 250	1 000	1 000
The higher 2021-2022 target is due to the timing of new programs – Manufacturing and Industry Development Fund (MIDF) and Industry Recovery and Growth Fund (IRGF) – being launched and opening in mid-late 2020-21. This reflects funding allocated to MIDF and IRGF programs in the 2021-22 financial year. *This measure contributes to Whole of Victorian Government Victorian Jobs and Investment Fund measures and incorporates jobs generated through investment facilitation support.*				
Jobs Victoria Services (Advocates, Mentors, Careers Counsellors) delivered to Victorian jobseekers	number	70 000	34 000	34 000
This performance measure renames the 2020-21 performance measure 'Jobseekers supported through Jobs Victoria services (mentors and advocates)'. The new performance measure reports on the same activity however has been amended for clarity. *The higher 2021-22 target reflects the expectation that services will be fully operational and able to achieve greater outcomes in the 2021-22 year.*				
Migrant talent nominated for the Skilled, Investor and Business Migration Program	number	2 000	nm	nm
This performance measure is proposed to replace 2020-21 performance measure 'Victoria's market share of nominated investor and business migrants' as the market share measure is not a useful indicator of the State Government's influence due to the nomination places being allocated by the Commonwealth Government. It has been replaced to better reflect the Victorian government's performance in nominating talent to migrate to Victoria through state nomination.				
Proportion of disadvantaged jobseekers who achieve sustainable employment (minimum number of 26 weeks) with the support of Jobs Victoria Services	per cent	50	45	45
This performance measure renames the 2020-21 performance measure 'Jobseekers supported into work who sustain employment for at least 26 weeks'. The new performance measure reports on the same activity however has been amended for clarity. *The higher 2021-22 target reflects the anticipated proportion of jobseekers to be placed into sustained employment under the new Jobs Victoria Service model.*				
Proportion of Jobs Victoria Fund allocated to women	per cent	60	nm	nm
New performance measure for 2021-22 to clearly reflect the proportion of the Jobs Victoria Fund allocated to creation of jobs for women.				
Retrenched workers supported with employment assistance	number	2 000	400	2 000
The 2020-21 expected outcome is lower than the 2020-21 target as the Department did not provide face-to-face support for retrenched workers via the Workers in Transition service due to the impacts of COVID-19. Though, retrenched workers were able to access support through the Working for Victoria initiative, which created more than 12 000 new jobs..				
Subsidised jobs for jobseekers through the Jobs Victoria Fund	number	4 000	4 000	4 000
This performance measure renames the 2020-21 performance measure 'Subsidised jobs for Victorians at risk of long-term unemployment'. The new performance measure reports on the same activity however has been amended for clarity.				
Quality				
Client satisfaction with investor, business and skilled migration services provided	per cent	85	85	85
Jobseeker satisfaction with Jobs Victoria Services	per cent	70	nm	nm
New performance measure for 2021-22 to report on the performance of Jobs Victoria Services in meeting jobseeker requirements.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Timeliness				
Average processing time for investor, business and skilled migration visa nomination applications	days	20	20	20
Cost				
Total output cost	$ million	310.0	2 839.7	2 885.0
Total output cost including the CAC	*$ million*	*316.3*	*2 852.2*	*2 897.5*

The lower 2021-22 target mainly reflects additional funding received in 2020-21 through the Business Support initiative and Working for Victoria Fund.
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.

Source: Department of Jobs, Precincts and Regions

Objective 2: Foster a competitive business environment

This objective seeks to grow Victorian industries and businesses by working with priority industry sectors, supporting growth and innovation opportunities for industry, supporting startups and small businesses, and assisting industries in transition.

The departmental objective indicators are:

- change in Victoria's real gross state product; and
- engagement with businesses.

Outputs

Industry, Innovation, Medical Research and Small Business

(2021-22: $251.2 million)

This output provides access to information and connections and builds the capability of Victorian businesses and industry to develop and effectively use new practices and technologies to increase productivity and competitiveness, advocating for a fair and competitive business environment, and supporting small businesses.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Industry, Innovation and Small Business				
This sub-output supports Victorian businesses, from global enterprises to small, medium and startup businesses, to grow, create more job opportunities, lead innovation, promote digital connectivity and develop strategic industries.				
This is achieved by facilitating new investments, investing in digital connectivity, developing and attracting world-class talent, enhancing industry capability to build on the State's reputation for innovation and encouraging a competitive and fair business environment and a strong, diversified economy.				
Quantity				
Businesses whose growth and productivity issues are resolved by the Department	number	1 200	1 200	1 200
Companies or new entrants supported through the LaunchVic initiative	number	127	127	127
Engagements with businesses	number	14 000	14 000	14 000
Individuals supported under digital skills initiatives	number	2000	500	500
The higher 2021-22 target is because the program typically targets 500 per quarter, and commenced in Q4 of 2020-21.				
Industry roundtables and engagement forums	number	25	25	25
Locations to receive broadband infrastructure upgrades	number	65	nm	nm
New performance measure for 2021-22 to reflect Government priorities from the 2020-21 Budget *for Victoria's Digital Future Now (Gigabit State component).*				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
New mobile base stations facilitated	number	20	35	45
The 2020-21 expected outcome is lower than the 2020-21 target, based on the completion of the majority of the remaining Victorian Mobile Project Round 1 – 5 sites. Some Round 4 and 5 sites together with some of the more challenging sites from earlier rounds are not likely to be complete until 2021-22. *The lower 2021-22 target is because funding for Victoria's Digital Future Now – Mobile Connectivity will not have an impact on mobile tower completions until 2022-23. This is due to the significant lead times between the commitment of funding to mobile tower projects and the planning, construction and commissioning of infrastructure.*				
Participation in Small Business Victoria events and access to business programs	number	20 000	22 000	30 000
The 2020-21 expected outcome is lower than the 2020-21 target due to the access impediments caused by the COVID-19 pandemic, particularly in the first half of 2020-21 and the lapsing of the Business Victoria Local Events program. *The lower 2021-2022 target will reflect the number of businesses that participate in the Small Business Support Toolkits Program and will not include events that were delivered through the now lapsed Business Victoria Local Events program.* *This performance measure renames the 2020-21 performance measure 'Participation in Small Business Victoria targeted and inclusive events and business programs'. The new measure reports on similar activity as the previous measure however has been amended for increased clarity and to remove components relating to a now lapsed program.*				
Visits to Business Victoria digital channels	number	4 000 000	10 000 000	3 000 000
The 2020-21 expected outcome is higher than the 2020-21 target due to significantly higher than expected traffic. Higher traffic is expected to continue in the second half of the financial year. *The higher 2021-2022 target takes into account the ongoing trend upwards in vistation, but is lower than the 2020-21 expected outcome, as it is expected comparative traffic to the Business Victoria digital channels will reduce as access to COVID-19 grant programs is reduced.*				
Quality				
Client satisfaction of small business information, referral, coaching service and business programs	per cent	90	90	90
This performance measure renames the 2020-21 performance measure 'Client satisfaction of small business information, referral, mentoring service and business programs'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.				
Client satisfaction with the Victorian Government Business Offices	per cent	80	80	80
Client satisfaction with Victorian Small Business Commission mediation service	per cent	85	85	85
Proportion of business disputes presented to the Victorian Small Business Commission successfully mediated	per cent	75	75	75
Proportion of business disputes resolved by the Victorian Small Business Commission prior to mediation	per cent	30	30	30
Cost				
Total output cost	$ million	187.6	559.3	405.9
Total output cost including the CAC	*$ million*	*191.1*	*562.8*	*409.4*
The lower 2021-22 target mainly reflects additional funding received in 2020-21 for a range of programs within the Business Support initiative. *The 2020-21 expected outcome is higher than the 2020-21 target mainly due to the realignment of programs within the Business Support initiative from the Jobs output to the Industry, Innovation and Small Business output during 2020-21.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget*.* *The CAC is discontinued from the* 2021-22 Budget*.*				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Medical Research				
This sub-output supports maintaining Victoria's position as a leader in health and medical research, while protecting and growing jobs in the sector by funding visionary research through providing critical infrastructure to flagship projects and research institutes and strengthening commercialisation.				
Quantity				
Operational infrastructure supports grants under management	number	12	12	12
Projects supported through building and scaling up messenger Ribonucleic Acid Vaccine (mRNA) manufacturing capability in Victoria		5	nm	nm
New performance measure for 2021-22 to reflect funding in the 2021-22 Budget *for Stage one of building and scaling up messenger Ribonucleic Acid Vaccine (mRNA) manufacturing capability in Victoria.*				
Victorian families participating in the Generation Victoria study	number	56 000	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding Generation Victoria medical research. The measure is based on expected commitments by Victorian health services to support recruitment of participants in Generation Victoria study.				
Cost				
Total output cost	$ million	63.6	105.1	98.4
Total output cost including the CAC	*$ million*	*63.6*	*105.1*	*98.4*
The lower 2021-22 target mainly reflects the funding profile of initiatives within the output.				
The 2020-21 expected outcome is higher than the 2020-21 target mainly due to the transfer of responsibilities for the Melbourne Genomics Health Alliance and Respiratory challenge trials into the output.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget*.*				
The CAC is discontinued from the 2021-22 Budget.				
This output did not have a provision for CAC in previous budgets.				

Source: Department of Jobs, Precincts and Regions

Objective 3: Be a globally connected economy

This objective seeks to connect Victoria to the world by helping Victorian businesses successfully trade into global markets, and growing Victoria's proportion of international student enrolments in Australia.

The departmental objective indicators are:

- export sales generated from government programs; and
- Victoria's share of international student enrolments.

Outputs

Trade and Global Engagement (2021-22: $39.2 million)

This output promotes business growth opportunities by connecting organisations to global business opportunities in priority markets and supporting the establishment and deepening of strategic commercial partnerships. It also positions Victoria as a destination of choice for international students.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Actual export sales generated as a result of participation in government programs	$ million	550	550	550
Clients engaged in export and trade programs.	number	2 000	2 000	2 000
Number of Victorian companies assisted by Wine Industry initiatives	number	60	60	60
Significant interactions with Victorian agri-food companies and exporters, international customers and trading partners that facilitate export and investment outcomes for Victoria	number	250	250	250
Victoria's proportion of all international student enrolments in Australia	per cent	30	32.2	30
The 2020-21 expected outcome is higher than the 2020-21 target as Victoria has maintained its national market share despite the impacts of COVID-19 on the international education sector and overall international student enrolment numbers declining. Calendar year 2020 will be the latest nationwide full year data available for 2020-21.				
Visits to the Global Victoria website	number	100 000	200 000	100 000
The 2020-21 expected outcome is higher than the 2020-21 target due to a significant increase in visitation attributable to Victorian Government assistance and grants for COVID-19 recovery.				
Quality				
Client satisfaction with export assistance offered	per cent	90	90	90
International student satisfaction with Study Melbourne student programs	per cent	75	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding the recovery and growth of Victoria's international education sector.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Cost				
Total output cost	$ million	39.2	105.9	105.9
Total output cost including the CAC	*$ million*	*39.4*	*106.1*	*106.1*

The lower 2021-22 target mainly reflects additional funding received in 2020-21 for a range of COVID-19 response initiatives including International Education Sector Recovery Strategy, International Student Emergency Relief Fund and Trade: Export Recovery Plan.

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.

The CAC is discontinued from the 2021-22 Budget.

Source: Department of Jobs, Precincts and Regions

Objective 4: Build prosperous and liveable regions and precincts

This objective seeks to ensure that Victoria's precincts, suburbs and regions are developed to create places where all Victorians have an opportunity to participate in communities that are well-connected, prosperous, vibrant and diverse.

The departmental objective indicators are:

- precincts developed and delivered;
- community satisfaction in public places; and
- community satisfaction with the performance of councils as measured through the Local Government Community Satisfaction Survey.

Outputs

Business Precincts (2021-22: $16.6 million)

This output delivers activities to build vibrant and prosperous precincts that drive economic growth and opportunities. The Department works collaboratively with government, industry and community stakeholders to identify opportunities for the development and delivery of initiatives to strengthen our economy, create jobs and improve liveability for all Victorians.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Precincts in the design or delivery phase	number	4	7	7
The lower 2021-22 target is due to three precincts which previously measured by the Department having moved to the Department of Transport following a machinery of government change (Sunshine, Arden and Richmond to Flinders Street). Precincts of Fishermans Bend, Docklands, Footscray, Parkville are the four remaining precincts within the Department to be measured as outputs.				
Quality				
Key stakeholders satisfied with the services provided in relation to precincts	per cent	80	80	80
Timeliness				
Delivery of financial obligations for departmental public private partnership projects in accordance with contractual timelines	per cent	85	85	85
Cost				
Total output cost	$ million	16.6	22.5	20.0
Total output cost including the CAC	*$ million*	*21.2*	*26.9*	*24.4*
The lower 2021-22 target mainly reflects the transfer of responsibilities for the Sunshine Revitalisation Stimulus Project to the Department of Transport.				
The 2020-21 expected outcome is higher than the 2020-21 target mainly due to a funding realignment of Princes Pier: Protecting Community Safety at One of Victoria's Iconic Cultural Heritage assets, from capital funding to operating funding.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Department of Jobs, Precincts and Regions

Local Government and Suburban Development (2021-22: $145.4 million)

This output delivers activities in partnership with the local government sector to support effective and efficient local governance, leadership, infrastructure and service provision. The Department also works collaboratively to develop Melbourne's suburbs through the Suburban Revitalisation Program and the six Metropolitan Partnerships and improve suburban liveability. Through this output, the Department administers programs to support local governments to increase accountability and provide support to the Victorian Local Government Grants Commission.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Attendance at public library community programs	number (000)	2 263	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding the Public Libraries Funding Program.				
Average number of monthly pageviews on www.knowyourcouncil.vic.gov.au	number (000)	160	140	140
The higher 2021-22 target reflects increased public interest in the site.				
Community Leadership Program training places offered to women	number	40	nm	nm
New performance measure for 2021-22 to reflect the Government priorities regarding the Jobs and Leadership: Women in Local Govenrment initiative and the Government's commitment to achieve gender equality targets in local government representation by offering leadership training places over four years to increase women's leadership capability in municipalities where they remain under-represented.				
Community meetings held with Metropolitan Partnerships	number	18	6	6
The higher 2021-22 target reflects additional funding through the Strengthening Regional and Metropolitan Partnerships initiative.				
Councils with approved roadside weeds and pests control plan	number	56	56	56
Meetings held annually with Victorian councils regarding the Victorian Local Government Grants Commission financial assistance grants allocation model	number	19	19	19
Meetings held with Local Government Mayoral Advisory Panel	number	4	4	4
Metropolitan Partnership Development Fund projects completed	number	7	nm	nm
This performance measure is proposed to replace the 2020-21 performance measure 'Partnership priorities receiving a government response by 30 June'. The new measure more accurately reflects the engagement between government and community to understand and progress community priorities.				
Number of visitors to Metropolitan Public Libraries	number (million)	18.8	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding the Public Libraries Funding Program.				
Number of visitors to Regional Public Libraries	number (million)	12.0	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding the Public Libraries Funding Program.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Projects in the planning or delivery phase to support and facilitate the revitalisation of Broadmeadows and Frankston	number	6	6	6
Submissions that fully meet the objectives within the Growing Suburbs Fund program guidelines	per cent	80	80	80
Quality				
Council satisfaction with the communication, support and advice received from Local Government Victoria in relation to the Local Government Performance Reporting Framework	per cent	80	70	70
The higher 2021-22 target reflects planned improvements in service, as a result of greater engagement with councils and more frequent and enhanced advice provided by Local Government Victoria staff.				
Participants satisfied with their experience of Metropolitan Partnership community meetings	per cent	80	80	80
This performance measure renames the 2020-21 performance measure 'Participants satisfied with their experience of partnership assemblies'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.				
Timeliness				
Average number of days for Municipal Emergency Resource Program grant payments to be made following completion of agreed milestones in the funding agreement	days	21	21	21
Average number of days for Public Library Services grant payments to be made following completion of agreed milestones in the funding agreement	days	21	21	21
Projects completed in accordance with approved milestones within the Growing Suburbs Fund funding agreements	per cent	80	80	80
Roadside Weeds and Pests program grant payments made within 21 days of completion of agreed milestones in the funding agreement	per cent	100	100	100
Victoria Local Government Grants Commission allocations finalised to support the completion of council budgets within statutory timeframes	per cent	100	100	100
Cost				
Total output cost	$ million	145.4	183.8	178.6
Total output cost including the CAC	*$ million*	*145.4*	*183.8*	*178.6*
The lower 2021-22 target mainly reflects the funding profile of initiatives within the output.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				
This output did not have a provision for CAC in previous budgets.				

Source: Department of Jobs, Precincts and Regions

Regional Development (2021-22: $256.0 million)

This output guides engagement with industry and communities to identify opportunities to support job growth and new investment in regional Victoria, including support and services to grow regional jobs and capability in regional communities.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Actual export sales generated for regional businesses as a result of participation in government programs	$ million	110	55	110
The 2020-21 expected outcome is lower than the 2020-21 target due to Global Victoria's Global Gateway initiative having just commenced and there being minimal trade fairs and missions activities due to the COVID-19 pandemic.				
Economic development and service delivery projects supported	number	175	380	150
The 2020-21 expected outcome is higher than the 2020-21 target as it includes a significant amount of COVID-19 response projects, including the Working for Victoria – Agriculture Workforce Plan approvals, in addition to business as usual regional economic development projects. *The higher 2021-22 target is due to a calculation of achievable outcomes based on the number of projects currently in various stages of delivery, noting that these projects include one-off initiatives which justifies the increase for the 2021-22 year.*				
Jobs in regional Victoria resulting from government investment facilitation services and assistance	number	1 770	1 770	1 770
New investment in regional Victoria resulting from government facilitation services and assistance	$ million	1 400	1 000	1 400
The 2020-21 expected outcome is lower than the 2020-21 target due to the impacts of COVID-19 and the resulting economic conditions.				
Quality				
Participant satisfaction with implementation of Regional Development Victoria programs	per cent	90	90	90
Cost				
Total output cost	$ million	256.0	539.2	538.7
Total output cost including the CAC	*$ million*	*257.5*	*540.4*	*539.9*
The lower 2021-22 target mainly reflects the funding profile of a range of initiatives within the output. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the 2021-22 Budget.*				

Source: Department of Jobs, Precincts and Regions

Objective 5: Grow vibrant, active and creative communities

This objective seeks to increase the economic, social and cultural value of the creative, sport and recreation industries to Victoria, grow the number and yield of visitors, position Victoria as a major events destination, and ensure the best cultural and sporting experiences are accessible to everyone.

The departmental objective indicators are:

- attendances at Creative Industries agencies and funded Major Performing Arts organisations;
- employment in the Creative Industries sector;
- employment in the Visitor Economy sector;
- tourists attracted to Victoria;
- increase rates of community engagement, including through participation in sport and recreation; and
- wagering turnover on Victorian racing as a proportion of the national market.

Outputs

Creative Industries Access, Development and Innovation (2021-22: $54.8 million)

This output supports the creative industries to deliver economic, social and cultural benefit through talent and leadership; the creative and business ecology; innovation and social impact; participation and place making; and international engagement.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output:

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Attendances at major performing arts organisations	number (000)	1 000	142	1 000
The 2020-21 expected outcome is lower than the 2020-21 target due to venue closures and capacity restrictions in accordance with Government directives to mitigate the impact of COVID-19.				
Creative Learning Partnerships	number	14	14	14
Design organisations supported	number	22	22	22
International market development and exchange initiatives	number	12	12	12
Organisations recurrently funded	number	154	140	140
The higher 2021-22 target reflects new funding in the 2021-22 Budget *for the* Creative State 2021-25 *initiative.*				
Project companies and artists funded	number	450	900	900
The lower 2021-22 target reflects lapsing COVID-19 funds and new funding in the 2021-22 Budget *for the* Creative State 2021-25 *initiative.*				
Project companies and artists funded which are regionally based	per cent	23	23	23

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Regionally based organisations recurrently funded	number	56	53	54
The higher 2021-22 target reflects new funding in the 2021-22 Budget *for the* Creative State 2021-25 *initiative.*				
Quality				
Creative Victoria grant recipients who met or exceeded agreed milestones	per cent	85	85	85
Public information rated 'informative' or 'very informative' by grant applicants	per cent	90	90	90
Timeliness				
Performance and grant agreements acquitted within timeframes specified in the funding agreement	per cent	83	83	83
Cost				
Total output cost	$ million	54.8	81.9	69.1
Total output cost including the CAC	*$ million*	*64.4*	*91.4*	*78.7*
The lower 2021-22 target primarily reflects additional funding allocated in 2020-21 in response to the COVID-19 pandemic. *The 2020-21 expected outcome is higher than the 2020-21 target mainly due to additional funding received for Creative Industries Survival Package.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Jobs, Precincts and Regions

Creative Industries Portfolio Agencies (2021-22: $393.7 million)

This output promotes, presents and preserves our heritage and the creative industries through Victoria's creative industries agencies: Arts Centre Melbourne, Australian Centre for the Moving Image (ACMI), Docklands Studios Melbourne, Film Victoria, Geelong Performing Arts Centre, Melbourne Recital Centre, Museums Victoria, National Gallery of Victoria (NGV), and the State Library Victoria.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Additional employment from production supported by Film Victoria	number	11 358	9 556	8 732
The 2020-21 outcome is higher than the 2020-21 target due to additional funding being secured for a major international production that has commenced filming in Victoria. *The higher 2021-22 target reflects new funding in the* 2021-22 Budget *for the Victorian Government Screen Industry Strategy 2021-2025 initiative and the lapsing COVID-19 funds introduced in 2020-21.*				
Agency website visitation	number (000)	21 200	17 000	21 200
The 2020-21 expected outcome is lower that the 2020-21 target due to the impact of COVID-19 and closures at the agencies which affected online visitation to agency websites.				
Attendances at Arts Centre Melbourne	number (000)	2 200	119	2 200
The 2020-21 expected outcome is lower than the 2020-21 target due to closures and restrictions during the COVID-19 pandemic.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Attendances at Australian Centre for the Moving Image	number (000)	800	500	800
The 2020-21 expected outcome is lower than the 2020-21 target due to closure arising from the Australian Centre for Moving Image (ACMI) redevelopment project and a delayed reopening as a result of COVID-19. ACMI is scheduled to reopen in February 2021.				
Attendances at Geelong Arts Centre	number (000)	100	40	100
The 2020-21 expected outcome is lower than the 2020-21 target due to closures and restrictions brought about by COVID-19.				
Attendances at Melbourne Recital Centre	number (000)	230	70	230
The 2020-21 expected outcome is lower than the 2020-21 target due to closures and restrictions brought about by COVID-19.				
Attendances at Museums Victoria	number (000)	2 000	800	2 000
The 2020-21 expected outcome is lower than the 2020-21 target due to closures and restrictions brought about by COVID-19.				
Attendances at National Gallery of Victoria	number (000)	2 235	750	2 235
The 2020-21 expected outcome is lower than the 2020-21 target due to closures and restrictions brought about by COVID-19.				
Attendances at State Library Victoria	number (000)	2 250	850	2 250
The 2020-21 expected outcome is lower than the 2020-21 target due to closures and restrictions brought about by COVID-19.				
Direct Full-Time Equivalent (FTE) roles from production supported by Film Victoria	number	2 335	nm	nm
New peformance measure for 2021-22 to reflect Government priorities regarding new Victorian Government Screen Industry Strategy 2021-2025 funding.				
Members and friends of agencies	number	57 000	57 000	57 000
Students participating in agency education programs	number	550 000	126 200	550 000
The 2020-21 expected outcome is lower due to the impact of COVID-19 and closures at the agencies, which meant school groups were unable to attend the various education programs hosted by agencies. Agencies are offering online education programs.				
Value of film, television and digital media production supported by Film Victoria	$ million	350	344	327
The 2020-21 expected outcome is higher than the 2020-21 target due to additional funding being secured for a major international production that has commenced filming in Victoria. *The higher 2021-22 target reflects new funding in the* 2021-22 Budget *for the Victorian Government Screen Industry Strategy 2021-2025 initiative.*				
Volunteer hours	number	98 900	19 700	98 900
The 2020-21 expected outcome is lower than the 2020-21 target due to impact of COVID-19 and closures at the agencies.				
Quality				
Agency collections storage meeting industry standard	per cent	86	85	86
Visitors satisfied with visit: Arts Centre Melbourne	per cent	90	90	90
Visitors satisfied with visit: Australian Centre for the Moving Image	per cent	95	95	95
Visitors satisfied with visit: Geelong Arts Centre	per cent	98	98	98
Visitors satisfied with visit: Melbourne Recital Centre	per cent	95	95	95

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Visitors satisfied with visit: Museums Victoria	per cent	96	95	95
The higher 2021-22 target reflects new funding in the 2021-22 Budget *for the Melbourne Museum Transformed and Scienceworks Reimagined initiatives.*				
Visitors satisfied with visit: National Gallery of Victoria	per cent	95	95	95
Visitors satisfied with visit: State Library Victoria	per cent	90	90	90
Cost				
Total output cost	$ million	393.7	467.0	425.1
Total output cost including the CAC	*$ million*	*431.9*	*505.1*	*463.2*
The lower 2021-22 target primarily reflects additional funding allocated in 2020-21 in response to the COVID-19 pandemic. *The 2020-21 expected outcome is higher than the 2020-21 target mainly due to additional funding received for Creative Industries Survival Package and Screen industry Survival Package.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Jobs, Precincts and Regions

Cultural Infrastructure and Facilities (2021-22: $65.3 million)

This output supports Victorian cultural venues and State-owned facilities through strategic assessment and provision of advice on portfolio infrastructure proposals and projects. The output includes consolidation of portfolio asset management plans and management of funding programs for maintenance and minor capital works.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
All facility safety audits conducted	number	16	16	16
Infrastructure development projects underway	number	10	8	8
The higher 2021-22 target reflects new funding in the 2021-22 Budget *for Revitalising our Cultural Institutions.*				
Quality				
State-owned tenanted cultural facilities maintained to agreed service standards	per cent	90	90	90
Success measures of projects achieved	per cent	90	90	90
Timeliness				
Cultural Facilities Maintenance Fund projects delivered within agreed timeframes	per cent	90	90	90
Cost				
Total output cost	$ million	65.3	63.0	81.9
Total output cost including the CAC	*$ million*	*122.8*	*120.2*	*139.1*
The lower 2021-22 target mainly reflects the additional funding received in 2020-21 for Regional Creative Infrastructure projects. *The 2020-21 expected outcome is lower than the 2020-21 target mainly due to adjustment of the funding profile of initiatives within the output.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Jobs, Precincts and Regions

Sport, Recreation and Racing (2021-22: $497.4 million)

This output provides strategic leadership and investment in the sport, recreation and racing industries through innovation, sector and industry development and funding support. It supports community participation and inclusion in the sport, recreation and racing sectors by strengthening the capacity of sport and recreation organisations to deliver participation opportunities, improving community sport and recreation facilities across the state and guiding the development and management of State-level sporting facilities and events, to encourage participation by all Victorians.

This output also supports the development of the Victorian racing industry through strategic investment in world-class racing and training infrastructure, the promotion of animal welfare and integrity initiatives and encourages participation and investment in the breeding industry to cement Victoria's position as Australia's premier racing state.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Combat sports licences, registrations and permits issued	number	550	300	550
The 2020-21 expected outcome is lower than the 2020-21 target due to the impacts of COVID-19 resulting in a significant reduction in the amount of combat sports events that were able to be held, leading to a reduction in applications for licenses, registrations and permits.				
Community Facility Grants: number approved	number	140	215	200
The 2020-21 expected outcome is higher than the 2020-21 target as a greater number of high-quality applications were able to be supported within the allocated program budgets. *The lower 2021-22 target is due to changes to the funding profile for community sport infrastructure projects in 2021-22.*				
Local Sports Infrastructure grant recipients which are regionally based	per cent	45	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding the Investing in Local Sports Infrastructure initiative.				
Funded State Sport and Recreation Associations that have a minimum of 40 per cent women on their boards	per cent	90	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding the Change Our Game – the Office for Women in Sport and Recreation initiative.				
Organisations submitting nominations for the Community Sport and Recreation Awards	number	70	55	70
The 2020-21 expected outcome is lower than the 2020-21 target due to the reduction in awards categories offered for the 2021 Community Sport and Recreation Awards from 19 to eight, reflecting impacts of the COVID-19 on sector activity and participation throughout 2020.				
Projects in progress that relate to the planning and development of State-level facilities	number	20	21	19
The 2020-21 expected outcome is higher than the 2020-21 target due to additional planning studies commencing in 2020-21. *The higher 2021-22 target is due to additional infrastructure projects confirmed through the* 2021-22 Budget.				
Racing industry development initiatives	number	9	9	9
Racing matters processed (including licences, permits and grant applications)	number	300	150	300
The 2020-21 expected outcome is lower than the 2020-21 target due to the impacts of COVID-19 on the industry. COVID-19 reduced the number of attendees at racing events and reduced the demand for Raceday attraction grants, licenses and permits.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Significant Sporting Events Program – Events Facilitated	number	75	28	75
The 2020-21 expected outcome is lower than the 2020-21 target due to the impacts of COVID-19 on the planning and delivery of sporting events.				
Sport and recreation organisations undertaking programs or activities to enhance participation	number	112	112	112
Sporting club grants to recipients which are based in low socio-economic areas as identified by the SEIFA index	per cent	45	53	45
The 2020-21 expected outcome is higher than the 2020-21 target due to a higher number of applications received and grants approved to recipients in low socio-economic areas.				
Sporting club grants to recipients which are regionally based	per cent	35	46	35
The 2020-21 expected outcome is higher than the 2020-21 target due to a higher number of applications received and grants approved to recipients in regional areas.				
Sporting club grants: number approved	number	750	2 500	2 500
The lower 2021-22 target reflects the impact of the lapsing Sporting Club Grants initiative funded in the 2020-21 Budget*.*				
Sports with athletes on Victorian Institute of Sport (VIS) scholarships	number	45	44	25
The 2020-21 expected outcome is higher than the 2020-21 target as a result of additional funding received by the Victorian Institute of Sport from National Sporting Organisations. *The higher 2021-22 target is due to additional funding for the A sustainable Victorian Institute of Sport initiative as part of the* 2021-22 Budget*.*				
Victorian categorised athletes supported by the VIS	per cent	45	nm	nm
New performance measure for 2021-22 to reflect Government priorities regarding the A sustainable Victorian Institute of Sport initiative.				
Victorian Institute of Sport scholarship holders on national teams/squads	per cent	60	60	60
Quality				
Contract management of outdoor recreation camps meets agreed key performance indicators	per cent	90	90	90
Timeliness				
Community Cricket Program milestones delivered within agreed timeframes	per cent	90	93	90
Cost				
Total output cost	$ million	497.4	744.7	776.6
Total output cost including the CAC	*$ million*	*500.3*	*747.6*	*779.4*
The lower 2021-22 target mainly reflects additional funding received in 2020-21 for initiatives including Community Sport and Recreation Recovery and Infrastructure-based stimulus. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget*.* *The CAC is discontinued from the* 2021-22 Budget*.*				

Source: Department of Jobs, Precincts and Regions

Tourism and Major Events (2021-22: $197.9 million)

This output maximises employment and the long-term economic benefits of tourism and major events to Victoria by developing and marketing the State as a competitive destination.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Always Live events held	number	50	nm	nm
New performance measure for 2021-22 to reflect delivery of the Always Live program events in 2021-22.				
Business program grants delivered	number	12	12	12
Major sporting and cultural events held	number	21	9	21
The 2020-21 expected outcome is lower than the 2020-21 target due to COVID-19 related restrictions on events, travel and mass gatherings.				
Tourism infrastructure projects facilitated	number	30	30	30
Visit Victoria's total engaged digital audience	number (million)	6.2	5	5.4
The 2020-21 expected outcome is lower than the 2020-21 target due to the ongoing impacts of COVID-19 on international and interstate travel. *The higher 2021-22 target reflects the projected increases to Visit Victoria digital channel activities excluding the impact of COVID-19.*				
Visitor expenditure: domestic	$ billion	23.2	10.0	23.2
The 2020-21 expected outcome is lower than the 2020-21 target due to the ongoing impacts of COVID-19. State border closures and ongoing movement/travel restrictions have limited visitation to the State in the year to date.				
Visitor expenditure: international	$ billion	9	0.05	9
The 2020-21 expected outcome is lower than the 2020-21 target because international borders to Australia have been shut in order to prevent the spread of COVID-19.				
Visitor expenditure: regional Victoria (domestic)	$ billion	11.1	5.1	11.1
The 2020-21 expected outcome is lower than the 2020-21 target due to the ongoing impacts of COVID-19. State border closures and ongoing movement/ travel restrictions have limited visitation to regional Victoria in the year to date.				
Visitor expenditure: regional Victoria (international)	$ million	600	5	600
The 2020-21 expected outcome is lower than the 2020-21 target as it is expected that international borders to Australia will remain shut in order to prevent the spread of COVID-19.				
Visitor expenditure: regional Victoria (intrastate overnight)	$ billion	5.7	2.2	5.7
The 2020-21 expected outcome is lower than the 2020-21 target due to the ongoing impacts of COVID-19. Travel restrictions have limited visitation to regional Victoria in the year to date.				
Visitors (domestic overnight)	number (million)	29.5	16.7	29.5
The 2020-21 expected outcome is lower than the 2020-21 target due to the ongoing impacts of COVID-19. State border closures and travel restrictions have limited visitation to the State in the year to date.				
Visitors (international)	number (million)	3.2	0.02	3.2
The 2020-21 expected outcome is lower than the 2020-21 target because international borders to Australia have been shut in order to prevent the spread of COVID-19.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Visitors: regional Victoria (intrastate overnight)	number (million)	16.4	8.7	16.4
The 2020-21 expected outcome is lower than the 2020-21 target due to the ongoing impacts of COVID-19, which are expected to have an impact on intrastate overnight visitation in regional Victoria in the 2020-21 financial year.				
Quality				
Value of media coverage generated: domestic	$ million	23	22	22
The higher 2021-22 target is due to a greater focus on public relations activities with the anticipated growth in travel sentiment.				
Value of media coverage generated: international	$ million	47	15	46
The 2020-21 expected outcome is lower than the 2020-21 target due to the ongoing impacts of COVID-19 on international travel. *The higher 2021-22 target is due to the return of global public relations activities to leverage the anticipated easing of international travel restrictions.*				
Timeliness				
Completion of post-event reports and economic impact assessments of each event (where required) within agreed timeframes	per cent	100	100	100
Cost				
Total output cost	$ million	197.9	478.0	354.1
Total output cost including the CAC	*$ million*	*199.4*	*479.6*	*355.6*
The lower 2021-22 target mainly reflects the additional funding received in 2020-21 for Visitor Economy: Regional Tourism Investment Fund and Visitor Economy: Victorian Regional Travel Voucher Scheme. *The 2020-21 expected outcome is higher than the 2020-21 target mainly due to additional Major Events funding that was held centrally until contractual arrangements were finalised.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget*.* *The CAC is discontinued from the* 2021-22 Budget*.*				

Source: Department of Jobs, Precincts and Regions

Objective 6: Promote productive and sustainably used natural resources

This objective supports more productive, globally competitive, sustainable and jobs-rich agriculture, food and fibre, and resources sectors.

The Department delivers the objective in collaboration with partners, local communities and industry to deliver outcomes that provide benefits to all Victorians.

The departmental objective indicators are:

- value of Victorian agriculture production;
- value of Victorian food and fibre exports;
- metres drilled for minerals exploration in Victoria; and
- level of production of minerals and extractives.

Outputs

Agriculture (2021-22: $464.7 million)

This output delivers services to the agriculture, food and fibre sectors to enhance productivity, connect the sector with international markets, create jobs, support growth and maintain effective biosecurity.

This output delivers effective, and efficient regulation, compliance, emergency management, biosecurity research and development, and diagnostic services to protect and enhance market access by addressing trade barriers and managing the risks of pests, diseases and chemical use. The Department undertakes research and development to develop new technologies and practices and provides services to enhance their adoption to increase farm productivity and supply chain efficiencies. It provides policy advice and support to industries and businesses to innovate, manage economic and climatic volatility, natural disasters and biosecurity emergencies, and meet consumer and community expectations for food quality, food safety and animal welfare and environmental standards.

The output also creates the conditions to grow the natural resources economy by ensuring resources are sustainably allocated and used for both recreational and commercial purposes.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Agriculture Industry Development and Regulation				
This sub-output supports a more productive, competitive, sustainable and jobs-rich food and fibre sector by delivering policy advice, regulation and support to meet consumer and community expectations for agriculture industry development, pets and animal welfare, regulatory policies and frameworks.				
Quantity				
Farms and related small businesses facing significant adjustment pressures supported to make better-informed decisions by the Rural Financial Counselling Service	number	1 700	1 700	1 700
Inspections or audits of scientific establishments undertaken to provide assurance of compliance with relevant industry standards for animal welfare	number	25	20	25
The 2020-21 expected outcome is lower than the 2020-21 target due to redirection of staff to biosecurity responses and recent staff turnover.				
Number of small scale local and craft producers attending workshops / mentoring programs	number	50	50	50
Strategies developed to maintain and / or grow export opportunities, pathways and capability and overcome identified trade barriers	number	3	7	7
The lower target reflects the reduction in funding due to the lapsing Growing Food and Fibre Markets Program component of the Growing Agriculture Exports, Farms and Tourism program. *The performance measure 'Strategies developed to overcome identified trade barriers' was proposed to be discontinued in the* 2019-20 Budget*, however has been reinstated following the Public Accounts and Estimates Committee's* Report on the 2019-20 Budget Estimates*. This performance renames the previous performance measure 'Strategies developed to overcome identified trade barriers'. The renamed performance measure is broader and reflects the priority to not only retain and enhance existing market access (and overcome trade barriers) but also to undertake work that supports diversification to establish new markets.*				
Visits of the Responsible Pet Ownership program to Victorian kindergartens and primary schools	number	3 100	1 420	3 100
The 2020-21 expected outcome is lower than the 2020-21 target as school visits were suspended due to COVID-19 workplace restrictions.				
Young farmer scholarships awarded	number	12	13	12
The 2020-21 expected outcome is higher than the 2020-21 target as 13 scholarships were able to be awarded this financial year within the allocated annual budget. The original 12 applications received were for less than the maximum scholarship allowable, and following the merit of applications, an additional scholarship was able to be awarded in 2020-21.				
Quality				
Grant recipients who met or exceeded agreed milestones	per cent	75	75	75
Timeliness				
Performance and grant agreements acquitted within timeframes specified in the funding agreement	per cent	90	90	90
Cost				
Total output cost	$ million	163.1	235.6	217.7
Total output cost including the CAC	*$ million*	*170.3*	*242.8*	*224.9*
The lower 2021-22 target mainly reflects the funding profile of initiatives within the output. *The 2020-21 expected outcome is higher than the 2020-21 target mainly due to additional funding received in 2020-21 for the Seasonal Agriculture Workforce Support.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget*.* *The CAC is discontinued from the* 2021-22 Budget*.*				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Agriculture Research				
This sub-output supports more productive, competitive, sustainable and jobs-rich food and fibre sectors by delivering research and innovation to develop innovative new technologies and farming systems that increase food and fibre productivity and product quality.				
Quantity				
Applications for intellectual property protection	number	16	16	16
Commercial technology licence agreements finalised	number	16	16	16
Genetic improvement of dairy cows achieved through breeding contributing to increased milk production and dairy productivity	per cent	1	1	1
Key bioscience platform technologies established	number	1	1	1
Postgraduate-level/PhD students in training	number	65	67	65
Value of co-investment from external (non-state) funding sources attracted to the Department's research projects that support productive agriculture	$ million	41	42.6	41
Quality				
Satisfaction rating of industry investors in agriculture productivity research and development	number	7	7	7
Scientific and technical publications subjected to independent peer review in international and national journals that promote productive agriculture	number	260	260	260
Timeliness				
Provision of technical advice, diagnostic identification tests on pests and diseases including suspected exotics within agreed timeframes	per cent	85	85	85
Research project milestones and reports completed on time	per cent	90	86	90
Cost				
Total output cost	$ million	123.2	121.2	120.3
Total output cost including the CAC	*$ million*	*149.9*	*147.9*	*147.0*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				
Biosecurity and Agriculture Services				
This sub-output delivers biosecurity, agriculture and emergency management services and regulatory programs which support the food and fibre sector to achieve sustainable growth while managing risks and minimising adverse impacts to the economy, environment and public health and safety.				
Quantity				
Animal pest, disease and residue control programs maintained to ensure Victorian agricultural produce complies with food safety and biosecurity standards required to access markets	number	5	4	5
The 2020-21 expected outcome is lower than the 2020-21 target due to Animal Health and Welfare programs being impacted by COVID-19 restrictions and redirection of resources to the Avian Influenza emergency response.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Client interactions with land health services	number	1 700	1 600	1 700
The 2020-21 expected outcome is lower than the 2020-21 target due to a changed service delivery model associated with COVID-19 public health restrictions and significant redirection of staff resources to support Avian Influenza and Khapra beetle emergency responses and COVID-19 state border and supply chain responses. *This performance measure was proposed to be discontinued in the* 2019-20 Budget*, however, has been reinstated following the Public Accounts and Estimates Committee's* Report on the 2019-20 Budget Estimates*.*				
Clients engaged with agriculture productivity services	number	3 910	2 900	3 910
The 2020-21 expected outcome is lower than the 2020-21 target due to a changed service delivery model associated with COVID-19 public health restrictions and significant redirection of staff resources to support Avian Influenza and Khapra beetle emergency responses and COVID-19 state border and supply chain responses. *This performance measure was proposed to be discontinued in the* 2019-20 Budget*, however, has been reinstated following the* Public Accounts and Estimates Committee's Report on the 2019-20 Budget Estimates*.*				
Improved agricultural services, programs and products developed	number	10	10	10
Known state prohibited weed sites monitored and treated in line with the relevant weed action plan	per cent	95	95	95
New or amended Interstate Certificate Assurance (ICA) or other market access accreditations developed to restore or enable trade	number	2	8	2
The 2020-21 expected outcome is higher than the 2020-21 target due to external factors that are not directly influenced by the Department, including changes to requirements of other jurisdictions, chemical use patterns, industry demand, and in response to new pests and/or disease incursions.				
Plant pest, disease and residue control programs maintained to ensure Victorian agricultural produce complies with food safety and biosecurity standards required to access markets	number	6	6	6
Properties inspected for invasive plant and animal priority species	number	2 700	2 500	2 700
The 2020-21 expected outcome is lower than the 2020-21 target due to the impacts of staff redirection to assist with the Avian Influenza emergency response. There is also likely to be further impacts in the second half of the financial year from staff redirection to a Khapra beetle response.				
Quality				
Client satisfaction rating of agricultural services	number	8	8	8
National biosecurity, agriculture/veterinary chemical use and animal welfare programs implemented in accordance with agreed plans	per cent	96	100	95
The 2020-21 expected outcome is higher than the 2020-21 target as it is likely that Agriculture Victoria will be able to respond to all requests associated with national work programs. *The higher 2021-22 target reflects that the target has been exceeded consistently over several years due to strong departmental performance to deliver these high-priority programs.*				
Preparedness activities implemented, in line with agreed plans, to ensure response readiness for emergency animal and plant pest, disease and natural disaster incidents	per cent	90	90	90
Timeliness				
Animal health certificates issued within specified timeframes to support international market access	per cent	95	95	95
This performance measure was proposed to be discontinued in the 2019-20 Budget*, though has been reinstated following the Public Accounts and Estimates Committee's* Report on the 2019-20 Budget Estimates*.*				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Initial action taken to respond to reported emergency animal and plant pest, disease and natural disaster incidents complies with national agreements and obligations	per cent	100	100	100
Plant health certificates issued within specified timeframes at the Melbourne Wholesale Fruit and Vegetable Market to support domestic market access	per cent	95	95	95
This performance measure was proposed to be discontinued in the 2019-20 Budget*, though has been reinstated following the Public Accounts and Estimates Committee's* Report on the 2019-20 Budget Estimates*.*				
Cost				
Total output cost	$ million	113.3	137.2	111.3
Total output cost including the CAC	*$ million*	*115.5*	*139.4*	*113.5*
The 2020-21 expected outcome is higher than the 2020-21 target mainly due to additional funding in 2020-21 for Avian Influenza control and eradication. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget*.* *The CAC is discontinued from the* 2021-22 Budget*.*				
Sustainably manage forest and game resources				
This sub-output creates the conditions to ensure the natural resources economy including forestry and game resources are sustainably allocated and used for both recreational and commercial purposes.				
Quality				
Key statutory obligations relevant to the Game Management Authority complied with (tabling annual report, audits, business plan and board appointments)	per cent	100	100	100
Key statutory obligations relevant to VicForests complied with (tabling annual reports, audits, corporate plan and board appointments)	per cent	100	75	100
The 2020-21 expected outcome is lower than the 2020-21 target due to a delay in VicForests tabling its Corporate Plan (which was due on 31 August 2020)				
Timeliness				
Facilitate the delivery of game projects in line with key project milestones	per cent	100	100	100
Facilitate the delivery of the Victorian Forestry Plan in line with key project milestones	per cent	100	100	100
Cost				
Total output cost	$ million	65.1	96.1	76.6
Total output cost including the CAC	*$ million*	*67.3*	*98.3*	*78.8*
The lower 2021-22 target mainly reflects additional funding received in 2020-21 for Timber Salvage Operations. *The 2020-21 expected outcome is higher than the 2020-21 Target mainly due to additional funding received in 2020-21 for the implementation of the Victorian Forestry Plan.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget*.* *The CAC is discontinued from the* 2021-22 Budget*.*				

Source: Department of Jobs, Precincts and Regions

Resources (2021-22: $66.2 million)

This output develops and delivers policy, programs and regulation to enable investment and generate jobs through the sustainable development of the State's earth resources, including extractives, minerals and petroleum.

The Department acquires and provides access to high-quality geoscience data and knowledge to inform government decision making and attract new investment and jobs to the State. It develops and implements legislative and regulatory reforms in the earth resources sector to improve outcomes for all stakeholders.

Supporting investment in resources and low emission technologies, the Department fosters innovation, productivity, jobs and trade in the State's earth resources sector. Through strategic resource and related land use planning, new opportunities are able to be identified for Victoria's earth resources, along with supporting major infrastructure development in the State.

The Department also regulates the earth resources sector through transparent, consistent and timely regulatory processes that provide industry with confidence to invest and have regard to the needs of communities and minimise impacts to the environment.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Community and stakeholder engagement information forums	number	55	55	55
Quality				
Exploration and mining licences which are active	per cent	82.5	82.5	82.5
Timeliness				
Delivery of key CarbonNet milestones, in line with funding agreements and agreed project deliverables	per cent	100	100	100
Extractive Industries Work Authority work plans processed within regulatory timeframes	per cent	95	95	95
Facilitate the delivery of resources projects in line with grant agreements and project milestones	per cent	100	98	100
Industry geoscience data packages released for minerals and petroleum sectors consistent with agreed timelines	number	10	10	10
Mineral licence applications and work plans processed within regulatory timeframes	per cent	95	70	95
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of a significant increase in the level of licence applications received due to the record levels of mineral exploration activity.				
Regulatory audits completed within agreed timelines	per cent	98	98	98
Cost				
Total output cost	$ million	66.2	72.3	72.3
Total output cost including the CAC	*$ million*	*67.1*	*73.2*	*73.2*
The lower 2021-22 target mainly reflects the funding profile of initiatives within the output.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Department of Jobs, Precincts and Regions

DEPARTMENT OF JUSTICE AND COMMUNITY SAFETY

Ministerial portfolios

The Department supports the ministerial portfolios of the Attorney General, Police and Emergency Services, Crime Prevention, Corrections, Youth Justice, Victim Support, Consumer Affairs, Gaming and Liquor Regulation and Workplace Safety.

Departmental mission statement

The Department of Justice and Community Safety provides policy and organisational management focus for the vision of a justice and community safety system that works together to build a safer, fairer and stronger Victoria by:

- integrating services and tailoring them for local communities;
- prioritising Victorians in need;
- focusing on victims and survivors; and
- strengthening stakeholder partnerships.

The Department contributes to the Victorian Government's commitment to a stronger, fairer, better Victoria by providing safer and more resilient communities, ensuring a trusted justice and community safety system with easy access to justice and safety systems and services and ensuring a fair and accessible justice system for Aboriginal people.

Departmental objectives

Objective 1: Ensuring community safety through policing, law enforcement and crime prevention activities

This objective aims to provide a safe and secure environment for the Victorian community. This objective delivers on activities relating to the provision of effective policing, law enforcement and infringement processing services that aim to prevent, detect, investigate and prosecute crime, and promote safer road user behaviour. It focuses on activities which enable Victorians to undertake their lawful pursuits confidently, safely and without fear of crime.

Objective 2: Reduce the impact of, and consequences from, natural disasters and other emergencies on people, infrastructure, the economy and the environment

This objective aims to deliver a coordinated, all communities, all emergencies approach to emergency management, focusing on risk mitigation and active partnership with the Victorian community.

Emergency management encompasses prevention, preparation and planning for, responding to and recovering from natural disasters (such as bushfires, floods and severe storms), the consequences of terrorism, hazardous material incidents (such as chemical spills and gas leaks), and individual and personal emergencies (such as land and sea rescues, car accidents and residential and commercial fires).

Objective 3: Effective management of prisoners and offenders and provision of opportunities for rehabilitation and reparation

This objective relates to the management of the State's adult correctional system. The overarching purpose of the correctional system is to promote community safety through community-based and custodial supervision of prisoners and offenders through effective management and services to provide opportunities for rehabilitation and reparation.

Objective 4: Effective supervision of children and young people through the provision of youth justice services promoting rehabilitation

This objective aims to promote opportunities for rehabilitation of children and young people in the youth justice system and contribute to the reduction of crime in the community by providing a range of services including diversion services, advice to courts, offence-related programs, community-based and custodial supervision.

Objective 5: A fair and accessible justice system that supports confidence in the Victorian community

This objective relates to the provision of and access to justice services that support legal processes and law reform. Services that support legal processes include legal assistance and education services, prosecution services and the delivery of independent, expert forensic medical services to the justice system.

Other services that contribute to this objective include legal policy advice to government, law reform, dispute resolution and initiatives focusing on crime prevention and supporting Kooris in the criminal justice system.

Objective 6: Victorians are protected with equal opportunities, secure identities, information freedoms and privacy rights

This objective aims to support the Victorian community through the provision of services relating to rights and equal opportunity, advocacy and guardianship for Victorians with a disability or mental illness and support for victims of crime. This objective supports identity protection of Victorians through life event registration, protection of children through adoption services and risk assessments for those working with or caring for children. The objective also contributes to public sector integrity, information freedoms and privacy protection of Victorians.

Objective 7: A fair marketplace for Victorian consumers and businesses with responsible and sustainable liquor and gambling sectors

This objective relates to harm minimisation through the regulation of the gambling and liquor industries. This objective promotes the empowerment of consumers and businesses to know their rights and responsibilities to promote a well-functioning market economy through regulation and support to consumers and businesses. There is a specific focus on the needs of vulnerable and disadvantaged consumers.

Changes to the output structure

The Department has made changes to its output structure for 2021-22 as shown in the table below.

2020-21 outputs	*Reason*	*2021-22 outputs*
Crime Prevention, Fines and Enforcement	This output has been disaggregated into two outputs (Community Crime Prevention, and Fines and Road Safety Enforcement) in 2021-22 to enhance transparency and alignment with ministerial portfolios. As part of this disaggregation, the Restorative Engagement and Redress Scheme for Victoria Police has also been transferred into Advocacy, Human Rights and Victim Support, which better aligns with the activity of the outputs.	Community Crime Prevention Fines and Road Safety Enforcement Advocacy, Human Rights and Victim Support
Protection of Vulnerable People, Human Rights and Victim Support	This output has been renamed in 2021-22 for clarity.	Advocacy, Human Rights and Victim Support
Protection of Children and Personal Identity	This output has been renamed in 2021-22 for clarity and to reflect the inclusion of NDIS screening services.	Protection of Children, Personal Identity and Screening Services

Source: Department of Justice and Community Safety

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2020-21 budget	*2020-21 expected outcome*	*2021-22 budget*	*Variation [(a)] %*
Ensuring community safety through policing, law enforcement and crime prevention activities				
Policing and Community Safety	3 668.0	3 671.7	3 702.8	0.9
Community Crime Prevention	43.1	40.4	20.9	(51.5)
Fines and Road Safety Enforcement	225.7	251.7	256.1	13.5
Reduce the impact of, and consequences from, natural disasters and other emergencies on people, infrastructure, the economy and the environment				
Emergency Management Capability	1 658.1	1 837.7	1.715.0	3.4
Effective management of prisoners and offenders and provision of opportunities for rehabilitation and reparation				
Community Based Offender Supervision	304.8	292.8	290.9	(4.6)
Prisoner Supervision and Support	1 415.5	1 458.2	1 384.4	(2.2)
Effective supervision of children and young people through the provision of youth justice services promoting rehabilitation				
Youth Justice Community Based Services	62.9	66.3	76.7	21.9
Youth Justice Custodial Services	176.3	179.7	191.3	8.5
A fair and accessible justice system that supports confidence in the Victorian community				
Public Prosecutions and Legal Assistance	347.0	349.4	355.2	2.4
Justice Policy, Services and Law Reform	229.7	239.5	212.9	(7.3)
Victorians are protected with equal opportunities, secure identities, information freedoms and privacy rights				
Advocacy, Human Rights and Victim Support	107.4	113.3	136.2	26.9
Protection of Children, Personal Identity and Screening Services	47.5	50.4	45.7	(3.8)
Public Sector Information Management, Privacy and Integrity	16.7	15.9	18.9	13.2
A fair marketplace for Victorian consumers and businesses with responsible and sustainable liquor and gambling sectors				
Regulation of the Victorian Consumer Marketplace	149.0	148.7	137.2	(7.9)
Gambling and Liquor Regulation	76.6	79.4	79.9	4.3
Total [(b)(c)]	**8 528.2**	**8 795.1**	**8 624.1**	**1.1**

Source: Department of Justice and Community Safety

Notes:

(a) Variation between 2020-21 budget and 2021-22 budget.

(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget *and CAC impacts are therefore excluded from the figures. Refer to individual output sections for comparative output costs inclusive of CAC.*

(c) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.12 outlines the Department's income from transactions and Table 2.13 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.12: Income from transactions **($ million)**

	2019-20 actual	*2020-21 budget*	*2020-21 revised*	*2021-22 budget [(a)]*
Output appropriations [(b)]	8 330.2	8 768.5	9 068.9	8 379.7
Special appropriations	3.5	8.2	9.5	5.1
Interest	36.9	25.2	25.2	27.1
Sale of goods and services	28.1	20.7	19.1	19.0
Grants	95.2	78.5	77.0	91.6
Fair value of assets and services received free of charge or for nominal consideration	6.2	..	..	..
Other income	50.8	44.4	47.1	38.9
Total income from transactions [(c)]	**8 550.8**	**8 945.7**	**9 247.0**	**8 561.4**

Source: Department of Justice and Community Safety

Notes:

(a) Includes an estimated $4.3 million of non-public account contributions in 2021-22.

(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget.

(c) Table may not add due to rounding.

Table 2.13: Parliamentary authority for resources **($ million)**

	2020-21 budget	*2020-21 revised*	*2021-22 budget*
Annual appropriations	**9 831.6**	**9 913.3**	**9 490.2**
Provision of outputs [(a)(b)]	8 419.2	8 774.4	8 108.7
Additions to the net asset base	1 254.0	980.6	1 328.5
Payments made on behalf of the State	158.4	158.4	53.0
Receipts credited to appropriations	**314.3**	**310.2**	**271.6**
Unapplied previous years appropriation	**115.0**	**115.0**	**..**
Provision of outputs	35.6	35.6	..
Additions to the net asset base	79.4	79.4	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**10 260.8**	**10 338.5**	**9 761.8**
Special appropriations	**137.9**	**149.2**	**120.9**
Trust funds	**165.7**	**164.0**	**180.5**
Residential Tenancy Fund [(c)]	28.8	28.8	30.5
Victorian Property Fund [(d)]	20.6	20.6	21.6
Victorian Responsible Gambling Trust [(e)]	36.8	36.8	38.4
Other [(f)]	79.5	77.9	90.1
Total parliamentary authority [(g)]	**10 564.5**	**10 651.8**	**10 063.2**

Source: Department of Justice and Community Safety

Notes:

(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget*.*

(b) Includes appropriation relating to the Victorian Law Reform Commission pursuant to section 17(b) of the Victorian Law Reform Commission Act 2000*.*

(c) The purpose of this trust primarily relates to holding Victorian residential tenancy bonds, including those on rented premises, long-term caravans, rooming houses and sites under site agreements.

(d) The purpose of this trust primarily relates to holding funds from license fees and fines paid by estate agents and can be used for various property-related purposes.

(e) The purpose of this trust primarily relates to programs to reduce the prevalence of problem gambling and to foster responsible gambling.

(f) Includes inter-departmental transfers.

(g) Table may not add due to rounding.

Departmental performance statement

Objective 1: Ensuring community safety through policing, law enforcement and crime prevention activities

This objective aims to provide a safe and secure environment for the Victorian community. This objective delivers on activities relating to the provision of effective policing, law enforcement and infringement processing services that aim to prevent, detect, investigate, and prosecute crime, and promote safer road user behaviour. It focuses on activities which enable Victorians to undertake their lawful pursuits confidently, safely and without fear of crime.

The departmental objective indicators are:

- community safety during the day and at night;
- community safety on public transport[(a)];
- crime statistics;
- road fatalities and injuries; and
- an effective fines system[(b)].

Notes:

(a) New objective indicator for 2021-22 to enhance reporting against this objective and for consistency with presentation of data in the Annual Report.

(b) New objective indicator for 2021-22, replacing the previous objective indicator 'infringements notices processed' to more effectively report on the Department's work in managing an effective fines system for all Victorians.

Outputs

Policing and Community Safety (2021-22: $3 702.8 million)

Victoria Police strives to reduce violence and crime through law enforcement, judicial support, community assistance, guidance, and leadership. The output reflects the Government's focus on reducing the overall incidence and fear of crime and enhancing the safety of individuals and families.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Community calls for assistance to which a Victoria Police response is dispatched	number	900 000	900 000	900 000
The expected outcome is based on previous years data and anticipated future trends, as there have been data extraction issues during 2020-21.				
Contravention of family violence intervention order (FVIO) offences per 100 000 population	number	720	861.1	670
The 2020-21 expected outcome is higher than the 2020-21 target due to increased targeted operations under Operation Ribbon focused on FV perpetrators. The restricted mobility of the community due to the coronavirus (COVID-19) pandemic has seen an increased number of reported family violence incidents. *The higher 2021-22 target reflects the organisation's heightened community safety focus.*				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Crimes against property – excluding family violence related crime (rate per 100 000 population)	number	4 200	3 622.40	4 200
The 2020-21 expected outcome is lower than the 2020-21 target due to the reduced movement of the community due to COVID-19 impacts.				
Crimes against property – family violence-related crime (rate per 100 000 population)	number	160	175.1	160
The 2020-21 expected outcome is higher than the 2020-21 target due to people being contained in the home under the Chief Health Officer's directions.				
Crimes against the person – excluding family violence related crime (rate per 100 000 population)	number	660	661.9	660
Crimes against the person – family violence related crime (rate per 100 000 population)	number	580	590.5	580
Number of alcohol screening tests conducted	number	3 000 000	1 100 000	3 000 000
The 2020-21 expected outcome is lower than the 2020-21 target due to COVID-19 impacts on operational policing activities.				
Number of prohibited drug screening tests conducted by booze and drug buses and highway patrol units	number	150 000	100 000	150 000
The 2020-21 expected outcome is lower than the 2020-21 target due to COVID-19 impacts on operational policing activities.				
Number of youth referrals	number	2 050	2 346	2 050
The 2020-21 expected outcome is higher than the 2020-21 target due to more youth referrals made than was expected using the previous data and the COVID-19 impact based on the first quarter.				
Police record checks conducted to contribute to community safety	number	703 000	632 000	703 000
The 2020-21 expected outcome is lower than the 2020-21 target due to Fingerprint Services being closed during lockdown and re-opening in November 2020. In addition, there were considerably less Jury lists due to court closures during the lockdown period. There was a decrease in external agency investigations / prosecutions as a direct result of the Chief Health Officer's directions.				
Total reported road fatalities in vehicle collisions	number	≤200	200	≤200
Total persons reported injured in vehicle collisions	number	15 000	14 156	15 000
The 2020-21 expected outcome is lower than the 2020-21 target due to the reduced traffic recorded over the past 12 months.				
Quality				
Perceptions of safety – walking locally at night	per cent	55	59	53
The 2020-21 expected outcome is higher than the 2020-21 target due to more people walking in the local area for exercise and the increase in police presence due to COVID-19 restrictions. *The higher 2021-22 target reflects recording of lower volume of crime and increasing community perception of safety.*				
Proportion of community satisfied with policing services (general satisfaction)	per cent	80	81	80
Proportion of drivers tested by road safety cameras who comply with posted speed limits	per cent	99.5	99.9	99.5
Proportion of drivers tested who return clear result for prohibited drugs – quality	per cent	93	89	93
Proportion of Family Incident Report affected family members receiving referrals	per cent	87	87.7	85
The higher 2021-22 target reflects the expectation of more referrals being issued with heightened community safety focus for Victoria Police.				
Proportion of successful prosecution outcomes	per cent	92	92	92
Proportion of the community who have confidence in police (an integrity indicator)	per cent	82	82	87
The 2020-21 expected outcome is lower than the 2020-21 target due to community interactions with police in relation to Chief Health Officer's directions. *The lower 2021-22 target reflects a five-year trend.*				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Timeliness				
Proportion of crimes against the person resolved within 30 days	per cent	45	44.2	45
Proportion of property crime resolved within 30 days	per cent	25	22.9	25
The 2020-21 expected outcome is lower than the 2020-21 target due to the reprioritisation of members to specialised operations over the 2019 Victorian Bushfire and COVID-19 response periods.				
Cost				
Total output cost	$ million	3 702.8	3 671.7	3 668.0
Total output cost including the CAC	*$ million*	*3 830.4*	*3 797.5*	*3 793.9*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Justice and Community Safety

Community Crime Prevention (2021-22: $20.9 million)

This output reports on activities relating to Crime Prevention through the Community Crime Prevention Program, which supports communities in preventing crime and addressing local crime issues. This output also reports on Countering Violent Extremism, which helps keep communities safe from violent extremism through the identification of individuals at risk of radicalisation.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number community members engaged in Crime Prevention capacity building activities, to increase community capability to deliver crime prevention initiatives	number	500	nm	nm
New performance measure for 2021-22 to enhance transparency and coverage of crime prevention activities by reporting on the number of community members attending crime prevention events.				
Quality				
Community Crime Prevention grant payments properly acquitted	per cent	100	100	100
Percentage of funded initiatives that support local communities to deliver innovative crime and community safety solutions in local areas; promote the development and delivery of collaborative, partnership approaches to crime prevention; or build community capability through knowledge sharing and strengthened relationships	per cent	100	nm	nm
New performance measure for 2021-22 to enhance transparency by reporting, within 12 months of project completion, on the percentage of projects funded under the Building Safer Communities Program that meet at least one of the published program objectives.				
Timeliness				
Outcomes of Crime Prevention funded projects published within 12 months of project completion	per cent	100	nm	nm
New performance measure for 2021-22 to enhance transparency and publish outcomes of projects within 12 months of project completion on the Crime Prevention website.				
Cost				
Total output cost	$ million	20.9	40.4	43.1
Total output cost including the CAC	*$ million*	*20.9*	*40.4*	*43.1*

New output in 2021-22, disaggregating the previous output 'Crime Prevention, Fines and Enforcement'. The 2020-21 expected outcome and 2020-21 target have been restated to reflect the new output.
The 2020-21 expected outcome is lower than the 2020-21 target mainly due to the transfer of components of the Crime prevention initiative to the Youth Justice Community-Based Services output. In addition, some crime prevention initiatives have been rephased into 2021-22.
The lower 2021-22 target mainly reflects the sunsetting of the Melbourne CBD security measures initiative in 2020-21 and a reducing funding profile for initiatives as announced in previous budget including the whole of Victorian building works package.
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.
This output did not have a provision for CAC in previous budgets.

Source: Department of Justice and Community Safety

Fines and Road Safety Enforcement (2021-22: $256.1 million)

This output reports on enforcement action by the Sheriff's Office of Victoria and the management of fines, warrants and infringement notices under this output serves as an administrative method for dealing with minor criminal offences.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Infringement notices processed	number (million)	2.7–2.9	1.68	2.7–2.9
The 2020-21 expected outcome is lower than the 2020-21 target due to the COVID-19 crisis which resulted in fewer fines referred to Fines Victoria. Significant factors were reduced traffic volumes and enforcement agencies COVID-19 response relating in fewer fines being referred.				
Warrants actioned	number	450 000	105 000	450 000
The 2020-21 expected outcome is lower than the 2020-21 target due to Sheriff Office of Victoria's inability to execute warrants due to COVID-19 restrictions. Alternative opportunities to increase warrant activity are being explored.				
Quality				
Proportion of images that are capable of supporting the issue of an infringement notice	per cent	95	95	95
This performance measure renames the 2020-21 performance measure 'Prosecutable images'. The new measure reports on the same activity as the previous measure but has been renamed for increased clarity.				
Timeliness				
Clearance of infringements within 180 days	per cent	75	67	75
The 2020-21 expected outcome is lower than the 2020-21 target mainly due to the suspension of debt campaigns for three months due to COVID-19 and the additional time to pay provided to fine recipients.				
Cost				
Total output cost	$ million	256.1	251.7	225.7
Total output cost including the CAC	*$ million*	*257.4*	*252.9*	*226.9*
New output in 2021-22, disaggregating the previous output 'Crime Prevention, Fines and Enforcement'. The 2020-21 expected outcome and 2020-21 target have been restated to reflect the new output. *The 2020-21 expected outcome is higher than the 2020-21 target mainly due to incremental funding from initiatives announced in previous budgets including Technology and resources to support Victoria's fines system and the Road safety package.* *The higher 2021-22 target mainly reflects funding released after the* 2020-21 Budget *for the Technology and resources to support Victoria's fines system initiative.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Justice and Community Safety

Objective 2: Reduce the impact of, and consequences from, natural disasters and other emergencies on people, infrastructure, the economy and the environment

This objective aims to deliver a coordinated, all communities, all emergencies approach to emergency management, focusing on risk mitigation and active partnership with the Victorian community.

Emergency management encompasses prevention, preparation and planning for, responding to and recovering from natural disasters (such as bushfires, floods and severe storms), the consequences of terrorism, hazardous material incidents (such as chemical spills and gas leaks), and individual and personal emergencies (such as land and sea rescues, car accidents and residential and commercial fires).

The departmental objective indicators are:

- value of domestic fire insurance claims; and
- rate of deaths from fire events.

Outputs

Emergency Management Capability (2021-22: $1 715.0 million)

This output provides for the management of emergencies by developing and adopting emergency prevention and mitigation strategies, providing fire suppression and road crash rescue services, and supporting local government and communities in disaster mitigation and recovery. Key components of this output reduce the level of risk to the community of emergencies occurring and the adverse effects of emergency events, such as death and injury rates.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Permanent operational staff	number	3 722	3 514	3 722
The 2020-21 expected outcome is lower than the 2020-21 target due to the COVID-19 pandemic impacting the ability to recruit and train new operational staff.				
Permanent support staff	number	1 618	1 608	1 560
The higher 2021-22 target reflects extra positions created as part of the Fire Service Reforms.				
Volunteers – Operational	number	40 000 – 41 000	34 478	43 000 – 44 000
The 2020-21 expected outcome is lower than the 2020-21 target due to a reclassification of operational staff to support staff, to ensure that only those with current and appropriate training were classified as operational. *The 2021-22 target has been reduced to reflect the optimum number of operational volunteers as the previous target represented a significant amount of excess capability.*				
Volunteers – Support	number	24 000 – 25 000	24 629	21 000 – 22 000
The 2020-21 expected outcome is higher than the 2020-21 target due to a reclassification of operational staff to support staff, to ensure that only those with current and appropriate training were classified as operational. The 2021-22 target has been increased to reflect Victoria's capacity to respond to emergencies.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quality				
Level 3 Incident Controller trained staff and volunteers	number	70	67	96
The 2020-21 expected outcome is lower than the 2020-21 target due to the COVID-19 pandemic and associated restrictions delaying the reaccreditation process. *The 2021-22 target is indicative only of accredited personnel funded through the Emergency Management Capability Output. Additional capability exists within the DELWP portfolio.*				
Road accident rescue accredited brigades/units	number	131	131	131
Structural fire confined to room of origin	number	80	78	80
Timeliness				
Emergency response times meeting benchmarks – emergency medical response	per cent	90	93	90
Emergency response times meeting benchmarks – road accident rescue response	per cent	90	87	90
Emergency response times meeting benchmarks – structural fires	per cent	90	90	90
Cost				
Total output cost	$ million	1 715.0	1 837.7	1 658.1
Total output cost including the CAC	*$ million*	*1 719.1*	*1 842.0*	*1 662.4*
The 2020-21 expected outcome is higher than the 2020-21 target mainly due to funding for new initiatives announced in the 2021-22 Budget *including COVID-19 Quarantine Victoria, High Risk Industries: Engagement and Enforcement Operation and Emergency management sector reform: implementation of reviews and inquiries. This is partly offset by a reduction in expenses estimated for the Emergency Management Operations Communication Trust in 2021-22.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Justice and Community Safety

Objective 3: Effective management of prisoners and offenders and provision of opportunities for rehabilitation and reparation

This objective relates to the management of the State's adult correctional system. The overarching purpose of the correctional system is to promote community safety through community-based and custodial supervision of prisoners and offenders through effective management and services to provide opportunities for rehabilitation and reparation.

The departmental objective indicators are:

- escapes from corrective facilities;
- percentage of community corrections orders completed;
- rate of prisoner return to prison within two years; and
- rate of offender return to corrective services within two years.

Community Based Offender Supervision (2021-22: $290.9 million)

This output relates to the effective supervision of offenders in the community, including ensuring compliance with orders of the court and Adult Parole Board, engagement in programs to reduce reoffending and reparation to the community.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Average daily offenders with reparation orders	number	2 900	847	2 900
The 2020-21 expected outcome is lower than the 2020-21 target due to a significant slowdown of fine orders being issued following reforms to the fines system, compounded by the impact of COVID-19 on criminal justice system activity.				
Average daily offenders with supervised court orders	number	11 750	6 992	11 750
The 2020-21 expected outcome is lower than the 2020-21 target due to a decrease in the number of community correction orders imposed by courts, compounded by the impact of COVID-19 on criminal justice system activity.				
Average daily prisoners on parole	number	1 000	911	1 000
The 2020-21 expected outcome is lower than the 2020-21 target due to the ongoing impact of reforms to Victoria's parole system and other sentencing changes in recent years.				
Community work hours performed	number	700 000	352 708	700 000
The 2020-21 expected outcome is lower than the 2020-21 target due to a combination of factors, including fewer hours being ordered by the courts, fewer fine orders being issued and the adverse impact of COVID-19 restricting in-person attendance at community work sites.				
Quality				
Rate of return to corrective services within two years of discharge from a community corrections order	per cent	16	13	16
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 restrictions, with changes to criminal justice system activity resulting in fewer supervised court orders being registered during 2020. This in turn reduced the rate of ex-offenders returning to corrective services.				
Successful completion of parole orders	per cent	75	81.7	75
The 2020-21 expected outcome is higher than the 2020-21 target due to the ongoing impact of improvements to the operation of Victoria's parole system.				
Successful completion of reparation orders	per cent	68	62.8	68
The 2020-21 expected outcome is lower than the 2020-21 target due to a combination of factors, including an increase in concurrent orders impacting on successful completions and a reduction in fine order completions arising from transitioning to a new fines system.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Successful completion of supervised court orders	per cent	65	60.6	62
The higher 2021-22 target reflects ongoing improvements to the operation of community-based offender supervision.				
Percentage of community work hours ordered that are completed	per cent	70	69.2	70
Successful completion of violence-related programs for family violence offenders in community corrections	per cent	70	60.3	70
The 2020-21 expected outcome is lower than the 2020-21 target due to disruptions in program delivery due to COVID-19 restrictions that made face-to-face client engagement challenging, and the implementation of new Men's Behaviour Change Minimum Standards which have lengthened the duration of the program.				
Timeliness				
Offenders with a treatment or rehabilitation program condition who have been appropriately referred to a program	per cent	95	95.7	95
Cost				
Total output cost	$ million	290.9	292.8	304.8
Total output cost including the CAC	*$ million*	*295.0*	*297.0*	*309.0*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Justice and Community Safety

Prisoner Supervision and Support (2021-22: $1 384.4 million)

This output relates to the safe, secure, and humane containment of prisoners as well as the delivery of programs and effective case management to engage prisoners in positive behavioural change.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Average daily male prison utilisation rate of total male prison capacity	per cent	85–90	80.7	90–95
The 2020-21 expected outcome is lower than the 2020-21 target due to a decrease in the number of male prisoners during the COVID-19 pandemic period. The capacity of the men's prisons has remained stable. The lower 2021-22 target reflects the expected impact of reduced prisoner numbers.				
Average daily female prison utilisation rate of total female prison capacity	per cent	85–90	66.6	90–95
The 2020-21 expected outcome is lower than the 2020-21 target due to a decrease in the number of female prisoners during the COVID-19 pandemic period. The capacity of the women's prisons has remained stable. The lower 2021-22 target reflects the expected impact of reduced prisoner numbers.				
Annual daily average number of male prisoners	number	7 100 – 7 518	6 738	7 996 – 8 440
The 2020-21 expected outcome is lower than the 2020-21 target due to slower than forecast growth in male prisoner numbers, arising largely from the impact of changes to criminal justice system activity during the COVID-19 restrictions. The lower 2021-22 target reflects expected prison system capacity and target utilisation rate.				
Annual daily average number of female prisoners	number	544 – 576	426	582 – 614
Total annual number of random drug tests undertaken	number	10 492 – 11 110	9 572	11 824 – 12 481
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to a decrease in prisoner numbers which is attributed to the impact of changes to criminal justice system activity during the COVID-19 pandemic. The lower 2021-22 target reflects the expected impact of reduced prisoner numbers.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quality				
Proportion of benchmark measures in prison services agreement achieved	per cent	90	82.8	90
The 2020-21 expected outcome is lower than the 2020-21 target due to the COVID-19 restrictions in prisons, which impacted the ability of prisons and providers to deliver services, along with continued pressures on the prison system from an increased remand population.				
Proportion of eligible prisoners in employment	per cent	89	92.1	89
Rate of prisoner participation in education	per cent	36	35.9	36
Rate of return to prison within two years	per cent	41	44.1	41
The 2020-21 expected outcome is higher than the 2020-21 target due to an increase in prisoners returning to custody with shorter sentences and more prisoners returning to prison on remand within two years and subsequently receiving a sentence.				
Percentage of positive random drug tests	per cent	5	2.9	5
The 2020-21 expected outcome is lower than the 2020-21 target due to the restriction of prisoner movements and prison visits as part of the COVID-19 pandemic restrictions, which limited the availability of contraband.				
Percentage of education modules successfully completed	per cent	80	83.4	80
Average daily out-of-cell hours – secure prisons	number	10.5	9	10.5
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 restrictions which led to restricted movements for prisoners across quarter four 2020.				
Average daily out-of-cell hours – open prisons	number	14	13.9	14
Timeliness				
Assessment of prisoners 'at risk' undertaken within two hours	per cent	100	99.8	100
Proportion of prisoner risk assessments completed within set timeframes	per cent	95	99.1	95
Cost				
Total output cost	$ million	1 384.4	1 458.2	1 415.5
Total output cost including the CAC	*$ million*	*1 668.2*	*1 683.9*	*1 641.2*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Department of Justice and Community Safety

Objective 4: Effective supervision of children and young people through the provision of youth justice services promoting rehabilitation.

This objective aims to promote opportunities for rehabilitation of children and young people in the youth justice system and contribute to the reduction of crime in the community by providing a range of services including diversion services, advice to courts, offence-related programs, community-based and custodial supervision.

The departmental objective indicators are:

- percentage of community-based orders successfully completed; and
- young people in youth justice participating in community reintegration activities.

Youth Justice Community Based Services (2021-22: $76.7 million)

This output provides community statutory supervision and support to young people subject to community-based dispositions in order to divert young people from the youth justice system and minimise the likelihood of further offending.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Average daily number of young people under community-based supervision	number	800	760	800
The 2020-21 expected outcome is lower than the 2020-21 target due to a reduction in young people under community-based supervision due to a focus on diversion. This reduction represents a redirection of young people from the Youth Justice System.				
Proportion of young people in youth justice under community-based supervision	per cent	85	85	85
Quality				
Community-based orders completed successfully	per cent	88	90	85
The 2020-21 expected outcome is higher than target due to the higher proportion of young people successfully completing their orders. The higher 2021-22 target reflects this trend.				
Timeliness				
Young people on supervised orders who have a case plan completed within six weeks of the commencement of the order	per cent	95	95	95
Cost				
Total output cost	$ million	76.7	66.3	62.9
Total output cost including the CAC	*$ million*	*76.7*	*66.3*	*62.9*
The 2020-21 expected outcome is higher than the 2020-21 target mainly due to the transfer of funds following the 2020-21 Budget *that support the diversion of children and young people away from the Youth Justice system.*				
The higher 2021-22 target mainly reflects funding in the 2021-22 Budget *and funding previously allocated under the custodial output group that supports the diversion of children and young people from the Youth Justice system in the community.*				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget*.*				
The CAC is discontinued from the 2021-22 Budget*.*				
This output did not have a provision for CAC in previous budgets.				

Source: Department of Justice and Community Safety

Youth Justice Custodial Services (2021-22: $191.3 million)

This output provides supervision and rehabilitation, through the provision of case management, health and education services and the establishment of structured community supports, to assist young people to address offending behaviour, develop non-offending lifestyles and support reintegration of young people into the community on their exit from custody.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Annual daily average number of young people in custody – male (under 15 years) and female	number	15 – 25	20	15 – 25
Annual daily average number of young people in custody – males (15 years plus)	number	210 – 250	170	210 – 250
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to a decline in the number of young people in custody across the 2020-21 year due to a focus on diversion. This reduction represents a redirection of young people from the Youth Justice System.				
Average daily custodial centre utilisation rate of total centre capacity – males (15 years plus)	per cent	90 – 95	72	90 – 95
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to a decline in the number of young people in custody across the 2020-21 year due to a focus on diversion. This reduction represents a redirection of young people from the Youth Justice System.				
Average daily custodial centre utilisation rate of total centre capacity – males (under 15 years) and female	per cent	60 – 80	70	60 – 80
Average daily number of Aboriginal children and young people (10-17 years) in custody	number	14 – 18	18	16 – 20
The lower 2021-22 target reflects the priority to divert more Aboriginal children from Youth Justice custody.				
Quality				
Young people in youth justice participating in community re-integration activities	per cent	80	20	80
The 2020-21 expected outcome is lower than the 2020-21 target as temporary leave from custody to undertake re-integration activities had been suspended for large parts of the financial year safety reasons to reduce transmission of COVID-19.				
Timeliness				
Young people on custodial orders who have a case plan completed within six weeks of the commencement of the order	per cent	95	95	95
Cost				
Total output cost	$ million	191.3	179.7	176.3
Total output cost including the CAC	*$ million*	*250.6*	*236.4*	*233.0*
The higher 2021-22 target reflects funding announced in the 2021-22 Budget*, including the opening of Cherry Creek and funding to support historical abuse claims. This is partially offset by a redirection of funding to the community output to support early intervention and diversion.*				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget*.*				
The CAC is discontinued from the 2021-22 Budget*.*				

Source: Department of Justice and Community Safety

Objective 5: A fair and accessible justice system that supports confidence in the Victorian community

This objective relates to the provision of and access to justice services that support legal processes and law reform. Services that support legal processes include legal assistance and education services, prosecution services and the delivery of independent, expert forensic medical services to the justice system.

Other services that contribute to this objective include legal policy advice to government, law reform, dispute resolution and initiatives focusing on crime prevention and supporting Kooris in the criminal justice system.

The departmental objective indicators are:

- prosecutions completed and returning guilty outcomes (OPP (percentage of total case finalisations);
- legal advice and assistance provided (VLA);
- law reform projects completed (VLA);
- medico legal death investigations (VIFM);
- number of Sentencing Advisory Council publications (SAC); and
- dispute resolution services provided in the Dispute Settlement Centre of Victoria (DSCV).

Public Prosecutions and Legal Assistance (2021-22: $355.2 million)

This output delivers activities relating to Victoria's public prosecutions service and Victoria Legal Aid (VLA).

The Office of Public Prosecutions (OPP) provides an independent, effective, and efficient prosecutions service on behalf of the Director of Public Prosecutions (DPP). In addition to the prosecution of serious crimes, the OPP also provides professional support to prosecution witnesses and victims of crime involved in its cases.

VLA is an independent statutory authority that provides a range of legal services for both Victorian and Commonwealth law matters. These services include legal representation, legal advice, advocacy, and education services.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Judicial Officer sitting days requiring prosecutors (OPP)	number	11 000 – 13 000	11 800	11 000 – 13 000
Number of briefs prepared, and hearings attended (OPP)	number	74 500 – 78 500	81 500	72 500 – 78 500
The higher 2021-22 target reflects a general upward trend in this measure, with increased court hearing numbers across all court jurisdictions.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Number of victim and witness consultations (OPP)	number	34 000 – 36 000	35 000	12 500 – 14 500
The 2020-21 expected outcome is higher than the 2020-21 target due to increased victim and witness engagement undertaken by OPP solicitors, both generally to meet obligations under the Victims Charter Act 2006*, and specifically to victims and witnesses apprised of progress of their case under the changing court listings in response to the COVID-19 pandemic. The higher 2021-22 target reflects the additional activity undertaken by the OPP in response to its victim and witness engagement obligations reflecting changes to the* Victims Charter Act 2006*.*				
Community legal education and information services (VLA) – excluding family violence-related services	number	101 000 - 103 000	84 000	105 000 – 115 000
The 2020-21 expected outcome is lower than the 2020-21 target due to a period of decreased operating hours of the Legal Help services and increasing complexity of advice which lengthens call times. The lower 2021-22 target reflects changes within the Legal Help service, with COVID-19 funded roles ending early in the 2021-22 year, and disruption due to the implementation of new technology to assist in decreasing wait times, which in turn has adversely impacted the service's ability to deliver information sessions.				
Community legal education and information services (VLA) – family violence related services	number	26 000 – 28 000	22 000	26 000 – 28 000
The 2020-21 expected outcome is lower than the 2020-21 target due to a period of decreased operating hours of the Legal Help services and increasing complexity of advice which lengthens call times.				
Duty lawyer services – excluding family violence related services (VLA)	number	69 000 – 71 000	38 000	69 000 – 71 000
The 2020-21 expected outcome is lower than the 2020-21 target due to the lower number of cases being heard at courts and tribunals as part of the public health response to the COVID-19 pandemic.				
Grants of legal assistance provided by VLA – excluding family violence-related services	number	32 900	30 000	32 900
The 2020-21 expected outcome is lower than the 2020-21 target due to the lower number of cases being heard at courts and tribunals as part of the public health response to the COVID-19 pandemic.				
Legal advice and minor assistance for clients – excluding family violence-related services (VLA)	number	40 000 – 42 000	29 000	40 000 – 42 000
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to an increase in the complexity of advice provided which increases the length of time of delivery, reducing staff availability to answer information calls.				
Family violence legal services (VLA)	number	46 000	38 000	45 000
The 2020-21 expected outcome is lower than the 2020-21 target due to the cumulative effect of a lower number of family violence-related cases being heard at courts and tribunals as part of the public health response to the COVID-19 pandemic. The higher 2021-22 target reflects an anticipated return to pre-pandemic service delivery levels.				
Number of unique clients who accessed one or more of VLA's legal services	number	105 000	79 000	105 000
The 2020-21 expected outcome is lower than the 2020-21 target due to the lower number of cases being heard at courts and tribunals owing to the COVID-19 restrictions.				
Quality				
Guilty outcomes (guilty pleas and trial convictions) as a percentage of case completions (OPP)	per cent	89	92	89
Client satisfaction with services provided by Victoria Legal Aid	per cent	80	94	80
The 2020-21 expected outcome is higher than the 2020-21 target but is statistically unreliable and needs to be treated with caution. This is due to a small sample size as a result of the inability to access clients to undertake the revised survey process.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Timeliness				
Proportion of trials listed which did not proceed to adjournment on application of the Crown (OPP)	per cent	99	99	99
Average call wait time to the Legal Help phone line (VLA)	minutes	<15	18	<10
The 2020-21 expected outcome is higher than the 2020-21 target due to a number of factors, the ongoing impacts of the COVID-19 pandemic, VLA temporarily reducing operating hours of Legal Help to accommodate wellbeing challenges with staff working from home and the increasing complexity of matters requiring advice. *The higher 2021-22 target reflects the anticipated adverse impacts of the increasing complexity of information and advice sought, the continuing impacts of the COVID-19 pandemic and the end of COVID-19 funded roles.*				
Cost				
Total output cost	$ million	355.2	349.4	347.0
Total output cost including the CAC	*$ million*	355.3	349.5	347.1
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Justice and Community Safety

Justice Policy, Services and Law Reform (2021-22: $212.9 million)

This output delivers a broad range of services including the provision of law reform and sentencing advisory information. It also includes forensic medical services and medico legal advice provided through the Victorian Institute of Forensic Medicine (VIFM), practical legal solutions and strategic advice to through the Victorian Government Solicitor's Office (VGSO) and dispute resolution and mediation services to members of the community through the Dispute Settlement Centre of Victoria (DSCV).

This output also reports on the activities of the Native Tile Unit (NTU) and the Koori Justice Unit (KJU). The NTU seeks to increase the economic, social, and cultural development of traditional owner communities by negotiating comprehensive settlements of native title claims. The KJU focuses on Victoria's commitment to the Aboriginal Justice Agreement and other initiatives focused on crime prevention and reducing reoffending of Kooris in the criminal justice system.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Clinical forensic medical services by the Victorian Institute of Forensic Medicine (VIFM)	number	2 600 – 3 000	3 500	2 300 – 2 700
The 2020-21 expected outcome is higher than the 2020-21 target due to increased demand from Victoria Police. The higher 2021-22 target reflects the increased demand for VIFM services.				
Medico legal death investigations (VIFM)	number	6 450 – 6 950	7 200	6 150 – 6 550
The 2020-21 expected outcome is higher than the 2020-21 target due to increased demand. The higher 2021-22 target reflects the increased demand for VIFM services.				
Provision of expert forensic medical and scientific evidence in court (VIFM)	number	150 – 250	150	150 – 250
Community education and consultation sessions conducted by Victorian Law Reform Commission (VLRC)	number	100	100	100
Law reform projects conducted by VLRC	number	3	3	3

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Number of Sentencing Advisory Council (SAC) publications	number	6	6	6
Grant and program funding administered by the KJU provided to Aboriginal Community Controlled Organisations (ACCOs)	per cent	95	95	95
Number of Recognition and Settlement Agreements that commence (NTU)	number	3	nm	nm
New performance measure for 2021-21 to better reflect the work of the Aboriginal Justice group in commencing settlement agreements, including Eastern Maar Stage A, Wotjobaluk and Gunaikurnai in 2021-22.				
Dispute resolution services provided in the Dispute Settlement Centre of Victoria (DSCV)	number	25 000	11 000	25 000
The 2020-21 expected outcome is lower than the 2020-21 target due to reduced operating capacity as a result of COVID-19 restrictions and the reallocation of staff to the Residential Tenancies Dispute Resolution Scheme.				
Quality				
Audited medico legal death investigation reports with no significant diagnostic errors (VIFM)	per cent	95	95	95
Teachers and students who are satisfied with education programs delivered by VLRC	per cent	85	na	85
The 2020-21 expected outcome is n/a as the survey results for VLRC's education programs will not be compiled owing to the impact of COVID-19 restrictions, which curtailed the operation of the VLRC's education programs.				
Client satisfaction with quality of legal advice provided (VGSO)	per cent	85	85	85
Overall client satisfaction rate (DSCV)	per cent	85	na	85
The 2020-21 expected outcome is n/a as data for this measure is unavailable due to resources being diverted to Residential Tenancies Dispute Resolution Scheme. There has been a reduction of services within the standard dispute resolution space due to this diversion and surveys were unable to be sent due to files not progressing past the information and advice stage.				
Settlement rate of mediation (DSCV)	per cent	65	80	65
The 2020-21 expected outcome is higher than the 2020-21 target due to a small number of matters that were listed for mediation as urgent matters.				
Timeliness				
Medical and scientific investigations on the body of the deceased completed within two days (VIFM)	per cent	75 – 85	68	75 – 85
The 2020-21 expected outcome is lower than the 2020-21 target owing to flow-on impacts of increased demand across VIFM's suite of mandated service deliverables.				
Medico-legal death investigation reports issued within agreed period (VIFM)	per cent	60 – 70	62	60 – 70
Client satisfaction with timeliness of legal advice provided (VGSO)	per cent	85	85	85
Proportion of Native Title negotiations progressed in accordance with the Department's annual work plan and timeframes monitored by the Federal Court (NTU)	per cent	100	100	100
Intake and mediation services conducted within agreed timeframes by the DSCV	per cent	85	100	85
The 2020-21 expected outcome is higher than the 2020-21 target due to a small number of matters that progress beyond the information and advice stage. Information and advice has been delivered within agreed timeframes.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Cost				
Total output cost	$ million	212.9	239.5	229.7
Total output cost including the CAC	*$ million*	*220.2*	*246.8*	*237.0*

The lower 2021-22 target reflects lapsing funding for initiatives as announced in previous budgets including Native title implementation team and settlements. This is partly offset by funding announced in the 2021-22 Budget *including Royal Commission into the Management of Police Informants, Supporting the State's forensic capability and Preventing Aboriginal deaths in custody.*

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.

The CAC is discontinued from the 2021-22 Budget.

Source: Department of Justice and Community Safety

Objective 6: Victorians are protected with equal opportunities, secure identities, information freedoms and privacy rights

This objective aims to support the Victorian community through the provision of services relating to rights and equal opportunity, advocacy, and guardianship for Victorians with a disability or mental illness and support for victims of crime.

The objective supports identity protection of Victorians through life event registration, protection of children through adoption services and risk assessments for those working with or caring for children.

The objective also contributes to public sector integrity, information freedoms and privacy protection of Victorians.

The departmental objective indicators are:

- complaint files received and handled by the Victorian Equal Opportunity and Human Rights Commission (VEOHRC);
- people assisted through Public Advocate advice and education activities (OPA);
- services provided to victims of crime against the person (VSA);
- births, deaths and marriages registration transaction accuracy rate (BDM);
- Working with Children and NDIS Checks processed (negative notices issued within three days of receiving decision)[a]; and
- education and training activities delivered by the Office of Victorian Information Commissioner (OVIC).

Note:

[a] *New objective indicator for 2021-22 replacing the previous objective indicator 'Working with Children Checks processed (negative notices issued within three days of receiving decision) to provide better insight into the DJCS objective of 'Victorians are protected with equal opportunities, secure identities, information freedoms and privacy rights'.*

Advocacy, Human Rights and Victim Support (2021-22: $136.2 million)

This output focuses on the delivery of services aimed at protecting vulnerable people, supporting victims and safeguarding human rights through the work of the Office of the Public Advocate (OPA), the Victim Support Agency (VSA) and the Victorian Equal Opportunity and Human Rights Commission (VEOHRC). OPA protects the rights, interests, and dignity of people with disability and mental illness. VSA provides support to victims of crime with practical assistance, counselling, and support through the justice system. VEOHRC provides education and capacity building to protect and promote human rights in Victoria.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Complaint files received and handled by VEOHRC	number	900 – 1 050	1 200	900 – 1 050
The 2020-21 expected outcome is higher than the 2020-21 target due to a substantial increase in the number of complaints received. The increased demand is, for the most part, directly related to the impact of the COVID-19 pandemic.				
Education and consultancy sessions delivered by VEOHRC	number	600	600	350
The 2020-21 expected outcome is higher than the 2020-21 target due to inclusion of completed eLearning modules delivered by the Commission. *The higher 2021-22 target reflects increased delivery of eLearning programs to clients to accommodate significantly changed working arrangements for the workforce.*				
Information and advice provided by VEOHRC	number	8 000 – 8 500	8 000	8 000 – 8 500
Information and advice provided by OPA	number	11 334 – 13 306	12 560	11 334 – 13 306
Community education sessions (OPA)	number	150 – 190	90	150 – 190
The 2020-21 expected outcome is lower than the 2020-21 target due to the substantial adverse impact of COVID-19 restrictions on service delivery in the first half of the 2020-21 financial year.				
Public Advocate auspiced volunteer interventions for people with disability (OPA)	number	7 900 – 8 200	7 200	7 900 – 8 200
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 restrictions on the provision of face-to-face interview requests for an Independent Third Party and permitted visits to facilities.				
New guardianship and investigation orders of VCAT actioned by OPA	number	1 340 – 1 480	1 348	1 340 – 1 480
Advocacy matters opened by OPA	number	348 – 389	370	348 – 389
Decisions made by the Public Advocate under the *Medical Treatment Planning and Decisions Act 2016* (OPA)	number	464 – 533	420	464 – 533
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 restrictions on requests for this service.				
Victims receiving a service from the Victims of Crime Helpline, Victims Register, Youth Justice Group Conferencing and Victims Support (VSA)	number	23 500	25 000	23 500
The 2020-21 expected outcome is higher than the 2020-21 target due to an increase in L17 referrals from Victoria Police to the Victims of Crime Helpline for male victims of family violence during the COVID-19 pandemic.				
Victims receiving a service from the Victims Assistance Program (VSA)	number	12 000	10 375	12 000
The 2020-21 expected outcome is lower than the 2020-21 target due to a reduction in referrals from Victoria Police to the Victims Assistance Program (VAP) during the COVID-19 pandemic. This resulted in less referrals being made to the VAP for 'new' clients.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quality				
Customer satisfaction rating – Education and consultancy sessions delivered by VEOHRC	per cent	85	85	85
Customer satisfaction rating – Conciliation delivered by VEOHRC	per cent	85	95	85
The 2020-21 expected outcome is higher than the 2020-21 target due to the continuous improvement activities undertaken to monitor and adapt services, such as introducing video conferencing owing to the impact of the COVID-19 pandemic.				
Settlement rate of conciliation (VEOHRC)	per cent	65	65	65
Client satisfaction with victim services	per cent	80	nm	nm
New performance measure for 2021-22 to assess the effectiveness of services provided to victims of crime.				
Timeliness				
VEOHRC complaints finalised within six months	per cent	85	85	85
Average number of days a guardianship or investigation order of VCAT is held on a wait list prior to being allocated to a delegated officer by the Public Advocate (OPA)	number	15 – 19	17.1	15 – 19
Confiscated assets sold or destroyed within 90 days	per cent	85	55	85
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 restrictions on the sale of forfeited property via public auctions which are held in person by Victoria Police. There is a significant backlog of property which needs to be sold, however capacity of personnel and not flooding the second-hand market are the inhibitors.				
Cost				
Total output cost	$ million	136.2	113.3	107.4
Total output cost including the CAC	*$ million*	*136.3*	*113.3*	*107.4*
The Restorative Engagement and Redress Scheme for Victoria Police employees initiative has transferred from the previous output 'Crime Prevention, Fines and Enforcement'. The comparatives have been reinstated to reflect this change.				
The higher 2021-22 target reflects funding approved in the 2021-22 Budget *including Restorative Engagement and Redress Scheme for Victoria Police employees, Justice response to family violence and Supporting vulnerable Victorians and Honorary Justices, and incremental funding for initiatives announced in previous budgets including Making our buildings safer.*				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				
This output did not have a provision for CAC in previous budgets.				

Source: Department of Justice and Community Safety

Protection of Children, Personal Identity and Screening Services

(2021-22: $45.7 million)

This output supports the protection of children through adoption services and in protecting children from sexual and physical harm by providing screening of persons who work with or care for, children and screening of persons engaged in risk assessed roles for the purposes of the National Disability Insurance Scheme. This output protects personal identity through the registration of significant life events by the Victorian Registry of Births, Deaths and Marriages (BDM).

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of Working with Children and NDIS checks processed	number (thousand)	380 – 420	350	400 – 450
This performance measure has been renamed from 'Number of Working with Children checks processed' to 'Number of Working with Children and NDIS checks processed' in 2021-22 to reflect the inclusion of screening for the National Disability Insurance Scheme. *The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 on demand for services. The lower 2021-22 target reflects the expected demand based on prior years, outside the impact of COVID-19 from 1 February 2021.*				
Number of Adoption Records released	number	350	350	350
Quality				
Births, Deaths and Marriages registration transaction accuracy rate (BDM)	per cent	99	99	99
Customer satisfaction rating – BDM service centre	per cent	85	na	85
The 2020-21 expected outcome is n/a due to the closure of the customer service centre since late March 2020 due to COVID-19. As a result of the closure, survey data could not be collected.				
Clearances for Working with Children and NDIS checks issued within three days of receiving a clear notification	per cent	98	98	98
This performance measure has been renamed from 'Working with Children Checks – Assessment issued within three days of receiving a clear notification' for increased clarity and to reflect the inclusion of screening for the National Disability Insurance Scheme from 1 February 2021.				
Exclusions for Working with Children and NDIS checks issued within three days of receiving the delegate's decision	per cent	100	100	100
This performance measure has been renamed from 'Working with Children Checks – Assessment issued within three days of receiving a clear notification' to 'Exclusions for Working with Children and NDIS checks issued within three days of receiving the delegate's decision' in 2020-21 for increased clarity and to reflect the inclusion of screening for the National Disability Insurance Scheme from 1 February 2021.				
Timeliness				
Average number of days to process compliant applications for birth, death, and marriage certificates	per cent	<10	7.7	<10
This performance measure has been edited for 2021-22 from 'Compliant applications for birth, death and marriage certificates processed within ten days of receipt (BDM)' to 'Average number of days to process compliant applications for birth, death and marriage certificates'. The new measure reports on the same activity as the previous measure but has been amended to reflect changes to processing timeframes resulting from updates to BDM's operating model.				

Performance measures	Unit of measure	2021-22 target	2020-21 expected outcome	2020-21 target
Cost				
Total output cost	$ million	45.7	50.4	47.5
Total output cost including the CAC	*$ million*	*45.7*	*50.4*	*47.5*
The 2020-21 expected outcome is higher than the 2020-21 target due to incremental funding approved in the 2021-22 Budget *for the Working with Children Check and National Disability Insurance Scheme worker screening* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Justice and Community Safety

Public Sector Information Management, Privacy and Integrity (2021-22: $18.9 million)

This output provides for the function of the Victorian Information Commissioner, which has oversight of the Victorian government's collection, use and disclosure of information. The Information Commissioner enhances the Victorian government's transparency and openness and oversees the Victorian Protective Data Security regime. This output also includes the function of the Local Government Inspectorate, that contributes to public sector integrity by ensuring Victorian councils follow the *Local Government Act 2020*.

Performance measures	Unit of measure	2021-22 target	2020-21 expected outcome	2020-21 target
Quantity				
Education and training activities delivered by Office of the Victorian Information Commissioner	number	120	120	120
Regulatory actions conducted: Examinations, reviews, audits or investigations	number	5	3	5
The 2020-21 expected outcome is lower than the 2020-21 target due to COVID-19 restrictions in visiting sites, particularly scheduled in-person site inspections of Victoria Police facilities.				
Reviews and complaints closed by Office of the Victorian Information Commissioner	number	950	950	850
The 2020-21 expected outcome is higher than the 2020-21 target due to the increased number of reviews and complaints received by OVIC and improvements made to OVIC's business processes that provide for the timelier conduct of reviews and handling of complaints. *The higher 2021-22 target reflects increased number of reviews and complaints received by OVIC and improvements made to OVIC's business processes that provide for the timelier conduct of reviews and handling of complaints.*				
Quality				
Local Government Inspectorate (LGI) Governance recommendations adopted and implemented by councils	per cent	100	100	100
Client satisfaction with education and training provided	per cent	90	90	90
FOI review decisions overturned or set aside on appeal to VCAT	per cent	<25	25	<25
FOI reviews withdrawn by agreement following internal resolution	per cent	25	25	25

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Timeliness				
FOI reviews completed within timelines agreed with applicant	per cent	60	60	60
Complaints received by the Local Government Inspectorate assessed and actioned within five working days	per cent	95	85	95
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 remote working arrangements and the high number of complaints arising out of the October 2020 local government elections.				
Councillor serious misconduct matters referred to Conduct Panel within 30 days of allegations being substantiated	per cent	100	100	100
Cost				
Total output cost	$ million	18.9	15.9	16.7
Total output cost including the CAC	*$ million*	*19.0*	*16.0*	*16.8*
The higher 2021-22 target mainly reflects new funding for Safeguarding human rights and accountability in the information age announced in the 2021-22 Budget.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Department of Justice and Community Safety

Objective 7: A fair marketplace for Victorian consumers and businesses with responsible and sustainable liquor and gambling sectors

This objective relates to harm minimisation through the regulation of the gambling and liquor industries. This objective promotes the empowerment of consumers and businesses to know their rights and responsibilities to promote a well-functioning market economy through regulation and support to consumers and businesses. There is a specific focus on the needs of vulnerable and disadvantaged consumers.

The departmental objective indicators are:

- Increased access by consumers, tenants and businesses to digital information;
- Percentage of licensed venues with a rating that is greater than three stars; and
- Responsive Gamblers Help Services.

Regulation of the Victorian Consumer Marketplace (2021-22: $137.2 million)

This output upholds a fair and competitive Victorian marketplace. As Victoria's consumer regulator, Consumer Affairs Victoria (CAV) works to ensure that the market works effectively by detecting and addressing non-compliance with the law. The output provides for informing consumers and businesses about their rights and responsibilities under the law, engaging with business to ensure compliance, registration and occupational licensing for individuals and organisations and regulation of the residential tenancies market. Domestic Building Dispute Resolution Victoria is an independent government agency that provides free services to help resolve domestic (residential) building disputes.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of court and administrative actions	number	900	300	900
The 2020-21 expected outcome is lower than the 2020-21 target due to the prioritisation of Residential Tenancies Dispute Resolution Scheme services and a decrease in business activity throughout much of the year due to COVID-19.				
Information and advice provided to consumers, tenants and businesses – through other services including written correspondence, face-to-face and dispute assistance	number	115 700	144 152	115 700
The 2020-21 expected outcome is higher than the 2020-21 target due to both the increased consumer enquires driven by the rental eviction moratorium and Residential Tenancies Dispute Resolution Scheme, and the restriction of telephone-based services put in place during part of 2020 as part of the COVID-19 response.				
Information and advice provided to consumers, tenants and businesses – through telephone service	number	302 900	226 133	302 900
The 2020-21 expected outcome is lower than the 2020-21 target due to the prioritisation of Residential Tenancies Dispute Resolution Scheme services and the restriction of other telephone-based services put in place during part of 2020 as part of the COVID-19 response.				
Transactions undertaken – Residential Tenancies Bond Authority (RTBA) transactions	number	490 000	470 000	476 000
The higher 2021-22 target reflects the expectation that rental market activity will return to regular rates of growth from next year.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Transactions undertaken – registration and licensing transactions	number	95 500	85 950	95 500
The 2020-21 expected outcome is lower than the 2020-21 target due to reduced business and community activity arising from the COVID-19 public health restrictions.				
Victims of family violence assisted with financial counselling	number	3 750	2 400	3 750
The 2020-21 expected outcome is lower than the 2020-21 target due to fewer people accessing the service as a result of COVID-19.				
Dispute resolution services provided by Domestic Building Dispute Resolution Victoria	number	6 000	4 700	6 000
The 2020-21 expected outcome is lower than the 2020-21 target due to COVID-19 impacts and the cessation of the Building Information Line service throughout most of the2020-21 financial year, which is a common referral pathway.				
Quality				
Rate of compliance with key consumer laws	per cent	95	93	95
Proportion of high-priority breaches resulting in regulatory response	per cent	100	100	100
Timeliness				
Regulatory functions delivered within agreed timeframes	per cent	95	95	95
Cost				
Total output cost	$ million	137.2	148.7	149.0
Total output cost including the CAC	*$ million*	*137.2*	*148.7*	*149.0*
The lower 2021-22 target mainly reflects the one-off funding in 2020-21 for the Residential Tenancies Act reforms and Residential Tenancies Dispute Resolution Scheme as announced in the 2020-21 Budget *and lower costs estimated for the Victorian property trust fund in 2021-22.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Justice and Community Safety

Gambling and Liquor Regulation (2021-22: $79.9 million)

This output provides for monitoring and regulation of gambling and liquor activities in Victoria, including the operations of the Victorian Commission for Gambling and Liquor Regulation (VCGLR) and the Victorian Responsible Gambling Foundation (VRGF). It also provides leadership and strategic policy advice to the Minister for Consumer Affairs, Gaming and Liquor Regulation on the regulation of the gambling and liquor industries, problem gambling and harm minimisation in relation to liquor and gambling.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Liquor and gambling applications and licensee monitoring activities (VCGLR)	number	50 000	45 000	50 000
The 2020-21 expected outcome is lower than the 2020-21 target due to a decrease in demand during the period of COVID-19 restrictions on the liquor and gambling industries.				
Liquor and gambling information and advice (VCGLR)	number	128 000	150 000	128 000
The 2020-21 expected outcome is higher than the 2020-21 target due to increased demand from licensees seeking information as a result of COVID-19. This included information and government support for fee waivers and new licence conditions for the sale of takeaway liquor and supply of liquor in outdoor areas.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Liquor inspections completed by the VCGLR – metropolitan	number	5 400	3 995	5 400
The 2020-21 expected outcome is lower than the target due to inspections being temporarily suspended as a consequence of pandemic restrictions and the subsequent temporary closure of many licensed premises. Those who did trade were significantly restricted. When inspections resumed under the Restricted Activity Directions, resources were authorised to support DHHS compliance which also impacted the number of inspections completed.				
Liquor inspections completed by the VCGLR – regional	number	1 500	800	1 500
The 2020-21 expected outcome is lower than the target due to inspections being temporarily suspended as a consequence of pandemic restrictions and the subsequent temporary closure of many licenced premises. Those who did trade were significantly restricted. When inspections resumed under the Restricted Activity Directions resources were authorised to support DHHS compliance which also impacted the number of inspections completed.				
Gambling inspections completed by the VCGLR – metropolitan	number	1 350	675	1 350
The 2020-21 expected outcome is lower than the target due to the extended temporary closure of gaming venues and the Melbourne casino as a consequence of the COVID-19 pandemic.				
Gambling inspections completed by the VCGLR – regional	number	250	100	250
The expected outcome is lower than target due to the extended temporary closure of gaming venues as a consequence of the pandemic.				
Mainstream Gambler's Help client service hours provided by therapeutic and financial counselling activities (VRGF)	number	75 400	75 400	75 400
Increased access to digital information by the community and stakeholders who have an interest in gambling harm (VRGF)	number	623 000	623 700	567 000
The 2020-21 expected outcome is higher than the 2020-21 target due to new/improved self-help tools and digital marketing performance, providing additional online support to those impacted by gambling harm, following an increase in online gambling products and use. *The 2021-22 target has been increased to reflect this change and the level of investment associated with supporting those seeking this information.*				
Operations with co-regulators to identify licensees supplying alcohol to minors or persons who are intoxicated – Metropolitan (VCGLR)	number	15	5	15
The 2020-21 expected outcome is lower than the target due to the pandemic and opposing priorities of agencies. Work conducted with co-regulators for the majority of the financial year has been focussed on COVID-19 compliance activities.				
Operations with co-regulators to identify licensees supplying alcohol to minors or persons who are intoxicated – Regional (VCGLR)	number	5	3	5
The 2020-21 expected outcome is lower than the target due to the pandemic and opposing priorities of agencies. Work conducted with co-regulators for the majority of the financial year has been focussed on COVID-19 compliance activities.				
Audits of casino operations undertaken by the VCGLR	number	1 260	550	1 260
The 2020-21 expected outcome is lower than the target as the casino was closed from March to November 2020 and briefly during February 2021 due to COVID-19 restrictions. The casino also reopened in a limited capacity after November 2020.				
Quality				
Liquor and gambling licensing client satisfaction (VCGLR)	per cent	85	85	85
Liquor and gambling inspections conducted at high risk times (VCGLR)	per cent	12	2	12
The 2020-21 expected outcome is lower than the target due to COVID-19, with many venues temporarily closing or operating at a significantly reduced capacity between March and November 2020, and briefly during February 2021, due to COVID-19 restrictions. The venues that did trade during the restrictions did so in a limited capacity and were not permitted to trade during high-risk times.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Proportion of high-harm breaches resulting in regulatory action (VCGLR)	per cent	95	nm	nm
New performance measure to reflect the Government priorities on reporting outcomes to the Victorian community. This performance measure replaces the 2020-21 performance measure 'Court and regulatory actions undertaken by the VCGLR' and is intended to better reflect the transition to a risk-based approach to regulation with a focus on voluntary compliance.				
Timeliness				
Calls to VCGLR client services answered within 60 seconds	per cent	80	55	80
The 2020-21 expected outcome is lower than target due to the impact of COVID-19 which generated significant increases in call volumes as a result of licensees seeking information on new rules or Government announcements. This included licensees seeking clarification on temporary limited licensing applications and outdoor licensing requirements for the reopening of the hospitality industry as restrictions eased.				
Gamblers Help Service clients who receive a service within five days of referral (VRGF)	per cent	96	96	96
Liquor and gambling approvals, licence, permit applications and variations completed within set time (VCGLR)	per cent	85	89	85
Cost				
Total output cost	$ million	79.9	79.4	76.6
Total output cost including the CAC	*$ million*	*79.9*	*79.4*	*76.7*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Justice and Community Safety

DEPARTMENT OF PREMIER AND CABINET

Ministerial portfolios

The Department supports the ministerial portfolios of the Premier, Aboriginal Affairs, Government Services, and Industrial Relations.

Departmental mission statement

The Department of Premier and Cabinet's mission is to support the people of Victoria by:

- helping government achieve its strategic objectives;
- providing leadership to the public sector to improve its effectiveness; and
- promoting collaboration across government to drive performance and improve outcomes.

Departmental objectives

Strong policy outcomes

- Pursue policy and service delivery excellence and reform.
- Lead the public sector response to significant state issues, policy challenges and projects.
- Support the effective administration of government.

First Peoples in Victoria are strong and self-determining

- Improve outcomes and services for First Peoples through prioritising actions to enable self-determination, including advancing treaty, protecting and promoting cultural rights and conducting a truth telling process.
- Address trauma and support healing; address racism established through colonisation.
- Provide culturally-safe systems and services; and transfer power and resources to communities.

Professional public administration

- Foster and promote a high-performing public service.
- Ensure effective whole of government performance and outcomes.
- Protect the values of good public governance, integrity and accountability in support of public trust.

Changes to the output structure

The Department has made changes to its output structure for 2021-22, in addition to the machinery of government changes reflected in Table 2.1, as shown in the table below.

2020-21 outputs	*Reason*	*2021-22 outputs*
LGBTIQ+ equality policy and programs Multicultural affairs policy and programs Support to veterans in Victoria Women's policy Youth	These outputs were transferred to the Department of Families, Fairness and Housing on 1 February 2021.	No change

Source: Department of Premier and Cabinet

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2020–21 budget	*2020–21 revised*	*2021–22 budget*	*Variation [(a)] %*
Strong policy outcomes				
Government-wide leadership, reform and implementation	149.0	140.9	80.2	(46.2)
Strategic advice and government support	118.9	117.0	123.2	3.6
Digital government and communications	70.9	82.9	91.2	28.6
Office of the Victorian Government Architect	1.2	1.2	1.2	(3.2)
Industrial relations	20.7	19.6	27.3	31.6
First Peoples in Victoria are strong and self-determining [(b)]				
Aboriginal policy, strengthening Aboriginal cultural heritage and communities	76.5	75.6	99.8	30.4
Professional public administration				
Advice and support to the Governor	12.8	12.7	12.7	(0.9)
Chief Parliamentary Counsel services	6.6	6.6	7.9	19.0
Management of Victoria's public records	12.6	13.4	11.6	(8.2)
Public administration advice and support	9.7	16.1	15.6	60.8
State electoral roll and electoral events	76.3	76.3	42.6	(44.2)
Total [(c)(d)]	**555.3**	**562.5**	**513.2**	**(7.6)**

Source: Department of Premier and Cabinet

Notes:

(a) Variation between the 2020–21 budget and the 2021–22 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant output cost.

(b) The 2020–21 Departmental objective 'Engaged citizens' has been replaced with 'First Peoples in Victoria are strong and self-determining' due to the machinery of government transfer of the Equality, Multicultural Affairs, Veterans, Women and Youth portfolios to the Department of Families, Fairness and Housing.

(c) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget and CAC impacts are therefore excluded from the figures. Refer to individual output sections for comparative output costs inclusive of CAC.

(d) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.14 outlines the Department's income from transactions and Table 2.15 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.14: Income from transactions **($ million)**

	2019-20 actual	*2020-21 budget*	*2020-21 revised*	*2021-22 budget [(a)]*
Output appropriations [(b)]	688.3	663.3	560.7	470.0
Special appropriations	38.5	82.7	77.0	43.1
Sale of goods and services	71.4	145.1	180.4	186.8
Grants	82.5	4.0	18.0	3.2
Other income	3.7	2.3	123.3	2.8
Total income from transactions [(c)]	**884.3**	**897.3**	**959.5**	**706.0**

Source: Department of Premier and Cabinet

Notes:
(a) Includes an estimated $176.5 million of non-public account contributions in 2020-21.
(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget*.*
(c) Table may not add due to rounding.

Table 2.15: Parliamentary authority for resources **($ million)**

	2020-21 budget	*2020-21 revised*	*2021-22 budget*
Annual appropriations	**681.3**	**576.2**	**469.3**
Provision of outputs [(a)]	660.5	557.8	456.5
Additions to the net asset base	20.8	18.4	12.8
Payments made on behalf of the State	..	..	..
Receipts credited to appropriations	**0.7**	**0.8**	**0.8**
Unapplied previous years appropriation	**2.2**	**2.2**	**12.8**
Provision of outputs	2.1	2.1	12.8
Additions to the net asset base	0.1	0.1	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**684.2**	**579.2**	**482.8**
Special appropriations	**101.0**	**102.9**	**61.5**
Trust funds	**10.7**	**18.9**	**10.0**
Departmental Suspense Account [(b)]	5.9	5.9	5.9
Treasury Trust Fund [(c)]	2.6	2.6	2.6
Other [(d)]	2.2	10.4	1.5
Total parliamentary authority [(e)]	**795.9**	**701.0**	**554.3**

Source: Department of Premier and Cabinet

Notes:
(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget*.*
(b) This account is a departmental working account.
(c) The purpose of this trust primarily relates to facilitating the exchange of unclaimed monies and other funds held in trust.
(d) Includes inter-departmental transfers.
(e) Table may not add due to rounding.

Departmental performance statement

Objective 1: Strong policy outcomes

This objective pursues policy, service and administration excellence and reform. It leads the public sector response to significant state issues, policy challenges and projects. It supports the effective administration of government. It supports the delivery of policy and projects that enables increased productivity and competitiveness in Victoria.

The departmental objective indicators are:

- DPC's policy advice and its support for Cabinet, committee members and the Executive Council are valued and inform decision making; and
- the development and effective use of technology supports productivity and competitiveness.

Government-wide leadership, reform and implementation

(2021-22: $80.2 million)

This output provides advice and support to the Premier and Cabinet on all aspects of government policy. This includes advice on issues as they arise, policy coordination, research and analysis, consultation with stakeholders and leadership in long-term policy development.

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Whole of government emergency management forums, meetings and exercises facilitated	number	20	166	20
The 2020–21 expected outcome is higher than the 2020–21 target due to the large number of meetings held in response to the coronavirus (COVID-19) pandemic.				
Whole of government forums, meetings and advisory groups chaired	number	85	80	80
The higher 2021–22 target reflects the number of meetings held in 2018–19, before the Government required increased coordination associated with the 2019–20 Victorian bushfires and the COVID-19 pandemic.				
Number of projects and advisory support provided to departments facilitated by the Behavioural Insights Unit	number	60	10	10
The higher 2021–22 target reflects Government funding for the 'Ensuring ongoing behavioural science capability in the VPS' initiative.				
New investment resulting from Government facilitation services and assistance under the Victorian Jobs and Investment Fund	$ million	120	250	150
The 2020–21 expected outcome is higher than the 2020–21 target due to large multi-year projects being contracted with high capital expenditure anticipated during their earlier stages. *The lower 2021–22 target reflects reduced available funds within the Victorian Jobs and Investment Fund.* *These are whole-of-government targets. The Departments of Jobs, Precincts and Regions and Premier and Cabinet and Invest Victoria contribute to these performance measures.*				
Jobs resulting from Government facilitation services and assistance under the Victorian Jobs and Investment Fund	number	2 000	2 500	2 500
The lower 2021–22 target reflects reduced available funds within the Victorian Jobs and Investment Fund. *These are whole-of-government targets. The Departments of Jobs, Precincts and Regions and Premier and Cabinet and Invest Victoria contribute to these performance measures.*				

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Number of data sharing arrangements enabled by Victorian Centre for Data Insights (VCDI)	number	15	24	15
The 2020–21 expected outcome is higher than the 2020–21 target due to increased demand in VCDI's services, including enabling COVID-19 related inter-jurisdictional data sharing agreements.				
Companies and consortia supported by the Breakthrough Victoria Fund	number	5	nm	nm
This measure is proposed to replace the 2020–21 measure 'Development of a long-term investment plan for the Breakthrough Victoria Fund'. It has been replaced so that development of the Fund can be observed from year to year and to reflect that the entity has progressed from establishment phase.				
Quality				
Relevant communication activity compliant with government advertising and communication guidelines	per cent	100	100	100
VCDI Satisfaction Rating	per cent	70	70	70
Satisfaction with services provided by the Behavioural Insights Unit to government agencies	per cent	70	nm	nm
New performance measure for 2021–22 to reflect the quality of the Behavioural Insight Unit's services.				
Timeliness				
VCDI: Proportion of data published on agreed cadence	per cent	80	nm	nm
New performance measure for 2021–22 to reflect Government funding for the 'Insights Victoria' initiative.				
Cost				
Total output cost	$ million	80.2	140.9	149.0
Total output cost including the CAC	*$ million*	*81.5*	*142.5*	*150.5*
The 2020–21 expected outcome is lower than the 2020-21 target primarily reflecting the machinery of government transfers of the Jobs and Skills Exchange to the 'Public administration advice and support' output and family violence functions to the Department of Families, Fairness and Housing.				
The lower 2021–22 target primarily reflects additional funding allocated in 2020-21 in response to the COVID-19 pandemic.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Department of Premier and Cabinet

Strategic advice and government support (2021-22: $123.2 million)

This output provides strategic policy analysis and advice to the Premier, leads policy development on key priority issues and supports informed government decision making.

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of briefs supporting Cabinet and Cabinet committee decision making	number	1 200	1 500	1 200
The 2020–21 expected outcome is higher than the 2020–21 target due to higher briefing volumes during the COVID-19 pandemic.				
Establishment or renewal of ICT whole of government State Purchase Contracts	number	6	6	7
The 2020–21 expected outcome is lower than the 2020–21 target due to the delay in approaching the market for one procurement.				
The lower 2021–22 target reflects that there are fewer State Purchase Contracts that require an extension, variation or renewal.				

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Quality				
Policy services satisfaction rating	per cent	90	90	90
Timeliness				
Policy services timeliness rating	per cent	95	95	95
Timely delivery of State events and functions	per cent	100	100	100
Cost				
Total output cost	$ million	123.2	117.0	118.9
Total output cost including the CAC	*$ million*	*123.6*	*117.3*	*119.2*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Premier and Cabinet

Digital government and communications (2021-22: $91.2 million)

This output encourages innovative use of ICT to improve service delivery and business processes, and provides information and services to Victorian citizens and businesses through digital and other delivery channels.

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Average number of monthly visits to www.vic.gov.au	number	356 000	1 500 000	310 000
The 2020–21 expected outcome is higher than the 2020–21 target due to increased traffic to the COVID-19 media hub content and Victorians applying for the Regional Travel Voucher Scheme. The higher 2021–22 target reflects Government funding for the 'Whole of Victorian Government transition to Single Digital Presence' initiative.				
Existing Victorian Government department or entity websites transitioned, or new websites built, on the Single Digital Presence Platform	number	49	22	22
The higher 2021–22 target reflects Government funding for the 'Whole of Victorian Government transition to Single Digital Presence' initiative.				
Average number of monthly visits to www.together.gov.au	number	40 000	nm	nm
New performance measure for 2021–22 to reflect Government funding for the 'Victoria Together' initiative.				
Average number of monthly visits to Data.Vic	number	22 000	nm	nm
New performance measure for 2021–22 to reflect Government funding for the 'Victoria's Open Data Program' initiative.				
Number of VPS active users in the Data Directory	number	250	nm	nm
New performance measure for 2021–22 to reflect Government funding for the 'Victoria's Open Data Program' initiative.				
Government entities reporting cyber maturity	number	75	75	75
Government board members trained on Cyber Security	number	60	50	50
The higher 2021–22 target reflects Government funding for the 'Cyber Safe Victoria 2021' initiative.				
Digital Victoria: Milestones delivered in accordance with agreed budget and timeline	per cent	75	100	100
The lower 2021–22 target reflects moving to a new phase of project delivery with a new structure and operating environment.				

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Victorian Government entities using the Standard User Experience Framework	number	25	41	20
This performance measure is transferred directly from the 'Strategic advice and government support' output. *The 2020–21 expected outcome is higher than the 2020–21 target due to DPC's release of a technical guide, with subsequent training across the VPS, encouraging more users.* *The higher 2021–22 target reflects continuous improvement in signing up entities to the Standard User Experience Framework.*				
Average monthly analysis reports generated to guide government decision making	number	65	78	65
This performance measure is transferred directly from the 'Strategic advice and government support' output. *The 2020–21 expected outcome is higher than the 2020–21 target due to DPC's release of a technical guide, with subsequent training across the VPS, encouraging more users to generate analysis reports.*				
Quality				
Overall satisfaction of customers completing a transaction on the Service Victoria digital customer platform	per cent	95	95	95
This performance measure renames the 2020–21 performance measure 'Overall satisfaction of customers transacting on Service Victoria's digital customer platform'. The new measure reports on the same activity as the previous measure however wording has been amended for increased clarity				
Cost				
Total output cost	$ million	91.2	82.9	70.9
Total output cost including the CAC	*$ million*	*91.2*	*82.9*	*70.9*
The 2020-21 expected outcome is higher than the 2020–21 target primarily due to funding released from contingency for Digital Victoria. *The higher 2021–22 target is due to Government funding announced in the* 2021–22 Budget *including the 'Whole of Victorian Government transition to Single Digital Presence' initiative.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget*.* *The CAC is discontinued from the* 2021-22 Budget*.* *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Premier and Cabinet

Office of the Victorian Government Architect (2021-22: $1.2 million)

This output provides strategic leadership and advice to government and key stakeholders on architecture and the built environment.

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Strategic advice on significant public and private sector projects from project inception and procurement to design and delivery	number	80	80	80
Quality				
Stakeholder satisfaction with the quality of advice on significant public and private sector projects	per cent	80	80	80
Timeliness				
Average number of business days to issue formal advice	days	10	10	10

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Cost				
Total output cost	$ million	1.2	1.2	1.2
Total output cost including the CAC	*$ million*	*1.2*	*1.2*	*1.2*

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.
This output did not have a provision for CAC in previous budgets.

Source: Department of Premier and Cabinet

Industrial Relations (2021-22: $27.3 million)

This output contributes to providing fair jobs and a positive industrial relations environment through sound industrial relations policy and advice to government. This includes oversight of enterprise bargaining across the Victorian public sector and support for Victoria's participation in the national workplace relations system.

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Employers informed on OH&S obligations under both State and Commonwealth legislation and regulations	number	>3 500	na	>3 500
Workers informed on OH&S obligations under both State and Commonwealth legislation and regulations	number	>40 000	na	>40 000
Child employment investigations completed	number	170	170	170
Quality				
Public sector agreements renewed and approved within current enterprise bargaining framework	per cent	100	100	100
Victoria represented in major industrial relations cases and inquiries	per cent	100	100	100
Timeliness				
Review and assessment of submitted public sector enterprise bargaining costings and proposed agreements completed and submitted for approval within four weeks	per cent	90	90	90
Long Service leave investigations completed within 90 days of lodgement	per cent	15	100	15
Cost				
Total output cost	$ million	27.3	19.6	20.7
Total output cost including the CAC	*$ million*	*27.3*	*19.6*	*20.7*

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.
This output did not have a provision for CAC in previous budgets.

Source: Department of Premier and Cabinet

Objective 2: First Peoples in Victoria are strong and self-determining

This objective focuses on improving outcomes and services for First Peoples through prioritising actions to enable self-determination, including advancing treaty, protecting and promoting cultural rights and conducting a truth telling process. It addresses trauma and supports healing; addresses racism established through colonisation; and provides culturally safe systems and services. It also transfers power and resources to communities.

The departmental objective indicator is:

- First Peoples in Victoria have increased control over decisions that impact their lives.

Outputs

Aboriginal policy, strengthening Aboriginal cultural heritage and communities (2021-22: $99.8 million)

This output supports the Victorian Government's commitment to self-determination for Aboriginal Victorians and to improving long-term social and economic outcomes for Aboriginal Victorians. This includes the protection and management of Aboriginal cultural heritage; strengthening Aboriginal community organisations; progress towards treaty; broad community engagement; and work to reform government to enable self-determination.

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Capacity-building activities provided for Traditional Owners to support the management and protection of Aboriginal cultural and intangible heritage	number	16	8	16
Average weekly hours of case management provided to members of the Stolen Generations	number	80	118	80
The 2020–21 expected outcome is higher than the 2020–21 target due to the availability of additional staff to increase contact hours with clients.				
Delivery of a public report on outcomes for Aboriginal Victorians to be tabled in Parliament	number	1	1	1
Number of family history investigations conducted by the Victorian Koorie Family History Service on behalf of members of the Stolen Generations	number	240	318	240
The 2020–21 expected outcome is higher than the 2020–21 target due to the Koorie Heritage Trust engaging with more clients than expected.				
Victorian Aboriginal Heritage Council meetings conducted within legislative timeframes	number	6	8	6
The 2020–21 expected outcome is higher than the 2020–21 target due to more meetings required than anticipated, partly due to increased applications from Registered Aboriginal Parties.				
Number of Assembly and/or State-Assembly meeting held	number	40	40	12
The higher 2020–21 expected outcome and 2021–22 target reflects that the State and the First Peoples' Assembly of Victoria are meeting more frequently than originally anticipated.				

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Participation of Aboriginal people in Local Aboriginal Networks	number	2 800	2 800	2 800
Removal of first mortgages on titles of property owned by Aboriginal Community-Controlled Organisations	number	4	6	6
The lower 2021–22 target reflects the 16 first mortgages expected to be removed over the next four years.				
Quality				
Funding payments for Aboriginal community initiatives made in accordance with milestones	per cent	100	nm	nm
This performance measure is proposed to replace the performance measures 'Funding payments for the municipal essential services at Lake Tyers and Framlingham Trusts made in accordance with milestones', 'Funding payments for the Removal of First Mortgages initiative made in accordance with milestones', 'Funding payments for the Cultural Strengthening initiative made in accordance with milestones', 'Funding payments for the Community Infrastructure Program made in accordance with milestones' and 'Funding payments for Community Capacity and Co-Design made in accordance with milestones'. The measures have been replaced due to their similarities and to enable meaningful comparison over time.				
Funding payments for Aboriginal cultural heritage protection initiatives, sector support and nation building made in accordance with milestones	number	100	nm	nm
This performance measure is proposed to replace the performance measures 'Funding payments to Strengthen Cultural Heritage Protection and Management initiative made in accordance with milestones' and 'Traditional Owner Nation-Building Support payments made according to milestones'. The measures have been replaced due to their similarities and to enable meaningful comparison over time.				
Timeliness				
Assessments completed by Aboriginal Victoria within legislative timeframe — cultural heritage management plans, cultural heritage permits, preliminary Aboriginal heritage tests	per cent	100	100	100
Koorie Heritage Trust initiative grants acquitted within the timeframe specified in the funding agreements	per cent	100	100	100
Cost				
Total output cost	$ million	99.8	75.6	76.5
Total output cost including the CAC	*$ million*	*100.2*	*76.1*	*77.0*
The higher 2021–22 target is due to Government funding announced in the 2021–22 Budget *including the 'Delivering a Victorian Truth and Justice process' initiative.*				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget*.*				
The CAC is discontinued from the 2021-22 Budget*.*				

Source: Department of Premier and Cabinet

Objective 3: Professional public administration

This objective fosters and promotes a high-performing public service. It ensures effective whole of government performance and outcomes. It protects the values of good public governance in support of public trust.

The departmental objective indicator is:

- a values-driven, high-integrity public service characterised by employees who collaborate across government and in partnership with the community and other sectors, and who use evidence to support decisions that drive the progress of Victoria socially and economically.

Advice and support to the Governor (2021-22: $12.7 million)

This output provides advice and support to the Governor, and maintenance to Government House and its collections as a heritage asset of national importance.

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Increase in the annual number of guests and visitors to Government House	per cent	5	(90)	5
The 2020–21 expected outcome is lower than the 2020–21 target as and general requirement for physical distancing during the COVID-19 pandemic meant a reduction in the number of visitors to Government House.				
Quality				
Maintenance of Government House in accordance with the asset management strategy	per cent	79	79	79
Standard, physical appearance of gardens and grounds in accordance with contract key performance indicators	per cent	85	85	85
Timeliness				
Support the Governor's community engagement activities by arranging all internal and external events in a timely manner	per cent	100	100	100
Cost				
Total output cost	$ million	12.7	12.7	12.8
Total output cost including the CAC	*$ million*	*16.7*	*16.6*	*16.7*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Premier and Cabinet

Chief Parliamentary Counsel services (2021-22: $7.9 million)

This output provides Bills for introduction in parliament, including providing quality and timely legislative drafting services; hard copy and electronic publication of Acts and Statutory Rules; and maintaining a database of Victorian legislation and legislative information at www.legislation.vic.gov.au.

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Formal advice provided on legislation	number	465	465	465
Acts and Statutory Rules published electronically and in hard copy without error	per cent	96	96	96
Statutory Rules made and Bills prepared and introduced into Parliament	number	220	220	220
Number of sets of House Amendments drafted for Members of Parliament	number	60	60	60
Quality				
Bills and Statutory Rules drafted or settled which meet required standard	per cent	97	97	97
Timeliness				
Bills and Statutory Rules drafted or settled within required timeframe	per cent	97	97	97
Electronically published versions of Principal Acts and Statutory Rules published within three business days of coming into operation and new Acts and Statutory Rules published within 24 hours of making	per cent	96	96	96
Cost				
Total output cost	$ million	7.9	6.6	6.6
Total output cost including the CAC	*$ million*	*7.9*	*6.7*	*6.6*

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.
This output did not have a provision for CAC in previous budgets.

Source: Department of Premier and Cabinet

Management of Victoria's public records (2021-22: $11.6 million)

This output provides direction to government on the management of public records and ensures the historical memory of the Victorian Government endures, is secure and accessible.

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Collection Usage: Utilisation of physical and digital records held by Public Record Office Victoria	number	5 400 000	5 800 000	4 800 000
The 2020–21 expected outcome is higher than the 2020–21 target due to increased digital image downloads from third party websites. *The higher 2021–22 target reflects an increasing trend in online utilisation of digital records and this trend will be supported and boosted by PROV's Digital Archives systems going live by the end of 2020–21.*				
Quality				
Satisfaction with services provided by Public Records Office Victoria to government agencies and to the public	per cent	90	90	90
Timeliness				
Provision of services within published timeframes	per cent	95	89	95
The 2020–21 expected outcome is lower than the 2020–21 target as COVID-19 restrictions during the year meant that physical records could not be delivered to the Victorian Archives Centre Reading Room.				
Cost				
Total output cost	$ million	11.6	13.4	12.6
Total output cost including the CAC	*$ million*	16.4	18.2	17.4
The higher 2021–22 target is due to Government funding announced in the 2021–22 Budget *for the 'Asset Maintenance and Future Storage' initiative.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget*.* *The CAC is discontinued from the* 2021-22 Budget*.*				

Source: Department of Premier and Cabinet

Public administration advice and support (2021-22: $15.6 million)

This output provides advice and support on issues relevant to public sector administration, Members of Parliament and executive officer remuneration, governance, service delivery and workforce matters, as well as to public sector professionalism and integrity. It includes related research, determinations, data collection, reporting and dissemination of information.

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Percentage of VPS jobs advertised through the Jobs and Skills Exchange	per cent	90	90	90
This performance measure is transferred directly from the 'Government-wide leadership, reform and implementation' output.				
Number of engagement and promotion activities undertaken by the Jobs and Skills Exchange	number	20	20	20
This performance measure is transferred directly from the 'Government-wide leadership, reform and implementation' output.				

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Percentage of new-to-VPS executives participating in the VPSC induction program	per cent	78	100	78
The 2020–21 expected outcome is higher than the 2020–21 target due to all new-to-VPS executives expected to participate in the program.				
Quality				
Satisfaction with response to user queries on the Jobs and Skills Exchange platform	per cent	80	80	80
This performance measure is transferred directly from the 'Government-wide leadership, reform and implementation' output.				
Percentage of agencies who interacted with VPSC and who indicated VPSC advice and support assisted them to improve integrity capability	per cent	85	85	85
Overall satisfaction with engagement, consultation and responsiveness from the VPSC GRADS team	per cent	85	85	85
Stakeholder satisfaction with the Remuneration Tribunal's process regarding determinations, reviews, and advice	per cent	80	80	80
This performance measure renames the 2020–21 performance measure 'Stakeholder satisfaction with the quality of advice from the Remuneration Tribunal on determinations'. This measure reports on the same activity as the previous measure and has been renamed to increase clarity.				
Timeliness				
Percentage of collection, validation and reporting of Victorian public sector annual workforce data completed by the end of February each year	per cent	95	95	100
This performance measure renames the 2020–21 performance measure 'Proportion of data collection and reporting activities completed within target timeframes'. This measure reports on the same activity as the previous measure however it is now more descriptive of the various activities involved in the data collection process. *The lower 2020–21 expected outcome and 2021–22 target reflects the COVID-19 impact on Victorian public sector bodies' ability to meet collection deadlines. The reduction accommodates any late or missing information that may impact the Victorian Public Sector Commission's ability to provide complete reporting in time.*				
Advice from the Remuneration Tribunal provided within 15 working days of receipt of submission	per cent	90	53	90
The 2020–21 expected outcome is lower than the 2020–21 target due to changes to internal analysis and reporting processes during the reporting period.				
Cost				
Total output cost	$ million	15.6	16.1	9.7
Total output cost including the CAC	*$ million*	*15.7*	*16.1*	*9.7*
The higher 2020–21 expected outcome and 2021–22 target is due to the transfer of the Victorian Independent Remuneration Tribunal from the 'Strategic advice and government support' output. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget*.* *The CAC is discontinued from the* 2021-22 Budget*.* *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Premier and Cabinet

State electoral roll and electoral events (2021-22: $42.6 million)

This output, through the Victorian Electoral Commission, provides a high-quality electoral system that supports democracy in Victoria through the administration of an accurate and secure electoral roll, electoral services to ensure fair and equitable representation, the conduct of fair and impartial elections and encouraging greater participation in civic life through education and awareness activities and improving ease of access.

Performance measures	*Unit of measure*	*2021–22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Election events conducted by the Victorian Electoral Commission, including State elections and by-elections, local government elections, by-elections and countbacks, and statutory elections or polls	number	28	22	22
The higher 2021–22 target is due to an anticipated increase in by-elections and delivery of a general election.				
Quality				
Election events invalidated by a court of disputed returns as a result of a proven claim against the Victorian Electoral Commission's conduct of that event	number	0	0	0
Timeliness				
Electoral enrolment transactions are applied to the Victorian Register of Electors within set timeframes	per cent	90	90	90
Cost				
Total output cost	$ million	42.6	76.3	76.3
Total output cost including the CAC	$ million	*42.7*	*76.4*	*76.4*
The lower 2021–22 target is due to additional funding allocated in 2020–21 for the 2020 local council elections.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Department of Premier and Cabinet

DEPARTMENT OF TRANSPORT

Ministerial portfolios

The Department supports the ministerial portfolios of Transport Infrastructure, Public Transport, Roads and Road Safety, Ports and Freight and Fishing and Boating.

Departmental mission statement

The Department of Transport's mission is to meet the aspirations of Victorians for an integrated transport system that contributes to an inclusive, prosperous and environmentally responsible state. The Department plans, builds and operates the transport system in a way that meets the needs of the people and freight that travel on it, now and in the future, and works with transport agencies and operators to achieve this. It brings together management of ports, boating and fisheries for commercial and recreational uses.

Departmental objectives

Reliable and people-focused transport services

The Department enhances liveability by providing Victorians with a transport system that connects people and places, taking them where they want to go, when they want to go.

The Bus Services, Tram Services and Train Services outputs contribute to the objective by delivering safe, inclusive, reliable and cost-effective public transport services across Victoria and infrastructure investments. This includes services delivered through contractual arrangements with private operators.

The Road Operations output contributes to this objective by delivering initiatives that provide more predictable and reliable journeys, improve safety and meet the service quality expected from transport users.

The objective indicators are:

- user satisfaction with the transport system; and
- reliable travel.

Safe and well-regulated transport services

The Department focuses on helping Victorians arrive safely, whether they are travelling by road, rail or water.

The Regulation of Commercial Passenger Vehicle Services output contributes to this objective by delivering a commercial passenger vehicle industry that is customer-focused, safe, accessible and competitive through the regulation of commercial passenger vehicles, booking service providers and drivers.

The Transport Safety and Security output contributes to this objective by delivering initiatives and regulatory activities that will improve safety and security on Victoria's transport network.

The objective indicator is:

- safety of the transport system.

Deliver investments that achieve social and economic benefits

The Department delivers infrastructure investments to transform the way that Victorians travel.

The Transport Infrastructure output contributes to this objective by delivering strategic transport infrastructure activities that are value for money and focused on user outcomes to improve the transport system.

The Ports and Freight output contributes to this objective by delivering a range of capital initiatives and programs to increase the capacity, efficiency and safety of the ports, freight and logistics network.

The Road Asset Management output contributes to the objective by delivering programs and initiatives to maintain Victoria's freeways and arterial roads.

The objective indicator is:

- improved transport infrastructure and planning.

Sustainably managed fish and boating resources

The Department supports the development of sustainable fishing and aquaculture activities in Victoria and promotion of responsible boating, fishing and fishing-related activities so that boating and fishing are more accessible to more people.

This includes commercial and recreational licensing and quota management, education, enforcement, fishery monitoring and assessment, administration of recreational fishing grants and on-ground delivery of fishing-related election commitments, and working with a number of partners, local communities and industry to deliver positive outcomes that provide benefits to Victorians.

The Sustainably Managed Fish and Boating Resources output contributes to this objective by delivering improved recreational boating and fishing services and facilities.

The objective indicators are:

- sustainability of assessed fish stocks; and
- improved recreational fishing and boating services and facilities.

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2020-21 budget	*2020-21 revised*	*2021-22 budget*	*Variation [(a)] %*
Reliable and people-focused transport services				
Bus Services	1 273.9	1 288.4	1 356.9	6.5
Road Operations	1 851.3	1 743.8	1 827.6	(1.3)
Train Services	2 225.2	2 390.4	2 016.9	(9.4)
Tram Services	463.4	526.9	369.8	(20.2)
Safe and well-regulated transport services				
Regulation of Commercial Passenger Vehicle Services	128.5	130.4	117.6	(8.5)
Transport Safety and Security	28.8	28.6	40.0	38.9
Deliver investments that achieve social and economic benefit				
Ports and Freight	95.0	93.9	97.4	2.5
Road Asset Management	807.4	823.0	616.9	(23.6)
Transport Infrastructure	636.4	753.4	378.1	(40.6)
Sustainably managed fish and boating resources				
Sustainably Managed Fish and Boating Resources	68.2	54.8	72.8	6.7
Total [(b)(c)]	**7 578.1**	**7 833.6**	**6 894.0**	**(9.0)**

Source: Department of Transport

Notes:

(a) Variation between 2020-21 budget and 2021-22 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant outputs.

(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget *and CAC impacts are therefore excluded from the figures. Refer to individual output sections for comparative output costs inclusive of CAC.*

(c) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.16 outlines the Department's income from transactions and Table 2.17 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.16: Income from transactions **($ million)**

	2019-20 actual	*2020-21 budget*	*2020-21 revised*	*2021-22 budget [a]*
Output appropriations [b]	7 541.0	8 377.6	8 616.0	4 999.1
Special appropriations	438.5	531.8	539.8	621.4
Interest	2.7	3.5	3.5	3.5
Sale of goods and services	318.8	226.8	111.2	388.4
Grants	467.0	511.3	452.0	462.4
Fair value of assets and services received free of charge or for nominal consideration	11.1	..	423.9	708.4
Other income	321.4	283.5	184.7	248.1
Total income from transactions [c]	**9 100.5**	**9 934.5**	**10 331.0**	**7 431.2**

Source: Department of Transport

Notes:
(a) Includes an estimated $955 million of non-public account contributions in 2021-22.
(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget*.*
(c) Table may not add due to rounding.

Table 2.17: Parliamentary authority for resources **($ million)**

	2020-21 budget	*2020-21 revised*	*2021-22 budget*
Annual appropriations	**13 348.8**	**14 260.9**	**11 600.3**
Provision of outputs [a]	7 757.4	8 015.8	4 593.0
Additions to the net asset base	5 591.4	6 245.1	7 007.3
Payments made on behalf of the State	..	..	..
Receipts credited to appropriations	**890.0**	**950.1**	**1 553.8**
Unapplied previous years appropriation	**1 276.9**	**1 276.9**	**..**
Provision of outputs	117.6	118.3	..
Additions to the net asset base	1 159.3	1 158.6	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**15 515.7**	**16 487.8**	**13 154.1**
Special appropriations	**1 125.5**	**1 132.0**	**902.1**
Trust funds	**771.7**	**593.5**	**885.8**
Public Transport Fund [b]	249.8	133.5	414.5
Recreational Fishing Licence Trust [c]	8.5	8.5	8.5
Road Safety Fund [d]	260.3	217.1	202.0
State Development Special Projects Trust [e]	52.7	26.8	54.5
Other [f]	200.5	207.6	206.3
Total parliamentary authority [g]	**17 412.9**	**18 213.3**	**14 942.1**

Source: Department of Transport

Notes:
(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget*.*
(b) The purpose of this trust primarily relates to public transport functions of the Head, Transport for Victoria (Head, TfV), as per section 39A of the Transport Integration Act 2010*.*
(c) The purpose of this trust primarily relates to recreational fishing projects funded from income received from the sale of recreational fishing licences.
(d) The purpose of this trust primarily relates to the income received and payments made for the road system and road functions of the Head, TfV and the Secretary of the department. The majority of the funds from the Transport Accident Commission will be receipted here.
(e) The purpose of this trust primarily relates to funding for initiatives that enhance economic development.
(f) Primarily relates to inter-departmental transfers
(g) Table may not add due to rounding.

Departmental performance statement

Objective 1: Reliable and people-focused transport services

This objective group enhances liveability by providing Victorians with a transport system that connects people and places, taking them where they want to go, when they want to go.

The departmental objective indicators are:

- user satisfaction with the transport system; and
- reliable travel.

Outputs

Bus Services (2021-22: $ 1 356.9 million)

This output delivers reliable and cost-effective statewide bus services and infrastructure investments, including services delivered through contractual arrangements with private operators.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Bus Services – Metropolitan				
This sub-output reports on bus services delivered in metropolitan Melbourne.				
Quantity				
Passengers carried: metropolitan bus services	number (million)	121.8	64.8	121.8
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the coronavirus (COVID-19) impact on public transport demands. A gradual recovery is anticipated through 2021.				
Payments made for: metropolitan bus services	$ million	779.7	768	768
Scheduled services delivered: metropolitan bus	per cent	99.9	100	99.9
Total kilometres scheduled: metropolitan bus	km (million)	125.8	125.73	125.5
Quality				
Customer satisfaction index: metropolitan bus services	score	77	78	77
Timeliness				
Service punctuality for: metropolitan bus services	per cent	86	92.5	86
The 2020-21 expected outcome is higher than the 2020-21 target due to reduced road traffic and patronage.				
Cost				
Total output cost	$ million	867.4	808.8	803.3
Total output cost including the CAC	*$ million*	*867.4*	*808.8*	*803.3*
The 2021-22 target is higher than 2020-21 target primarily due to indexation on contract payments and additional funding for the Bus service improvements and reform initiative. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Bus Services – Regional				
This sub-output reports on bus services delivered in regional Victoria.				
Quantity				
Passengers carried: regional bus services	number (million)	14.3	9.44	14.3
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the COVID-19 impact on public transport demands. A gradual recovery is anticipated through 2021.				
Payments made for: regional bus services	$ million	152	147.6	147.6
Scheduled services delivered: regional bus	per cent	99	100	99
Total kilometres scheduled: regional bus	km (million)	27.3	27.25	27.3
Quality				
Customer satisfaction index: regional coach services	score	84	84	84
Timeliness				
Service punctuality for: regional bus services	per cent	92	94	92
Cost				
Total output cost	$ million	155.8	152.1	151.0
Total output cost including the CAC	*$ million*	*155.8*	*152.1*	*151.0*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				
Bus Services – Statewide				
This sub-output reports on upgrades and school bus services delivered statewide.				
Quantity				
Number of bus routes upgraded	number	40	18	31
The 2020-21 expected outcome is lower than the 2020-21 target due to the deferral of route upgrades until 2021-22. *The higher 2021-22 target reflects the projects scheduled for delivery in the financial year and additional funding for the Bus service improvements and reform initiative.*				
Scheduled services delivered: school bus	per cent	99	98.5	99
Total kilometres scheduled: school bus	km (million)	31.2	30.8	31.1
Cost				
Total output cost	$ million	333.7	327.5	319.5
Total output cost including the CAC	*$ million*	*333.7*	*327.6*	*319.5*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Transport

Road Operations (2021-22: $ 1 827.6 million)

This output operates the road network by managing access and use, and delivering initiatives that provide more predictable and reliable journeys, improve safety and meet the service quality expected from transport users.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Road Network Performance				
This sub-output reports on the operation of the road network in Victoria and initiatives to improve network performance.				
Quantity				
Active transport: cycling projects completed	number	8	3	7
The 2020-21 expected outcome is lower than the 2020-21 target due to rescheduling of a number of projects to allow for additional community engagement. *The higher 2021-22 target reflects the projects scheduled for delivery in the financial year.*				
Active transport: pedestrian projects completed	number	3	7	2
The 2020-21 expected outcome is higher than the 2020-21 target due to the identification and delivery of additional work that was not included in the original target. *The higher 2021-22 target reflects the projects scheduled for delivery in the financial year.*				
Bridge strengthening and replacement projects completed: metropolitan	number	3	1	1
The higher 2021-22 target reflects the projects scheduled for delivery in the financial year.				
Bridge strengthening and replacement projects completed: regional	number	9	4	4
The higher 2021-22 target reflects the projects scheduled for delivery in the financial year and additional funding.				
Congestion management and minor road improvements completed: metropolitan	number	9	12	12
The lower 2021-22 target reflects the projects scheduled for delivery in the financial year.				
Congestion management and minor road improvements completed: regional	number	16	20	20
The lower 2021-22 target reflects the projects scheduled for delivery in the financial year.				
Road vehicle and driver regulation: driver licences renewed	number (thousand)	905	780	750
The higher 2021-22 target reflects cyclical trends in licence renewal.				
Road vehicle and driver regulation: new driver licences issued	number (thousand)	190	185	190
Road vehicle and driver regulation: new vehicle registrations issued	number (thousand)	580	540	580
The 2020-21 expected outcome is lower than the 2020-21 target due to COVID-19 restrictions and a decline in new car sales.				
Road vehicle and driver regulation: vehicle and driver information requests, including toll operator and council requests, processed	number (thousand)	4 030	3 000	4 030
This performance measure relates to information requests received from police, toll operators etc. concerning Victorian driver and vehicle information. *The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of COVID-19 restrictions on activities.*				
Road vehicle and driver regulation: vehicle registration transfers	number (thousand)	910	865	910
Road vehicle and driver regulation: vehicle registrations renewed	number (thousand)	10 070	9 800	9 540
The higher 2021-22 target reflects forecasts based on historical trends.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quality				
Road projects completed within agreed scope and standards: metropolitan	per cent	100	100	100
Road projects completed within agreed scope and standards: regional	per cent	100	100	100
Road vehicle and driver regulation: currency of vehicle registration and driver licensing records	per cent	99	99	99
Road vehicle and driver regulation: user satisfaction with vehicle registration and driver licensing	per cent	85	85	85
Timeliness				
Average incident response time within agreed timeframes: metropolitan	per cent	80	80	80
Programmed works completed within agreed timeframes: metropolitan	per cent	80	80	80
Programmed works completed within agreed timeframes: regional	per cent	80	80	80
Road vehicle and driver regulation: average speed of calls answered in registration and licensing call centres	seconds	240	500	240
The 2020-21 expected outcome is higher than the 2020-21 target due to an increase in the volume and complexity of inquiries caused by COVID-19 restrictions.				
Road vehicle and driver regulation: customers served within 10 minutes in registration and licensing customer service centres	per cent	80	65	80
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 response.				
Cost				
Total output cost	$ million	1 690.7	1 629.1	1 733.3
Total output cost including the CAC	*$ million*	*1 740.4*	*1 678.9*	*1 783.1*
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of COVID-19 on the delivery of road operations programs. *The 2021-22 target is lower than the 2020-21 target mainly due to the completion of programs of work.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget*.* *The CAC is discontinued from the* 2021-22 Budget*.*				
Road Safety				
This sub-output reports on the safety of the road network in Victoria and initiatives to improve road safety.				
Quantity				
High risk driver reviews	number (thousand)	152	nm	nm
New performance measure for 2021-22 to reflect work undertaken under various programs to address high risk drivers and keep our roads safer.				
Kilometres of road treated with tactile line marking	km	466	1 151	792
The 2020-21 expected outcome is higher than the 2020-21 target due to the identification and delivery of additional work including projects that were not in the original target. *The lower 2021-22 target reflects the work currently scheduled for the year or anticipated through the Commonwealth Road Safety Program.*				
Kilometres of safety barrier installed	km	167	219	165
The 2020-21 expected outcome is higher than the 2020-21 target due to the identification and delivery of additional work including projects that were not in the original target. *The 2021-22 target reflects the work currently scheduled for the year or anticipated through the Road Safety Strategy initiatives.*				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Road safety initiatives completed	number	50	50	50
Road vehicle safety certificates issued	number (thousand)	875	nm	nm
New performance measure for 2021-22 to reflect the work to keep unsafe vehicles off our roads.				
Vehicle safety inspections	number	1 350	nm	nm
New performance measure for 2021-22 to reflect the work to keep unsafe vehicles off our roads.				
Quality				
Number of schools reached by the Road Smart program-Metro	number	268	nm	nm
New performance measure for 2021-22 to reflect efforts to reduce fatalities and serious injuries of young Victorians.				
Number of schools reached by the Road Smart program-regional	number	208	nm	nm
New performance measure for 2021-22 to reflect efforts to reduce fatalities and serious injuries of young Victorians.				
Road safety projects completed within agreed scope and standards	per cent	100	100	100
Timeliness				
Road safety programmed works completed within agreed timeframes	per cent	80	80	80
Cost				
Total output cost	$ million	136.9	114.7	118.0
Total output cost including the CAC	*$ million*	*136.9*	*114.7*	*118.0*
The 2021-22 target is higher than the 2020-21 target primarily due to expendtiture on the Safe System Road Infrastructure Program. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Transport

Train Services (2021-22: $2 016.9 million)

This output delivers reliable and cost-effective train services and infrastructure investments across the Victorian rail network, including services delivered through contractual arrangements with private operators.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Train Services – Metropolitan				
This sub-output reports on train services and maintenance works in metropolitan Melbourne.				
Quantity				
Passengers carried: metropolitan train services	number (million)	249.7	92.1	249.7
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the COVID-19 impact on public transport demands. A gradual recovery is anticipated through 2021.				
Payments made for: metropolitan train services	$ million	1 021.5	1 061.3	1 061.3
Scheduled services delivered: metropolitan train	per cent	99	99	99
Total kilometres scheduled: metropolitan train	km (million)	24.9	23.9	23.8

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quality				
Availability of rolling stock: metropolitan trains	per cent	94	94	94
Customer satisfaction index: metropolitan train services	score	75	77	75
Metropolitan fare compliance rate across all public transport modes	per cent	96.5	96.5	96.5
Timeliness				
Major periodic maintenance works completed against plan: metropolitan train network	per cent	100	100	100
Service punctuality for: metropolitan train services	per cent	92.5	94.5	92.5
Cost				
Total output cost	$ million	997.0	1 176.3	1 178.5
Total output cost including the CAC	*$ million*	*2 354.8*	*2 488.5*	*2 490.2*
The 2021-22 target is lower than the 2020-21 target as it does not include the COVID-19 support funded in 2020-21, and due to the expensing of project works in 2020-21 that were found to be operating rather than capital in nature in line with accounting standards. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				
Train Services – Regional				
This sub-output reports on train services and maintenance works in regional Victoria.				
Quantity				
Passengers carried: regional train and coach services	number (million)	24.4	9.69	24.4
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the COVID-19 impact on public transport demands. A gradual recovery is anticipated through 2021.				
Payments made for: regional train and coach services	$ million	727.8	694.1	694.1
The higher 2021-22 target is due to funding for Regional rail sustainability.				
Scheduled services delivered: regional train	per cent	98.5	96.5	98.5
Total kilometres scheduled: regional train and coach	km (million)	27.5	26.5	25.9
The higher 2021-22 target reflects updated timetables.				
Quality				
Availability of rolling stock: VLocity fleet	per cent	92.5	87	92.5
The 2020-21 expected outcome is lower than the 2020-21 target due to a number of factors including ongoing maintenance and repair work.				
Customer satisfaction index: regional train services	score	78	80	78
Scheduled services not delayed by infrastructure faults: regional train network	per cent	97	99	97
Timeliness				
Major periodic maintenance works completed against plan: regional train network	per cent	100	100	100
Service punctuality for: regional train services	per cent	92	92.5	92
Cost				
Total output cost	$ million	763.6	778.9	776.7
Total output cost including the CAC	*$ million*	*1 401.3*	*1 396.9*	*1 394.9*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Train Services – Statewide				
This sub-output reports on train services and network improvements delivered statewide.				
Quantity				
Myki: device speed - number of touch on/offs per minute	number	37	37	28
The 2020-21 expected outcome is higher than the 2020-21 target due to the rollout of next generation myki readers. *The higher 2021-22 target reflects the impact of the rollout of next generation myki readers.*				
Public railway crossings upgraded	number	53	28	23
The 2020-21 expected outcome is higher than the 2020-21 target due to additional upgrades in 2020-21 which were not included when setting the original target. *The higher 2021-22 target reflects the projects scheduled for delivery in the financial year.*				
Public transport network improvement: minor projects completed – train	number	17	6	11
The 2020-21 expected outcome is lower than the 2020-21 target due to rescheduling and rescoping of some projects. *The higher 2021-22 target reflects additional funding for the Public transport accessibility and amenity upgrades initiative, as well as deferred projects from the previous year.*				
Quality				
Myki device availability	per cent	99.5	99.9	99.5
Public transport network improvement: performance against master project schedule	per cent	90	90	90
Timeliness				
Calls to the public transport call centre answered within 30 seconds	per cent	80	80	80
Cost				
Total output cost	$ million	256.3	435.2	270.0
Total output cost including the CAC	*$ million*	*256.3*	*435.2*	*270.0*
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to the impact of COVID-19 on public transport. *The 2021-22 target is lower than the 2020-21 target as it does not include COVID-19 support funded in 2020-21.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Transport

Tram Services (2021-22: $ 369.8 million)

This output delivers reliable and cost-effective tram services and infrastructure investments, including public transport services delivered through contractual arrangements with private operators.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of tram routes upgraded	number	1	2	2
The lower 2021-22 target reflects the projects scheduled for delivery in the financial year.				
Passengers carried: tram services	number (million)	208.1	68.4	208.1
The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the COVID-19 impact on public transport demand. A gradual recovery is anticipated through 2021.				
Payments made for: tram services	$ million	380.9	416.6	416.6
The lower 2021-22 target reflects the expected payments to operators to provide tram services.				
Progress of tram procurement and supporting infrastructure – cumulative project expenditure	per cent	97.5	96.0	97.5
Public transport accessibility: level access tram stops upgraded	number	4	2	2
The higher 2021-22 target reflects the projects scheduled for delivery in the financial year.				
Scheduled services delivered: tram	per cent	99.2	98.5	99.2
Total kilometres scheduled: tram	km (million)	24.6	24.6	24.6
Quality				
Availability of rolling stock: trams	per cent	94	91	94
Customer satisfaction index: tram services	score	76.5	80	76.5
Timeliness				
Major periodic maintenance works completed against plan: tram network	per cent	100	100	100
Service punctuality for: tram services	per cent	82.9	90.5	82.9
The 2020-21 expected outcome is higher than the 2020-21 target due to reduced road traffic and patronage.				
Cost				
Total output cost	$ million	369.8	526.9	463.4
Total output cost including the CAC	*$ million*	*930.9*	*1 070.3*	*1 006.9*
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to the impact of COVID-19 on public transport. *The 2021-22 target is lower than the 2020-21 target as it reflects the agreed profile of the franchise contract. In addition, the 2020-21 target reflects COVID-19 support funded in 2020-21.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Transport

Objective 2: Safe and well-regulated transport services

This objective focuses on helping Victorians arrive safely, whether they are travelling by road, rail or water.

The departmental objective indicator is:

- safety of the transport system.

Outputs

Regulation of Commercial Passenger Vehicle Services (2021-22: $ 117.6 million)

This output delivers a commercial passenger vehicle industry that is customer-focused, safe, accessible and competitive in metropolitan and regional Victoria through regulating commercial passenger vehicles, booking service providers, and drivers.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Driver accreditation applications processed	number	43 000	40 000	43 000
The 2020-21 expected outcome is lower than the 2020-21 target due to reduced customer demand.				
Multi-Purpose Taxi Program: number of trips subsidised	number (thousand)	6 178	4 000	6 178
The 2020-21 expected outcome is lower than the 2020-21 target reflecting reduced trip volumes due to COVID-19 restrictions.				
Multi-Purpose Taxi Program: number of wheelchair and scooter lifting fees paid	number (thousand)	1 437	878	1 437
The 2020-21 expected outcome is lower than the 2020-21 target reflecting reduced trip volumes due to COVID-19 restrictions.				
Quality				
Average wait time for conventional commercial passenger vehicles booked to arrive during daytime periods of demand	minutes	4.8	4.8	4.8
Average wait time for wheelchair accessible commercial passenger vehicles booked to arrive during daytime periods of demand	minutes	10.1	10.1	10.1
Calls to the Commercial Passenger Vehicles Victoria call centre resolved at the first point of contact	per cent	80	80	80
Commercial passenger vehicle industry participants conform to key safety requirements	per cent	75	75	75
Commercial passenger vehicles met safety standards	per cent	85	85	85
Overall satisfaction with level of commercial passenger vehicle regulatory service provided by Commercial Passenger Vehicles Victoria.	per cent	80	80	80
Timeliness				
Commercial passenger vehicle service complaints and intelligence reports investigated and closed within 45 days	per cent	92	92	92
Multi-Purpose Taxi Program: applications assessed and completed within 14 days	per cent	97	97	97

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Road vehicle and driver regulation: new and renewed driving instructor authority applications processed within 14 days	per cent	90	64	90
The 2020-21 expected outcome is lower than the 2020-21 target due to changed working practices in response to COVID-19.				
Valid driver accreditation applications determined within 20 business days in accordance with statutory requirements.	per cent	85	85	85
Cost				
Total output cost	$ million	117.6	130.4	128.5
Total output cost including the CAC	*$ million*	*118.9*	*131.4*	*129.6*
The 2021-22 target is lower than the 2020-21 target as it does not include COVID-19 support funded in 2020-21.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Department of Transport

Transport Safety and Security (2021-22: $ 40.0 million)

This output delivers initiatives and regulatory activities that will improve safety and security on Victoria's transport network.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Accredited State maritime training providers audited in accordance with risk-based annual audit plan	number	21	20	20
Risk-based vessel inspections undertaken to determine compliance with State marine safety law	number	500	500	500
Safety audits of bus safety duty holders conducted in accordance with risk-based plan	per cent	100	nm	nm
This performance measure is proposed to replace the 2020-21 performance measure "Safety audits of bus safety duty holders conducted in accordance with Bus Safety Action 2009 (Vic) requirements". The change enables Transport Safety Victoria audit program to be responsive to dynamic risks.				
Sector Resilience Plans endorsed by State Crisis and Resilience Council	number	1	1	1
Security and emergency management exercises coordinated or contributed to by the Department	number	9	3	9
The 2020-21 expected outcome is lower than the 2020-21 target because of exemptions granted to six organisations where emergency management processes were adequately tested by the impact of COVID-19.				
Transport and marine safety investigations: proportion of notified accidents with passenger fatalities and/or multiple serious passenger injuries investigated	per cent	100	100	100
Quality				
Compliance inspections of commercial maritime duty holders other than vessel owners and operators audited in accordance with legislative requirements and timelines	per cent	100	100	100

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Prosecution success rate of transport safety offences	per cent	80	80	80
Risk assessment of managed and unmanaged Victorian waterways with high levels of boating activity and competing use	number	30	6	30
The 2020-21 expected outcome is lower than the 2020-21 target due to COVID-19 restrictions, which prevented waterway audits.				
Timeliness				
Applications for bus operator registration and safety accreditation processed on time in accordance with *Bus Safety Act 2009* (Vic) requirements	per cent	100	100	100
Initiate marine pollution response action within 60 minutes of incident notification	per cent	100	100	100
Transport and marine safety investigations: accidents/incidents assessed within two days of notification to determine need for detailed investigation	per cent	100	100	100
Transport and marine safety investigations: investigations completed within 12 months	per cent	50	50	50
Cost				
Total output cost	$ million	40.0	28.6	28.8
Total output cost including the CAC	*$ million*	*40.0*	*28.7*	*28.8*
The 2021-22 target is higher than the 2020-21 target primarily due to funding for Emergency Management Sector Reform. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Transport

Objective 3: Deliver investments that achieve social and economic benefits

The objective delivers infrastructure investments to transform the way that Victorians travel.

The departmental objective indicator is:

- improved transport infrastructure and planning.

Outputs

Ports and Freight (2021-22: $ 97.4 million)

This output delivers a range of capital initiatives and programs to increase the capacity, efficiency and safety of the ports, freight and logistics network.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Accessible local ports	number	14	14	14
Containers transported by rail under the Mode Shift Incentive Scheme program	number	42 508	42 508	42 508
Number of months per year average channel depth at Lakes Entrance meets standards	number	12	12	10
The 2020-21 expected outcome is higher than the 2020-21 target due to lower than anticipated accretion. *The higher 2021-22 target is in line with the 2020-21 expected outcome, and reflects the performance of dredging operations.*				
Progress with delivery of a Metropolitan Intermodal System – percentage of project funding expended	per cent	85	45	45
The higher 2021-22 target reflects progressive payments being made under this program.				
Quality				
Road-based freight accessibility and reliability improvement projects completed	number	2	2	2
Road network permitted for use by high productivity freight vehicles	per cent	30	25	18
The 2020-21 expected outcome is higher than the 2020-21 target due to the addition of several main routes, including the Loddon Valley Highway, the Murray Valley Highway, the Midland Highway and the Northern Highway. *The higher 2021-22 target reflects additional funding provided through the A more productive road network for freight initiative.*				
Road-based freight accessibility and reliability projects completed within specified scope and standards	per cent	100	100	100
Timeliness				
Road-based freight accessibility and reliability projects completed within agreed timeframes	per cent	80	80	80
Cost				
Total output cost	$ million	97.4	93.9	95.0
Total output cost including the CAC	*$ million*	*97.4*	*93.9*	*95.0*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget. *This output did not have a provision for CAC in previous budgets.*				

Source: Department of Transport

Road Asset Management (2021-22: $ 616.9 million)

This output delivers programs and initiatives to maintain Victoria's freeways and arterial roads.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Bridges maintained: metropolitan	number	984	984	982
Bridges maintained: regional	number	2 232	2 232	2 229
Road area treated: roads in inner metropolitan Melbourne	m^2 (000)	350	nm	nm
This performance measure replaces the 2020-21 performance measure 'Road area treated: roads in metropolitan Melbourne'. The change improves transparency and aligns with Better Roads Victoria Trust Account reporting requirements.				
Road area treated: roads in outer suburban Melbourne	m^2 (000)	690	nm	nm
This performance measure replaces the 2020-21 performance measure 'Road area treated: roads in metropolitan Melbourne'. The change improves transparency and aligsn with Better Roads Victoria Trust Account reporting requirements.				
Road area treated: roads in regional Victoria	m^2 (000)	11 800	13 107	9 306
The 2020-21 expected outcome is higher than the 2020-21 target due to additional roads identified for treatment. The higher 2021-22 target reflects the funding for road maintenance in the financial year.				
Road network maintained: inner metropolitan	m^2 (000)	24 006	nm	nm
This performance measure replaces the 2020-21 performance measure 'Road network maintained: metropolitan'. This change improves transparency and aligns with Better Roads Victoria Trust Account reporting requirements.				
Road network maintained: outer suburban	m^2 (000)	31 632	nm	nm
This performance measure replaces the 2020-21 performance measure 'Road network maintained: metropolitan'. The change improves transparency and aligns with Better Roads Victoria Trust Account reporting requirements.				
Road network maintained: regional	m^2 (000)	173 410	173 410	173 327
Quality				
Bridges that are acceptable for legal load vehicles: metropolitan	per cent	99.7	99.7	99.7
Bridges that are acceptable for legal load vehicles: regional	per cent	99.6	99.6	99.6
Road length meeting cracking standard: metropolitan	per cent	92.8	95.3	95
Road length meeting cracking standard: regional	per cent	95.1	97.5	97
Road length meeting roughness standard: metropolitan	per cent	92.2	93.1	93.2
Road length meeting roughness standard: regional	per cent	93	93.6	94.7
Road length meeting rutting standard: metropolitan	per cent	93.6	95.6	98.6
The lower 2021-22 target reflects the impact of the short-term road maintenance boost funded as part of the Building Works economic stimulus package.				
Road length meeting rutting standard: regional	per cent	97.8	98.4	98.8
Traffic signal operational availability	per cent	100	99.9	100
Traffic signal performance – communications ('DA Alarm'): vehicle detector connectivity to signals	per cent	97	99.6	97
Traffic signal performance – communications ('Stop Talk'): connectivity between different traffic signals	per cent	99.6	99.5	99.6
Timeliness				
Annual road maintenance program completed within agreed timeframes: metropolitan	per cent	100	100	100
Annual road maintenance program completed within agreed timeframes: regional	per cent	100	100	100

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Cost				
Total output cost	$ million	616.9	823.0	807.4
Total output cost including the CAC	*$ million*	*617.0*	*823.0*	*807.4*
The 2020-21 expected outcome is higher than 2020-21 target mainly due to stimulus funding for road maintenance works.				
The 2021-22 target is lower than 2020-21 target primarily due to the forecast completion of maintenance and renewal works and other stimulus works.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget*.*				
The CAC is discontinued from the 2021-22 Budget*.*				

Source: Department of Transport

Transport Infrastructure (2021-22: $ 378.1 million)

This output delivers strategic transport infrastructure and planning initiatives to improve the transport system and transform the way that Victorians travel, to create more productive and liveable cities and regions.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Integrated transport planning to support urban renewal projects	number	4	4	4
Major rail improvement projects completed: regional	number	5	nm	nm
New performance measure for 2021-22 to report on delivery of the Regional Rail Revival program.				
Major road improvement projects completed: metropolitan	number	2	2	3
The 2020-21 expected outcome is lower than the 2020-21 target due to COVID-19 restrictions limiting the on-site workforce.				
The lower 2021-22 target reflects the projects scheduled for delivery in the financial year.				
Major road improvement projects completed: regional	number	3	0	0
The higher 2021-22 target reflects the projects scheduled for delivery in the financial year.				
Planning projects for other major transport infrastructure	number	6	5	5
The higher 2020-21 target reflects the projects scheduled for the year.				
Quality				
Level Crossing Removal Project: milestones delivered in accordance with agreed budget and timelines	per cent	100	100	100
Metro Tunnel Project – milestones delivered in accordance with agreed budget and timelines	per cent	100	100	100
North East Link Project – milestones delivered in accordance with agreed budget and timelines	per cent	100	100	100
West Gate Tunnel Project – milestones delivered in accordance with agreed budget and timelines	per cent	100	100	100
Cost				
Total output cost	$ million	378.1	753.4	636.4
Total output cost including the CAC	*$ million*	*589.2*	*871.2*	*754.4*
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to expenditure reclassification according to accounting standards.				
The 2021-22 target is lower than the 2020-21 target primarily due to infrastructure projects progressing from development phase (supported by operating expenditure) to project delivery phase (supported by capital expenditure).				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget*.*				
The CAC is discontinued from the 2021-22 Budget*.*				

Source: Department of Transport

Objective 4: Sustainably Managed Fish and Boating Resources

This objective supports the development of sustainable fishing and aquaculture activities in Victoria and the delivery of improved recreational fishing and boating services and facilities so that boating and fishing are more accessible to more people and deliver outcomes that provide benefits to Victorians.

The departmental objective indicators are:

- sustainability of assessed fish stocks, and
- improved recreational fishing and boating services and facilities.

Outputs

Sustainably managed fish and boating resources (2021-22: $ 72.8 million)

This output delivers improved recreational boating and fishing services and facilities.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Better boating initiatives commenced	number	16	8	8
The higher 2021-22 target reflects additional funding provided through the Better boating facilities initiative.				
Community and stakeholder engagement information forums – Fisheries	number	10	10	10
Complete stock assessment for key quota managed fish species	number	3	3	3
Complete total allowable commercial catch setting processes for key quota managed fish species	number	3	3	3
Develop, implement and review overarching fisheries compliance strategy	number	1	1	1
Enhance levels of community participation in achieving fisheries compliance through calls to the 13FISH reporting line	number	1 750	1 750	1 750
Key fisheries managed in accordance with best practice management plans	number	6	6	6
Minimum number of uniformed fisheries officers maintaining operational coverage for priority fishing activity periods, as defined by the Compliance Strategic Assessment	number	17	17	17
Native and salmonid fish stocked	number (thousand)	10 000	8 000	8 000
The higher 2021-22 target aligns with the relevant election commitment to stock 10 million fish anually by 2022.				
Recreational boating and fishing infrastructure improvements delivered	number	2	6	6
The lower 2021-22 target reflects the projects scheduled for delivery in the financial year.				
Recreational fishing licences sold online as a proportion of total sales	per cent	90	90	90
Undertake activities to detect, disrupt and dismantle serious or organised fisheries criminal entities (individuals or groups)	number	20	20	20

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quality				
Key statutory obligations relevant to the Victorian Fisheries Authority complied with (tabling annual report, audits, business plan and board appointments)	per cent	100	100	100
Timeliness				
Proportion of fisheries cost recovery levies reviewed and set prior to the commencement of the licensing year (1 April)	per cent	100	100	100
Research project milestones and reports completed on time (Fisheries)	per cent	90	90	90
Cost				
Total output cost	$ million	72.8	54.8	68.2
Total output cost including the CAC	*$ million*	*75.3*	*57.2*	*70.6*

The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the adjusted expenditure profile of the Better Boating fund and free boat ramp launching and parking initiative.
The 2021-22 target is higher than the 2020-21 target primarily due to the adjusted expenditure profile of the Better Boating fund and free boat ramp launching and parking initiative.
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget*.*
The CAC is discontinued from the 2021-22 Budget.

Source: Department of Transport

DEPARTMENT OF TREASURY AND FINANCE

Ministerial portfolios

The Department supports the ministerial portfolios of the Treasurer, Minister for Economic Development, Assistant Treasurer, and Minister for Regulatory Reform.

Departmental mission statement

The Department of Treasury and Finance's mission is to provide economic, commercial, financial and resource management advice to help the Victorian Government deliver its policies.

Departmental objectives

Optimise Victoria's fiscal resources

The Department of Treasury and Finance has a central role in providing high-quality advice to Government on sustainable financial, resource and performance management policy and other key policy priorities; overseeing related frameworks; as well as leading the production of the State budget papers and reports of both financial and non-financial performance in the Victorian public sector.

The Budget and Financial Advice output contributes to this objective by providing strategic, timely and comprehensive analysis and information to Government to support decision-making and reporting.

The Revenue Management and Administrative Services to Government output contributes to this objective by providing revenue management and administration services across the various state-based taxes for the benefit of all Victorians.

Strengthen Victoria's economic performance

The Department of Treasury and Finance provides Government with advice on key economic matters and policies to increase economic productivity, competitiveness and equity across the Victorian economy.

The Economic and Policy Advice output contributes to this objective by providing strategic, timely and comprehensive analysis and information to Government to support decision-making and reporting.

The Economic Regulatory Services output contributes to this objective by providing economic regulation of utilities and other specified markets in Victoria to protect the long-term interests of Victorian consumers with regard to price, quality and reliability of essential services.

The Invest Victoria output contributes to this objective by facilitating private sector investment in Victoria to strengthen innovation, productivity, job creation, and diversification of Victoria's economy.

Improve how Government manages its balance sheet, commercial activities and public sector infrastructure

The Department of Treasury and Finance develops and applies prudent financial and commercial principles and practices to influence and help deliver Government policies focused on overseeing the State's balance sheet, major infrastructure and government business enterprises (in the public non-financial corporations (PNFC) sector and public financial corporations (PFC) sector).

The Commercial and Infrastructure Advice output contributes to this objective by providing strategic, timely and comprehensive analysis and information to Government to support decision-making and reporting.

Deliver strategic and efficient whole of government common services

The Department of Treasury and Finance assists government agencies by delivering integrated and client-centred common services that achieve value for the Victorian public sector.

The Services to Government output contributes to this objective by delivering whole of government services, policies and initiatives in areas including procurement, fleet and accommodation.

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives and outputs, together with key performance indicators, are presented in subsequent tables.

($ million)

	2020-21 budget	*2020-21 revised*	*2021-22 budget*	*Variation [(a)] %*
Optimise Victoria's fiscal resources				
Budget and Financial Advice	32.6	37.3	36.8	12.9
Revenue Management and Administrative Services to Government	146.7	147.0	153.1	4.3
Strengthen Victoria's economic performance				
Economic and Policy Advice	66.4	63.3	96.8	45.8
Economic Regulatory Services	31.6	30.8	31.7	0.3
Invest Victoria	137.3	58.4	147.7	7.6
Improve how Government manages its balance sheet, commercial activities and public sector infrastructure				
Commercial and Infrastructure Advice	77.5	79.6	83.6	7.9
Infrastructure Victoria	9.5	9.5	9.9	4.3
Deliver strategic and efficient whole of government common services				
Services to Government	46.1	42.2	48.9	6.1
Total [(b)(c)]	**547.7**	**468.1**	**608.5**	**11.1**

Source: Department of Treasury and Finance

Notes:

(a) Variation between the 2020-21 budget and the 2021-22 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant output cost.

(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget *and CAC impacts are therefore excluded from the figures. Refer to individual output sections for comparative output costs inclusive of CAC.*

(c) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.18 outlines the Department's income from transactions and Table 2.19 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.18: Income from transactions **($ million)**

	2019-20 actual	*2020-21 budget*	*2020-21 revised*	*2021-22 budget*
Output appropriations [(a)]	441.3	633.1	539.3	587.8
Interest	0.7	0.2	0.2	..
Sale of goods and services	204.4	31.5	31.5	15.2
Grants	8.6	17.3	17.6	18.1
Other income	28.0	36.7	36.7	37.3
Total income from transactions [(b)]	**682.9**	**718.8**	**625.3**	**658.3**

Source: Department of Treasury and Finance

Notes:
(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget.
(b) Table may not add due to rounding.

Table 2.19: Parliamentary authority for resources **($ million)**

	2020-21 budget	*2020-21 revised*	*2021-22 budget*
Annual appropriations	**17 645.2**	**7 819.3**	**20 752.2**
Provision of outputs [(a)]	596.7	480.1	579.3
Additions to the net asset base	123.5	123.8	147.1
Payments made on behalf of the State	16 925.0	7 215.5	20 025.8
Receipts credited to appropriations	**21.0**	**8.5**	**8.5**
Unapplied previous years appropriation	**15.3**	**15.3**	**..**
Provision of outputs	15.3	15.3	..
Additions to the net asset base	..	..	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**17 681.6**	**7 843.1**	**20 760.8**
Special appropriations	**2 747.0**	**2 650.7**	**2 738.5**
Trust funds	**4 316.6**	**4 376.4**	**4 721.2**
Commonwealth Treasury Trust Fund [(b)]	3 833.9	3 881.0	4 201.5
Victorian Transport Fund [(c)]	28.6	40.0	22.7
Other [(d)]	454.1	455.4	497.0
Total parliamentary authority [(e)]	**24 745.1**	**14 870.3**	**28 220.5**

Source: Department of Treasury and Finance

Notes:
(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget.
(b) The purpose of this trust primarily relates to the receipt of Commonwealth Government grants to be on-passed to relevant departments.
(c) The purpose of this trust primarily relates to the use of the funds received from the lease over the operations of the Port of Melbourne towards the removal of level crossings and other transport initiatives.
(d) Includes inter-departmental transfers.
(e) Table may not add due to rounding.

Departmental performance statement

Objective 1: Optimise Victoria's fiscal resources

Under this objective, the Department provides analysis and advice to Government on the management of Victoria's fiscal resources to support decision-making and reporting for the benefit of all Victorians.

The Department leads the development of financial policy advice to Government and the Victorian public sector through detailed analysis of key policy priorities including resource allocation, financial risk and government service performance, financial reporting frameworks, and the State's budget position to inform and support the publication of key whole of state financial reports.

The departmental objective indicators that support the Government to achieve its fiscal objectives are:

- general government net debt as a percentage of gross state product (GSP) to stabilise in the medium term;
- fully fund the unfunded superannuation liability by 2035;
- a net operating cash surplus consistent with maintaining general government net debt at a sustainable level after the economy has recovered after the coronavirus (COVID-19) pandemic;
- general government interest expense as a percentage of revenue to stabilise in the medium term;
- agency compliance with the Standing Directions under the *Financial Management Act 1994*; and
- advice contributes to the achievement of Government policies and priorities relating to optimising Victoria's fiscal resources.

Outputs

Budget and Financial Advice (2021-22: $36.8 million)

This output contributes to the provision of strategic, timely and comprehensive analysis and advice to Ministers, Cabinet and Cabinet Sub-Committees on:

- Victorian public sector resource allocation;
- departmental financial, output and asset delivery performance to support government in making decisions on the allocation of the State's fiscal resources; and
- departmental and agency funding reviews.

This output maintains the integrity of systems and information for financial planning, management, monitoring and reporting of the State of Victoria via:

- a best practice financial reporting framework, and whole of state management information systems, supporting financial reporting across the Victorian public sector;
- publication of the State budget and financial reports, including quarterly, mid-year, annual and estimated financial reports;
- publication of non-financial performance in the Victorian public sector; and
- management of the Public Account operations.

This output develops and maintains cohesive financial and resource management frameworks that drive sound financial and resource management practices in the Victorian public sector by:

- enhancing key frameworks to drive performance;
- monitoring Victorian Public Sector (VPS) agencies' compliance;
- advising government and key stakeholders on financial and resource management and compliance issues;
- ensuring that financial and resource management frameworks are established and complied with;
- promoting continuous improvement in VPS resource allocation and management through regular reviews and updates to ensure the frameworks represent good practice; and
- promoting awareness of financial management accountabilities and roles.

This output contributes to the Department's objective to optimise Victoria's fiscal resources.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of funding reviews contributed to by DTF	number	3	3	3
Quality				
Variance of the revised estimate of general government budget expenditure	per cent	≤5.0	≤5.0	≤5.0
Unqualified audit reports/reviews for the State of Victoria Financial Report and Estimated Financial Statements	number	2	3	2
The 2020-21 expected outcome is higher than the 2020-21 target reflecting the publication of two budgets in 2020-21 (the 2020-21 Budget *was published in November 2020 and the* 2021-22 Budget *in May 2021) and the* 2019-20 Financial Report.				
Recommendations on financial management framework matters made by PAEC and VAGO and supported by Government are actioned	per cent	100	100	100
VPS stakeholder feedback indicates delivery of advice and information sessions supported the financial reporting framework across the VPS and supported the VPS to understand the financial management framework	per cent	80	80	80
Timeliness				
Delivery of advice to Government on portfolio performance within agreed timeframes	per cent	100	100	100
Annual Budget published by date agreed by Treasurer	date	May 2022	May 2021	May 2021
Budget Update, Financial Report for the State of Victoria, Mid-Year Financial Report, and Quarterly Financial Reports are transmitted by legislated timelines	per cent	100	100	100
Annual financial management compliance report for the previous financial year is submitted to the Assistant Treasurer	date	By 15 Dec 2021	23 Apr 2021	By 15 Dec 2020
The 2020-21 expected outcome is later than the 2020-21 target due to impacts of the COVID-19 pandemic.				
Cost				
Total output cost	$ million	36.8	37.3	32.6
Total output cost including the CAC	*$ million*	*37.0*	*37.5*	*32.8*
The 2020-21 expected outcome is higher than the 2020-21 target due to internal reprioritisation of resources required to provide additional analysis and advice on government initiatives relating to the COVID-19 pandemic. *The higher 2021-22 target reflects additional funding for improving expenditure advice, oversight and accountability.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Treasury and Finance

Revenue Management and Administrative Services to Government (2021-22: $153.1 million)

This output provides revenue management and administrative services across the various state-based taxes in a fair and efficient manner for the benefit of all Victorians. By administering Victoria's taxation legislation and collecting a range of taxes, duties and levies, this output contributes to the Department's objective to optimise Victoria's fiscal resources.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Revenue collected as a percentage of State budget target	per cent	≥99	≥99	≥99
Cost to collect $100 of tax revenue raised is less than the average of State and Territory Revenue Offices	achieved/ not achieved	achieved	achieved	achieved
Compliance revenue assessed meets target	per cent	≥95	90	≥95
The 2020-21 expected outcome is lower than the 2020-21 target because during quarter three, a number of compliance programs remained on hold and resources were redirected to deliver the taxation components of the Government's COVID-19 pandemic economic stimulus packages and HomeBuilder. This is likely to continue during quarter four.				
Quality				
Customer satisfaction level	per cent	≥85	96	≥85
Business processes maintained to retain ISO 9001 (Quality Management Systems) Certification	per cent	100	100	100
Ratio of outstanding debt to total revenue (monthly average)	per cent	<2	3.30	<2
The 2020-21 expected outcome is higher than the 2020-21 target due to numerous factors related to the COVID-19 pandemic. This includes granting of payment deferrals and extensions, Land Tax relief applications, and temporary suspension of debt activities such as reminder letters. In addition, legal action and external debt collection reduced payment capacity of taxpayers and carry over of debt from 2019 Land Tax assessments.				
Objections received to assessments issued as a result of compliance projects	per cent	<3	<4	<4
The lower 2021-22 target reflects expected performance following a review.				
Timeliness				
Revenue banked on day of receipt	per cent	≥99	100	≥99
Timely handling of objections (within 90 days)	per cent	≥80	80	≥80
Timely handling of private rulings (within 90 days)	per cent	≥80	80	≥80
Cost				
Total output cost	$ million	153.1	147.0	146.7
Total output cost including the CAC	*$ million*	*153.7*	*147.8*	*147.5*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Treasury and Finance

Objective 2: Strengthen Victoria's economic performance

Under this objective, the Department delivers advice on economic policy, forecasts, legislation and frameworks. It also supports Government by administering economic regulation of utilities and other specified markets in Victoria to protect the long-term interests of Victorian consumers with regard to price, quality, efficiency and reliability of essential services.

The Department leads the development of advice to Government on key economic and financial strategies including regulatory reform, Government tax policy and intergovernmental relations to drive improvements in Victoria's productive and efficient resource allocation, competitiveness and equity across the Victorian economy.

Invest Victoria contributes to the Department's objective to strengthen Victoria's economic performance through facilitating private sector investment in Victoria. This is achieved through a focus on investments that strengthen innovation, productivity, job creation and diversification of Victoria's economy.

The departmental objective indicators are:

- economic growth to exceed population growth as expressed by GSP per capita increasing in real terms (annual percentage change);
- total Victorian employment to grow each year (annual percentage change); and
- advice contributes to the achievement of Government policies and priorities relating to economic and social outcomes.

Outputs

Economic and Policy Advice (2021-22: $96.8 million)

This output contributes to the Department's objective to strengthen Victoria's economic performance through increased productive and efficient resource allocation, competitiveness and equity by providing evidence, advice and engagement on:

- medium and longer-term strategies to strengthen productivity, participation and the State's overall competitiveness;
- State tax and revenue policy;
- intergovernmental relations, including the distribution of Commonwealth funding to Australian states and territories (including representation on various inter-jurisdictional committees);
- production of the economic and revenue forecasts that underpin the State budget;
- economic cost benefit analysis, demand forecasting and evaluation of best practice regulatory frameworks; and
- approaches for innovative, effective and efficient delivery of government services, including social services.

This output also provides advice on ways the Government can improve the business environment by the Commissioner for Better Regulation and Red Tape Commissioner:

- reviewing Regulatory Impact Statements, Legislative Impact Assessments, and providing advice for Regulatory Change Measurements;
- assisting agencies to improve the quality of regulation in Victoria and undertaking research into matters referred to it by the Government;
- operating Victoria's competitive neutrality unit; and
- working with businesses and not-for-profit organisations to identify and solve red tape issues.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Economic research projects and papers completed that contribute to deeper understanding of economic issues and development of government policy	number	8	8	8
Regulation reviews completed	number	6	nm	nm
New performance measure for 2021-22 reflects funding approved for regulation reviews.				
High-level engagement with non-Victorian Public Service stakeholder groups that contributes to public policy debate	number	20	20	20
Quality				
Conduct an annual survey to assess the impact of changes to Victorian regulations on business	number	1	1	1
Accuracy of estimating State taxation revenue in the State budget	percentage variance	≤5.0	≤5.0	≤5.0
Accuracy of estimating the employment growth rate in the State budget	percentage point variance	≤1.0	na	≤1.0
The outcome for employment growth estimate will be available in July 2021.				
Accuracy of estimating the gross state product rate in the State budget	percentage point variance	≤1.0	na	≤1.0
The gross state product growth estimate will be available in November 2021.				
Better Regulation Victoria's support for preparing Regulatory Impact Statements or Legislative Impact Assessments was valuable overall, as assessed by departments	per cent	90	90	90
Proportion of people making inquiries to the Red Tape Unit who found it responsive to issues raised	per cent	80	80	80
This performance measure renames the 2020-21 performance measure 'Proportion of people making inquiries to the Red Tape Unit who found it responsive and helpful' to better reflect the intent of the measure.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Timeliness				
Briefings on key Australian Bureau of Statistics economic data on day of release	per cent	100	100	100
Better Regulation Victoria's advice on Regulatory Impact Statements or Legislative Impact Assessments was timely, as assessed by departments	per cent	90	90	90
Regulation reviews completed by scheduled date *New performance measure for 2021-22.*	per cent	100	nm	nm
Cost				
Total output cost	$ million	96.8	63.3	66.4
Total output cost including the CAC	*$ million*	*97.1*	*63.6*	*66.6*
The higher 2021-22 target includes social housing initiatives which have been delayed due to the COVID-19 pandemic and related economic conditions. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Treasury and Finance

Economic Regulatory Services (2021-22: $31.7 million)

This output provides economic regulation of utilities and other specified markets in Victoria to protect the long-term interests of Victorian consumers with regard to price, quality, reliability and efficiency of essential services. By providing these services, this output contributes to the Departmental objective to strengthen Victoria's economic performance.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
New or revised regulatory instruments issued *The 2020-21 expected outcome is higher than the 2020-21 target because of the amendment of regulatory instruments due to the COVID-19 pandemic to provide additional protection to customers and small business in accordance with National Cabinet debt recovery principles.*	number	9	11	9
Performance reports for regulated businesses or industries *The 2020-21 expected outcome is higher than the 2020-21 target due to the commencement of unplanned monthly COVID-19 pandemic reporting by the Energy Division following the onset of the COVID-19 pandemic.* *The lower 2021-22 target is due to the local government outcomes report being required only every two years.*	number	12	24	13
Performance reviews and compliance audits of regulated businesses *The lower 2021-22 target is due to a change in the mix of audits because of changed operational requirements.*	number	142	147	143
Price approvals of regulated businesses	number	20	20	20

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Registration, project-based activity, product and accreditation decisions/approvals in relation to the Victorian Energy Upgrades program	number	5 250	4 000	5 000
This performance measure renames the 2020-21 performance measure 'Registration and accreditation decisions/approvals in relation to the Victorian Energy Efficiency Target Scheme' to better define the types of decisions included in the measure. *The 2020-21 expected outcome is lower than the 2020-21 target due to COVID-19 pandemic restrictions causing a significant reduction in residential activity resulting in fewer submissions for approval.* *The higher 2021-22 target reflects additional funding approved for the Expansion of the Victorian Energy Upgrade program.*				
Reviews, investigations or advisory projects	number	2	6	3
The 2020-21 expected outcome is higher than the 2020-21 target due to an additional review survey in relation to COVID-19 pandemic impacts and other projects not envisaged when targets were set. *The lower 2021-22 target is due to an increased focus to be given to a single retail energy market competition review compared with previous allowances for two reviews.*				
Compliance and enforcement activities – energy	number	150	150	36
The 2020-21 expected outcome is higher than the 2020-21 target due to additional compliance and enforcement activity as a result of additional funding received in the 2019-20 Budget. *The higher 2021-22 target reflects the passage of the Essential Services Commission (Compliance and Enforcement Powers) Amendment Bill 2019 and the changes to the nature and number of activities undertaken.*				
Setting of regulated price and tariffs	number	15	17	16
The 2020-21 expected outcome is higher than the 2020-21 target due to an additional tariff decision (the 2020-21 target was incorrectly reported as 6 in the 2020-21 Budget*).* *The lower 2021-22 target reflects no water price determination being required in that year.*				
Quality				
Decisions overturned on review or appeal	number	0	nm	nm
This performance measure replaces the 2020-21 performance measure 'Decisions upheld where subject to review, appeal or disallowance' to better measure outcomes of reviews and appeals of Commission decisions.				
Timeliness				
Delivery of major milestones within agreed timelines	per cent	100	100	100
Cost				
Total output cost	$ million	31.7	30.8	31.6
Total output cost including the CAC	*$ million*	*31.7*	*30.9*	*31.7*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Treasury and Finance

Invest Victoria (2021-22: $147.7 million)

This output contributes to the Department's objective to strengthen Victoria's economic performance through facilitating private sector investment in Victoria. This is achieved through a focus on investments that strengthen innovation, productivity, job creation and export growth in Victoria's economy.

This output also provides support and advice to Government on Victoria's long-term economic development, including in relation to:

- ensuring Victoria is a leading destination for business, innovation and talent globally;
- continuous enhancement on Victoria's approach to investment attraction; and
- enhancing Victoria's business investment environment.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Jobs generated from international investment secured through Government facilitation services and assistance	number	1 250	nm	nm
New performance measure for 2021-22 to reflect Invest Victoria's focus on attracting foreign direct investment and replaces the previous whole of government measures 'Jobs resulting from government investment facilitation services and assistance' and 'New investment resulting from government facilitation services and assistance'. This measure contributes to the 2021-22 Victorian Jobs and Investment Fund targets.				
Wages generated from international investment secured through Government facilitation services and assistance	$ million	110	100	85
The 2020-21 expected outcome is higher than the 2020-21 target as a result of foreign-owned companies that have grown during the pandemic and facilitated by Invest Victoria. *The higher 2021-22 target reflects the increased focus by Invest Victoria on highly skilled jobs and attraction of innovative investments in line with the objectives of the International Investment Strategy.*				
Innovation expenditure generated from international investment secured through Government facilitation services and assistance	$ million	60	120	60
The 2020-21 expected outcome is higher than the 2020-21 target due to an extraordinary Information and Communications Technology project secured by Invest Victoria in 2020-21.				
Cost				
Total output cost	$ million	147.7	58.4	137.3
Total output cost including the CAC	*$ million*	*147.8*	*58.6*	*137.4*
The 2020-21 expected outcome is lower than the 2020-21 target due to the delays in a range of grants programs resulting from the COVID-19 pandemic and related economic conditions. *The higher 2021-22 target includes a range of grants programs which have been delayed due to the COVID-19 pandemic and related economic conditions.* *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Treasury and Finance

Objective 3: Improve how Government manages its balance sheet, commercial activities and public sector infrastructure

Under this objective, the Department delivers Government policies focused on overseeing the State's balance sheet, major infrastructure and Government Business Enterprises by the delivery and application of prudent financial and commercial principles and practices.

The Department leads the development of strategic commercial and financial advice to Government to support key decisions regarding the State's financial assets and liabilities and infrastructure investment to drive improvement in public sector commercial and asset management and the delivery of infrastructure for the State of Victoria.

The departmental objective indicators are:

- High-Value High-Risk (HVHR) projects have had risks identified and managed through tailored project assurance, policy advice and governance to increase the likelihood that projects are completed within agreed timeframes, budget and scope;
- Government Business Enterprises performing against agreed financial and non-financial indicators;
- advice contributes to the achievement of Government policies and priorities relating to Victoria's balance sheet, commercial activities and public sector infrastructure; and
- quality infrastructure drives economic growth activity in Victoria.

Outputs

Commercial and Infrastructure Advice (2021-22: $83.6 million)

This output contributes to the Department's objective to improve how Government manages its balance sheet, commercial activities and public sector infrastructure by:

- providing advice to Government and guidance to departments on infrastructure investment and other major commercial projects;
- overseeing a range of commercial and transactional activities on behalf of Government, including providing governance oversight of Government Business Enterprises and advice to Government, departments and agencies relating to future uses or disposal of surplus government land, management of contaminated land liabilities, office accommodation for the public service, and management of the Greener Government Buildings Program;
- providing advice and reports on the State's financial assets and liabilities and associated financial risks, including the State's investments, debts, unfunded superannuation, insurance claims liabilities and overseeing the registration and regulation of rental housing agencies;
- providing commercial, financial and risk management advice to Government and guidance to departments regarding infrastructure projects including Partnerships Victoria projects, administration of the Market-led Proposals Guideline and managing major commercial activities on behalf of Government;

- Office of Projects Victoria (OPV) providing project advice on technical, scope, cost and scheduling matters at key milestones in a project's lifecycle to complement the economic, financial, contractual and risk advice provided by the Department;
- overseeing potential commercialisation opportunities; and
- producing budget and financial reporting data for Government Business Enterprise sectors.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Gateway reviews undertaken	number	70	70	70
Develop and implement policy guidance and infrastructure investment frameworks to govern and build capability to deliver infrastructure	number	58	58	58
Develop and implement training to build capability to deliver infrastructure	number	56	56	56
Undertake project reviews to support the Government's program in the delivery of public infrastructure projects	number	12	8	8
This performance measure renames the 2020-21 performance measure 'Undertake independent project assurance reviews to support the government's assurance program in the delivery of public infrastructure projects'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity. *The higher 2021-22 target reflects funding approved for project reviews in the* 2021-22 Budget.				
Number of cost redesign reviews undertaken	number	9	nm	nm
New performance measures for 2021-22 to reflect new funding for cost redesign work.				
Revenue from sale of surplus Government land including Crown land	$ million	150	100	150
The 2020-21 expected outcome is lower than the 2020-21 target as most land sales were delayed for the first six months of 2020-21 due to COVID-19 pandemic restrictions preventing auctions from being held.				
Provision of PNFC/PFC financial estimates and actuals, along with commentary and analysis, for the State budget papers and financial reports	number	6	6	6
Number of HVHR project assurance plans in place	number	6	14	14
The lower 2021-22 target reflects funding approved for HVHR projects in the 2021-22 Budget.				
Quality				
Conduct surveys on the stakeholder experiences of OPV initiatives to determine the effectiveness of project system initiatives, technical advice and trainings provided to internal government clients	grading	satisfactory	satisfactory	satisfactory
Percentage of registered housing agencies assessed annually as meeting performance standards	per cent	90	100	90
The 2020-21 expected outcome is higher than the 2020-21 target, reflecting all annual Compliance Assessments completed by the target date of 31 March 2021.				
Credit agencies agree that the presentation and information provided support annual assessment	per cent	80	100	80
The 2020-21 expected outcome is higher than the 2020-21 target, reflecting the quality of the presentation delivered.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Senior responsible owner agrees Gateway review was beneficial and would impact positively on project outcomes	per cent	90	100	90
The 2020-21 expected outcome is higher than the 2020-21 target as there were no negative responses received.				
Timeliness				
Advice provided to Government on board appointments at least three months prior to upcoming board vacancies	per cent	100	100	100
Analysis and review of corporate plans within two months of receipt	per cent	95	100	95
The 2020-21 expected outcome is higher than the 2020-21 target, reflecting that all corporate plans received were analysed and reviewed within two months of receipt.				
Dividend collection in accordance with budget decisions	per cent	100	100	100
Develop and implement reporting to ensure the effective monitoring of the delivery of HVHR public infrastructure commitments	per cent	100	100	100
Cost				
Total output cost	$ million	83.6	79.6	77.5
Total output cost including the CAC	*$ million*	*96.3*	*92.0*	*96.3*
The higher 2021-22 target reflects additional funding for monitoring and assurance of the State Capital Program, providing advice on infrastructure investments and overseeing a range of commercial and transactional activities on behalf of the Government. *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Treasury and Finance

Infrastructure Victoria (2021-22: $9.9 million)

This output provides independent and transparent advice to government on infrastructure priorities and sets a long-term strategy for infrastructure investment.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of publications or discussion papers released	number	6	6	6
Quality				
Stakeholder satisfaction with consultation process	per cent	75	77	75
Timeliness				
Delivery of research, advisory or infrastructure strategies within agreed timelines	per cent	100	100	100
Cost				
Total output cost	$ million	9.9	9.5	9.5
Total output cost including the CAC	*$ million*	*9.9*	*9.9*	*9.9*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Department of Treasury and Finance

Objective 4: Deliver strategic and efficient whole of government common services

Under this objective, the Department delivers whole of government common services through working with business partners.

The Department leads the delivery of integrated and client-centred whole of government services, policies and initiatives to achieve value for the Victorian public sector. Areas include procurement, office accommodation management, carpool and government library services.

The departmental objective indicators are:

- benefits delivered as a percentage of expenditure by mandated agencies under state purchase contracts managed by the department, including reduced and avoided costs;
- low vacancy rates for government office accommodation maintained; and
- high-quality whole of government common services provided to government agencies, as assessed by feedback from key clients.

Outputs

Services to Government (2021-22: $48.9 million)

The output contributes to the Department's objective of delivering strategic and efficient whole of government common services to the Victorian public sector by:

- developing and maintaining a framework of whole of government policies, strategies, standards and guidelines which promote the efficient and effective use of common services including procurement, office accommodation management, carpool and government library services;
- managing a program of whole of government procurement contracts to ensure optimum benefit to government;
- supporting the operations of the Victorian Government Purchasing Board;
- providing strategic and fit-for-purpose shared services advisory to clients to deliver value to the Victorian Government;
- providing whole of government office accommodation and accommodation management; and
- providing carpool and government library services.

The performance measures below compare targets and expected results from the delivery of programs and services as part of this output.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Total accommodation cost	$ per square metre per year	397	397	397
Workspace ratio	square metre per FTE	12.0	12.0	12.0
Quality				
Client agencies' satisfaction with the service provided by the Shared Service Provider	per cent	70	70	70
Cost				
Total output cost	$ million	48.9	42.2	46.1
Total output cost including the CAC	*$ million*	*115.4*	*99.5*	*94.7*

The 2020-21 expected outcome is lower than the 2020-21 target reflecting lower depreciation expenses than expected.
The higher 2021-22 target is due to additional funding to support the replacement of 400 government vehicles to zero emission vehicles.
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.

Source: Department of Treasury and Finance

PARLIAMENT (INCLUDING THE VICTORIAN AUDITOR-GENERAL'S OFFICE, PARLIAMENTARY BUDGET OFFICE, AND THE INTEGRITY AGENCIES)

The Parliament of Victoria is an independent body that, through its elected representatives, is accountable to the Victorian community for the provision and conduct of representative government in the interests of Victorians.

The Parliament of Victoria's vision is to deliver apolitical, professional and innovative services which will support Victoria's elected representatives and the Parliament as an institution to ensure the proper, effective and independent functioning of the Parliament.

Victorian Auditor-General's Office

Victoria's *Constitution Act 1975* provides that the Auditor-General is an independent officer of Parliament. For budgetary purposes, the Victorian Auditor-General's Office is included as an output classification within Parliament.

The main purpose of the Victorian Auditor-General's Office is to provide assurance to Parliament on the accountability and performance of the Victorian public sector.

Parliamentary Budget Office

The Parliamentary Budget Office informs policy choices by providing trusted fiscal, economic and financial advice.

Independent Broad-based Anti-corruption Commission

The Independent Broad-based Anti-corruption Commission (IBAC) is Victoria's independent anti-corruption agency responsible for identifying and preventing public sector corruption and police misconduct. Our jurisdiction covers state and local government, police, parliament and the judiciary.

The Commissioner is appointed by the Governor in Council and holds office for a term of five years. For budgetary purposes, the Independent Broad-based Anti-corruption Commission is included as an output classification within Parliament. The Independent Broad-based Anti-corruption Commission reports direct to Parliament.

Under the General Order, The Attorney-General is responsible for overseeing IBAC's legislation.

Victorian Inspectorate

The Inspector is appointed by the Governor in Council and holds office for a term of five years. As an Independent Officer of the Parliament, the Inspector reports directly to Parliament and does not report to any Minister. For budgetary purposes, the Victorian Inspectorate (VI) is included as an output classification within Parliament. The VI was established in 2013 by the *Victorian Inspectorate Act 2011*, to provide oversight of other integrity, accountability or investigatory bodies and their officers.

Victorian Ombudsman

The Victorian Ombudsman provides a service essential to promoting public confidence in the integrity of government. In view of the unique nature of its work, investigating government-related decisions and promoting accountability, the Victorian Ombudsman seeks to be above, and be seen to be above, the politics of the day, funded to do the job expected by Parliament.

The Ombudsman acts to ensure fairness for Victorians in their dealings with the public sector and to improve public administration. The Ombudsman is open, transparent and evidence-based, focussing on practical and meaningful outcomes to address injustice. The Ombudsman is sensitive to the circumstances of individuals and communities with specific needs.

Departmental objectives

Parliament

The Departments of the Parliament of Victoria aim to:

- support members to fulfil their roles;
- protect the independence and integrity of Parliament;
- inform and engage with the community;
- engage with Victoria's First People; and
- ensure the organisational resilience and efficiency of Parliament.

Victorian Auditor-General's Office

The Victorian Auditor-General's Office vision is for 'Better lives for Victorians through our insights and influence' and aims to:

- increase our relevance – be more relevant by delivering credible and authoritative reports and advice about things that matter and will make a difference;
- grow our influence – be valued for our independence and more influential because of the unique perspectives provided;
- invest in our people – enable high performance by our people through a supportive culture, professional development and collaboration; and
- lead by example – model exemplary performance in everything the Victorian Auditor-General's Office does.

Parliamentary Budget Office

The Parliamentary Budget Office:

- provides members of parliament with ongoing, authoritative, independent, and credible policy costing and advisory services;
- provides policy costing and advisory services that are delivered in a timely, relevant, and readily understandable manner; and
- informs policy development and public debate in the Parliament and the community.

Independent Broad-based Anti-corruption Commission

The Independent Broad-based Anti-corruption Commission aims to prevent and expose public sector corruption and police misconduct in Victoria.

The Commission does this by:

- receiving and assessing complaints and notifications, including assessing all complaints to see if they qualify as public interest disclosures;
- referring matters to other appropriate agencies (such as public sector bodies and integrity agencies) for action;
- investigating allegations of serious or systemic corruption and police misconduct; and
- undertaking strategic research and other initiatives to inform the public sector, police and the community of the detrimental impacts of corruption and how it can be prevented.

Victorian Inspectorate

The Victorian Inspectorate's vision is that Victoria's integrity system is robust and trusted.

Aspirations

Public confidence and trust in Victoria's integrity system

- The right checks and balances are in place.
- The community knows to come to the VI to protect their rights.
- Intrusive and coercive powers are exercised lawfully.

A robust Victorian integrity system

- Parliament has confidence in the VI.
- The VI is positively influencing the conduct of integrity agencies.
- The public sector is being held to account.

Victorian Ombudsman

The Ombudsman acts to ensure fairness for Victorians in their dealings with the public sector and to improve public administration. The Ombudsman is open, transparent and evidence-based, focusing on practical and meaningful outcomes to address injustice. The Ombudsman is sensitive to the circumstances of individuals and communities with specific needs.

Complaint resolution

- Provides timely, efficient, effective, flexible and independent means of complaint resolution.
- Facilitates the mitigation or rectification of mistakes in public administration.

Accountability

- Independently investigates serious matters.
- Reports on misconduct and poor administration.
- Provides authoritative and informative reports to the Victorian Parliament.

Access

- Makes it easier for vulnerable people to complain.
- Prioritises the most vulnerable and disadvantaged groups in Victoria.

Effectiveness

- Constructively assists the public sector to continuously improve its standards and practices through agreed improvements to practice, policy or law reform.
- Assists public sector agencies to learn from complaints and investigations.
- Investigates systemic issues and identify solutions.

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2020-21 budget	*2020-21 revised*	*2021-22 budget*	*Variation [(a)] %*
Legislative Council	22.8	19.9	23.5	3.2
Legislative Assembly	44.8	38.4	45.1	0.7
Parliamentary Investigatory Committees	5.5	5.5	6.0	9.1
Parliamentary Services	134.0	127.4	133.7	(0.2)
Parliamentary Budget Office	3.3	3.2	3.3	..
Victorian Inspectorate	6.5	5.3	7.3	12.3
Victorian Auditor-General's Office	45.2	45.2	46.8	3.5
Independent Broad-based Anti-corruption Commission	48.4	48.4	54.0	11.6
Victorian Ombudsman	19.6	19.6	20.2	3.1
Total [(b)(c)]	**330.1**	**312.9**	**339.9**	**3.0**

Sources: Parliament of Victoria, Victorian Auditor-General's Office and Parliamentary Budget Office, Victorian Inspectorate, Victorian Ombudsman, Independent Broad-based Anti-corruption Commission

Notes:

(a) Variation between 2020-21 budget and 2021-22 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant outputs.

(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget and CAC impacts are therefore excluded from the figures. Refer to individual output sections for comparative output costs inclusive of CAC.

(c) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.20 outlines the Department's income from transactions and Table 2.21 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.20: Income from transactions **($ million)**

	2019-20 actual	*2020-21 budget*	*2020-21 revised*	*2021-22 budget*
Output appropriations [(a)]	189.6	275.9	268.2	282.6
Special appropriations	44.2	56.0	46.7	56.1
Sale of goods and services	1.3	0.1	0.1	0.0
Total income from transactions [(b)]	**235.1**	**332.0**	**315.0**	**338.8**

Source: Parliament of Victoria, Victorian Auditor-General's Office, Parliamentary Budget Office, Victorian Inspectorate, Victorian Ombudsman and Independent Broad-based Anti-corruption Commission

Notes:
(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget*.*
(b) Table may not add due to rounding.

Table 2.21: Parliamentary authority for resources **($ million)**

	2020-21 budget	*2020-21 revised*	*2021-22 budget*
Annual appropriations	**250.7**	**240.5**	**264.1**
Provision of outputs [(a)]	241.5	233.8	248.2
Additions to the net asset base	9.2	6.6	15.9
Payments made on behalf of the State	..	..	..
Receipts credited to appropriations	**27.1**	**27.1**	**27.7**
Unapplied previous years appropriation	**7.3**	**7.3**	**6.7**
Provision of outputs	7.3	7.3	6.7
Additions to the net asset base	..	..	0.1
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**285.1**	**274.9**	**298.6**
Special appropriations	**74.8**	**65.5**	**56.1**
Trust funds	**0.0**	**0.0**	**..**
Total parliamentary authority [(b)]	**359.9**	**340.4**	**354.7**

Source: Parliament of Victoria, Victorian Auditor-General's Office, Parliamentary Budget Office, Victorian Inspectorate, Victorian Ombudsman and Independent Broad-based Anti-corruption Commission

Notes:
(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget*.*
(b) Table may not add due to rounding.

Departmental performance statement

Outputs

Legislative Council (2021-22: $23.5 million)

This output involves the provision of procedural advice to Members of the Legislative Council including: processing of legislation; preparation of the records of the proceedings and documentation required for the sittings of the Council; provision of assistance to Parliamentary Committees; provision of information relating to the proceedings of the Council; and the enhancement of public awareness of Parliament.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Procedural References – updates published biannually	number	2	2	2
Quarterly allowance reports published in accordance with Victorian Independent Remuneration Tribunal and Improving Parliamentary Standards Act 2019	number	4	4	4
Quality				
Bills and amendments processed accurately through all relevant stages and other business of the House conducted according to law, Standing and Sessional Orders	per cent	98	98	98
Member satisfaction with accuracy, clarity and timeliness of advice	per cent	80	80	80
Timeliness				
Documents tabled within time guidelines	per cent	90	90	90
House documents and other Sitting related information available one day after sitting day	per cent	95	95	95
Cost				
Total output cost	$ million	23.5	19.9	22.8
Total output cost including the CAC	*$ million*	*23.5*	*19.9*	*22.8*

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.
This output did not have a provision for CAC in previous budgets

Legislative Assembly (2021-22: $45.1 million)

This output involves the provision of procedural advice to Members of the Legislative Assembly including: processing of legislation; preparation of the records of the proceedings and documentation required for the sittings of the Assembly; provision of assistance to Parliamentary Committees; provision of information relating to the proceedings of the Assembly; and the enhancement of public awareness of Parliament.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Procedural References – updates published biannually	number	2	2	2
Quarterly allowance reports published in accordance with Victorian Independent Remuneration Tribunal and *Improving Parliamentary Standards Act 2019*	number	4	4	4
Regional visits to schools to conduct Parliamentary role plays	number	5	5	5
Quality				
Bills and amendments processed accurately through all relevant stages in compliance with constitutional requirements and standing orders	per cent	100	100	100
Member satisfaction that advice is responsive, prompt, clear and objective	per cent	80	80	80
Teacher satisfaction with tours of Parliament for school groups	per cent	95	95	95
Timeliness				
Documents tabled within time guidelines	per cent	90	90	90
House documents available one day after sitting day	per cent	100	100	100
Online information relating to bills updated within one day	per cent	95	95	95
Cost				
Total output cost	$ million	45.1	38.4	44.8
Total output cost including the CAC	*$ million*	*45.1*	*38.4*	*44.8*

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.
This output did not have a provision for CAC in previous budgets

Parliamentary Investigatory Committees (2021-22: $6.0 million)

Joint Investigatory Committees are appointed pursuant to the *Parliamentary Committees Act 2003* to inquire into and report on matters referred by either House or the Governor in Council, or which may be self-generated by a committee.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Reports tabled per annum	number	20	20	20
Quality				
Committee members satisfied that advice about procedure, research and administration is responsive, clear, objective and prompt	per cent	80	80	80
Inquiries conducted and reports produced in compliance with procedural and legislative requirements	per cent	95	95	95
Timeliness				
Reports tabled in compliance with procedural and legislative deadlines	per cent	95	95	95
Cost				
Total output cost	$ million	6.0	5.5	5.5
Total output cost including the CAC	*$ million*	*6.0*	*5.5*	*5.5*

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.
This output did not have a provision for CAC in previous budgets.

Source: Parliament of Victoria

Parliamentary Services (2021-22: $133.7 million)

Parliamentary Services provides consultancy, advisory and support services in the areas of library, Hansard, education, human resources, finance, security, information technology (IT), maintenance, grounds and facilities along with planning, implementation and management of capital projects, for the Parliament of Victoria.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Percentage of chamber proceedings available to MPs and Electorate Officers through Video on Demand.	per cent	99	99	99
Quarterly budget reports published in accordance with Victorian Independent Remuneration Tribunal and *Improving Parliamentary Standards Act 2019*	number	4	4	4
Provide MPs with an approved standard electorate office	per cent	95	95	95
Quality				
Clients satisfied with quality of information provided by Library staff	per cent	85	85	85
MP Offices visited by a member of DPS Staff during the year	per cent	95	95	95
Legislative activities at Parliament House undisrupted by service interruptions or security incidents	per cent	98	98	98
Scheduled availability of IT systems (network, email, and windows file and print)	per cent	99	99	99
Timeliness				
Indexes, records, speeches, video and transcripts available within published timeframes *The 2021-22 target has been reduced due to staff potentially continuing to work remotely as a result of coronavirus (COVID-19).*	per cent	85	90	90
Payroll processing completed accurately and within agreed timeframes	per cent	99	99	99
Monthly budget management reports to MPs and departments within five business days after closing monthly accounts	number	12	12	12
Cost				
Total output cost	$ million	133.7	127.4	134.0
Total output cost including the CAC *The output cost including the CAC is provided for comparative purposes in the* 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.	*$ million*	*142.3*	*134.4*	*141.0*

Source: Parliament of Victoria

Parliamentary Budget Office (2021-22: $3.3 million)

The Parliamentary Budget Office provides independent and confidential policy costing and advisory services to all members of parliament

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of requests	number	100	210	na
Request completion rate	per cent	80	85	80
Quality				
Satisfaction of parliamentary stakeholders	per cent	80	80	80
Timeliness				
Requests responded to by due date	per cent	80	95	80
Cost				
Total output cost	$ million	3.3	3.2	3.3
Total output cost including the CAC	*$ million*	*3.3*	*3.2*	*3.3*

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.
This output did not have a provision for CAC in previous budgets.

Source: Parliamentary Budget Office

Victorian Inspectorate (2021-22: $7.3 million)

The Victorian Inspectorate (VI) was established to provide oversight of other integrity, accountability or investigatory bodies and their officers. The VI is committed to providing the Parliament and the people of Victoria with independent assurance that these bodies, which collectively constitute Victoria's 'integrity system', act lawfully and properly in the performance of their functions. Under the *Victorian Inspectorate Act 2011*, the VI receives and investigates complaints, monitors how bodies use their coercive powers and inspects records of bodies that use covert powers including the conduct of controlled operations and the use of surveillance devices and police counter-terrorism powers. In addition, the VI has a key function under the *Public Interest Disclosures Act 2012* to receive disclosures and to assess and investigate some public interest complaints.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Recommendations of the VI accepted by agencies	per cent	75	75	75
Reasons for decisions provided for complaint outcomes	per cent	100	100	100
Quality				
Improvements to the integrity system	number	6	5	5
Cost				
Total output cost	$ million	7.3	5.3	6.5
Total output cost including the CAC	*$ million*	*7.4*	*5.4*	*6.6*

The 2020-21 expected outcome is lower than the target primarily due to budgets rephased into 2021-22 from 2020-21.
The 2021-22 target is higher than the 2020-21 target primarily due to higher funding allocated in 2021-22 for the VI's fiscal sustainability and budgets rephase.
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.

Source: Victorian Inspectorate

Victorian Auditor-General's Office

The purpose of the Victorian Auditor-General's Office is to help the Parliament hold government to account and help the public sector to improve its performance. Under the *Audit Act 1994*, the Auditor-General audits financial statements prepared by Victorian public sector agencies and issues audit reports. In addition, the Auditor-General carries out performance audits and assurance reviews to determine whether authorities, operations or activities are operating effectively, economically and efficiently in compliance with all relevant Acts.

Audit opinions on financial and performance statements (2021-22: $28.4 million)

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Average cost of audit opinions issued on performance statements	$ thousand	5.4	5.2	5.3
The higher 2021-22 target reflects indexation offset by internal efficiencies.				
Average cost of audit opinions issued on the financial statements of agencies	$ thousand	50.0	48.8	51.0
The lower 2020-21 target reflects changes to the mix in size and number of audited entities and internal efficiencies.				
Quality				
External/peer reviews finding no material departures from professional and regulatory standards	per cent	100	93	100
The 2020-21 expected outcome is lower than the 2020-21 target because one of the 15 audit files reviewed was found to have some material departures from professional standards. Despite this, VAGO is expected to observe a very low disclosure rate of prior period errors by agencies during 2020-21, which indicates that any identified material departures from standards are not leading to significant or systemic material misstatements.				
Proportion of agencies disclosing prior period material errors in financial statements	per cent	≤5	1.6	≤5
Timeliness				
Audit opinions issued within statutory deadlines	per cent	98	98	98
Management letters to agencies issued within established timeframes	per cent	90	90	90
Cost				
Total output cost	$ million	28.4	27.9	27.9
Total output cost including the CAC	*$ million*	*28.5*	*28.0*	*28.0*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Victorian Auditor-General's Office

Parliamentary reports and services (2021-22: $18.4 million)

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Average cost of parliamentary reports	$ thousand	527	508.8	519
The higher 2021-22 target reflects changes to the audit mix – fewer limited scope and follow-up performance audits and a greater focus on delivering broader-scoped performance audits.				
Quality				
Percentage of performance audit recommendations accepted which are reported as implemented by audited agencies	per cent	80	80	80
Overall level of external satisfaction with audit reports and services — parliamentarians	per cent	85	85	85
Timeliness				
Average duration taken to finalise responses to inquiries from Members of Parliament (MPs)	days	≤20	15	≤20
Average duration taken to produce performance audit parliamentary reports	months	≤9	11.9	≤9
The 2020-21 expected outcome is higher than the 2020-21 target as agencies requested more time to respond due to the impacts of COVID-19, replacement of audit staff due to unexpected leave and departures, and needing to undertake additional unplanned work either due to new evidence, or to obtain sufficient and appropriate evidence to support conclusions and findings.				
Average duration taken to produce financial audit parliamentary reports after balance date	months	≤5	6.7	≤5
The 2020-21 expected outcome is higher than the 2020-21 target due to the impact of COVID-19 and extensions granted for annual reporting in the local government sector.				
Cost				
Total output cost	$ million	18.4	17.3	17.3
Total output cost including the CAC	*$ million*	*18.4*	*17.4*	*17.4*
The higher 2021-22 target reflects indexation.				
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.				
The CAC is discontinued from the 2021-22 Budget.				

Source: Victorian Auditor-General's Office

Independent Broad-based Anti-corruption Commission (2021-22: $54.0 million)

The Independent Broad-based Anti-corruption Commission (IBAC) is Victoria's agency responsible for preventing and exposing public sector corruption and police misconduct. Our jurisdiction covers state and local government, police, parliament and the judiciary.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Corruption prevention measures delivered by IBAC	number	100	113	90
The higher 2021-22 target reflects additional funding approved for corruption prevention measures. *The 2020-21 expected outcome is higher than the 2020-21 target due to the increase in number of prevention resources published on IBAC's website and additional speaking engagements with Victoria Police*				
Quality				
Satisfaction rating with corruption prevention initiatives delivered by IBAC	per cent	95	97	95
Timeliness				
Public Interest Disclosure (PID) complaints and notifications assessed within 30 days	per cent	70	nm	nm
The new output measure pertaining to PID complaints and notifications assessed within 30 days is a metric that is not currently tracked. Consequently, 2020-21 target measures for this output have not been included, to allow IBAC an opportunity to begin data collection to establish a baseline and estimate appropriate targets.				
Complaints or notifications about public sector corrupt conduct (excluding police personnel conduct and police personnel corrupt conduct) assessed by IBAC within 45 days	per cent	85	52	85
The 2020-21 expected outcome is lower than the 2020-21 target due to an increase in total volume of complaints received combined with the impacts of processing Public Interest Disclosures (amendments were made to the legislation in January 2020 introducing Public Interest Disclosures), an increased complexity of assessments and the impacts of COVID-19 making it difficult to employ, induct and train new staff to replace departed staff.				
Complaints or notifications about police personnel conduct and police personnel corrupt conduct assessed by IBAC within 45 days	per cent	90	40	90
The 2020-21 expected outcome is lower than the 2020-21 target due to an increase in total volume of complaints received combined with the impacts of processing Public Interest Disclosures (amendments were made to the legislation in January 2020 introducing Public Interest Disclosures), an increased complexity of assessments and the impacts of COVID-19 making it difficult to employ, induct and train new staff to replace departed staff.				
Proportion of standard IBAC investigations into public sector corrupt conduct (excluding police personnel conduct and police personnel corrupt conduct) completed within 9 months	per cent	60	60	60
Proportion of complex IBAC investigations into public sector corrupt conduct (excluding police personnel conduct and police personnel corrupt conduct) completed within 18 months	per cent	60	60	60
Proportion of standard IBAC investigations into police personnel conduct and police personnel corrupt conduct completed within 9 months	per cent	60	60	60
Proportion of complex IBAC investigations into police personnel conduct and police personnel corrupt conduct completed within 18 months	per cent	60	60	60

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Cost				
Total output cost	$ million	54.0	48.4	48.4
Total output cost including the CAC	*$ million*	*54.2*	*48.4*	*48.4*

The 2020-21 expected outcome and the 2020-21 target figures includes a $6.4 million allocation from the IBAC Trust Fund.
A Treasurer's Advance of $7 million in 2021-22 will also be approved for urgent additional investigative, prevention, review and communications activities.
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget*.*
The CAC is discontinued from the 2021-22 Budget*.*
This output did not have a provision for CAC in previous budgets.

Source: Independent Broad-based Anti-corruption Commission

Victorian Ombudsman (2021-22: $20.2 million)

The Ombudsman is a constitutional entrenched and independent officer of Parliament. Under the *Ombudsman Act 1973* (Vic), the Ombudsman resolves and investigates complaints, protected disclosure complaints and 'own motion' matters. The Ombudsman is a timely, efficient, effective, flexible and independent means of resolving complaints about administrative actions of authorities, and has a role to expose and prevent maladministration, improper conduct and corrupt conduct. Core to the Ombudsman's role is to improve the quality of public administration where an authority appears to have acted in a way that is unlawful, unreasonable, oppressive, unjust, improperly discriminatory or wrong.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Number of jurisdictional cases opened	number	14 000	nm	nm

This performance measure is proposed to replace the 2020-21 performance measure of 'jurisdictional complaints finalised'. The proposed measure more accurately reflects the full extent of the work commenced by the Victorian Ombudsman within a financial year, demonstrating the overall volume and output.
The data to assess this measure is retrieved from the Victorian Ombudsman's case management system (Resolve), through developed reports that target the date a case is opened and its relevant case classification. Case classification is determined at the initiation of a case.

Jurisdictional cases selected for enquiry/investigation	per cent	20	nm	nm

This performance measure is proposed to replace the 2020-21 performance measure of 'proportion of jurisdictional complaints independently investigated by the Victorian Ombudsman'. The wording of the proposed performance measure better reflects the Victorian Ombudsman's overall functions and activity, clarifying that it conducts both enquiries and investigations. Further, it more accurately portrays the Victorian Ombudsman's discretion to select cases for enquiry/investigation, which is done in consideration of the Victorian Ombudsman's strategic objectives and limited resources.
The data to assess this performance measure is retrieved from the Victorian Ombudsman's case management system (Resolve), through developed reports that target a combination of the date a case is opened, its classification and file types.

Education and training participants	number	642	nm	nm

This is a new performance measure for 2021-22 to capture the already existing educational function of the Victorian Ombudsman recently enshrined in the Ombudsman Act 1973 *(Vic). The Victorian Ombudsman delivers training workshops to government agency staff as an important preventative mechanism aimed at improving their decision making and ethical awareness.*
The data to assess performance against this measure is drawn from the number of participants who registered attendance at an education session that is recorded in the Victorian Ombudsman's registration system, reconciled against the number of actual attendees that are documented at the commencement of each training workshop. Records are created and kept in accordance with the Public Records Act 1973 *(Vic), allowing for annual measurement and comparisons to be drawn across years.*

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quality				
Jurisdictional cases that lead to an agreed improvement (e.g. practice / policy / law reform, remedial / rectification / mitigation action)	per cent	35	nm	nm
This performance measure is proposed to replace the 2020-21 performance measure of 'recommendations accepted by agencies upon completion of investigations. The current measure applies only to the Victorian Ombudsman's investigations, leaving the remaining approximately 90 per cent of work conducted in accordance with the Victorian Ombudsman's statutory functions unmeasured. The wording of the proposed measure more accurately reflects the nature of the Victorian Ombudsman's role of facilitating administrative improvement/remedy. It also reflects the Victorian Ombudsman's new data capability to record the outputs of all work with greater accuracy to demonstrate the office's effectiveness. *The data to assess this measure is retrieved from the Victorian Ombudsman's case management system (Resolve) through a developed report. The report counts jurisdictional cases that have been subject to enquiry/investigation in which an agency has agreed to take improvement action. It is intentional that the measure does not reflect the agency's implementation of the agreement, as this is dependent on external factors, such as legislative amendment, time considerations and funding. Instead, the Victorian Ombudsman monitors agencies' implementation of investigation recommendations and publishes the result in a biennial report.*				
Public sector education program satisfaction rate	per cent	85	nm	nm
This is a new performance measure for 2021-22 to capture the already existing educational function of the Victorian Ombudsman recently enshrined in the Ombudsman Act 1973 *(Vic). In addition to the proposed measure of 'education and training participants', the Victorian Ombudsman also proposes this performance measure to quantify and reflect the quality of its educational programs and demonstrate the extent they are meeting the educational needs and expectations of the public sector participants.* *This measure aggregates and averages the total satisfaction rate of participants of the Victorian Ombudsman's Public Sector Education Programs. Participants are provided with a survey that asks three questions to assess satisfaction rate against whether the content is useful, the facilitators are engaging and overall satisfaction rate. Participants are given a choice to rank the quality of the education services between 1 and 5. Of the approximate 95 per cent of complete surveys, the Victorian Ombudsman's Education Services extracts and aggregates the results to report an average satisfaction rate.*				
Complaint service satisfaction	per cent	60	nm	nm
This performance measure is proposed to replace the 2020-21 performance measure of 'jurisdictional complaints finalised'. The proposed measure more accurately reflects the full extent of the work commenced by the Victorian Ombudsman within a financial year, demonstrating the overall volume and output. *The data to assess this measure is retrieved from the Victorian Ombudsman's case management system (Resolve), through developed reports that target the date a case is opened and its relevant case classification. Case classification is determined at the initiation of a case.*				
Timeliness				
Complaints closed within 30 days	per cent	85	nm	nm
This performance measure is proposed to replace the 2020-21 performance measure of 'complaints resolved within 30 calendar days of receipt'. The refinement of the measure is accompanied by a revision of the target from 95 per cent to 85 per cent, reflecting changes to the Victorian Ombudsman's business model in 2016. Under the revised model, the Ombudsman seeks to provide service excellence that is tailored to the unique and complex needs of the individuals who contact it, as opposed to providing a 'one size fits all' approach. *To assess performance against this measure, data is drawn from established reports that are generated from the Victorian Ombudsman's case management system (Resolve). These reports capture all complaints made to the Victorian Ombudsman and public interest disclosures assessed under the* Public Interest Disclosures Act 2012 *(Vic). The data is then further filtered to capture only those cases closed within elapsed days of less than or equal to 30 calendar days.*				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Investigations closed within 12 months	per cent	80	nm	nm
New performance measure for 2021-22 to capture an activity/function that was not previously covered by the Ombudsman's performance measures. The proposed performance measure, together with the other proposed measure of 'Complaints closed within 30 days', seeks to provide insight into how the Victorian Ombudsman meets community expectations in relation to timely service delivery. *To assess performance against this measure, data is drawn from established reports that are generated from the Ombudsman's case management system (Resolve). The report filters all cases to that which have an investigation classification matched against their 'file type' descriptor within the system. The report takes the overall cases and subtracts those which have been closed in the record system within elapsed days of less than or equal to 365 days. The overall result is then expressed as a percentage against the overall number of investigation files opened in the relevant financial year.*				
Cost				
Total output cost	$ million	20.2	19.6	19.6
Total output cost including the CAC	*$ million*	*20.5*	*19.9*	*19.9*
The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget. *The CAC is discontinued from the* 2021-22 Budget.				

Source: Victorian Ombudsman

COURT SERVICES VICTORIA

Ministerial portfolios

Victoria's courts and tribunals are part of the ministerial portfolio of the Attorney-General.

Departmental mission statement

The mission of Victoria's courts and tribunals is to safeguard and maintain the rule of law through the fair, timely and efficient dispensing of justice.

Victoria's courts and tribunals are supported by Court Services Victoria, which is an independent statutory body established to provide administrative services and facilities to support Victorian courts, the Victorian Civil and Administrative Tribunal, the Judicial College of Victoria and the Judicial Commission of Victoria.

Departmental objectives

The fair, timely and efficient dispensing of justice

Victoria's courts and tribunals aim to:

- provide equal access to justice;
- ensure fairness, impartiality and independence in decision making;
- follow processes that are transparent, timely and certain;
- strive for leadership and best practice in court administration; and
- strengthen links with the community.

The Courts output contributes to this objective by delivering court and tribunal services, which provide access to the highest standard of justice for the community, and inspire public confidence in the rule of law.

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2020-21 Budget	*2020-21 expected outcome*	*2021-22 budget*	*Variation [(a)] %*
The fair, timely and efficient dispensing of justice				
Courts	674.5	688.0	755.2	12.0
Total [(b)]	**674.5**	**688.0**	**755.2**	**12.0**

Source: Court Services Victoria

Notes:

(a) Variation between the 2020-21 budget and the 2021-22 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant output cost.

(b) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget *and the CAC impacts are therefore excluded from the figures. Refer to individual output sections for comparative output costs inclusive of the CAC.*

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.22 outlines the Department's income from transactions and Table 2.23 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.22: Income from transactions **($ million)**

	2019-20 actual	*2020-21 budget*	*2020-21 revised*	*2021-22 budget*
Output appropriations [(a)]	480.2	518.2	519.3	530.6
Special appropriations	167.7	187.4	193.5	200.6
Grants	25.6	17.0	23.5	24.0
Total income from transactions [(b)]	**673.8**	**722.7**	**736.3**	**755.2**

Source: Court Services Victoria

Notes:

(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget*.*

(b) Table may not add due to rounding.

Table 2.23: Parliamentary authority for resources **($ million)**

	2020-21 budget	*2020-21 revised*	*2021-22 budget*
Annual appropriations	**558.5**	**551.2**	**667.1**
Provision of outputs [(a)]	441.2	451.3	455.8
Additions to the net asset base	117.3	99.9	211.3
Payments made on behalf of the State	..	..	..
Receipts credited to appropriations	**74.1**	**65.1**	**74.8**
Unapplied previous years appropriation	**10.2**	**10.2**	**..**
Provision of outputs	2.9	2.9	..
Additions to the net asset base	7.3	7.3	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**642.9**	**626.5**	**741.9**
Special appropriations	**241.4**	**253.4**	**271.3**
Trust funds	**17.0**	**23.5**	**24.0**
Victorian Civil and Administrative Tribunal Trust [(b)]	17.0	23.5	23.8
Other [(c)]	..	..	0.3
Total parliamentary authority [(d)]	**901.3**	**903.4**	**1 037.2**

Source: Court Services Victoria

Notes:

(a) The Capital Assets Charge (CAC) policy is discontinued from the 2021-22 Budget*.*

(b) The purpose of this trust primarily relates to funding the Victorian Civil and Administrative Tribunal's Owners Corporation, Domestic Building, and Residential Tenancies lists.

(c) Includes inter-departmental transfers.

(d) Table may not add due to rounding.

Departmental performance statement

Objective 1: The fair, timely and efficient dispensing of justice

This objective delivers the fair, timely and efficient dispensing of justice for Victorians. It aims to provide equal access to justice for all, and ensure fairness, impartiality and independence in decision making. All processes followed by courts and tribunals are transparent, timely and certain for all parties. The delivery of this objective requires courts and tribunals to strive for leadership and best practice in court administration to dispense justice for Victorians, and engage with the community to strengthen their understanding of court procedure and confidence in the rule of law.

The departmental objective indicators are:

- clearance of criminal caseload (finalisations/lodgements); and
- clearance of civil caseload (finalisations/lodgements).

Courts **(2021-22: $755.2 million)**

This output delivers impartial and independent dispensing of justice across six jurisdictions:

- Supreme Court of Victoria;
- County Court of Victoria;
- Magistrates' Court of Victoria;
- Children's Court of Victoria;
- Coroners Court of Victoria; and
- Victorian Civil and Administrative Tribunal.

Other areas that contribute to the achievement of this objective include functions that support the operation of each jurisdiction. These include:

- corporate and service functions delivered by Court Services Victoria;
- criminal recording and transcription services delivered by the Victorian Government Reporting Service;
- judicial training and education delivered by the Judicial College of Victoria; and
- investigative and other functions of the Judicial Commission of Victoria.

The performance measures below compare estimates and expected results from the delivery of court services by the six jurisdictions as part of this output. Some performance measures have corresponding measures in other reports, such as the Productivity Commission's Report on Government Services. Despite similarities in names and descriptions of these measures, methodological differences between reports (such as counting rules) may lead to different results being published elsewhere.

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quantity				
Average cost per case – Civil matters disposed in the Supreme Court	dollars	2 745	3 144	2 592
The 2020-21 expected outcome is higher than the 2020-21 target due to changes in the Court's operations in response to the coronavirus (COVID-19) public health restrictions, which resulted in a lower than expected number of finalisations in 2020-21. *The 2021-22 target is higher than the 2020-21 target due to an increase in the Court's output budget.* *The 2020-21 target has been revised to reflect the exclusion of the CAC from the output cost in the* 2021-22 Budget.				
Average cost per case – Civil matters disposed in the County Court	dollars	7 564	7 498	6 975
The 2020-21 expected outcome is higher than the 2020-21 target due to changes in the Court's operations in response to the COVID-19 public health restrictions, which resulted in a lower than expected number of finalisations in 2020-21. *The 2021-22 target is higher than the 2020-21 target due to an increase in the Court's output budget.* *The 2020-21 target has been revised to reflect the exclusion of the CAC from the output cost in the* 2021-22 Budget.				
Average cost per case – Civil matters disposed in the Magistrates' Court	dollars	1 083	2 374	957
The 2020-21 expected outcome is higher than the 2020-21 target due to changes in the Court's operations in response to the COVID-19 public health restrictions, which resulted in a lower than expected number of finalisations in 2020-21. *The 2021-22 target is higher than the 2020-21 target due to an increase in the Court's output budget.* *The 2020-21 target has been revised to reflect the exclusion of the CAC from the output costs in the* 2021-22 Budget.				
Average cost per case – Family Division matters disposed in the Children's Court	dollars	1 436	1 444	1 379
The 2020-21 target has been revised to reflect the exclusion of the CAC from the output costs in the 2021-22 Budget.				
Average cost per case – Civil matters disposed in the Victorian Civil and Administrative Tribunal	dollars	1 185	1 524	956
The 2020-21 expected outcome is higher than the 2020-21 target due to changes in the Tribunal's operations in response to the COVID-19 public health restrictions, which resulted in a lower than expected number of finalisations in 2020-21. *The 2021-22 target is higher than the 2020-21 target due to an increase in the Court's output budget.* *The 2020-21 target has been revised to reflect the exclusion of the CAC from output costs in the* 2021-22 Budget.				
Average cost per case – Coronial matters disposed in the Coroners Court	dollars	4 267	3 805	4 278
The 2020-21 expected outcome is lower than the 2020-21 target due to an increase in the number of cases expected to be finalised. *The 2020-21 target has been revised to reflect the exclusion of the CAC from the output costs in the* 2021-22 Budget.				
Average cost per case – Criminal matters disposed in the Supreme Court	dollars	47 757	43 596	45 096
The 2021-22 target is higher than the 2020-21 target due to an increase in the Court's output budget. *The 2020-21 target has been revised to reflect the exclusion of the CAC from the output costs shown in the* 2021-22 Budget.				
Average cost per case – Criminal matters disposed in the County Court	dollars	17 936	31 765	16 539
The 2020-21 expected outcome is higher than the 2020-21 target due to changes in the Court's operations in response to the COVID-19 public health restrictions, which resulted in a lower than expected number of finalisations in 2020-21. *The 2021-22 target is higher than the 2020-21 target due to an increase in the Court's output budget.* *The 2020-21 target has been revised to reflect the exclusion of the CAC from the output costs in the* 2021-22 Budget.				
Average cost per case – Criminal matters disposed in the Magistrates' Court	dollars	1 342	2 105	1 185
The 2020-21 expected outcome is higher than the 2020-21 target due to changes in the Court's operations in response to the COVID-19 public health restrictions, which resulted in a lower than expected number of finalisations in 2020-21. *The 2021-22 target is higher than the 2020-21 target due to an increase in the Court's output budget.* *The 2020-21 target has been revised to reflect the exclusion of the CAC from the output costs in the* 2021-22 Budget.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Average cost per case – Criminal matters disposed in the Children's Court	dollars	1 130	1 787	1 085
The 2020-21 expected outcome is higher than the 2020-21 target due to changes in the Court's operations in response to COVID-19 public health restrictions, which resulted in a lower than expected number of finalisations. *The 2021-22 target is higher than the 2020-21 target due to an increase in the Court's output budget.* *The 2020-21 target has been revised to reflect the exclusion of the CAC from the output costs in the* 2021-22 Budget*.*				
Case clearance rate – Civil matters disposed in the Supreme Court	per cent	100	99.5	100
The case clearance rate is calculated as (number of cases disposed/number of cases initiated).				
Case clearance rate – Civil matters disposed in the County Court	per cent	100	95.1	100
The case clearance rate is calculated as (number of cases disposed/number of cases initiated).				
Case clearance rate – Civil matters disposed in the Magistrates' Court	per cent	100	100	100
The case clearance rate is calculated as (number of cases disposed/number of cases initiated).				
Case clearance rate – Family Division matters disposed in the Children's Court	per cent	100	100	100
The case clearance rate is calculated as (number of cases disposed/number of cases initiated).				
Case clearance rate – Civil matters disposed in the Victorian Civil and Administrative Tribunal	per cent	100	75	100
The case clearance rate is calculated as (number of cases disposed/number of cases initiated). *The 2020-21 expected outcome is lower than the target due to changes in the Tribunal's operations in response to COVID-19 public health restrictions, which reduced the Tribunal's capacity to hear and finalise matters, particularly in high-volume lists.*				
Case clearance rate – Coronial matters disposed in the Coroners Court	per cent	100	95	100
The case clearance rate is calculated as (number of cases disposed/number of cases initiated). *The 2020-21 expected outcome is lower than the target due to a rising number of new cases.*				
Case clearance rate – Criminal matters disposed in the Supreme Court	per cent	100	85	100
The case clearance rate is calculated as (number of cases disposed/number of cases initiated). *The 2020-21 expected outcome is lower than the target due to changes in the Court's operations in response to the COVID-19 public health restrictions.*				
Case clearance rate – Criminal matters disposed in the County Court	per cent	100	90	100
The case clearance rate is calculated as (number of cases disposed/number of cases initiated). *The 2020-21 expected outcome is lower than the target due to changes in the Court's operations in response to the COVID-19 public health restrictions, particularly the suspension of jury trials between March and November 2020, as well as the ongoing impact of social distancing which affects the volume of jury trials that can be serviced.*				
Case clearance rate – Criminal matters disposed in the Magistrates' Court	per cent	100	100	100
The case clearance rate is calculated as (number of cases disposed/number of cases initiated).				
Case clearance rate – Criminal matters disposed in the Children's Court	per cent	100	100	100
The case clearance rate is calculated as (number of cases disposed/number of cases initiated).				
Case clearance rate – Family violence intervention orders disposed in the Magistrates' and Children's Courts	per cent	100	100	100

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Quality				
Court file integrity in the Supreme Court – availability, accuracy and completeness	per cent	90	90	90
Court file integrity in the County Court – availability, accuracy and completeness	per cent	90	88	90
Court file integrity in the Magistrates' Court – availability, accuracy and completeness	per cent	90	90	90
Court file integrity in the Children's Court – availability, accuracy and completeness	per cent	90	90	90
Court file integrity in the Coroners Court – availability, accuracy and completeness	per cent	90	90	90
Court file integrity in the Victorian Civil and Administrative Tribunal – availability, accuracy and completeness	per cent	90	75	90
The 2020-21 expected outcome is lower than the 2020-21 target due to changes in the Tribunal's operations in response to the COVID-19 public health restrictions. Specifically, the lower expected outcome is the consequence of reduced file availability due to the impact of remote hearing and working practices on VCAT's paper operating environment, and VCAT's Planning and Environment List files being off-site between August and December 2020 as they were digitised.				
Timeliness				
On-time case processing – Civil matters resolved or otherwise finalised within established timeframes in the Supreme Court	per cent	90	90	90
On-time case processing – Civil matters resolved or otherwise finalised within established timeframes in the County Court	per cent	90	88	90
On-time case processing – Civil matters resolved or otherwise finalised within established timeframes in the Magistrates' Court	per cent	80	80	80
On-time case processing – Family Division matters resolved or otherwise finalised within established timeframes in the Children's Court	per cent	90	90	90
On-time case processing – Civil matters resolved or otherwise finalised within established timeframes in the Victorian Civil and Administrative Tribunal	per cent	90	95	90
The 2020-21 expected outcome is higher than the 2020-21 target due to the prioritisation of urgent and high-volume cases, including Residential Tenancy matters.				
On-time case processing – Coronial matters resolved or otherwise finalised within established timeframes in the Coroners Court	per cent	80	82	80
On-time case processing – Criminal matters resolved or otherwise finalised within established timeframes in the Supreme Court	per cent	85	85	85
On-time case processing – Criminal matters resolved or otherwise finalised within established timeframes in the County Court	per cent	90	80	90
The 2020-21 expected outcome is lower than the 2020-21 target due to the impact of the COVID-19 public health restrictions on the Court's operations, including delays caused by the suspension of jury trials and the overall decrease in appeal matters which usually require less time to finalise than other matters.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
On-time case processing – Criminal matters resolved or otherwise finalised within established timeframes in the Magistrates' Court	per cent	85	85	85
On-time case processing – Criminal matters resolved or otherwise finalised within established timeframes in the Children's Court	per cent	90	90	90
On-time case processing – Family violence intervention orders resolved or otherwise finalised within established timeframes in the Magistrates' and Children's Courts	per cent	90	90	90
Cost				
Total output cost	$ million	755.2	688.0	674.5
Total output cost including the CAC	*$ million*	*804.2*	*736.3*	*722.7*

The output cost including the CAC is provided for comparative purposes in the 2021-22 Budget.
The CAC is discontinued from the 2021-22 Budget.

Source: Court Services Victoria

APPENDIX A – OUTPUT PERFORMANCE MEASURES FOR REVIEW BY THE PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

DEPARTMENT OF EDUCATION AND TRAINING

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Support for students with Disability				
Quantity				
Students funded under the disabilities program in government schools as a proportion of the total student population	per cent	4.5	4.5	4.5
This performance measure is proposed to be discontinued as it has been replaced by the 2021-22 performance measure 'Proportion of government school students who receive adjustments to support their access and participation in learning because of disability as defined in the Disability Discrimination Act 1992 *(Cth).*				
School Education – Secondary				
Quality				
Percentage of Year 9 students with a Careers e-Portfolio	per cent	20	20	20
This performance measure is proposed to be discontinued as it has been replaced by the 2021-22 performance measure 'Percentage of Year 9 students in government schools that complete an online assessment using a career diagnostic tool'.				

Source: Department of Education and Training

DEPARTMENT OF ENVIRONMENT, LAND, WATER AND PLANNING

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Climate Change				
Quality				
Departmental stakeholder satisfaction with engagement in completed policy projects	number	75	75	75
This performance measure is proposed to be discontinued as it has been replaced by 'Stakeholder satisfaction with climate change engagement events' to better reflect the service being delivered.				
Environment and Biodiversity				
Quantity				
Victorian Landcare Groups supported by a facilitator	number	435	450	435
This performance measure is proposed to be discontinued as it has been replaced by the new 2021-22 performance measure 'Hours volunteered across all Victorian environmental volunteering programs' to reflect expansion of environmental volunteering under Victorians Volunteering for Nature – Environmental Volunteering Plan.				
Statutory Activities and Environment Protection				
Quantity				
Activities that support business to comply with environmental obligations	number	25–30	271	25–30
The 2020-21 expected outcome is higher than the 2020-21 target due to high levels of engagement with industry, government, and community stakeholders to ensure readiness for the amended Environment Protection Act 2017*, now intended to commence 1 July 2021.* *This performance measure is proposed to be discontinued as it has been replaced by 'Events and activities that engage business and community in environment protection' reflecting improvements to EPA engagement approach including newer and more flexible methods for engagement and reflect increased government focus on working with community and business to help them understand their environment and their duty in protecting it.*				
Events that engage business and community in environment protection	number	25–35	62	25–35
The 2020-21 expected outcome is higher than the 2020-21 target due to high levels of engagement with industry, government, and community stakeholders to ensure readiness for the amended Environment Protection Act 2017*, now intended to commence 1 July 2021.* *This performance measure is proposed to be discontinued as it has been replaced by 'Events and activities that engage business and community in environment protection' reflecting improvements to the EPA's engagement approach including newer and more flexible methods for engagement and reflect increased government focus on working with community and business to help them understand their environment and their duty in protecting it.*				
Management of Public Land and Forests				
Quality				
Investigations of alleged non-compliance with the Code of Practice for Timber Production undertaken in accordance with the Environment Compliance Policy and associated procedures	per cent	100	100	100
This performance measure is proposed to be discontinued as it has been replaced by the new 2021-22 performance measure 'Investigations of alleged non-compliance with the Code of Practice for Timber Production 2014 and other relevant law are completed within the statute of limitations of two years'. The new performance measure more effectively captures a key accountability of the Timber Harvesting Compliance program regarding the completion of investigations.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Planning				
Quantity				
Research published – demographic and spatial trends	number	5	5	5
This performance measure is proposed to be discontinued because it is no longer relevant. The measure was introduced in 2007-08 when research products were delivered in hard copy format only, available in limited volume and driven by more static timelines. The Department has since increased its focus on disseminating demographic and spatial research through its online platform: planning.vic.gov.au. The website includes a range of different data and research products that can provide timely and more interactive access to demographic and spatial data and information and facilitates availability of information to a broader audience.				
Government buildings identified as high priority that have commenced cladding rectification	number	na	28	10
This performance measure is proposed to be discontinued as it has been replaced by two new 2021-22 performance measures 'In-scope Government buildings that have commenced cladding rectification works' and 'In-scope Government buildings that have completed cladding rectification works'. Commencement of cladding rectification works is demonstrated when a construction contract has been awarded and rectification works have commenced onsite whereas this superseded measure counted projects that had been approved for funding.				
The 2020-21 expected outcome is higher than the 2020-21 target due to process efficiencies enabling an increased number of buildings able to be reviewed by Advisory Reference Panels on a regular basis.				

Source: Department of Environment, Land, Water and Planning

DEPARTMENT OF FAMILIES, FAIRNESS AND HOUSING

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Child Protection and Family Services				
Quality				
Proportion of placements that are home-based care	per cent	92.5	96.5	92.5
This measure is proposed to be discontinued as additional measures were introduced in the 2020-21 Budget *that provide greater visibility of the number of children in various types of care placements.*				
The 2020-21 expected outcome is higher than the 2020-21 target, reflecting greater than targeted proportion of children in home-based care.				
LGBTIQ+ equality policy and programs				
Quantity				
Number of community consultations on issues relevant to LGBTIQ+ communities	number	0	25	20
This measure is proposed to be discontinued as the LGBTIQ+ Strategy has moved from consultation to implementation phase.				
The 2020-21 expected outcome is higher than the 2020-21 target reflecting higher than anticipated engagement with LGBTIQ+ communities, including on the Government's response to the coronavirus (COVID-19) pandemic and the development of Victoria's new LGBTIQ+ Strategy.				
Women's policy				
Quantity				
Number of people participating in funded primary prevention and gender equality programs	number	6 800	6 800	6 800
This measure is proposed to be discontinued and replaced by the related disaggregated measures 'Number of people participating in funded gender equality programs' in the Women's policy output and 'Number of people participating in funded primary prevention programs' in the proposed new 'Primary prevention of family violence' output.				
Quality				
Gender equality and prevention of family violence grant recipients who met or exceeded contractually agreed outcomes	per cent	85	93	85
This measure is proposed to be discontinued and replaced by the related disaggregated measures 'Gender equality grant recipients who met or exceeded contractually agreed outcomes' in the Women's policy output and 'Prevention of family violence grant recipients who met or exceeded contractually agreed outcomes' in the new 'Primary prevention of family violence' output.				
The 2020-21 expected outcome is higher than the 2020-21 target reflecting high-quality activity by grants recipients and effective collaboration with the Office for Women.				
Quantity				
Women's and the Prevention of Family Violence projects and programs delivered on time	per cent	100	100	100
This measure is proposed to be discontinued and replaced by the related disaggregated measures 'Women's Portfolio projects and programs delivered on time' in the Women's policy output and 'Prevention of Family Violence projects and programs delivered on time' in the new 'Primary prevention of family violence' output.				

Source: Department of Families, Fairness and Housing

DEPARTMENT OF HEALTH

Performance measures	Unit of measure	2021-22 target	2020-21 expected outcome	2020-21 target
Admitted Services				
Quantity				
Weighted Inlier Equivalent Separations (WIES) – all hospitals except small rural health services	number (thousand)	na	1 360	1 461
This measure is proposed to be discontinued. Victoria is moving to a new National Funding Model, and Weighted Inlier Equivalent Separations will no longer apply to funding. *The 2020-21 expected outcome is lower than the 2020-21 target primarily due to the impact of the coronavirus (COVID-19) pandemic on activities.*				
Unplanned/unexpected readmission for acute myocardial infarction	per cent	2.0	2	2.0
This measure is proposed to be discontinued and replaced with the 2021-22 performance measure 'Unplanned readmission after treatment for acute myocardial infarction' as the current approach only reports on unplanned/unexpected readmissions to the same hospital at which the treatment was performed.				
Unplanned/unexpected readmission for heart failure	per cent	10.0	10	10.0
This measure is proposed to be discontinued and replaced with the 2021-22 performance measure 'Unplanned readmission after treatment for heart failure' as the current approach only reports on unplanned/unexpected readmissions to the same hospital at which the treatment was performed.				
Unplanned/unexpected readmission for hip replacement	per cent	2.5	3.8	2.5
This measure is proposed to be discontinued and replaced with the 2021-22 performance measure 'Unplanned readmission after hip replacement surgery' as the current approach only reports on unplanned/unexpected readmissions to the same hospital at which the treatment was performed. *The 2020-21 expected outcome is higher than the 2020-21 target as some health services continue to struggle to attain a readmission rate at the historic target level of 2.5 per cent.*				
Unplanned/unexpected readmission for paediatric tonsillectomy and adenoidectomy	per cent	2.2	2.2	2.2
This measure is proposed to be discontinued and replaced with the 2021-22 performance measure 'Unplanned readmission after paediatric tonsillectomy and aenoidectomy' as the current approach only reports on unplanned/unexpected readmissions to the same hospital at which the treatment was performed.				
Unplanned/unexpected readmission for knee replacement	per cent	6	6	6
This measure is proposed to be discontinued and replaced with the 2021-22 performance measure 'Unplanned readmission after knee replacement surgery' as the current approach only reports on unplanned/unexpected readmissions to the same hospital at which the treatment was performed.				
Ambulance Emergency Services				
Quality				
Proportion of adult VF/VT cardiac arrest patients with vital signs at hospital	per cent	50	50	50
This measure is proposed to be discontinued as it is not a measure of quality of care.				
Community Health Care				
Quantity				
Better Health Channel visits	number	40 000	40 000	40 000
This measure is proposed to be discontinued as it is not a measure of value provided to the community by the website.				
Health Advancement				
Quantity				
Workplaces and pubs and clubs complying with smoke-free environment laws	per cent	99	99	99
This measure is proposed to be discontinued and replaced with the 2021-22 performance measures 'Number of education or monitoring visits of tobacco or e-cigarette retailers', 'Number of sales to minors test purchases undertaken' and 'Number of education or monitoring visits of smoke-free areas'. It is proposed to be discontinued as, due to the manner which the measure is calculated, the results do not provide any meaningful indication of compliance.				

Source: Department of Health

DEPARTMENT OF JOBS, PRECINCTS AND REGIONS

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Jobs				
Quantity				
Number of jobs created through Working for Victoria	number	na	12 000	10 000
The 2020-21 expected outcome is higher than the 2020-21 target, as Working for Victoria exceeded its full-year target by 31 December 2020 due to the creation of over 12 000 new jobs for Victorians in jobs supporting local communities. *This performance measure is proposed to be discontinued as Working for Victoria was part of the Victorian Government's emergency response to COVID-19. It is superseded by funding under the* 2020-21 Budget *initiative Jobs for Victoria: Our Plan to Maximise Jobs and Help Victorians into Work.*				
Number of jobseekers placed into jobs through Working for Victoria	number	na	11 500	7 500
The 2020-21 expected outcome is higher than the 2020-21 target due to the placement of Victorian jobseekers in quick COVID-19 pandemic response short-term roles and longer-term six-month jobs supporting local communities. *This performance measure is proposed to be discontinued as Working for Victoria was part of the Victorian Government's emergency response to COVID-19. It is superseded by funding under the* 2020-21 Budget *initiative Jobs for Victoria: Our Plan to Maximise Jobs and Help Victorians into Work.*				
Social enterprises assisted	number	na	280	150
The 2020-21 expected outcome is higher than the 2020-21 target due to the number of social enterprises expected to continue to grow at a higher rate as a result of the expanded services being offered in response to coronavirus (COVID-19) and bushfire recovery. *This performance measure is proposed to be discontinued as the Social Enterprise Strategy funding is lapsing.*				
Victoria's market share of nominated investor and business migrants	per cent	na	45	45
This performance measure is proposed to be discontinued as it has been replaced by the 2021-22 performance measure 'Migrant talent nominated for the Skilled, Investor and Business Migration Program'. The new measure reflects a new program focus on attracting high-quality skilled, business and investor talent who can support innovation and job creation in Victorian strategic sectors. Market share is largely dependent on the Commonwealth Government's allocation of visa places to state and territory governments and does not measure the quality of client experience and service. The outputs of the Skilled and Business Migration program's services are also measured through the client satisfaction with services provided (qualitative) and average processing time (quantitative) measures.				
Trade and Global Engagement				
Quantity				
International delegates participated in the virtual inbound trade mission and key initiatives	number	na	1 000	1 000
This performance measure is proposed to be discontinued as it relates to delivery of virtual trade missions funded in 2020-21 through the Export Recovery Plan. Funding for Virtual Trade Missions through the Export Recovery Plan lapses at the end of 2020-21.				
Local Government and Suburban Development				
Timeliness				
Partnership priorities receiving a government response by 30 June	per cent	na	100	100
This performance measure is proposed to be discontinued and replaced with the new measure 'Metropolitan Partnership Development Fund projects completed' to more accurately reflect the engagement between government and commmunity to understand and progress community priorities.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Creative Industries Access, Development and Innovation				
Timeliness				
VicArts Grant acquittals assessed within 30 days of submission date	per cent	na	95	95
This performance measure is proposed to be discontinued as the VicArts grants program will be discontinued and replaced with a new program scheduled to start in 2021-22.				
VicArts Grant applications processed within 45 days for Ministerial consideration	per cent	na	0	100
The 2020-21 outcome is lower than the 2020-21 target due to a significant increase in the number of applications received as a result of the impacts of COVID-19 on the sector. This resulted in longer processing times. This performance measure is proposed to be discontinued as the VicArts grants program will be discontinued and replaced with a new program scheduled to start in 2021-22.				
Agriculture Industry Development and Regulation				
Quantity				
Strategic agriculture industry development and regulatory policy briefings	number	na	8	8
This performance measure is proposed to be discontinued as it was proposed to replace the 2018-19 performance measure 'Strategies developed to overcome identified trade barriers'. However, the 2018-19 performance measure 'Strategies developed to overcome identfiied trade barriers' has been reinstated with minor amendments following the Public Accounts and Estimates Committee's Report on the 2019-20 Budget Estimates *which would make this measure a duplication.*				
Biosecurity and Agriculture Services				
Quantity				
Clients engaged with agriculture services	number	na	3 150	4 300
The 2020-21 expected outcome is lower than the 2020-21 target due to a changed service delivery model associated with COVID-19 public health restrictions and significant redirection of staff resources to support Avian Influenza and Khapra beetle emergency responses and COVID-19 state border and supply chain responses.				
This performance measure is proposed to be discontinued as it was proposed to replace the 2018-19 performance measures 'Client interactions with land health services' and 'Clients engaged with agriculture productivity services'. However, both those measures have been reinstated following the Public Accounts and Estimates Committee's review Report on of the 2019-20 Budget Estimates which would make this measure a duplication.				
Timeliness				
Animal and plant certificates issued within specified timeframes to support domestic and international market access	per cent	na	95	95
This performance measure is proposed to be discontinued as it was proposed to replace the 2018-19 performance measures 'Animal health certificates issued within specified timeframes to support international market access' and 'Plant health certificates issued within specified timeframes at the Melbourne Wholesale Fruit and vegetable Vegetable Market to support domestic market access'. However, both those measures have been reinstated following the Public Accounts and Estimates Committee's review Report on the 2019-20 Budget Estimates which would make this measure a duplication.				

Source: Department of Jobs, Precincts and Regions

DEPARTMENT OF JUSTICE AND COMMUNITY SAFETY

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Policing and Community Safety				
Quality				
Number of hours of family violence-related education provided to police	number	3 500	1 700	1 995
This performance measure is proposed to be discontinued as the program is not funded beyond 30 June 2021, with family violence education now embedded into recruit training				
The 2020-21 expected outcome is lower than the 2020-21 target due to suspension of in-service training across Victoria Police due to COVID-19 restrictions.				
The higher 2021-22 target reflects the resumption of training which allows the back-capture of staff training as well as the roll-out of new program				
Emergency Management Capability				
Quality				
Multi agency joint procurements of systems or equipment	number	1	1	1
This performance measure is proposed to be discontinued as it is no longer fit for purpose and does not provide an accurate representation of cooperation across the emergency management sector.				
Justice Policy, Services and Law Reform				
Quantity				
Groups in negotiation towards resolution of Native Title	number	3	3	3
This performance measure is proposed to be discontinued as it has been replaced by the performance measure 'Number of Recognition and Settlement Agreements that commence' which provides improved clarity on services delivered by the Aboriginal Justice Group and agreements that commence.				
Gambling and Liquor Regulation				
Quantity				
Court and regulatory actions undertaken by the VCGLR	number	3 440	3 440	3 440
This performance measure is proposed to be discontinued as it has been replaced by the 2021-22 performance measure 'Proportion of high-harm breaches resulting in regulatory action'. This new performance measure is intended to better reflect the transition to a risk-based approach to regulation with a focus on voluntary compliance.				

Source: Department of Justice and Community Safety

DEPARTMENT OF PREMIER AND CABINET

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Timeliness				
Establishment of the Breakthrough Victoria entity and associated governance arrangements	per cent	na	100	100
This performance measure is proposed to be discontinued because the entity will be established before 1 July 2021.				
Develop of a long-term investment plan for the Breakthrough Victoria fund	per cent	na	100	100
This performance measure is proposed to be discontinued and replaced with 'Companies and consortia supported by the Breakthrough Victoria Fund'. It has been replaced so that development of the Fund can be observed from year to year and to reflect that the entity has progressed from establishment phase.				
Industrial relations				
Quantity				
Education and compliance inspections of providers/users conducted under the Labour Hire Licensing Scheme	number	na	2 400	2 400
Labour hire licence applications finalised and reviewed	number	na	2 200	2 200
This performance measure is proposed to be discontinued because the Labour Hire Authority will be self-funded from 1 July 2021.				
Workers registered under the Portable Long Service Scheme	number	na	148 000	75 000
This performance measure is proposed to be discontinued because the Portable Long Service Authority will be self-funded from 1 July 2021. *The 2020–21 expected outcome is higher than the 2020–21 target due to registering workers ahead of targeted timeframes.*				
Aboriginal policy, strengthening Aboriginal cultural heritage and communities				
Quality				
Funding payments for the municipal essential services at Lake Tyers and Framlingham Trusts made in accordance with milestones	per cent	na	na	100
This performance measure is proposed to be discontinued and replaced with 'Funding payments for Aboriginal community initiatives' made in accordance with milestones'. It has been consolidated with five other similar performance measures to enable meaningful comparison over time.				
Funding payments for the Removal of First Mortgages initiative made in accordance with milestones	per cent	na	95	100
This performance measure is proposed to be discontinued and replaced with 'Funding payments for Aboriginal community initiatives' made in accordance with milestones'. It has been consolidated with five other similar performance measures to enable meaningful comparison over time.				
Funding payments for the Cultural Strengthening initiative made in accordance with milestones	per cent	na	100	100
This performance measure is proposed to be discontinued and replaced with 'Funding payments for Aboriginal community initiatives' made in accordance with milestones'. It has been consolidated with five other similar performance measures to enable meaningful comparison over time.				
Funding payments to Strengthen Cultural Heritage Protection and Management initiative made in accordance with milestones	per cent	na	100	100
This performance measure is proposed to be discontinued and replaced with 'Funding payments for Aboriginal cultural heritage protection initiatives, sector support and nation building made in accordance with milestones'. It has been consolidated with the similar performance measure 'Traditional Owner Nation-Building Support payments made according to milestones' to enable meaningful comparison over time.				

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Funding payments for the Community Infrastructure Program made in accordance with milestones	per cent	na	100	100
This performance measure is proposed to be discontinued and replaced with 'Funding payments for Aboriginal community initiatives' made in accordance with milestones'. It has been consolidated with five other similar performance measures to enable meaningful comparison over time.				
Funding payments for Community Capacity and Co-Design made in accordance with milestones	per cent	na	100	100
This performance measure is proposed to be discontinued and replaced with 'Funding payments for Aboriginal community initiatives' made in accordance with milestones'. It has been consolidated with five other similar performance measures to enable meaningful comparison over time.				
Funding of activities to support Traditional Owner self-determination in accordance with Scheme design	per cent	na	75	100
The 2020–21 expected outcome is lower than the 2020–21 target due to a reduced number of workshops and projects due to public health advice related to the coronavirus (COVID-19) pandemic. *This performance measure is proposed to be discontinued as funding is not continuing for the Scheme*				
Traditional Owner Nation-Building Support payments made according to milestones	per cent	na	100	100
This performance measure is proposed to be discontinued and replaced with 'Funding payments for Aboriginal cultural heritage protection initiatives, sector support and nation building made in accordance with milestones'. It has been consolidated with the similar performance measure 'Funding payments to Strengthen Cultural Heritage Protection and Management initiative made in accordance with milestones' to enable meaningful comparison over time.				
Public administration advice and support				
Quality				
Overall participant satisfaction with the Victorian Leadership Academy	per cent	na	85	80

Source: Department of Premier and Cabinet

DEPARTMENT OF TRANSPORT

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Tram Services				
Quantity				
W-Class Trams fully restored	number	0	1	1
This performance measure is proposed to be discontinued as the program was completed in 2020-21.				
Transport Safety and Security				
Quantity				
Safety audits of bus safety duty holders conducted in accordance with *Bus Safety Act 2009* (Vic) requirements	number	280	835	560
This performance measure is proposed to be discontinued and replaced with a new measure 'Safety audits of bus safety duty holders conducted in accordance with risk-based plan'. The new measure will allow Transport Safety Victoria to be responsive to dynamic risks without the constraint of a fixed target number of audits. *The 2020-21 expected outcome is higher than the 2020-21 target due to the priority audit program on bus operators' COVIDSafe Plans.* *The lower 2021-22 target is due to risk based planning directing audits toward more bus operators that require detailed and lengthy audits compared to previous years.*				
Road Asset Management				
Quantity				
Road area treated: roads in metropolitan Melbourne	m^2 (000)	1 031	3 699	4 153
This performance measure is proposed to be discontinued as it has been replaced by two new performance measures targeting inner metropolitan 'Road area treated: roads in inner metropolitan Melbourne' and outer suburban areas 'Road area treated: roads in outer suburban Melbourne'. *The 2020-21 expected outcome is lower than the 2020-21 target due to the deferment of treatments from the Western Road Upgrade.* *The 2021-22 target is lower than 2020-21 target primarily due to the forecast completion of maintenance and renewal works and other stimulus works.*				
Road network maintained: metropolitan	m^2 (000)	55 638	55 638	54 795
This performance measure is proposed to be discontinued as it has been replaced by two new performance measures targeting inner metropolitan 'Road network maintained: inner metropolitan' and outer suburban areas 'Road network maintained: outer suburban'.				
Transport Infrastructure				
Quality				
Ballarat Line Upgrade – delivery: milestones delivered in accordance with agreed budget and timelines	per cent	0	100	100
This performance measure is proposed to be discontinued as the Ballarat Line Upgrade was delivered in 2020-21.				

Source: Department of Transport

DEPARTMENT OF TREASURY AND FINANCE

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Economic Regulatory Services				
Quality				
Decisions upheld where subject to review, appeal or disallowance	per cent	100	…	100
This performance measure is proposed to be discontinued and replaced with 'Decisions overturned on review or appeal'. It has been replaced to better measure outcomes of reviews and appeals.				
Invest Victoria				
Quantity				
Jobs resulting from government investment facilitation services and assistance	number	5 200	5 200	5 200
This performance measure is proposed to be discontinued and replaced with 'Jobs generated from international investment secured through Government facilitation services and assistance' in addition to the Department of Jobs, Precincts and Region measures 'Jobs created from industry growth programs and 'Jobs in regional Victoria resulting from government investment facilitation services and assistance'. This performance measure was a whole of government target with relevant activities across departments (including Department of Jobs, Precincts and Regions, Premier and Cabinet and Environment, Land, Water and Planning) contributing to these performance measures. The Victorian Jobs and Investment Fund contributes to these targets.				
New investment resulting from government facilitation services and assistance	number	2 300	2 300	2 300
This performance measure is proposed to be discontinued and replaced with 'Jobs generated from international investment secured through Government facilitation services and assistance' in addition to the Department of Jobs, Precincts and Region measures 'Jobs created from industry growth programs and 'Jobs in regional Victoria resulting from government investment facilitation services and assistance'. This performance measure was a whole of government target with relevant activities across departments (including Department of Jobs, Precincts and Regions, Premier and Cabinet and Environment, Land, Water and Planning) contributing to these performance measures. The Victorian Jobs and Investment Fund contributes to these targets.				

Source: Department of Treasury and Finance

PARLIAMENT (INCLUDING THE VICTORIAN AUDITOR-GENERAL'S OFFICE, PARLIAMENTARY BUDGET OFFICE, AND THE INTEGRITY AGENCIES)

Performance measures	*Unit of measure*	*2021-22 target*	*2020-21 expected outcome*	*2020-21 target*
Public sector integrity				
Quantity				
Jurisdictional complaints finalised – Victorian Ombudsman (VO)	number	14 000	16 985	1 400
This performance measure is proposed to be discontinued as it no longer reflects the full extent of the work commenced by the Victorian Ombudsman within a financial year. It has been replaced by the 2021-22 performance measure 'Number of jurisdictional cases opened'				
Proportion of jurisdictional complaints independently investigated by the Victorian Ombudsman	per cent	25	29	25
This performance measure is proposed to be discontinued and replaced with the 2021-22 performance measure 'Jurisdictional cases selected for enquiry/investigation' The wording of the proposed performance measure better reflects the Victorian Ombudsman's overall functions and activity, clarifying that it conducts both enquiries and investigations.				
Quality				
Proportion of jurisdictional complaints where the original outcome is set aside by a review undertaken in accordance with the Ombudsman's internal review policy	per cent	<1.5	5	<1.5
This performance measure is proposed to be discontinued. The performance measure represents a minute aspect of the Ombudsman's work. The Ombudsman will continue to provide members of the public and authorities the option to seek internal review of the original handling of a complaint. It is also noted that the Victorian Inspectorate has a similar measure to demonstrate its role in reviewing decisions and actions taken by integrity bodies and members of the public can raise concerns about the Ombudsman to the Victorian Inspectorate about procedural fairness and coercive powers.				
Recommendations accepted by agencies upon completion of investigations by the Victorian Ombudsman	per cent	95	95	95
This performance measure is proposed to be discontinued and replaced with the 2021-22 performance measure of 'Jurisdictional cases that lead to an agreed improvement' The current measure applies only to the Victorian Ombudsman's investigations, leaving the remaining approximately 90 per cent of work conducted in accordance with the Victorian Ombudsman's statutory functions unmeasured. The wording of the 2021-22 proposed measure more accurately reflects the nature of the Victorian Ombudsman's role of facilitating administrative improvement/remedy. It also reflects the Victorian Ombudsman's new data capability to record the outputs of all work with greater accuracy to demonstrate the office's effectiveness.				
Timeliness				
Jurisdictional complaints finalised – Victorian Ombudsman (VO)	per cent	95	96	95
This performance measure is proposed to be discontinued and replaced with two new measures in 2021-22 'Complaints closed within 30 days' and 'Investigations closed within 12 months'. These proposed performance measures together will seek to provide insight into how the Victorian Ombudsman meets community expectations in relation to timely service delivery.				

Source: Victorian Ombudsman

APPENDIX B – LOCAL GOVERNMENT FINANCIAL RELATIONS

This appendix provides an overview of the local government sector in Victoria and highlights the *2021-22 Budget* initiatives that impact on councils.

Local government is a distinct and essential tier of government, enshrined in Victoria's Constitution. Victoria has 79 councils providing a wide range of services and infrastructure. Many Victorian government programs are delivered by or in partnership with local governments.

SUPPORTING SUSTAINABLE AND EFFECTIVE LOCAL GOVERNMENT

Local councils play a critical role in creating liveable, inclusive and sustainable communities. Councils deliver vital services and infrastructure, support local economies and provide meaningful local democracy and governance.

The *Local Government Act 2020* came into operation on 24 March 2020. The Act enables a once in a generation change to the operations of Victoria's 79 councils and introduces a robust governance framework based on principles, community engagement and universal standards of conduct. The Act also strengthens the strategic planning and reporting requirements for councils and ensures that key strategies, such as the community vision and council plan, are developed through deliberative engagement processes with their communities. The Act is in its second year of implementation, guided by a project control board with sector representation, and based on co-design and collaborative engagement with the sector.

Reform continues through the ongoing Rural Councils Transformation Program, which aims to improve the long-term financial and operational sustainability of rural and regional councils. The program supports the sharing of knowledge, costs and resources at a regional scale so councils can deliver more efficient, effective and sustainable services for their communities.

The Victorian Government remains committed to ensuring that the impact of council rates on cost of living is minimised through the Fair Go Rates System. Victorian council rate rises have been capped at 1.5 per cent for 2021-22. Rating reforms will be guided by the Government's response to the local government rating system review final report. The Government's response in 2021-22 will prioritise support to ratepayers in financial hardship, improve the transparency and consistency of decision making by councils and build greater equity and fairness in the rating system.

An ongoing investment of $4.9 million towards the Municipal Emergency Resourcing Program increased the capacity and capability of councils to prepare for emergencies. Further development is being undertaken with councils to support the recommendations of the Inspector-General for Emergency Management Inquiry into the 2019-20 Victorian fire season and the Royal Commission into National Natural Disaster Arrangements.

Victoria's local government sector faces challenges that impact on its performance. In particular, interface and rural councils face challenges resulting from population movements, local economic circumstances and their capacity to deal with multi-faceted issues confronting their communities.

The Government's $50 million commitment to the Growing Suburbs Fund will assist Melbourne's interface and regional peri-urban councils to build the facilities they need for healthy and liveable communities in fast growing suburbs.

New investment of $1.4 million is also being made to improve the asset management of rural local roads.

Councils will continue to receive ongoing support through the Government's $2.9 million annual commitment for the roadside weeds and pests program to protect Victoria's agricultural production and environmental assets such as parks and forests.

An increase of $2.7 million in 2021-22 and a $2.2 million annual increase ongoing in the Public Libraries Funding Program will support Victoria's public library services and programs to better meet the needs of Victorians and stimulate job creation.

New investment of $1.8 million has been provided for a community leadership training program focused on leadership for women in local government to support local governments to increase diversity and inclusion.

FUNDING SOURCES TO LOCAL GOVERNMENT IN VICTORIA

Victorian councils spend about $9.4 billion a year[1]. Councils have vital responsibilities that include community services, planning, local roads, waste management, recreation and cultural activities.

Rates revenue of $6.3 billion in 2019-20 ($6.0 billion in 2018-19) made up 55 per cent of total revenue. The second largest revenue stream for the sector was government grants revenue, totalling $1.9 billion in 2019-20 ($2.0 billion in 2018-19).

The Government provides local government with exemptions from land and payroll tax and the Mental Health and Wellbeing Levy. It is estimated that these exemptions will benefit Victorian councils by about $563 million in 2021-22 (refer to Tables 5.2 and 5.4 in Budget Paper No. 5 *Statement of Finances*).

[1] Victorian Auditor-General's Results of 2019-20 Audits: Local Government

Table B.1: Grants and transfers to local government [(a)(b)] **($ thousand)**

Department	*2020-21 budget*	*2020-21 revised*	*2021-22 budget*
Department of Education and Training [(c)]	85 720	51 840	109 105
Department of Environment, Land, Water and Planning	6 307	5 169	5 445
Catchment Management Authorities	101	188	280
Environment Protection Authority	25	25	25
Department of Health	5 466	2 081	1 586
Department of Families, Fairness and Housing	..	5 595	6 217
Department of Jobs, Precincts and Regions	891 591	807 196	931 049
Department of Justice and Community Safety	31 755	80 355	13 777
Country Fire Authority	338	314	321
Department of Premier and Cabinet	4 110	4 110	5 104
Department of Transport	135 291	113 615	51 411
Department of Treasury and Finance	7 919	6 759	5 776
Total grants [(d)]	**1 168 622**	**1 077 246**	**1 130 097**

Source: Department of Treasury and Finance

Notes:

(a) The 2020-21 budget figures reflect the impact of machinery of government changes effective from 1 July 2020.

(b) The 2020-21 revised and 2021-22 budget figures reflect the impact of the machinery of government changes effective from 1 February 2021.

(c) Excludes funds provided to local government for service delivery, such as kindergarten services.

(d) Table may not add due to rounding.

Local Government Victoria provides the majority of funds to local government. Local Government Victoria was transferred to the Department of Jobs, Precincts and Regions from the Department of Environment, Land, Water and Planning as part of machinery of government changes effective from 1 July 2020. For 2021-22 it is estimated that around $637 million of total grants will be Commonwealth financial assistance grants, including road and general purpose grants that are passed on to local government in their entirety[2]. All administration costs are borne by the Department of Jobs, Precincts and Regions.

As shown in Table B.1, grants and transfers to local government are expected to be $1 077 million in 2020-21. This is a decrease of $91 million from the original 2020-21 estimate of $1 169 million. The key drivers of the variance in 2020-21 include:

- Department of Education and Training – a decrease in grants and transfers mainly driven by a rephase of Ready for School: Kinder for every three-year-old local capital grants from 2020-21 into the forward years;
- Department of Health – a decrease in grants and transfers mainly driven by the machinery of government changes effective from 1 February 2021 when the Department of Health and Human Services was renamed the Department of Health and the Department of Families, Fairness and Housing was created;
- Department of Jobs, Precincts and Regions – a decrease in grants and transfers mainly driven by a rephasing of Regional Development Victoria grants, Women and Girls in Sport grants and Local Sports Grants to local councils from 2020-21 into the forward years; and

[2] The Budget does not account for the grants and funding agreements announced by the Commonwealth Government as part of the *Commonwealth Budget 2021-22*, which are subject to negotiation and confirmation with the Victorian Government.

- Department of Transport – a decrease in grants and transfers mainly driven by a reduction of Commonwealth operating funding for local councils for road upgrades and a rephasing of Better Boating Victoria initiatives from 2020-21 into 2021-22.

This is partially offset by:

- Department of Families, Fairness and Housing – an increase in grants and transfers mainly driven by the machinery of government changes effective from 1 February 2021, and grants to support multicultural communities; and
- Department of Justice and Community Safety – an increase in grants and transfers mainly driven by the Government's commitment relating to the Commonwealth's registered natural disaster events and 2020-21 forecast expenditure.

The *2021-22 Budget* provides an estimated $1 130 million in grants and transfers to local government. This represents an increase of $53 million from the 2020-21 revised figures. The key drivers (excluding additional funding for *2021-22 Budget* initiatives) relate to:

- Department of Education and Training – an increase in grants and transfers mainly driven by new initiatives in the *2020-21 Budget*; and
- Department of Jobs, Precincts and Regions – an increase in grants and transfers mainly driven by the Commonwealth rephasing grant payments from 2020-21 to 2019-20, with no change in 2021-22.

This is partially offset by:

- Department of Justice and Community Safety – a decrease in grants and transfers mainly due to one-off funding provided in 2020-21 relating to Commonwealth registered natural disaster events; and
- Department of Transport – a decrease in grants and transfers mainly driven by lapsing Commonwealth funding for local council grants programs in 2020-21, completion of six temporary cycling corridors across Melbourne as part of the School and Community Safety program, and Commonwealth funding rephasing from 2021-22 into 2020-21 for the Commuter Car Park Upgrade program.

The value of grants and transfers made to local government by a number of departments is also expected to increase due to the funding of *2021-22 Budget* initiatives listed later in this appendix.

COMMUNITY SUPPORT FUND

The Government funds a range of initiatives through the Community Support Fund (CSF), many of which are delivered by councils. The CSF grants are paid from the Department of Treasury and Finance to other government departments, which administer and oversee the CSF projects and distribute the funds to CSF grant recipients including councils.

Due to public health restrictions placed on hotels since March 2020 to slow the spread of coronavirus (COVID-19), the CSF received lower than estimated revenue from electronic gaming machines (EGMs) in hotels during 2019-20. The CSF accessed cash reserves from prior years to meet all grant payment obligations in 2019-20.

In 2020-21, the CSF's revenue from EGMs in hotels continued to be impacted by the public health restrictions in response to the coronavirus (COVID-19) pandemic. EGMs have since recommenced operations from November 2020.

Councils have continued to receive funding from the CSF for existing projects awarded previously and new projects granted in 2019-20 and 2020-21 for the development of community infrastructure and the provision of community services and support.

Specific CSF funding projects approved in 2020-21 include:

- $17 163 to Ballarat City Council via the Department of Jobs, Precincts and Regions to upgrade the cricket nets at Russell Square to address the safety concerns for the East Ballarat Cricket Club players and other members of the community who use the facility; and
- $10 000 to Colac Otway Shire Council and $9 935 to Warrnambool City Council via the Department of Environment, Land, Water and Planning to improve and enhance the irrigation systems at the Colac Botanic Gardens and the Warrnambool Botanic Gardens.

DISASTER RESPONSE

Emergency Management Victoria, within the Department of Justice and Community Safety, administers the Commonwealth's Natural Disaster Relief and Recovery Arrangements (NDRRA) (for events occurring prior to 1 November 2018), and the Disaster Recovery Funding Arrangements (DRFA) (for events post 1 November 2018), which provides financial assistance to councils affected by disasters such as bushfires, floods and severe storms. This funding is largely used to reimburse eligible costs incurred by councils in counter disaster operations and in the repair and reinstatement of damaged essential public assets.

Actual expenditure fluctuates each year depending on the number and magnitude of natural disasters that have occurred.

Councils continue to receive financial assistance for the standard relief and recovery measures under the NDRRA/DRFA for natural disaster events that have occurred over the last two to three years. Additional financial support has also been provided to councils that were impacted by the 2019-20 Victorian bushfires. This has included activating special assistance financial measures available for significant events under the DRFA and funding initiatives outside of the DRFA.

2021-22 BUDGET INITIATIVES

This section outlines the key *2021-22 Budget* initiatives by department that will be undertaken in partnership with local government. This includes initiatives that broadly impact on local government. Funding details for each of these initiatives are provided in Chapter 1 – *Output, asset investment, savings and revenue initiatives*.

Whole of government

The whole of government *2021-22 Budget* initiative that affects local government is:

- Empowering Victorian Aboriginal communities through infrastructure and organisational sustainability.

Department of Education and Training

The Department of Education and Training works with local government to plan, provide or facilitate kindergarten services and provide financial support including capital grants for this purpose.

The Department of Education and Training's *2021-22 Budget* initiative that affects local government is:

- Ready for school: Kinder for every three-year-old.

Department of Environment, Land, Water and Planning

The Department of Environment, Land, Water and Planning works in close partnership with the local government sector to deliver programs across Victoria. This includes support for community infrastructure, parklands and campsites, pest and weed management and partnerships with local government to deliver integrated water management outcomes.

The Department of Environment, Land, Water and Planning's *2021-22 Budget* initiatives that affect local government are:

- EcoCentre redevelopment;
- Port Phillip Bay Fund;
- Pest and weed management;
- Revitalising Central Geelong;
- Streamlining for growth; and
- Sustaining the EPA's strengthened regulatory functions.

Department of Families, Fairness and Housing

The Department of Families, Fairness and Housing works together with local government to deliver programs that help Victorians to be safe and secure, participate in the economy, and be connected to culture and community.

The Department of Families, Fairness and Housing's *2021-22 Budget* initiatives that affect local government are:

- Changing Places;
- Engaging and supporting at-risk young people;
- Enhanced engagement approach with culturally and linguistically diverse (CALD) communities and complex families;
- Paving the Way Forward: pathway to recovery at North Melbourne and Flemington housing estates; and
- Putting Families First.

Department of Health

The Department of Health partners with community providers and local government across a range of areas. This includes working with local government to deliver public health services such as immunisation and health education.

The Department of Health's *2021-22 Budget* initiatives that affect local government are:

- Public health and local place-based delivery;
- Responding to community-based healthcare demand; and
- Ten new community hospitals to give patients the best care.

Department of Justice and Community Safety

The Department of Justice and Community Safety works in partnership with local government to deliver programs that ensure Victoria is a safe and just community where rights and responsibilities are respected. This includes Bushfire Recovery Victoria continuing to work with Alpine Shire Council, East Gippsland Shire Council and Towong Shire Council to strengthen local government capacity for bushfire recovery.

The Department of Justice and Community Safety's *2021-22 Budget* initiatives that affect local government are:

- Emergency service organisations infrastructure; and
- Initiatives to fast-track Victoria's recovery from the 2019-2020 Victorian bushfires.

Department of Jobs, Precincts and Regions

The Department of Jobs, Precincts and Regions works in close partnership with the local government sector to deliver programs across Victoria and to ensure Victorians enjoy responsive and accountable local government services. The Department provides financial and in-kind support to local government through Local Government Victoria including grants for vital community infrastructure, public libraries, as well as support to clear roadside weeds and pests. In addition, the Department partners with local government to deliver programs in areas such as creative industries, business precincts, regional development, sport and recreation, and suburban development.

The Department of Jobs, Precincts and Regions' *2021-22 Budget* initiatives that affect local government are:

- Addressing opportunities in place: A Thriving Central Goldfields Shire;
- Addressing opportunities in place: Portland Economic Diversification Plan;
- Creative State: Creative Neighbourhoods program;
- Creative State: Regional and outer suburban touring program;
- Digital Infrastructure Upgrade: Cremorne;
- Emergency management sector reform: implementation of reviews and inquiries;
- Fishermans Bend Innovation Precinct at the former General Motors Holden site;
- Free Wi-Fi in Ballarat and Bendigo central business districts;
- Growing Suburbs Fund;
- Investing in local sports infrastructure;
- Leadership for women in local government;
- Melbourne central business district economic package;
- Public Libraries Funding Program;
- Roadside Weeds and Pests Program;
- Rural Roads Support Package;
- Seymour revitalisation;
- Strengthening Regional and Metropolitan Partnerships;
- Suburban recovery and revitalisation; and
- Visitor Economy Partnerships.

Department of Transport

The Department of Transport works with local government to deliver a range of initiatives, including local transport infrastructure and roads to benefit Victorian communities. This can include providing financial and in-kind support to local government.

The Department of Transport's *2021-22 Budget* initiatives that affect local government are:

- A more productive road network for freight;
- Better boating facilities;
- Central Pier Docklands redevelopment;
- Fitzroy Gasworks Sports Centre;
- Ison Road – Rail Overpass;
- Lydiard Street Level Crossing Upgrade;
- School crossing supervisor program;
- Sustainable local ports; and
- Tram performance.

STYLE CONVENTIONS

Figures in the tables and in the text have been rounded. Discrepancies in tables between totals and sums of components reflect rounding. Percentage changes in all tables are based on the underlying unrounded amounts.

The notation used in the tables and charts is as follows:

n.a. or na	not available or not applicable
1 billion	1 000 million
1 basis point	0.01 per cent
..	zero, or rounded to zero
tbc	to be confirmed
ongoing	continuing output, program, project etc.
(x xxx.x)	negative amount
x xxx.0	rounded amount

Please refer to the **Treasury and Finance glossary for budget and financial reports** at dtf.vic.gov.au for additional terms and references.

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Victorian Budget 2021/22

Service Delivery
Budget Paper No. 3

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VICTORIA State Government | Treasury and Finance

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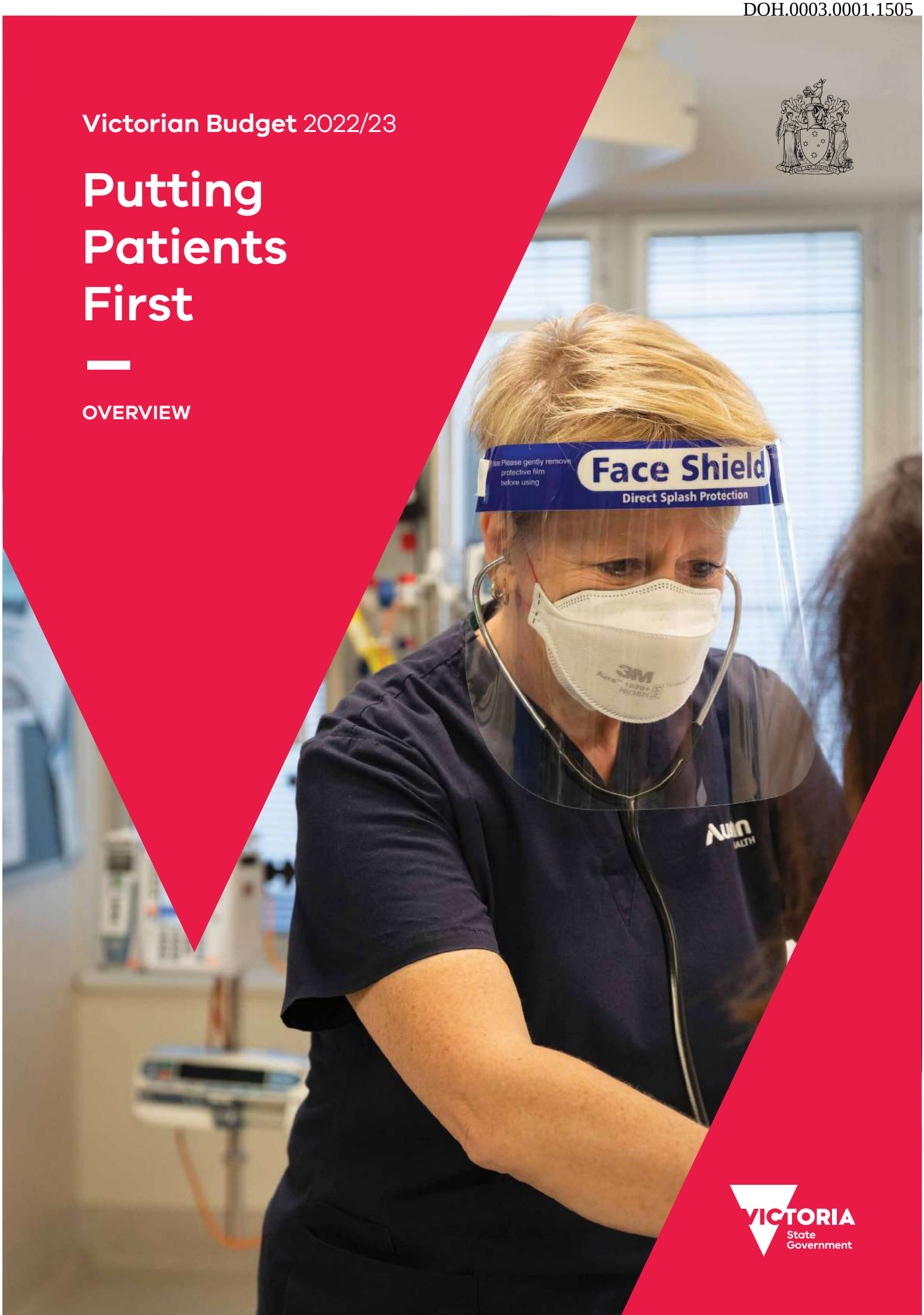
Victorian Budget 2022/23

Putting Patients First

OVERVIEW



VICTORIA State Government

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Budget Paper No. 3 – Service Delivery
Budget Paper No. 4 – State Capital Program
Budget Paper No. 5 – Statement of Finances
(incorporating Quarterly Financial Report No. 3)

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Treasurer's Message

Putting patients first.

Ever since the pandemic reached our shores, we've acted quickly to protect our people and our economy.

We stood by the Victorian community with support of more than $44 billion – to respond to the pandemic and keep workers in jobs and businesses afloat.

We provided rent relief, so Victorians kept a roof over their head, we supported people to test and isolate and relieved stress on businesses with direct financial support.

It built the foundations for Victoria's remarkable economic recovery.

Victorians are once again able to do the things they love. Restaurants and cafes are busy. Shops and theatres are bustling.

Businesses are hiring, with 280 000 jobs created across the state since September 2020. In regional Victoria, the unemployment rate is the lowest in the nation.

But across our nation – and around the world – the pandemic put unprecedented pressure on health systems.

From a sharp increase of critical COVID patients, disrupted care resulting in longer hospital recovery times and people delaying seeing their GP, the last few years have really knocked our health system around.

Now – just like we've done before – we'll ease the pandemic pressure points on our hospitals and our healthcare workers, to make sure every family can get the care they need, close to home.

That's what the *Victorian Budget 2022/23* is about. A Pandemic Repair Plan for more staff, better hospitals and first-class care.

We're backing our healthcare workers with training and the extra pair of helping hands they need – with funding to train and hire up to 7 000 new healthcare workers across the sector, to help relieve pressure on the system and improve care for all Victorians.

We will help Victorians catch-up on care and get more elective surgeries done, sooner.

And more people will get the care they need in the comfort of their own home, as we continue the Better at Home program.

So that every Victorian has the confidence that an ambulance will arrive in their hour of need, we're making record investments in our Triple Zero services and hiring more paramedics.

This Budget also delivers for regional Victorians, who deserve the same level of care as people in Melbourne.

We're upgrading regional hospitals and healthcare facilities in every corner of our state, with the largest ever investment in the Regional Health Infrastructure Fund.

We're also getting on with delivering the schools, roads and public transport services Victorians rely on.

With this Budget, we're building 13 new schools and upgrading a further 65 schools, because a good education is a good foundation for life.

We're upgrading 36 special schools, which means we will have upgraded every special school in our state since coming to Government. We understand that students with special needs are entitled to exactly the same opportunities as every other Victorian student.

We're investing in roads and rail, preparing for day one of the Metro Tunnel and getting on with removing dangerous and congested level crossings – because Victorians want to get home sooner and safer.

At its heart, this is a Budget that looks after the health and wellbeing of every single Victorian.

This is a Labor Budget that invests in the hospitals and healthcare our state needs and the Victorian workers we need to deliver it.

It's a Budget that delivers more staff, better hospitals and first-class care.

This is a Budget that is putting patients first.

Tim Pallas

Treasurer of Victoria

Victoria's economic recovery

SUPPORTING VICTORIANS AND RESTORING THE BUDGET

Today, there are almost as many Victorians in work as there ever have been.

Victorian unemployment is at the lowest since current records began, and in regional Victoria it is even lower.

People are heading back into work, and visitors and students are returning to our state once again.

Our economy is bouncing back from the global pandemic – businesses are busy, restaurants are buzzing again, and there are growing job opportunities for Victorian workers.

It's no accident that Victoria's economic outlook is so strong.

Our record investments have delivered the jobs we needed in the short-term and they're supporting our growing state into the future.

Our strong action to protect the health of all Victorians during the pandemic has helped shield our state from the very worst of this once-in-a-century event.

But our health system is under more pressure than ever due to the pandemic. From a sharp increase of critical COVID patients, disrupted care resulting in longer hospital recovery time or people delaying seeing their GP, the last few years have really knocked our health system around.

Which is why, in this year's Budget, we're putting patients first – with a Pandemic Repair Plan for more staff, better hospitals and first-class care.

This Budget invests to help our health system meet growing demand and ensure Victorians have the care they need close to home.

And when it comes to mental health, we held a Royal Commission to help us fix a broken system – one in which too often, Victorians in crisis ended up in an emergency department, or simply fell through the cracks because they didn't know where to turn, or who to turn to.

We're building a new mental health system from the ground up. A system where all Victorians can get the care they need much sooner and much closer to their families and communities.

We're also building and upgrading schools, with a focus on special schools – because kids with special needs should have exactly the same opportunities as every other student in Victoria.

And we're transforming the way people and freight move around our state, as well as investing in the industries and technologies of the future.

These investments will not only create decent, secure jobs right now, they will also support the growth of key industries and provide a stronger recovery that delivers more opportunities for workers into the future.

And we're not simply getting back to where we were before the pandemic – this Budget keeps us on track to deliver our fiscal strategy while continuing to make Victoria stronger, fairer and more prosperous than ever.

We are building big, and we're bouncing back.

Victoria has bounced back – and we're still growing strongly

JACKEROO

DELIVERING ON OUR FISCAL STRATEGY

This Government has a proven record of financial management.

During the pandemic, we used our balance sheet to support Victorian households and businesses, while also setting out a clear, four-step fiscal plan for the medium term:

- **Step 1:** Creating jobs, reducing unemployment and restoring economic growth
- **Step 2:** Returning to an operating cash surplus
- **Step 3:** Returning to operating surpluses
- **Step 4:** Stabilising debt levels.

We're pleased to report that in this Budget, having continued to deliver on the first two steps, we're successfully delivering Step 3 of our fiscal plan in 2025-26.

We are also turning our focus to Step 4 which prioritises stabilising debt levels over the medium term.

While we're delivering on our fiscal plan, we're also investing in initiatives that will support Victoria's long-term economic growth.

This Budget delivers for the industries that have the greatest potential to grow – industries that will leverage Victoria's strengths to create the jobs of the future.

Our continuing investments in our caring workforce and Big Build are creating quality jobs, improving people's lives and making it easier for Victorians to move around our state.

Victoria's economy is strong – the unemployment rate is the lowest since current records began, demand for workers is high, and business conditions and confidence are elevated. Victoria is on track for strong economic growth.

VICTORIAN FUTURE FUND

In this Budget, we are establishing the Victorian Future Fund to manage the fiscal impact of the pandemic and deliver positive outcomes for Victorians, by reducing the debt burden on future generations. The Fund will support the state's debt stabilisation strategy.

The Fund will be established using proceeds from the VicRoads Modernisation Joint Venture. The investment returns from the Fund will be quarantined and returned to the Fund so that its balance will grow over time to offset borrowings. Both the initial investment and future returns will be used to repay pandemic borrowings. The Fund is projected to have a balance of around $10 billion in the medium term.

Further investments will be made into the Fund through proceeds from designated government land sales and a proportion of future budget surpluses once net debt stabilises.

The Fund will be managed by the Victorian Funds Management Corporation (VFMC), the state's specialist investment agency. The VFMC will implement a diversified investment strategy designed to deliver the best possible returns for Victorians. Over time, this will improve the state's operating result and net debt position, further supporting the state's debt stabilisation strategy. The Fund will be managed in line with strict environmental, social and governance (ESG) principles consistent with other investments managed by the VFMC.

Victorian economic forecasts[a] (per cent)

	2020/21 actual	2021/22 forecast	2022/23 forecast	2023/24 forecast	2024/25 projection	2025/26 projection
Real gross state product	–0.4	5.50	3.25	2.25	2.75	2.75
Employment	–1.1	3.00	1.75	1.00	1.25	1.75
Unemployment rate[b]	6.2	4.25	4.00	4.25	4.50	4.75
Consumer price index[c]	1.4	3.00	2.50	2.25	2.50	2.50
Wage price index[d]	1.4	2.50	2.75	3.00	3.00	3.00
Population[e]	–0.7	0.10	1.20	1.70	1.70	1.70

Sources: Australian Bureau of Statistics; Department of Treasury and Finance

Notes:

[a] Percentage change in year average terms compared with the previous year, except for the unemployment rate (see note (b)) and population (see note (e)). Forecasts are rounded to the nearest 0.25 percentage points, except for population (see note (e)).

The key assumptions underlying the economic forecasts include interest rates that broadly follow market economists' expectations; an Australian dollar trade-weighted index of 61.2; and oil prices that follow the path suggested by oil futures.

[b] Year average.

[c] Melbourne consumer price index.

[d] Wage price index, Victoria (based on total hourly rates of pay, excluding bonuses).

[e] Percentage change over the year to 30 June. Forecasts are rounded to the nearest 0.1 percentage point.

General government fiscal aggregates

	Unit of measure	2020/21 actual	2021/22 revised	2022/23 budget	2023/24 estimate	2024/25 estimate	2025/26 estimate
Net result from transactions	$ billion	(14.6)	(17.6)	(7.9)	(3.3)	(1.1)	0.7
Net cash flows from operating activities	$ billion	(13.0)	(11.8)	1.3	0.8	3.6	5.5
Government infrastructure investment[a][b]	$ billion	15.0	18.9	21.4	23.0	21.7	19.2
Net debt	$ billion	72.7	101.9	118.5	137.4	154.8	167.5
Net debt to GSP[c]	per cent	15.3	19.8	21.7	24.1	25.8	26.5

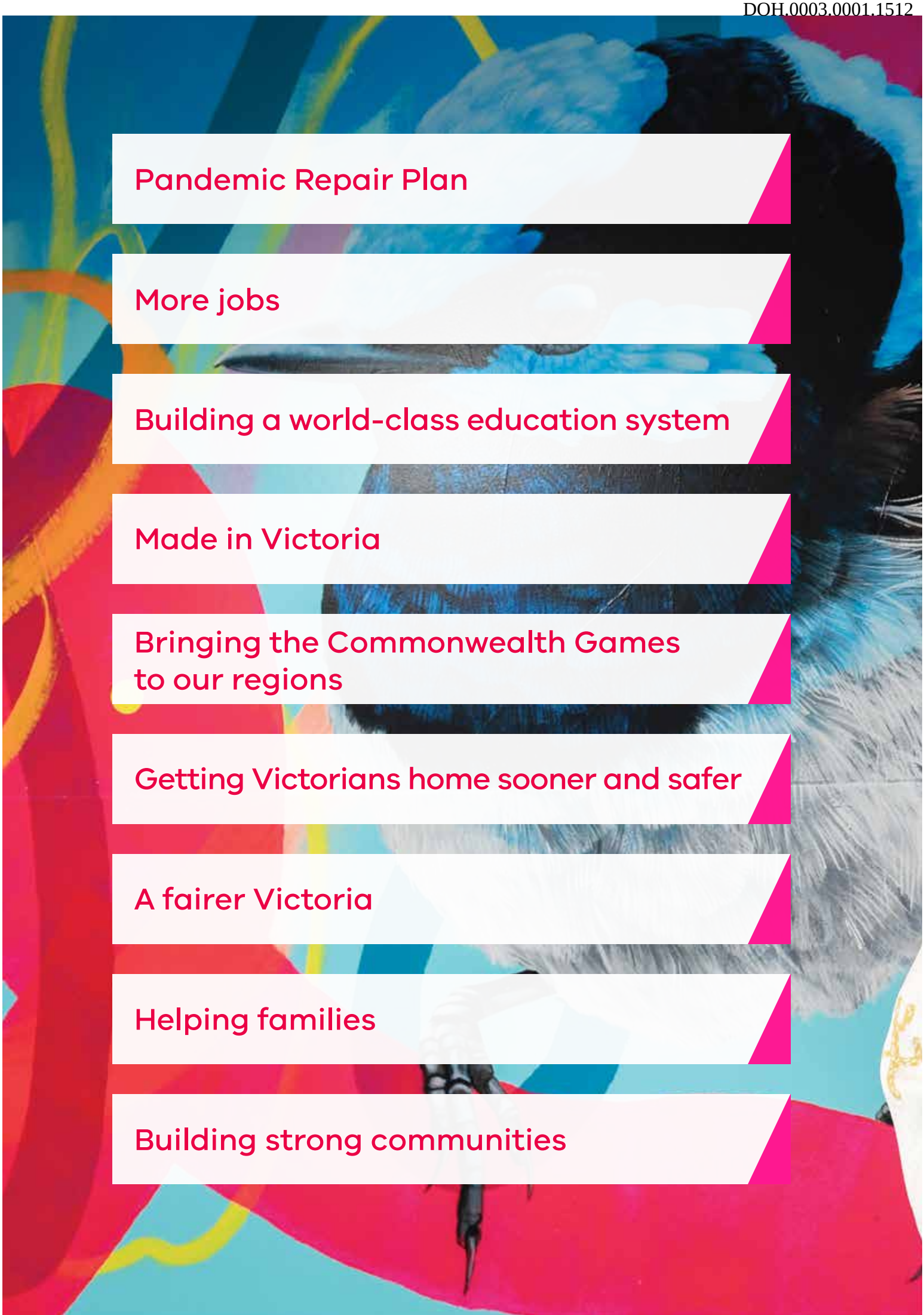
Source: Department of Treasury and Finance

Notes:

[a] Includes general government net infrastructure investment and the estimated construction costs of public private partnership projects.

[b] Includes the estimated private sector construction related expenditure associated with the North East Link held in the public non-financial corporations (PNFC) sector.

[c] The ratios to gross state product (GSP) may vary from publications year to year due to revisions to the Australian Bureau of Statistics GSP data.



Pandemic Repair Plan

More jobs

Building a world-class education system

Made in Victoria

Bringing the Commonwealth Games to our regions

Getting Victorians home sooner and safer

A fairer Victoria

Helping families

Building strong communities

Investing in every corner of the State

STATEWIDE

- $4.2 billion to support our ongoing pandemic response, including $522 million to support our hospitals to treat COVID-19; $1.1 billion to purchase and distribute free rapid antigen tests to schools, hospitals and Victorians with disability; $284 million for PPE; $258 million to protect and vaccinate Victorians against COVID-19; and $110 million for COVID-19 care pathways and to continue our 28 general practitioner respiratory clinics
- $1.8 billion for school infrastructure, including upgrades to 65 schools including 36 special schools, building 13 new schools, additional stages at four more schools, and expanding capacity at two schools to meet enrolment demand
- $1.5 billion for COVID Catch-up to enable record levels of surgical capacity
- $1 billion in low-interest loans and government guarantees for social and affordable housing
- $780 million in 2022/23 to undertake road maintenance works across the metropolitan and regional road network
- $698 million for Better at Home
- $383 million to switch on the Big Build, prepare for Metro Tunnel operations, and provide train timetable service upgrades across the state
- $372 million for our mental health workforce
- $342 million to recruit an extra 502 police and 50 Protective Services Officers over the next two years
- $300 million for the Regional Health Infrastructure Fund to boost regional healthcare
- $265 million to build and upgrade trains and trams, including 12 new VLocity trains, built and maintained in Victoria, for the regional rail network
- $263 million to continue to deliver Victoria's 2021-2030 Road Safety Strategy and first three-year action plan
- $250 million for the Power Saving Bonus to help households save on their energy bills
- $248 million to deliver a package of V/Line improvement projects to support regional passenger rail operations, and for maintenance works on freight rail corridors across the state
- $246 million to help our creative industries bounce back even stronger than before
- $246 million to fund the *Sick Pay Guarantee* pilot, to support casual or insecure workers in select industries that don't provide sick or carer's pay
- $215 million to give frontline police officers and protective services officers equipment to keep Victorians safe
- $158 million for accessibility and safety upgrades at various train stations and tram stops
- $151 million to prepare for Victoria's nation-leading treaty process
- $146 million to build three new public residential aged care facilities in regional areas and plan for two more
- $135 million to provide vital support to Victorians with disability who aren't eligible for the NDIS
- $131 million to continue four-year-old kindergarten services, including important support for rural and small services and continued help for disadvantaged children to access kindergarten
- $131 million for extra literacy and numeracy support for students who need it most, including tailored support for students in middle years
- $126 million in road upgrades in metropolitan Melbourne
- $124 million to put more paramedics on the road and improve ambulance performance
- $111 million to support Victoria's visitor and events economy, to attract more tourists and promote Victoria to the world
- $109 million to improve Victoria's suburban and regional bus services and bus stops
- $101 million for regional road upgrades, including intersection upgrades, new overtaking lanes and roundabouts on key regional roads and highways across the state

Bright new aged care facility planning

Princes Highway and Bairnsdale-Dargo Road intersection improvements

Orbost new aged care facility

Croajingolong Coastal Wilderness Walk

Bairnsdale train stabling upgrades

Latrobe Regional Hospital mental health ED hub

- Arts
- Clean energy
- Education
- Environment and parkland
- Health
- Justice
- Mental health
- Public transport
- Regional investment
- Roads
- Sport and recreation
- Strong communities

Pandemic Repair Plan

The pandemic has put unprecedented pressure on health systems right across Australia and around the world.

In Victoria, our health system has been stretched like never before – and a sharp increase in critical COVID-19 patients is only part of the picture.

The pandemic has also resulted in disrupted care and longer recovery times, and people delaying seeing their GP. All of this puts huge demands on our hospitals and healthcare workers.

When we came to government, we put an end to the war on our paramedics, and we took ambulance response times from the worst in our history to the best.

We did this by working alongside our nurses, doctors and paramedics – with a clear plan to get it done.

Now – just like before – we'll ease the pressure on our hospitals and healthcare workers by putting patients first.

Our Pandemic Repair Plan will mean more staff, better hospitals and first-class care.

This Budget gives a much-needed boost to our health system, including:

- Delivering record levels of surgical capacity across the state, to give Victorians the specialist care they need – before they end up in the emergency department
- More than $12 billion for health, including for more nurses, doctors, paramedics, health services and new and improved health infrastructure, so all Victorians have access to high-quality healthcare, closer to home
- Training and hiring up to 7 000 new healthcare workers, including 5 000 nurses.

Our Pandemic Repair Plan will mean more staff, better hospitals and first-class care

SUPPORTING OUR HEALTH WORKERS

Our health workers have borne the brunt of the pandemic, and Victorians are so proud of their dedication and sacrifice.

We know how important it is that we support them into the future.

That's why we're backing our healthcare workforce with training and the extra pair of helping hands they need – so they can give the very best care.

Ambulance Victoria will recruit 90 more paramedics with a $124 million investment to put more ambos on the road, while we're unclogging emergency departments to prevent ramping.

In a huge boost to care, we're delivering 1 125 new Registered Undergraduate Nursing Positions per year over the next two years. We will also improve training for nurses and midwives by reviewing clinical placements, and roll out nursing and midwifery pilot programs.

There's a further $9.7 million to support an additional 75 Registered Undergraduate Student of Midwifery positions, and to boost our flexible maternity staffing pool.

We are also supporting more cadetships, scholarships and traineeships for Aboriginal healthcare workers, to ensure that more Aboriginal Victorians can get culturally sensitive care.

Our paramedics, nurses and doctors have given so much to our state – and it's had a cost on their mental health.

That's why we are expanding the Nursing and Midwifery Health Program to provide one-on-one psychological support for up to 600 additional nurses and midwives.

We're also expanding Safer Care Victoria's Healthcare Worker Wellbeing Centre program. This will help our health system manage staff fatigue and stress, and provide advice and training opportunities.

Our investment includes $8 million for Ambulance Victoria to deliver the recommendations of the Equal Opportunity and Human Rights Commission's review into workplace equality.

IMPROVING OUR EMERGENCY RESPONSE

The pandemic has tested our emergency departments.

They've had to handle a sharp increase in critical patients.

And they've had to manage workforce disruptions when staff got sick, and roll out COVIDSafe practices that – while important – complicate and slow down care.

Across Australia, demand for emergency services is at an all-time high, with Triple Zero call-takers and dispatchers dealing with unprecedented call volumes.

But every Victorian should have confidence that when they call for emergency care, someone will come to help.

That's why this Budget invests in practical and immediate measures to cut wait times, expand emergency departments and get Victorians the help they need, when they need it most.

In addition to recruiting and training more paramedics, we are relieving pressure on our emergency response systems:

- We're investing $333 million to add nearly 400 new staff to increase Triple Zero call taking and dispatch capacity for Triple Zero services, including ambulances, and training more operators to allocate calls across the state
- We're expanding the emergency departments at Casey Hospital and Werribee Mercy Hospital with $236 million to at least double their current capacity and get patients home from hospital sooner
- We're enhancing our fleet management system and improving rostering and support functions at Ambulance Victoria with $99 million to meet the growing demand for ambulance services
- We're investing $12 million in Ambulance Victoria to establish a second mobile stroke unit in Melbourne's south-east, so that stroke victims can get the urgent care they need without delay.

BUILDING AND UPGRADING VICTORIA'S HOSPITALS

The pandemic has reminded us of what matters most – the health and wellbeing of the people we love.

Our hospitals and local health services have been at the frontline of the pandemic, and now we're ensuring they're at the forefront of our Budget.

This Budget invests $2.9 billion in health infrastructure, including building a new hospital and upgrading existing ones.

We're investing more than $900 million in a new tertiary hospital for Melbourne's west.

The new Melton Hospital will include a 24-hour emergency department, over 100 medical and surgical beds, an intensive care unit, maternity and neonatal services and more mental health services and outpatient care.

Building a local hospital also means local jobs – not only in construction but in running the hospital after it opens.

This Budget also provides more than $500 million to deliver the Barwon Women's and Children's Hospital.

We'll make sure that the Maternity Assessment and Short Stay unit, Special Care Nursery, birthing suites, and operating theatres can see more patients and give more support for paediatric outpatients. And we will build a new inpatient tower.

We're upgrading regional hospitals too, with a record $300 million boost for the Regional Health Infrastructure Fund for projects ranging from operating theatre refurbishments to equipment upgrades. Since the program began in 2016, we have funded over 480 projects and with this expansion our investment will total $790 million.

This Budget also means more life-saving equipment for hospitals and funding for upgrades and improvements across our health services.

- $35 million for the Medical Equipment Replacement Program for items like CT scanners, digital X-Ray units and ultrasounds
- $25 million for the Metropolitan Health Infrastructure Fund for a range of upgrades like refurbishment of consultation rooms or wards
- $20 million for the Engineering Infrastructure Replacement Program for items like aging generators, emergency lighting or nurse call systems.

This Budget provides more than $500 million to deliver the Barwon Women's and Children's Hospital for Geelong's rapidly growing population

COVID CATCH-UP

Victorians need access to life-saving and life-changing elective surgery without lengthy wait times.

Unfortunately, the pandemic has disrupted elective surgery care for many patients.

To tackle this, we're investing $1.5 billion to increase surgical activity beyond pre-pandemic levels by providing 40 000 extra surgeries in the next year, building up to a total of 240 000 surgeries annually by 2024.

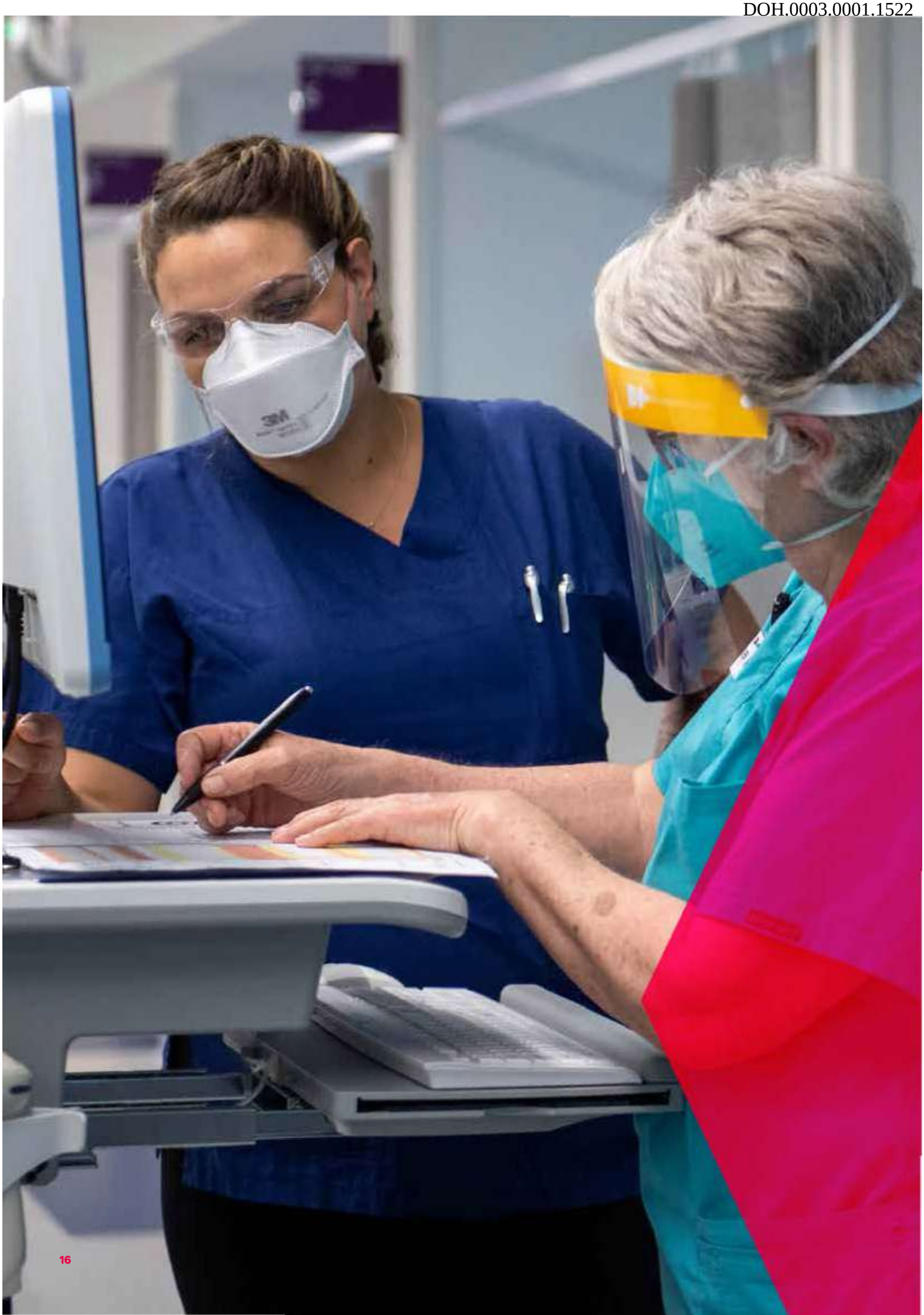
As part of this plan, we will establish Rapid Access Hubs and draw on the capacity of private hospitals to deliver public surgeries.

This includes transforming Frankston Private Hospital into a public surgery hub that will perform up to 9 000 public surgeries a year once it's fully operational.

We're also recruiting up to 2 000 ex-pat and international healthcare workers through a global workforce recruitment drive.

This Budget provides significant investment to further take the pressure off our hospitals and hardworking healthcare professionals, including:

- $2.4 billion for more emergency staff and to support new wards as they open
- $698 million for the Better at Home program to continue the delivery of healthcare through the use of home-delivered and virtual care, so more people can be treated at home
- $7.2 million to strengthen community-based healthcare in 20 registered community health services by ensuring GPs and providers are better coordinating patient care.



MANAGING THE PANDEMIC INTO THE FUTURE

Together, Victorians have achieved incredible things over the past two years.

Along with countless acts of kindness and support for each other, Victorians got vaccinated in record numbers.

As we move into this highly-vaccinated phase of the pandemic, we need to keep managing COVID-19 to minimise disruption and reduce the pressure on our hospitals and health workers.

That's why we are continuing to invest in the preventative measures that work – vaccines, testing and PPE, as well as COVID-19 care in and out of our hospitals.

This Budget delivers $4.2 billion to support our ongoing pandemic response.

To ensure that COVID-19 patients have the best chance of a full recovery, we are spending $522 million to support our hospitals to treat COVID-19, and a further $110 million on specialised care pathways and continuing our 28 general practitioner respiratory clinics.

Our investment in prevention includes $284 million for PPE and $258 million to vaccinate more Victorians including 5 to 11-year-olds and to expand our booster program.

And because accessible and free testing has helped Victorians return to school, work and normal life, we are investing $1.1 billion to purchase and distribute free rapid antigen tests to schools, hospitals, Victorians with disability and other priority cohorts.

We are also providing $40 million to support local public health units, which have been so crucial over the pandemic.

As well as showing how resilient Victorians are, the pandemic has also reminded us that we are home to some of the brightest minds and most innovative thinkers.

That's why this Budget is supporting the delivery of a new mRNA manufacturing facility.

This investment will bolster Victoria's capacity to produce life-saving vaccines and build on our reputation as a state that is at the forefront of medical research and innovation.

SPECIALIST CARE FOR VICTORIANS

Our Pandemic Repair Plan invests in the early detection, prevention and treatment of some of our most common health conditions, ensuring that our healthcare investment is spent where it makes the most difference.

This Budget delivers $20 million for additional breast cancer screening across new and existing services – and $1.2 million for catch-up vaccination against the Human Papilloma Virus for young Victorians to prevent and detect early common cancers affecting women.

We are also investing to support better outcomes for people experiencing substance abuse and addiction. This includes $36 million to construct a 30-bed Alcohol and Other Drugs residential facility in Mildura, building the capacity to provide specialised care for Victorians in need.

This Budget also invests $8.3 million for the Aboriginal Maternal and Child Health (MCH) program to better connect with Aboriginal organisations, so families have the choice of accessing MCH services at their local Aboriginal community-controlled organisation.

BUILDING A MENTAL HEALTH SYSTEM THAT WORKS

The Royal Commission into Victoria's Mental Health System told us, when it comes to accessing mental healthcare, Victorians often struggle to access the mental health support they need until it's too late.

Last year, we promised we'd fix our broken mental health system by building a new one from the ground up.

In the *2020/21 Budget*, we invested $869 million to lay the foundation for a new mental health and wellbeing system, and we provided extra funding for mental health services throughout the pandemic.

This was followed by a record investment of $3.8 billion in last year's Budget to support Victorians and speed up these nation-leading and life-saving reforms.

This Budget builds on these investments with $1.3 billion to take the next steps in this process, including:

- $218 million to operationalise 82 new beds in Victoria's mental health system and other priority initiatives
- $196 million to replace and expand the mental health facility at Goulburn Valley Health in Shepparton, and to purchase land and undertake further planning to deliver additional acute mental health beds in regional Victoria
- $124 million for the next stage of redevelopment of the Thomas Embling Hospital to deliver critical supporting infrastructure, additional parking and the bed replacement program
- $65 million to deliver an electronic mental health and wellbeing record, information exchange platform, and an online portal to support mental health and wellbeing services
- $62 million for upgrade works across intensive care areas of Victoria's mental health facilities, creating dedicated spaces to improve the separation of vulnerable patients, including providing for gender-based separation
- $54 million to deliver treatment, care and support for people with a co-occurring mental illness and substance use or addiction in all Adult and Youth Area Mental Health and Wellbeing Services
- $29 million to support the implementation of new mental health and wellbeing legislation, and to deliver an independent review of compulsory treatment criteria
- $10 million for the Mental Health and Alcohol and Other Drug Facilities Renewal Fund to help acute and community-based facilities to deliver the best, recovery-oriented services for Victorians
- $5 million to help plan the Victorian Collaborative Centre for Mental Health and Wellbeing – bringing together people with lived experience, researchers and clinicians to establish best practice in mental health and wellbeing services.

Community mental health services

When our mental health system fails Victorians in need, it fails their families and carers too. Instead of feeling supported, loved ones are often left searching in an overburdened and understaffed system.

This Budget invests $12 million in mental health and wellbeing support for regional families whose children are accessing acute care, and providing group-based parenting sessions to Victorian parents who need somewhere to turn while navigating the system.

We also know that local support systems are so important in improving mental health outcomes, which is why we're investing in Victoria's community mental health services. That means bringing together locals who know their communities best and can develop new solutions to improve and build community resilience, social connection and inclusion.

There is an extra $9.1 million to establish Social Inclusion Action groups in 10 local government areas to build on the success of local community mental health groups in these areas.

We know that the earlier we reach someone struggling with their mental health – the better. This Budget provides a $21 million package to support suicide prevention initiatives, including aftercare services and an 18-month pilot of a statewide peer call-back service for families, carers and supporters of people experiencing suicidal behaviour.

We are also investing $20 million to support broader approaches to eating disorder care and support. This includes funding to expand services with 15 dedicated beds to provide more care to Victorians with an eating disorder. We'll also fund a statewide eating disorder strategy and invest in existing programs – because no one should have to go it alone.

Victoria's mental health workforce

In addition to these key reforms, we are investing in our mental health workforce because building a new mental health system requires a lot of people.

We're investing a record $372 million in our mental health workforce – supporting clinical training for the existing workforce and additional jobs where they're needed most, on top of the approximately 580 extra places we have already delivered.

That's training for more than 1 500 mental health workers, including more than 100 psychiatrists, 300 psychologists and 400 mental health nurses, so they can give the very best care.

SUPPORTING OLDER VICTORIANS

We all deserve to be looked after in our later years.

In this Budget, we're investing to ensure that Victorians are treated with respect as they age.

We're continuing to provide important funding to the Elder Abuse Prevention Network, to raise awareness of elder abuse and help prevent it from occurring in the first place.

We're also continuing our financial counselling services to prevent financial abuse, as well as supporting elderly Victorians living in bushfire-affected communities.

Key investments delivered in this Budget include:

- $146 million to build three new public sector residential aged care facilities in Camperdown, Mansfield and Orbost including planning funding to redevelop the Bright and Heywood aged care facilities
- $30 million for places in public residential aged care so older Victorians receive the high-quality care and comfort they deserve
- $3 million for a range of initiatives to support social recovery programs for older Victorians and carers, including continuation of the reimagined Victorian Seniors Festival, COVIDSafe live performances in aged care facilities and tailored employment support for carers
- $2.9 million to continue the Elder Abuse Prevention Network, addressing family violence for older Victorians and stopping it from happening
- $800 000 for the design and planning of a new 60-bed public sector residential aged care services facility with 30 specialist mental health beds, and a 30-bed dementia unit at the Mornington Centre.

Creating decent, secure jobs

Every Victorian deserves the security and dignity of a good, stable job with a decent wage.

A job is about more than just a pay cheque – it means being able to provide for your family and plan for the future.

That's why the Andrews Labor Government is building local, buying local and hiring local.

This Budget is helping every Victorian find the fair and decent jobs they deserve.

Since November 2014, our economy has generated 560 000 new jobs, including more than 80 000 jobs in regional Victoria.

When the pandemic hit our shores we responded with record investment to protect Victorian lives and livelihoods. We had a plan to create 400 000 jobs by 2025, with a target to deliver half of them by 2022.

Today, Victoria has already far exceeded our goal – with employment rising by 280 000 since September 2020. We are well on track to reach our target of 400 000 jobs by 2025.

We now want to do even more, creating more opportunities for Victorians to find a job and giving them the training they need for the future.

We're backing local businesses and keeping Victorians in work, with more than $13 billion in COVID-19 related support provided to businesses since March 2020.

This Budget also provides $353 million to help our creative and major events industries bounce back.

We're focused on building jobs in the industries of the future, in areas such as advanced manufacturing, medical research and renewable energy.

And since 2014 our infrastructure agenda has supported, or will support, more than 191 000 jobs. This includes 14 000 jobs supported by new infrastructure projects announced in this Budget.

From schools to hospitals, roads and rail – we've strengthened our economy by delivering the projects that had been in the 'too hard' basket for too long.

We're investing in the services Victorians need, and in the Victorians we need to deliver them.

Whether that's a job in our mental health workforce or a role supporting children and families, we're creating thousands of opportunities for Victorians doing work that matters.

And not only are we creating more jobs, we're making them fairer too.

The Andrews Labor Government is piloting Australia's first *Sick Pay Guarantee* – where participants in casual or insecure work in select industries won't be forced to choose between a day's pay and looking after their health.

This Budget is helping create more jobs and opportunities for the future.

And it gives every Victorian the chance to succeed.

COST OF LIVING

We know that Victorians are paying too much for their energy bills – that's why we're stepping in to help families get the best deal. We're giving a once-off $250 payment for all Victorian households that use the Victorian Energy Compare (VEC) website – the Victorian Government's independent price comparator website – to search for the cheapest electricity deal. Typically, households can save $330 on energy bills annually by using the website and switching their retailer or plan – meaning that Victorians can save up to $580 through this initiative.

This is on top of targeted programs to support Victorians with:

- Children starting three-year-old kinder receiving a Kinder Kit to help parents support their children's early learning
- Free 30-day public transport travel passes to students experiencing crisis to ensure they can continue to travel to school and support services
- Additional rebates will be provided by Solar Victoria to eligible households, including renters, to install battery storage systems and solar panels on their homes.
- The VCAL reforms will save many Victorian families up to $1 000 by cutting out-of-pocket costs, with students no longer having to pay for essential learning materials for VET studies.

Building a world-class education system

A good education is the foundation of a good life.

And we're committed to giving our kids the very best lives we can.

We're creating a state where every student can learn and achieve – regardless of where they live or the barriers that stand in their way.

We're building schools where our kids don't just learn, they excel – with world-leading classrooms, great teachers and the very best resources on offer.

Every Victorian family, wherever they live, deserves a good quality school. That's why, since 2015 we've made significant investments in new schools, upgrades and improvements across the state.

This Budget brings our total investment in improving and building new schools to more than $12.8 billion over the past eight years. To help better meet the needs of local families, this Budget invests $1.8 billion in building new schools and upgrading existing schools.

The Andrews Labor Government is making a big investment in upgrading special schools in this Budget. This means that since we took office eight years ago, every single special school in Victoria will have received funding for a major upgrade – because students with disability deserve the same opportunities as every other student in Victoria.

We've funded doctors in schools, put mental health professionals on campuses, and provided free breakfast to kids who would otherwise go without.

We're also giving our youngest Victorians the best foundation possible, by extending universal kindergarten to all three-year-olds.

And we're investing to transform VCE and VCAL to help students graduate into a great job and a rewarding future.

Because we're building the Education State – for every Victorian child

READY FOR SCHOOL

Early years investment to support strong foundational education

This year, we reached a huge milestone for our youngest Victorians.

Children across the state gained access to at least five hours of funded three-year-old kindergarten each week, scaling up to 15 hours by 2029.

That $5 billion investment over the decade is helping set our kids up for brighter futures and better outcomes. And around a quarter of families are supported to access kinder at low or no cost.

This Budget builds on that investment, with $15 million to deliver Kinder Kits to kids starting three-year-old kinder in 2023 and 2024. This box of books and other educational items like locally-made puppets and games, will ensure their learning can continue when they're at home.

This Budget also invests $131 million to continue four-year-old kindergarten services, including important support for rural and small services, and continued help for disadvantaged children to access kindergarten.

Other investments in early childhood in this Budget include:

- $19 million for the LOOKOUT program, which supports children in out-of-home care to access kindergarten and transition to school, and to support vulnerable children and their families with an experienced and qualified facilitator through the Access to Early Learning program
- $17 million to assist children with significant disability or complex needs to participate in kindergarten through the Kindergarten Inclusion Support program
- $12 million to make kindergarten facilities and activities more accessible for children with disability, including funding new ramps and sensory equipment
- $5.5 million to continue the Early Childhood Language Program to deliver learning in another language in kindergartens, along with further professional support and training for teachers
- $4 million to provide targeted outreach support for children and families from culturally and linguistically diverse backgrounds, so that they aren't held back from learning and families are fully supported and included in their child's development
- $2.2 million to provide free or low-cost kindergarten for vulnerable children, including children holding a humanitarian or refugee visa.

Supporting students where they need it most

The Andrews Labor Government is investing in Victorian kids and ensuring that regardless of the barriers they face, every child can access the education they need and deserve.

More kids at risk of disengaging with school and support services will be identified and supported with a $37 million boost to the Navigator Program. This includes a pilot to extend the program, which will lower the age of eligibility to young people aged 10 to 11 years.

And a $21 million investment will continue to deliver the Active Schools program, providing advice and resources to ensure that Victorian students have the skills, confidence, and motivation to be active for life.

EXCELLENCE IN EDUCATION

The Andrews Labor Government is supporting every student to realise their potential.

This means responding to changing needs after the pandemic, increasing mental health support in schools, and reforming VCE and VCAL pathways.

This Budget invests in the tools our schools need to give young Victorians a great education and a bright future.

Key initiatives include:

- $131 million for extra literacy and numeracy support for students who need it most, including individualised support for those in middle years who need help catching up
- $37 million to continue the Student Excellence Program, supporting high-ability students to reach their full potential through more challenging study and opportunities
- $24 million to support the English as an Additional Language program, giving students who do not speak English at home more English language support at school so they don't fall behind
- $17 million to extend the Primary Mathematics and Science Specialists initiative to train an additional 100 government primary school teachers as mathematics specialists
- $5.2 million to establish the Regional Blended Learning Hub, so regional students can study subjects their school previously couldn't provide.

As kids spend more time online, this Budget is also investing $3.7 million to support students to be cyber safe and secure learners.

And in 2023, we will be undertaking the biggest reform to the VCE since its inception.

With the new VCE Vocational Major and Victorian Pathways Certificate replacing VCAL, we're creating one certificate to give every senior secondary student more choice, and ensure they have the skills they need for post-school education or work.

This Budget is investing $277 million to deliver this transformation of Victoria's senior secondary system.

This transformation includes:

- $88 million to increase the teaching workforce and support schools to hire more vocational teachers and support staff, to help students access vocational and applied learning
- $86 million to introduce an expanded offering of vocational and applied learning pathways and certificates in government secondary schools, to ensure that every senior secondary student has access to quality vocational and applied learning, no matter which government school they go to
- $69 million to expand statewide the Head Start school-based apprenticeship and traineeship model to support students to complete their senior secondary certificate while progressing towards a qualification
- $34 million to deliver professional learning for government school teachers to implement the new curriculum and support for non-school senior secondary providers to transition to the new framework.

Supporting our teachers

Victoria's teachers have gone above and beyond during the pandemic.

They ran classes online, supported students from home, and innovated to keep kids engaged and learning.

We heard from teachers that if they have more time to prepare lessons, plan, and mark work, their teaching will improve – that's why this budget will invest $779 million to recruit around 1 900 teachers. That means more time for each teacher to prepare and focus on each student and their needs.

To further support our school workforce, this Budget provides additional investment of $173 million. This funding will help grow the supply of teachers, encourage them to work in remote and challenging locations, and give them access to the best training and resources.

This includes:

- $104 million to upgrade school software so students, staff and administrators can connect better and faster
- $33 million to continue and expand the delivery of employment-based teacher education degrees for postgraduate students
- $14 million to expand the teacher financial incentives program and extend international teacher incentives and supports
- $10 million to continue the Secondary Mathematics and Science Initiative including to train 50 mathematics and 25 science out-of-field teachers in priority curriculum areas.

MAJOR UPGRADES FOR CLASSROOMS AND SPECIAL SCHOOLS

We committed to opening 100 new schools across our state by 2026, and we're well on our way to delivering on this promise.

This Budget will build another 13 schools across our state, bringing the total number of new schools to 75 since 2019.

Students with special needs should also have the same opportunities as every other student in Victoria.

So we are helping make our schools even more inclusive for students with disability and special needs by upgrading another 36 special schools – meaning since 2015 we have upgraded every special school in the state.

We're continuing to build and improve schools around the state, to ensure all our kids have the learning environment they need to succeed.

Because we're committed to ensuring high-quality schools for every child, wherever they live and whatever their needs.

And this investment won't just deliver great schools – it's also helping create jobs in construction and related industries across the state.

Key investments include:

- $581 million to build 13 brand new schools, and funding to complete additional stages at four schools
- $560 million to upgrade 65 schools across Victoria including $326 million for 36 special schools, improving educational outcomes through world-class classrooms and learning facilities
- $247 million for essential maintenance and compliance and the Accessible Buildings Program
- $92 million for new relocatable buildings to relieve pressure at schools that are reaching their capacity and to provide additional functional spaces for learning
- $56 million to expand capacity to meet enrolment growth at two established area schools ahead of the 2025 school year
- $42 million to fund minor capital works and priority projects at Victorian schools.

Metro schools

NEW METRO SCHOOL CONSTRUCTION

The following new schools (interim names listed below) will be constructed:

- Aintree Secondary School
- Aintree Specialist School
- Alexander Boulevard Primary School
- Black Forest East Primary School
- Brookfield Primary School
- Lockerbie Central Primary School
- Lollypop Creek Secondary School
- Lollypop Creek Specialist School
- Merrifield South Primary School
- Officer Brunt Road Primary School
- Riverdale Secondary School
- Tarneit North Primary School
- Truganina North Primary School

The following schools will build additional stages:

- Aintree Primary School
- Aitken Hill Primary School
- Gaayip-Yagila Primary School
- Truganina North Secondary School (Interim Name)

METRO SCHOOL UPGRADES

- Banyan Fields Primary School
- Bentleigh Secondary College
- Bittern Primary School
- Bundoora Secondary College
- Coldstream Primary School
- Diggers Rest Primary School
- Doreen Primary School
- Hawthorn West Primary School
- Kingston Heath Primary School
- Laburnum Primary School
- Merri Creek Primary School
- Moonee Ponds West Primary School
- Mordialloc Beach Primary School
- Mount Pleasant Road Nunawading Primary School
- Pascoe Vale Primary School
- Reservoir High School
- Sandringham East Primary School
- St Albans Heights Primary School
- The Patch Primary School
- Wantirna College
- Westgarth Primary School
- Yarra Primary School

METRO LAND ACQUISITION FOR NEW SCHOOLS

- Cardinia
- Casey
- Hume
- Melton
- Whittlesea
- Wyndham

METRO SPECIAL SCHOOL UPGRADES

- Ashwood School
- Aurora School
- Berendale School and Katandra School (merger)
- Broadmeadows Special Developmental School
- Burwood East Special Developmental School
- Croydon Special Developmental School
- Dandenong Valley Special Developmental School
- Eastern Ranges School
- Glenroy Specialist School
- Hume Valley School
- Jennings Street School
- Merriang Special Developmental School
- Montague Continuing Education Centre
- Mornington Special Developmental School
- Naranga School
- Northern School for Autism
- Officer Specialist School
- Peninsula Specialist College
- Springvale Park Special Developmental School
- Waratah Special Developmental School
- Warringa Park School – Warringa Crescent & Bethany Road Campuses
- Western Autistic School

SCHOOL UPGRADES: GROWTH FOR 2025

- Kambrya College
- Staughton College

New school – construction
School upgrade
School upgrade (growth for 2025)
Special school upgrade

Regional schools

REGIONAL SCHOOL UPGRADES

- Benalla P@12 College
- Darley Primary School
- East Loddon P@12 College
- Grasmere Primary School
- Mount Rowan Secondary College
- Wedderburn College
- Yinnar Primary School

REGIONAL LAND ACQUISITION FOR NEW SCHOOLS

- Greater Geelong

SPECIAL SCHOOL UPGRADES

- Bass Coast Specialist School
- Belvoir Wodonga Special Developmental School
- Bendigo Special Developmental School
- Cobram and District Specialist School
- East Gippsland Specialist School
- Hamlyn Views School
- Hampden Specialist School
- Mildura Specialist School
- Nelson Park School
- Skene Street School Stawell
- South Gippsland Specialist School
- Swan Hill Specialist School
- Verney Road School
- Warragul & District Specialist School

Made in Victoria

We're building Victoria's future by investing in Victorian jobs and industry. Because when we back homegrown businesses and innovation, every Victorian benefits.

SUPPORTING VICTORIAN MANUFACTURING

To keep Victoria moving forward, we're investing in the industries that will create jobs for years to come.

That's why we are delivering an mRNA manufacturing facility, the first in the southern hemisphere.

This will bolster Victoria's capacity to produce life-saving vaccines and build on and support the resurgence of Victoria as a manufacturing hub. And we're helping to establish Victoria's very own rapid diagnostics manufacturing facility too.

This facility will produce up to 50 million COVID-19 rapid antigen tests every year and create more than 70 local jobs for Victorians, protecting us from global supply shortages and opening new export markets for our state.

Supporting Victorian industry

The Victorian Industry Fund prioritises areas that are strategically important to Victoria's economic recovery, generating new investment and jobs for Victorians. The $120 million fund will also support the advancement of domestic manufacturing, in addition to other high priority sectors for the state.

This includes a new $40 million Victorian Industry Investment Fund to provide grants to support rapidly growing businesses, including supply chains that underpin economic resilience.

A further $40 million will be provided for targeted financial incentives to attract business investment into Victoria, in line with the Victorian Government's International Investment Strategy.

We're also delivering $20 million for an equity investment pilot fund that will attract young, highly-innovative companies looking to grow in areas that align with Victoria's priority strengths, such as medical technology, creating more jobs right across our state.

The $7 million Low-Carbon Manufacturing Grant Program will help Victorian manufacturers compete globally for renewable energy components, supporting Victoria's transition to net zero and all the jobs this will create.

We're also boosting training, with $4.5 million for 300 Digital Jobs for Manufacturing internships to help train, support and prepare the Victorian workers who will support these industries.

Funding of $1.5 million is provided for the Defence Science Institute to support defence research and development in Victoria.

The $2.6 million Defence Industry Workforce Development program delivers additional internship programs to train Victorians to leverage opportunities in the defence manufacturing industry.

Another key step in further developing an advanced manufacturing capability is $1.5 million in funding to explore the co-location of the CSIRO agrifood research and development capability with AgriBio at La Trobe University.

GM
SAFETY

BETTER, SAFER JOBS

Every Victorian has the right to go to work, earn a good wage, and return home safe.

And no one should ever have to put a day's pay before their health, or the health of a loved one.

That's why the Andrews Labor Government is working to fix inequalities faced by workers in every corner of our state.

This Budget provides $246 million to fund the *Sick Pay Guarantee* pilot, which supports casual or insecure workers in select industries that don't provide for sick or carer's pay.

Over 150 000 Victorians in insecure work will be able to participate in the guarantee, providing up to five days' sick pay every year at the national minimum wage. This builds on the $163 million we've invested in this Budget to support workers through the pandemic through the Test Isolation Payment and Pandemic Leave Disaster Payment.

And we're providing $6 million to ensure the Victorian Wage Inspectorate continues to have the power and resources it needs to fight wage theft in our state.

More than $5 million will be dedicated to the establishment of a support service for workers in the gig economy, as recommended by the landmark Inquiry into the Victorian On-Demand Workforce.

The Latrobe Valley Authority will continue to support the Valley and Gippsland transition to long-term, sustainable jobs and industries and help ensure that local communities benefit most.

This includes supporting young people through the Ladder Step Up program and giving communities and workers the skills and support they need to find secure jobs in new industries.

STRENGTHENING INDUSTRY

We're investing $28 million over two years to support and improve the building and construction industry, and create new investment opportunities for Victorian businesses.

We will also deliver a new Building Monitor to help protect consumers from dodgy outfits and better regulate the industry.

And we will establish an Office of the State Building Surveyor to oversee the industry and protect Victorian customers wanting to build a home of their own.

Supporting business

The Regional Jobs and Infrastructure Fund will support economic growth and development in regional and rural Victoria with $30 million funded in this Budget.

This investment will create and retain jobs, grow and diversify regional economies, and work in partnership with the private sector to identify new opportunities for investment.

This Budget also includes $10 million to deliver the Business Acceleration Fund, to cut red-tape and streamline regulations, saving precious time for businesses and the Victorians who run them.

This builds on the $75 million invested in the *2020/21 Budget* Regulatory Reform Package, which will continue to deliver an estimated $200 million in benefits to businesses every year.

SUPPORTING ARTS AND TOURISM TO RECOVER

Melbourne is the creative and events capital of the nation.

And tourism helps grow regional economies right around the state.

From local music venues and small tourism operators, to the big events that draw tens of thousands of people to Victoria.

When the visitors stopped and the curtains closed, the Victorians who relied on these industries took a real hit.

Which is why, with this Budget, we're continuing to help our arts and tourism industries to get back on their feet.

We are investing $17 million to restore and improve access to a range of iconic heritage and tourism sites across the state including the Werribee Park Mansion, Point Nepean Forts and Lighthouses at Cape Otway, Cape Schanck, Point Hicks and Wilsons Promontory.

Investing in creative industries

The Andrews Labor Government has always championed Victoria's creative industries.

Throughout the pandemic, we supported artists with measures like Victoria Together, which helped connect Victorians and gave work to creative talent through online content and music.

This Budget invests $246 million to help our creative industries bounce back even stronger than before.

It includes $6 million in affordable creative spaces for artists, and activating underutilised spaces run by local governments for local artists and creatives.

And the Go West Festivals Fund will commission stage shows and support jobs for artists from culturally and linguistically diverse backgrounds, taking the arts sector in our western suburbs to a whole new level.

This will sustain and grow jobs that deliver the world-class creative experiences Victorians and visitors come to our state to enjoy.

It will also ensure that the cultural capital of Australia continues to support and foster emerging local artists and performers.

Investing in Victoria's cultural institutions

More visitors to Victoria means more jobs for Victorians.

We're kickstarting Victoria's creative industries by supporting our galleries, museums and arts centres to do what they do best – put on a show.

With this Budget, the Andrews Labor Government is investing $127 million in Victoria's arts organisations and cultural institutions to be vibrant, strong employers and speed up business recovery.

This includes $32 million in funding to help support the National Gallery of Victoria (NGV).

This will fund Summer Programming and the NGV Triennial, bringing new major exhibitions and major tourism numbers to our state.

And with this Budget, Victorians can look forward to visiting our outstanding exhibitions and visitor experiences for many years to come, with a $17 million creative infrastructure package that will fund repairs, restoration and planning at some of our state's best theatres and galleries – creating local jobs in the construction and trades sector.

That includes upgrades for Theatre Works and the National Theatre in St Kilda, the Castlemaine Art Museum, Footscray Community Arts Centre and planning for the Tarneit Performing Arts Centre, and the Dandenong Arts Precinct.

Investing in tourism

The Andrews Labor Government is supporting Victoria's visitor economy with $111 million to attract more tourists and promote Victoria to the world.

These initiatives will boost our tourism industry as international borders reopen and our visitor economy bounces back. They will support more tourism, accommodation and hospitality jobs in every corner of the state.

A $2.6 million investment will continue to attract a pipeline of national business events to Melbourne and regional Victoria. These events play a vital role in supporting local jobs and the state's economic recovery during off-peak seasons.

In addition, the $4.4 million events recovery and support program will re-establish Victoria's calendar of world-class events as we recover from the pandemic.

We're also funding small- to medium-sized community events in Greater Melbourne, to help local neighbourhoods and communities come together after so much time apart.

Support for tourism operators

This Budget provides funds for the Emerald Tourist Railway, including the implementation of the Puffing Billy Master Plan. This will support the continued attraction of tourists to the railway and sustain local jobs.

Funding will also enable the Melbourne Convention and Exhibition Centre to relaunch activities this year, delivering more events with a strong workforce.

Funding of $5 million is provided to assist in the sustainable management of Victoria's alpine resorts, ensuring they can continue to be enjoyed by the community.

SKILLING VICTORIANS

The Government is investing in the skills and training Victorians need to find decent, secure jobs.

This Budget provides $12 million to continue and expand the Apprenticeship Support Officers program which will help provide apprentices and employers with tailored support, ensuring more Victorians complete their training and take up a job they want.

Funding will target learners most at risk of dropping out including female apprentices.

The Government is investing $83 million to support and strengthen TAFEs as they sustainably transition to a new funding model and expand coordination of practical placements for TAFE students.

This builds on our significant previous investment in TAFE, helping students access more TAFE courses and get trained for a wider variety of jobs.

This Budget provides $4.1 million to add Diploma and Advanced Diploma courses in Auslan to our successful Free TAFE program, making it easier for students to get the qualifications they need to support Victoria's deaf community.

Nearly $800 000 is also allocated to provide an accessibility review of all Victorian TAFE campuses to help people with disability access the training and skills they need to succeed.

And $10 million to establish new Skills Solutions Partnerships will help address skills shortages in priority areas through collaboration with government, industry, TAFEs and dual sector universities.

OPEN TO THE WORLD

Victoria has so much to offer the world.

From our highly-skilled workforce, to our growing technology and innovation sector, and world-class food, wine and produce.

International investment and exports are key to attracting new opportunities and fulfilling our state's trade potential.

The Andrews Labor Government is investing $20 million to support trade and identify opportunities for Victorian businesses as borders reopen across the world.

We will establish a new Victorian Government Trade and Investment office in Paris to create opportunities for Victorian businesses to further expand into European markets in key trade sectors.

This investment includes $2 million to support international students by providing them with access to public transport through the International Student Travel Pass.

It also includes $6.5 million to support the Trade Mission Program and ensure that key trade attraction facilities continue to engage and involve Victorian industries and generate jobs.

Bringing the Commonwealth Games to our regions

Big sporting events bring Victorians together.

And there is no better place to hold the 2026 Commonwealth Games than Victoria – the home of Australian sport.

For the first time, the Games will be hosted across Victoria's regions – with regional hubs in Ballarat, Bendigo, Geelong and Gippsland. Other regional towns and cities are now able to register their interest in hosting activities as part of the Games.

The regional hubs will host athletes, officials and fans following an Opening Ceremony at the iconic Melbourne Cricket Ground, using Melbourne as the gateway to regional Victoria.

Beyond the field of play, we will put on a show for Victorians and visitors alike – pulling out all the stops to feature cultural festivals, local business and great entertainment.

Melbourne hosted the first Olympic Games in the southern hemisphere in 1956, and regularly hosts world-class major events such as the Formula 1, Australian Open, Melbourne Cup Carnival and the Boxing Day Test – to name just a few.

With Victoria 2026, we'll be promoting regional Victoria to the world – because it has so much to offer.

We successfully hosted the Commonwealth Games in 2006, and we are now pleased to be bringing the Commonwealth Games back to Victoria in 2026.

And it will deliver the additional benefits of creating local jobs and housing and boosting regional economies. That's why this Budget includes funding of $2.6 billion so Victoria is ready to host the Commonwealth Games in 2026.

Victoria will deliver a world-class Commonwealth Games that leaves a lasting legacy in every corner of our state.

We will deliver a world-class Commonwealth Games that leaves a lasting legacy in every corner of our state

GS
DEMONS

Getting Victorians home sooner and safer

We haven't wasted a day in getting on with the road and rail projects Victorians need to get home safer and sooner.

The Andrews Labor Government has invested $97 billion in planning, building, operating and maintaining transport assets, including new trains, trams, tunnels and roads.

That includes getting on with the projects we promised: the Metro Tunnel, the Level Crossing Removal Program, the Suburban Rail Loop, the West Gate Tunnel, the North East Link and the Melbourne Airport Rail.

And our regional network is the backbone of our state, connecting communities to work, study and to each other.

Our investments in the Regional Rail Revival program and regional road improvements are providing more reliable transport options for growing communities and helping regional Victorians make it home safe.

These infrastructure investments are also creating jobs.

Our Big Build program supports jobs and has provided a career path for apprentices, cadets and trainees – giving Victorians the confidence that if they learn a trade, there will be a job for them on one of our major projects.

We'll partner with any Commonwealth Government willing to support Australia's most important infrastructure projects and will keep advocating for Victorians to get their fair share.

SWITCHING ON THE BIG BUILD

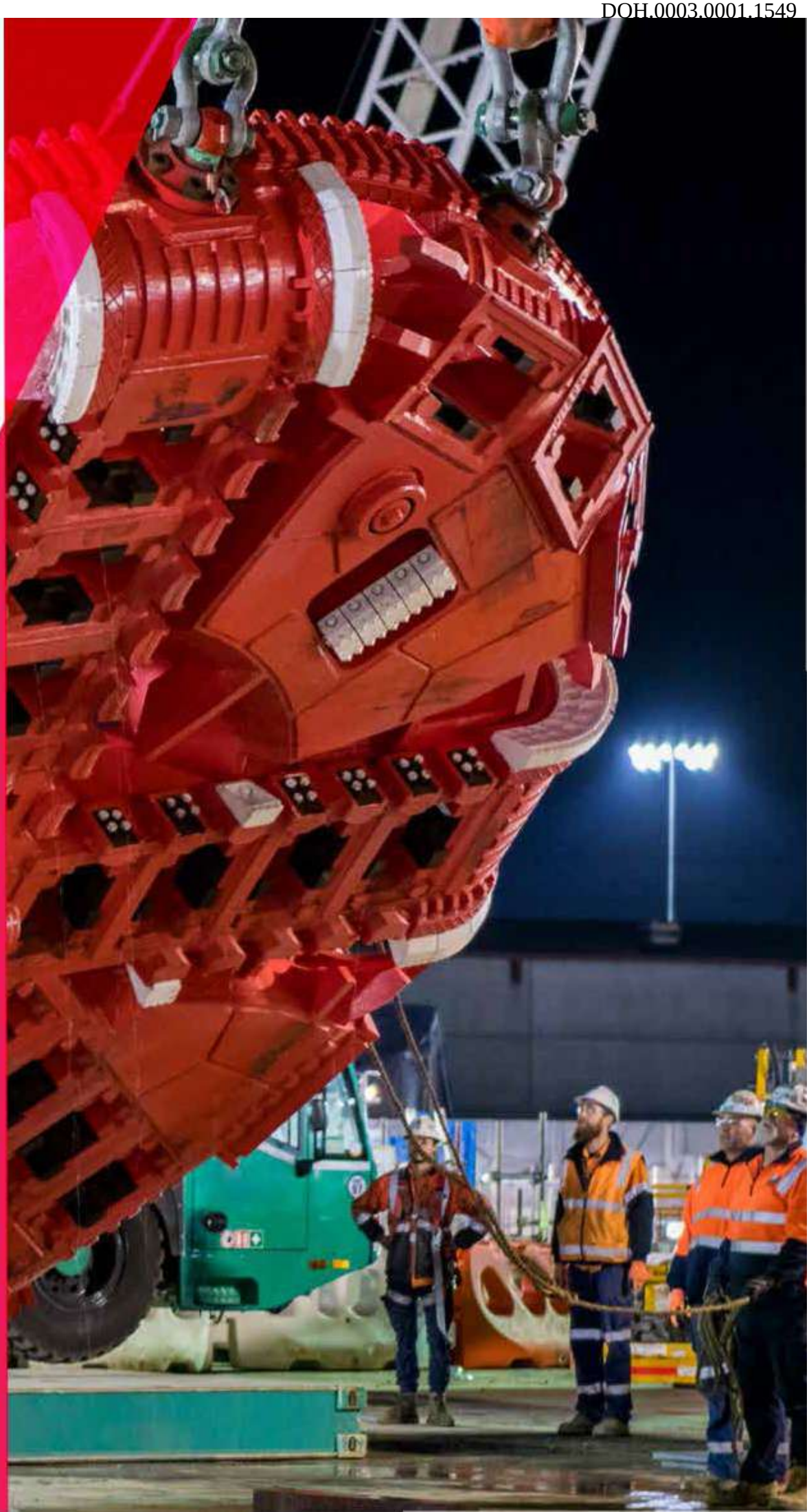
The Andrews Labor Government is powering ahead with rail projects right across the state – slashing travel times and supporting thousands of jobs.

The Budget provides $383 million to operate new transport infrastructure delivered as part of the Big Build, including level crossing removals, rail extensions, train station upgrades and road upgrades.

Train timetable service upgrades are being introduced across both regional and metropolitan rail networks following the completion of major projects including the Cranbourne Line Upgrade, the Waurn Ponds Station upgrade, Wyndham Vale corridor upgrades, and the Pakenham level crossing removals.

This funding also includes preparing for day one of the Metro Tunnel, including recruitment and training of train drivers and other critical staff, maintenance of new assets and the development of wayfinding and customer information.

Victorians will experience a more accessible and comfortable public transport network with $158 million for accessibility and safety upgrades at train stations and tram stops, including critical CBD tram stop upgrades to provide better connections and access to the Metro Tunnel when it opens.



IMPROVING OUR PUBLIC TRANSPORT SYSTEM

Since 2014, we have invested $59 billion to keep our public transport moving – and with this Budget, we'll keep building a public transport system that every Victorian can rely on.

The Government is investing a further $265 million into the state's unprecedented pipeline of new and upgraded trains and trams – built and maintained in Victoria for Victorians, supporting thousands of jobs in local manufacturing.

In a boost for regional Victoria, this Budget includes 12 brand-new VLocity trains built and maintained in Victoria for the regional rail network and new stabling facilities at Bairnsdale for Vlocity trains on the Gippsland line.

A further $248 million will be invested in Victoria's regional rail network to keep people and goods moving, including a package of V/Line organisational improvement projects to support the reliability and efficiency of regional passenger rail operations, and major periodic maintenance and routine maintenance works on freight rail corridors across the state.

We're delivering $109 million to improve Victoria's suburban and regional bus services and bus stops, connecting people to education and work and filling gaps in the network.

Suburban and regional train stations will be upgraded to improve accessibility and safety with a $58 million investment, including on the Dandenong and Mernda lines, and at Woodend and Warrnambool. The upgrades will include better signage, new passenger shelters, boarding ramps, CCTV, and bicycle parking facilities.

We're building a public transport system that every Victorian can rely on

BETTER, SAFER ROADS

The Andrews Labor Government is getting every Victorian home sooner and safer by continuing to invest in road upgrades across the state.

We have invested $35 billion since 2014 to expand the road network and deliver the critical maintenance work that ensures our roads are safe.

This Budget includes $213 million for the Mickleham Road 1.6-kilometre road upgrade, creating a safer journey for the thousands of drivers who use the road every day.

The project will deliver bus priority lanes at intersections, to help cut travel times for every commuter.

We're also investing $126 million for road upgrades in metropolitan Melbourne, including installing traffic lights, planning and development work, and other road improvements.

Regional Victorians know better than most how important it is to have safe and reliable roads.

Which is why this Budget is investing $101 million in regional road upgrades. These works include intersection upgrades, new overtaking lanes and new roundabouts on key regional roads and highways across the state, from Wodonga to Shepparton to Bairnsdale and Portland.

Safe roads are well-maintained roads, which is why the Andrews Labor Government is spending $780 million in 2022/23 on road maintenance works across the metropolitan and regional road network.

Works include routine maintenance, road resurfacing and bridge strengthening. This will ensure the roads we use today are safe and sound in the decades to come.

We're also focusing on road safety, because any death on our roads is tragic. This Budget includes $263 million to continue to deliver Victoria's 2021-2030 Road Safety Strategy and the first three-year Road Safety Action Plan.

SUBURBAN RAIL LOOP

The Suburban Rail Loop (SRL) is the single biggest transport investment in Victoria's history.

The 90-kilometre rail line will link every major rail line from the Frankston Line to the Werribee Line via Melbourne Airport, better connecting Victorians to jobs, retail, education, health services and each other.

Three transport super hubs at Clayton, Broadmeadows and Sunshine will connect regional services, so passengers outside Melbourne won't have to travel through the CBD to get to employment, world-class hospitals and universities in the suburbs.

The SRL will also deliver decades worth of local jobs, with up to 24 000 jobs supported across Victoria during the delivery of the SRL from Cheltenham to the Melbourne Airport.

In August 2021, we released the Business and Investment Case, which showed the project stacks up – every dollar invested will return $1.10 to $1.70 to the Victorian community.

The SRL East Initial and Early Works alone will create up to 800 direct jobs, with construction commencing in 2022.

Earlier this year, we released an expression of interest to the market for the SRL East tunnelling packages.

The first tunnelling package will deliver around 16 kilometres of twin tunnels between Cheltenham and Glen Waverley – the longest in Victoria's history.

The second will complete the SRL East corridor, with tunnels from Glen Waverley to Box Hill.

And the SRL East Community Projects Fund will invest in projects identified by local community groups and councils to create new green space, walking tracks, bike paths and local projects that benefit the entire community.

We know that SRL train stations will be a focal point for communities, and the Andrews Labor Government is committed to ensuring they become hubs that deliver the important services and community spaces that Victorians deserve.

REMOVING LEVEL CROSSINGS

When we set an ambitious target to remove 50 dangerous and congested level crossings by 2022, some said it couldn't be done.

But by the end of this year, we will have removed 68 – and we're not slowing down.

By 2025 the Andrews Labor Government will remove 85 dangerous and congested level crossings – getting rid of boom gates that have slowed down Victorians for decades.

The 10 new sites announced in July last year will create jobs for 2 100 people and another 1 900 workers will support the manufacturing supply chain:

- Warrigal Road, Mentone
- Parkers Road, Parkdale
- Keon Parade, Keon Park
- Bedford Road, Ringwood
- Dublin Road, Ringwood East
- Coolstore Road, Croydon
- Webb Street, Narre Warren
- Station Street, Beaconsfield
- Brunt Road, Beaconsfield
- Calder Park Drive, Calder Park.

We're also building five new stations at:

- Croydon
- Keon Park
- Narre Warren
- Parkdale
- Ringwood East.

While removing these level crossings is critical, we have put local communities at the heart of delivering these projects.

Right now, in suburbs across Melbourne, there are new sports facilitates, open spaces and bike paths delivered as part of our community-focused approach to removing level crossings.

Because we know that for new infrastructure to be effective, it needs to benefit the entire community.

A fairer Victoria

A fairer Victoria means supporting every single Victorian – regardless of who you are, where you're from, or what you believe.

It means providing the support and opportunity that people need to succeed.

This Budget delivers significant reform and investment to promote equality, tackle disadvantage, and improve fairness across our entire state.

This means providing homes for those who need them, progressing a treaty with Aboriginal Victorians, supporting our LGBTIQ+ community, and putting equality at the forefront of our decision making.

We're investing in a more equal state for every single Victorian.

HOMES FOR VICTORIANS

Having a home is so much more than just a roof over your head.

It gives you the base you need to hold down a job, or to study and get a good education.

It's a place where you can start a family of your own and create a great future for your kids.

And it means belonging to a community of people – it gives security and opportunity.

A home is the foundation of a better life, and our Government is so proud to offer thousands of Victorians the chance to achieve exactly that.

In October 2021, the Government launched its $500 million Victorian Homebuyer Fund, a shared equity scheme that has already helped over 900 Victorians to buy a home and approved more than a further 1 400 to start house hunting.

In the *2020/21 Budget*, we invested a record $5.3 billion to deliver more than 12 000 new homes, including 2 000 dwellings for Victorians living with a mental illness.

Government intends to work with the community housing sector to make available a further $1 billion in low interest loans and government guarantees to community housing agencies to deliver social and affordable housing.

This is expected to create up to 6 000 new social and affordable houses, providing accommodation for some of our most vulnerable Victorians.

Tackling homelessness

We're providing the programs and services that Victorians experiencing homelessness need to stay off the streets and find a safe, secure place to call their own.

We're investing $75 million to provide tailored homelessness support, and focus our delivery model on prevention, early intervention and sustainable housing.

We're investing $9.4 million to continue critical homelessness programs around Victoria.

This includes support for the Homelessness After-Hours Service, to help people seeking accommodation outside of business hours to find a safe place to sleep and avoid being left to sleep rough.

In the last year alone, the Homelessness After-Hours Service has provided emergency accommodation for thousands of Victorians in need.

FIRST PEOPLES

The foundation for a fairer Victoria starts with a fairer future for our First Peoples.

Our Government has funded almost $1.6 billion in programs and services to support and assist Victoria's Aboriginal community, including over $400 million in this Budget.

This includes work to support self-determination and further the treaty process between First Nations' Peoples and the State.

We're continuing to support our nation-leading treaty process with an investment of $151 million.

Other initiatives include:

- $36 million to deliver assessments for the protection of cultural significant Aboriginal Victorian sites
- $7.2 million to continue the Aboriginal Children and Families Innovation and Learning Fund, which provides grants to Aboriginal Community Controlled Organisations to undertake research that will allow them to better do their work
- $5.8 million to continue joint land management of the Barmah National Park in partnership with the Yorta Yorta people
- $5.8 million to deliver educational programs in schools that support learning and understanding of self-determination for Victorian Aboriginal communities
- $3.9 million to support returning water to Traditional Owners for cultural, spiritual and economic use
- $2.8 million to support the delivery of a Certificate IV in Teaching a First Nation's Language, to help increase the number of Aboriginal language teachers in Victorian classrooms
- $2.2 million to support the Lake Tyers and Framlingham Aboriginal Trusts to strengthen their independence and support emerging leaders
- $947 000 to deliver Aboriginal community events that foster continue greater public awareness of Victorian Aboriginal culture and history
- $748 000 to deliver the Traditional Owner Settlement Act Forum that supports Aboriginal communities to negotiate traditional owner land rights that help communities realise the full benefit of their native title settlements.

EQUALITY FOR ALL VICTORIANS

Equality is not negotiable in Victoria.

Regardless of who you are, who you love, or who you want to be, everyone deserves to be treated with respect and decency in our state.

The Andrews Labor Government has delivered on its commitment to release Victoria's first whole of government LGBTIQ+ Strategy.

And this Budget provides expanded funding to create a more inclusive state – where Victorians can be themselves and celebrate their diversity.

In this Budget we are committing $15 million to strengthen the health, wellbeing, and social and economic outcomes of LGBTIQ+ Victorians.

This includes continuing the LGBTIQ+ Grants Program, to help support even more community organisations and LGBTIQ+ groups to grow and expand their work.

We're proud to once again support the Pride Events and Festivals Fund, and provide funding for four years of the Melbourne Pride festival.

We will trial Safe Spaces for LGBTIQ+ youth in Western Victoria, including referral services and greater access to targeted medical and emotional supports.

And now that the Victorian Pride Centre is fully operational, we're continuing to invest in the services and programs that it supports, including a specialist LGBTIQ+ legal service and the Trans and Gender Diverse Community Health Program.

These services will better support LGBTIQ+ Victorians with specialist care and advice from workers and professionals who understand their community and their needs.

We are also leading the nation when it comes to gender equality, and we're drawing on international best practice to make sure this Budget supports the needs of all Victorians.

Gender responsive budgeting will ensure that Government investment helps address and advance women's needs and aspirations. That means greater investment to support gender equality, more targeted policies that consider the needs of all Victorians, services that are better targeted to the needs of women, and increased transparency and accountability across government.

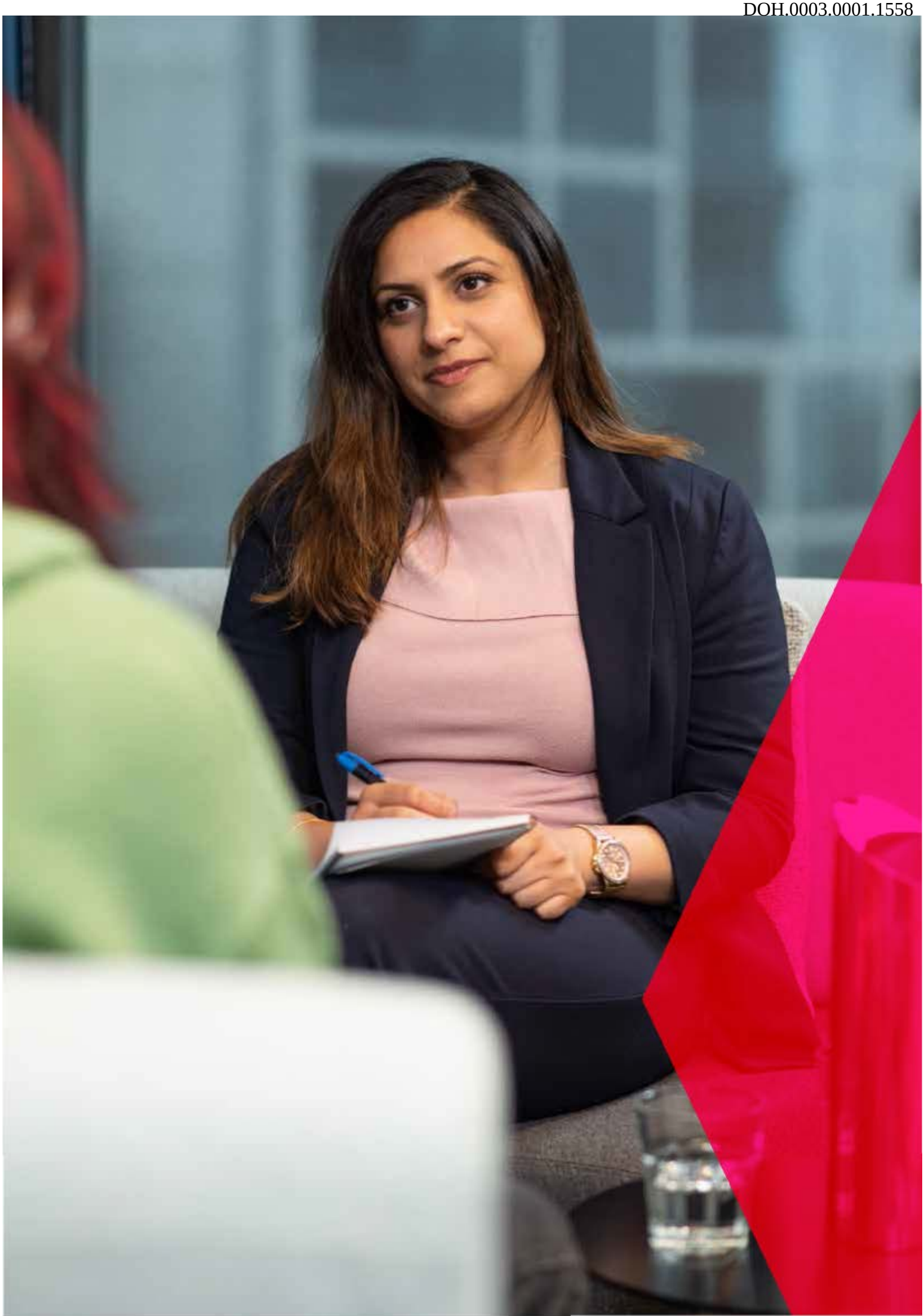
Following on from the introduction of the *Gender Equality Act 2020* we're prioritising gender equality in this Budget.

This focus will help us identify areas that need extra support so we can achieve our equality goals.

The *2022-23 Budget* invests around $940 million in initiatives primarily focussed on improving outcomes for women.

Our Government has always backed equality, and this Budget does exactly that.

Equality is not negotiable in Victoria



INVESTMENT IN EARLY INTERVENTION

From family violence to child protection and mental health – the Andrews Labor Government has a record of delivering for the Victorians who need it most.

And we know that the key to meaningful change for families and communities is early support when people first reach out for help – well before they reach a crisis point. Intervening early not only helps individuals and their families – it reduces the need for more acute and costly services.

The Government invested $324 million in early intervention in the *2021/22 Budget*. Building on last year's investment, this Budget delivers an additional $504 million for early intervention initiatives.

Investments this year support students in crisis, those suffering mental ill health, persons exiting prison and those experiencing homelessness.

A new system with community based services at its core

We're providing early access to substance use illness or addiction treatment as part of acute mental healthcare – meaning people get serious support early, rather than ending up in the emergency department during a crisis.

This Budget includes ongoing support to deliver integrated care, treatment and support for people living with an acute mental illness and substance use illness or addiction.

With this approach, we are ensuring that Victorians suffering from both illnesses receive the care they need in an accessible way.

Putting an end to homelessness

Stable housing is the bedrock of health and wellbeing. This Budget supports people who have a history of homelessness, to help them into the accommodation they need. The assistance provides street outreach and tailored case management to address barriers to exiting homelessness including substance abuse, poor physical and mental health and limited social supports, while also building their capacity to better manage their lives and their residential tenancy.

Supporting children at risk

This Budget will expand the Navigator program, helping an additional 1 400 severely disengaged young people to reconnect with learning.

This includes a trial to lower the eligibility age of the program to 10 to 11-year-olds, so they can get earlier intervention and support during the transition from primary school to secondary school.

Reducing re-offending and keeping Victorians safe

Targeted, earlier services and supports will reduce repeat offending and improve outcomes for over-represented cohorts in the justice system.

With an emphasis on holistic and integrated responses, the initiatives expand effective reintegration and support services, and provide new approaches that foster stronger employment and engagement with family and community, targeted support for people with disability, and safe accommodation to offenders who would otherwise be at risk of homelessness.

Helping families

Victorian families deserve to know that when they need help, it will be there. This Budget continues the Government's strong track record in delivering the services families need for peace of mind.

SUPPORT FOR VULNERABLE CHILDREN

Every child should grow up feeling safe, supported and loved.

And for our kids to lead happy and healthy lives, they need the very best start possible.

This is why the Andrews Labor Government has invested $2.9 billion since the *2019/20 Budget* to protect our children and help keep vulnerable families together.

These investments have expanded the child protection workforce, increased out-of-home placements, and provided care for vulnerable families.

This Budget builds on our commitment to support families and children, providing a further $272 million to improve services and safety. This investment includes:

- $85 million to meet demand for residential care and continue the Care Hub program, which supports young people who can't live with their families due to abuse or neglect. Care Hub's services help minimise the time young Victorians spend in care, and reunify them with their families sooner
- $58 million to meet increasing demand for family services, with support for up to 1 000 additional vulnerable families, and to strengthen child protection responses by increasing support staff capacity
- $7.2 million to support culturally-safe services for Aboriginal children in child protection and the continuation of the Aboriginal Children and Families Innovation and Learning Fund.

ENDING FAMILY VIOLENCE

Seven years ago, we held Australia's first ever Royal Commission into Family Violence.

Through the courage and conviction of so many Victorians, we started a national conversation about putting an end to this crisis.

We heard the call of thousands of victim survivors. We have made significant headway in delivering change and this Budget will assist us towards meeting all 227 Royal Commission recommendations.

The Andrews Labor Government has invested over $3.5 billion to protect and support Victorian women and children facing family violence. This Budget invests a further $241 million to support victim survivors.

This includes:

- $69 million to continue funding for family violence refuges, build and operate two new women's refuges, upgrade three existing partner agency-operated facilities and purchase six new crisis accommodation properties to support victim survivors
- $43 million for family violence services, including additional crisis case management for victim survivors of family violence, specialised therapeutic counselling services for children and young people, and financial supports for victim survivors fleeing family violence
- $30 million including continued support for perpetrators behavioural change programs, including enabling family violence specialists to engage with perpetrators who have gone through Male Behaviour Change Programs so we can understand how to make these services more effective in the future
- $30 million to expand the capabilities of the Central Information Point, a critical service that collates and shares relevant information about risks posed by known perpetrators and helps keep victim survivors safe.

Building strong communities

When Victorians look out for one another, we can overcome anything. Through this Budget, the Andrews Labor Government is supporting communities to be stronger than they've ever been.

INVESTING IN VICTORIAN COMMUNITIES

This Budget continues to invest in communities in Victoria's suburbs, with $50 million to extend the Growing Suburbs Fund.

The Fund will provide grants for local community infrastructure projects, such as health and wellbeing hubs; community centres; arts and cultural facilities; parks and reserves; early education and learning centres; and sport and recreation facilities. Because no matter where you choose to live, work and raise a family – every Victorian deserves a great community.

Other initiatives include:

- $20 million for Living Local, Shopping Local and local community grants programs to support smaller scale infrastructure in metropolitan Melbourne and regional Victoria. The Fund will deliver projects like new playgrounds, community gardens and upgrades to community centres
- $750 000 to support the planning processes for Fishermans Bend.

REINVIGORATING MAJOR ATTRACTIONS

We want to promote everything Victoria has to offer to the world.

Which is why we're rebuilding, upgrading and protecting some of Victoria's biggest attractions.

We're investing a total of $1.7 billion to transform the Melbourne Arts Precinct and position Victoria as a global arts destination.

This includes an additional $241 million to build on existing restoration works for the Arts Centre Melbourne, undertake critical maintenance works to the Theatres Building and deliver a range of new food and beverage outlets for visitors.

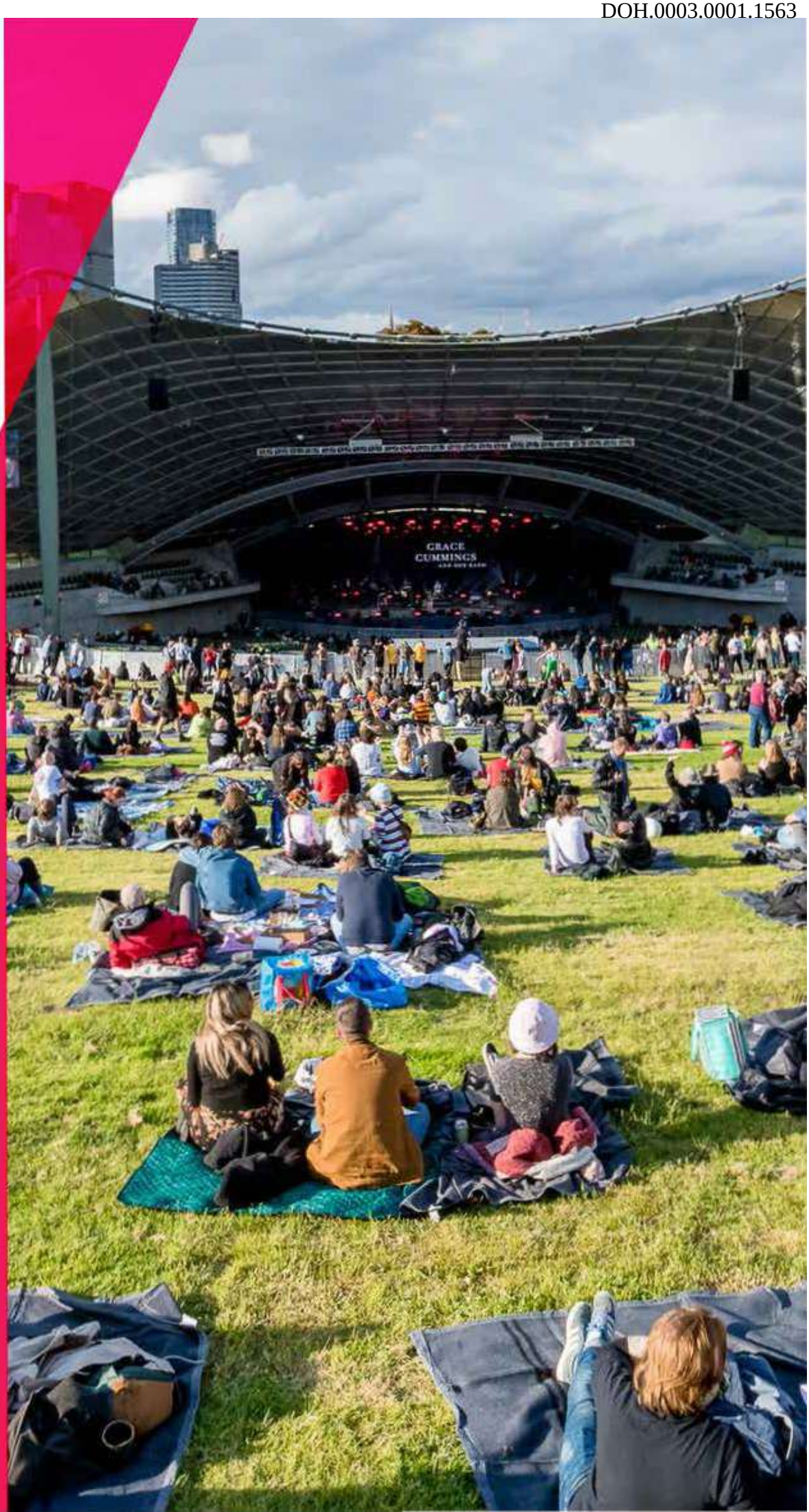
But being a first-choice destination for tourism means giving visitors something they've never seen before.

Which is why the Andrews Labor Government will deliver the largest modern art and design gallery in Australia – the new NGV Contemporary.

Designs for the gallery in Southbank have already been revealed – and plans include 13 000 square metres of display space for art and design and an expansive rooftop terrace with views of Melbourne's CBD.

A collective of 20 Victorian and Australian-based firms with expertise across architecture, design and engineering will bring the NGV Contemporary to life.

The project will support construction jobs and generate hundreds of ongoing creative sector jobs when it opens.


GRACE
CUMMINGS

LIVEABLE SUBURBS AND REGIONS

Better living

Every Victorian deserves the opportunity to get out and kick a ball, go for a run, walk the dog or enjoy their much-loved local parks and clubs.

That's why over the past four years, we've invested over $1.3 billion in community sport and parks to ensure that Victorians have the facilities they need to live active lives.

This Budget provides another $88 million for sport and recreation including funding to support the Local Sports Infrastructure Fund, Female Friendly Facilities Fund, and the Country Football and Netball Program.

Together, these programs will deliver up to 100 new and upgraded community sport and recreation facilities across the state, giving even more people the chance to connect with their community.

Multicultural communities

Victoria isn't just proud of its diversity – we consider it one of our greatest gifts.

Because when people come from abroad to make Victoria their home, they bring new perspectives, cultures and traditions – making our state and community stronger.

That's why this Budget invests in our multicultural communities, to help them succeed, and better celebrate everything that's important to them. These investments include:

- $6.7 million including legal support for asylum seekers and temporary visa holders so they can get the assistance they need as they manage their settlement in Victoria
- $6.4 million to continue the Multicultural Community Infrastructure Fund so that we can build and upgrade community facilities and places of worship, through projects such as new car parks, kitchens, and meeting spaces
- $4.4 million to support young members of Victoria's African communities with the delivery of targeted education support programs like homework clubs and community liaison officers who are embedded in schools to support families with their child's learning
- $3.7 million to support multicultural communities with tailored and translated messaging and programs to support COVIDSafe behaviours, such as vaccine uptake and testing
- $1.1 million to give our multicultural communities the chance to celebrate the holidays and events that they hold dear, with those they hold close.

Youth

Young people today, are the future of our state tomorrow. That's why we'll provide:

- $1.8 million for initiatives that help young people at risk of disengagement. This includes the Empower Youth program, which provides early intervention and case management for vulnerable young Victorians
- $1.3 million to subsidise 2 000 young people with the accreditation they need to get jobs in the sports and recreation sector, such as swimming instructors
- $581 000 to strengthen the Koorie Youth Council partnership with government in the design and delivery of initiatives affecting Aboriginal young people, consistent with Victoria's commitment to Aboriginal self-determination.

A FAIR GO FOR PEOPLE WITH A DISABILITY

The Andrews Labor Government is supporting Victorians living with a disability, to ensure every Victorian can reach their full potential.

An investment of $15 million in the State Disability Plan will help make our community and facilities more inclusive and accessible for everyone.

Travelling around the state will be made easier for people with disability with the expansion of Victoria's network of around 90 fully accessible restrooms.

And the Change Your Reactions public education campaign will help raise awareness of autism, and promote more positive attitudes towards autistic Victorians around the state.

We're continuing the Disability Liaison Officers Program, and grants to improve infrastructure accessibility at community facilities.

This Budget also invests $135 million to continue providing vital support to Victorians with disability who aren't eligible for the NDIS – and tailored support through the health, justice and child protection service systems.

KEEPING VICTORIANS SAFE

The Andrews Labor Government will deliver more police with more resources and more of the fit-for-purpose modern stations they need to keep protecting Victorians.

This Budget provides $342 million for an additional 502 police and 50 Protective Service Officers (PSOs) over the next two years to meet the growing needs of the state, building on the 3 135 new police officers already on our streets thanks to the Labor Government's record funding for Victoria Police.

The Andrews Labor Government is committed to providing a strong justice system that not only delivers a safer Victoria, but also minimises the chance that those who have been convicted of crimes will reoffend.

Central to this are initiatives designed to support a strengthening of our justice system, and provide resources for areas that require them such as:

- $215 million to equip frontline police officers and PSOs with conducted energy devices, including body-worn cameras and training, to ensure police and PSOs have additional non-lethal options to safely resolve violent or dangerous situations
- $47 million to build a replacement fit for purpose 24-hour South Melbourne police station and to build a new police station in Point Cook to serve the growing local community.

RESPONDING TO EMERGENCIES

Devastating bushfires, floods and natural disasters have highlighted how important it is that our state is prepared, connected and resourced to deliver quick and efficient emergency response.

This Budget ensures the safety of all Victorians by supporting the capacity of our emergency service operators and workforce to look after us, in times of need.

Preparedness

- $26 million for the maintenance of VICSES facilities and replacement of vehicles reaching end-of-life, and extra support for volunteers to deal with complex people and behaviours. And a further $2.7 million to deliver VICSES volunteer training and professional development programs
- $10 million to deliver energy resilience solutions such as microgrids to targeted locations that are exposed to power outages due to bushfires and extreme weather
- $2.4 million to continue to support the Powerline Bushfire Safety Program for the Victorian community to reduce the risk of powerlines starting bushfires.

Recovery

- $9.4 million to rebuild public roads and ensure the security of energy supply networks in communities affected by the 2021 storm and flood events
- $714 000 to continue recovery social support services to communities affected by the June 2021 flood and storm event.

Workforce

- $42 million to support our Forest Fire Operation Officers to deliver frontline firefighting and planned burning to reduce bushfire risk across the state
- $36 million to support the State Control Centre's 24-hour operations capability, workforce delivery, data analytics and digital infrastructure
- $11 million to the Country Fire Authority (CFA) for volunteer driver training, licensing and related emergency vehicle fleet.

LOOKING AFTER OUR ENVIRONMENT

Every day, our investments in renewable energy push Victoria closer to net zero emissions by 2050.

And our landmark Solar Homes program is helping reduce household power costs for thousands of Victorian families.

This Budget also protects our state's parks, coastlines, trails, wildlife and natural resources to preserve them for future generations.

Over the past eight years, the Andrews Labor Government has invested $2.2 billion to protect our environment. And this Budget builds on this landmark investment, providing an additional $215 million to ensure an environmentally sustainable future for our state.

Investments in this Budget include:

- $57 million to invest in projects that support more efficient use of our water supply, including construction of a fishway at Maffra Weir to improve aquatic biodiversity in the Macalister River and broader Gippsland catchment
- $28 million for investments in eucalyptus seed collection, upgrades to storage facilities and seed viability testing that will support forest contractors and ensure that forests can be reseeded after major fires, as well as improved forest protection regulations
- $18 million to repair and upgrade piers and jetties across the state to keep them safe for local communities to enjoy boating and fishing for decades to come, including Hampton Jetty, McLoughlins Beach Jetty and Mornington Fishermans Jetty
- $17 million to build a safe, healthier and more resilient marine and coastal environment for the community, addressing critical erosion and flood risks, protecting marine and coastal assets and ensuring the adaptation and resilience of coastal communities
- $10 million for investment in Great Ocean Road management reforms, to prevent and prepare for erosion
- $5.3 million for a package of wildlife protection initiatives, including funding to shelters rehabilitating injured and orphaned animals.

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Victorian Budget
2022/23

Overview

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VICTORIA State Government | Treasury and Finance

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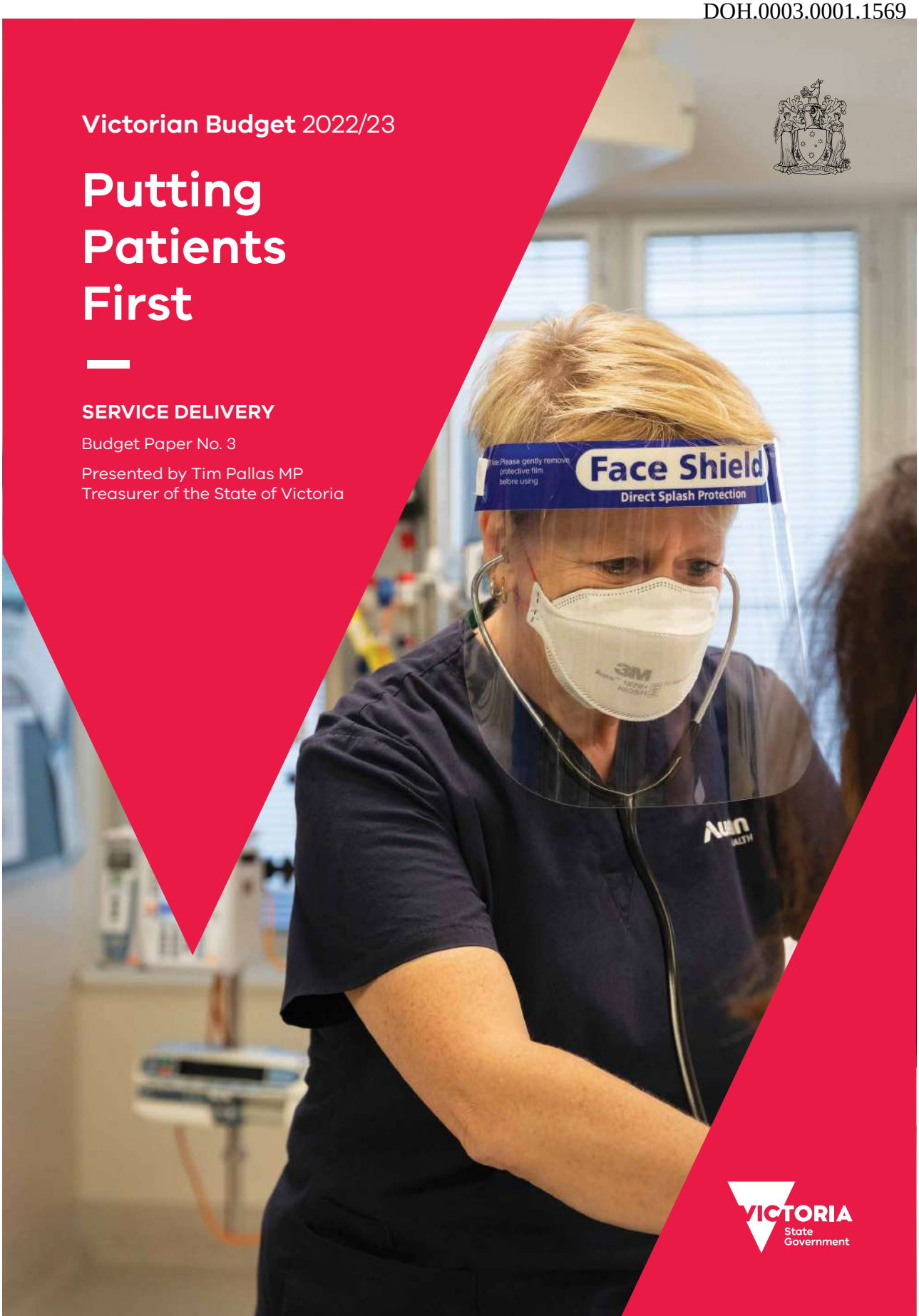
Victorian Budget 2022/23

Putting Patients First

SERVICE DELIVERY

Budget Paper No. 3

Presented by Tim Pallas MP
Treasurer of the State of Victoria



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Budget Paper No. 2 – Strategy and Outlook
Budget Paper No. 3 – Service Delivery
Budget Paper No. 4 – State Capital Program
Budget Paper No. 5 – Statement of Finances
(incorporating Quarterly Financial Report No. 3)

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Service Delivery

2022-23

Presented by

Tim Pallas MP

Treasurer of the State of Victoria

for the information of Honourable Members

Budget Paper No. 3

TABLE OF CONTENTS

Chapter 1 – Output, asset investment, savings and revenue initiatives..... 1
Whole of Government – Aboriginal Affairs 3
Department of Education and Training 8
Department of Environment, Land, Water and Planning 26
Department of Families, Fairness and Housing..... 38
Department of Health 54
Department of Jobs, Precincts and Regions 72
Department of Justice and Community Safety 89
Department of Premier and Cabinet 104
Department of Transport 109
Department of Treasury and Finance 122
Parliament 127
Court Services Victoria 130
Revenue initiatives 133
Chapter 2 – Department performance statements..... 135
Department of Education and Training 138
Department of Environment, Land, Water and Planning 165
Department of Families, Fairness and Housing..... 196
Department of Health 219
Department of Jobs, Precincts and Regions 245
Department of Justice and Community Safety 279
Department of Premier and Cabinet 311
Department of Transport 331
Department of Treasury and Finance 353
Parliament 370
Court Services Victoria 386

Appendix A – Output performance measures for review by the Public Accounts and Estimates Committee 393

Department of Education and Training 393

Department of Environment, Land, Water and Planning 394

Department of Families, Fairness and Housing 397

Department of Health 399

Department of Jobs, Precincts and Regions 400

Department of Justice and Community Safety 401

Department of Premier and Cabinet 403

Department of Transport 405

Department of Treasury and Finance 407

Appendix B – Local government financial relations 409

Supporting sustainable and effective local government 409

Funding sources to local government in Victoria 410

Community Support Fund 413

Disaster response 414

2022-23 Budget initiatives 414

Style conventions 419

CHAPTER 1 – OUTPUT, ASSET INVESTMENT, SAVINGS AND REVENUE INITIATIVES

Budget Paper No. 3 *Service Delivery* outlines the Government's priorities for the goods and services it provides to Victorians and details the Government's budget decisions.

The *2022-23 Budget* provides funding of $22.2 billion over five years in output initiatives since the *2021-22 Budget Update* and $6.7 billion TEI in new capital investment. This builds on the Government's $19.0 billion investment in output initiatives and up to $7.1 billion in capital projects in the *2021-22 Budget*.

Budget Paper No. 3 *Service Delivery* provides information on how the Government is meeting its performance targets for delivering outputs to the community, and how these outputs contribute to key objectives.

Table 1.1: Output summary **($ million)**

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*
Aboriginal Affairs	2.9	138.1	105.5	62.5	32.5
Education and Training	42.8	468.0	648.4	617.2	571.2
Environment, Land, Water and Planning	23.0	450.4	90.3	38.2	29.1
Families, Fairness and Housing	21.5	347.0	213.0	95.9	30.0
Health	3556.9	2620.1	1597.2	748.1	803.4
Jobs, Precincts and Regions	488.8	875.7	684.0	753.2	1175.7
Justice and Community Safety	934.0	637.0	462.7	383.4	384.6
Premier and Cabinet	2.0	98.1	23.4	..	..
Transport	829.4	661.1	107.5	71.7	57.8
Treasury and Finance	..	43.7	24.0	0.4	0.5
Parliament	0.8	13.3	16.2	17.3	17.5
Court Services Victoria	..	25.5	26.5	20.0	18.6
Total output initiatives [(a)]	**5902.0**	**6377.8**	**3998.7**	**2808.0**	**3120.9**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Table 1.2: Asset summary **($ million)**

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*	*TEI*
Aboriginal Affairs	..	..	..	..	..	..
Education and Training	..	481.7	727.5	416.2	22.1	1648.5
Environment, Land, Water and Planning	..	55.6	30.0	41.7	9.6	136.9
Families, Fairness and Housing	..	43.6	14.5	13.5	10.1	81.7
Health	117.0	468.2	305.2	465.2	596.1	2885.7
Jobs, Precincts and Regions	..	18.6	8.3	..	..	26.8
Justice and Community Safety	..	45.2	34.7	47.5	3.3	130.7
Premier and Cabinet	..	5.2	8.1	..	..	13.3
Transport	30.2	780.7	527.6	300.4	61.2	1737.9
Treasury and Finance	..	4.1	..	..	..	4.1
Parliament	..	4.5	0.6	..	..	5.1
Court Services Victoria	..	11.5	2.3	..	..	13.8
Total asset initiatives [(a)]	**147.2**	**1918.7**	**1658.7**	**1284.5**	**702.4**	**6684.5**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding. The TEI includes funding beyond 2025-26.

WHOLE OF GOVERNMENT – ABORIGINAL AFFAIRS

Output initiatives

Table 1.3: Output initiatives – Aboriginal Affairs **($ million)**

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*
Aboriginal family services and child protection	..	3.3	3.9	..	..
Aboriginal social and emotional wellbeing	..	0.5	..	..	..
Advancing Aboriginal employment in Victoria's health system	..	0.1	0.3	0.3	0.3
Boosting capacity and addressing demand in the Aboriginal cultural heritage system	..	19.6	16.1	..	..
Celebrating Victoria's rich Aboriginal cultures through community events	..	0.9	..	..	..
Early interventions for Aboriginal people	..	1.2	..	..	..
Enabling joint management of Barmah National Park	..	3.5	2.3	..	..
Improving capacity for Traditional Owner Corporations to negotiate Recognition and Settlement Agreements with the State	2.6	2.1	0.5	..	..
Marrung – teaching Aboriginal languages	..	0.7	0.8	0.6	0.8
Preparing the education system for self-determination	..	3.8	2.0	..	..
Progressing the First Principles Review	..	0.4	0.4	..	..
Progressing Victoria's historic treaty process with First Peoples	..	55.7	46.2	39.5	10.0
Stolen Generations Reparations Package	..	42.5	30.3	21.5	20.9
Strengthening the independence of Lake Tyers and Framlingham Aboriginal Trusts	0.3	1.1	0.3	0.3	0.3
Supporting Aboriginal youth engagement	..	0.3	0.3	..	..
Supporting artistic First Peoples across regional and outer-metropolitan Victoria	..	0.1	0.3	0.4	0.4
Victorian Aboriginal and Local Government Strategy 2021-2026	..	0.4	..	..	..
Water access and ownership for Traditional Owners	..	1.9	1.9	..	..
Total output initiatives [(a)]	**2.9**	**138.1**	**105.5**	**62.5**	**32.5**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Aboriginal family services and child protection

Funding is provided to continue the Aboriginal Children and Families Innovation and Learning Fund, which provides grants to Aboriginal Community Controlled Organisations to research new programs and interventions and to embed innovations into practice.

Funding is also provided to ensure Aboriginal children in care receive a cultural safety plan, consistent with legislative requirements in the *Children, Youth and Families Act 2005*.

This initiative contributes to the Department of Families, Fairness and Housing's Child Protection and Family Services output.

Aboriginal social and emotional wellbeing

Funding is provided to progress planning for two co-designed healing centres that will support and promote the social and emotional wellbeing of Aboriginal Victorians. This builds on previous funding provided and will be used to continue the co-design process, identify the workforce required to be employed within the healing centres, and engage with local mainstream health services to determine the best approaches for integrated models of care as part of the healing centres design.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System interim and final reports and the Department of Health's Mental Health Community Support Services output.

Advancing Aboriginal employment in Victoria's health system

Funding is provided to design and deliver an Aboriginal-led employee assistance program, which will include supervision and mentoring for all workers in the Aboriginal health sector to improve cultural safety and embed culture as a protective factor for workforce wellbeing.

This initiative contributes to the Department of Health's Community Health Care output.

Boosting capacity and addressing demand in the Aboriginal cultural heritage system

Funding is provided to support the continued functions and boost capacity of Victoria's Aboriginal cultural heritage system. This includes additional resources for Registered Aboriginal Parties to fulfil their statutory obligations and respond to increased demand, functionality improvements to the Aboriginal Cultural Heritage Registry, proactive identification and protection of Victoria's Aboriginal cultural heritage, and additional enforcement and compliance to promote protection of Aboriginal cultural heritage as per the *Aboriginal Heritage Act 2006*.

This initiative contributes to the Department of Premier and Cabinet's Traditional Owner Engagement and Cultural Heritage Management Programs output.

Celebrating Victoria's rich Aboriginal cultures through community events

Funding is provided to continue building greater public awareness, understanding and appreciation of Victorian Aboriginal cultures through the funding of Aboriginal community events. These events support and empower Aboriginal Victorians and provide a platform to celebrate Aboriginal communities and organisations across the state.

This initiative contributes to the Department of Premier and Cabinet's Self-determination Policy and Reform Advice and Programs output.

Early interventions for Aboriginal people

Funding is provided to expand existing early interventions initiatives, including:

- the expansion of the Bramung Jaarn program, which empowers young Aboriginal men through development of cultural strength and self-esteem with the aim of diverting them from the justice system
- tailored early intervention and prevention programs delivered by Djirra, enabling more young Aboriginal women to receive an appropriate intervention that targets family violence.

This initiative contributes to the Department of Justice and Community Safety's Justice Policy, Services and Law Reform output.

Enabling joint management of Barmah National Park

Funding is provided to continue joint land management of the Barmah National Park in partnership with the Yorta Yorta people.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Improving capacity for Traditional Owner Corporations to negotiate Recognition and Settlement Agreements with the State

Funding is provided to support Traditional Owner corporations when negotiating a Recognition and Settlement Agreement package with the State. This will ensure corporations are resourced to prepare for, and participate in, negotiations under the *Traditional Owner Settlement Act 2010*. This funding further demonstrates the Government's commitment to self-determination.

This initiative contributes to the Department of Justice and Community Safety's Justice Policy, Services and Law Reform output.

Marrung – teaching Aboriginal languages

Funding is provided to support the delivery of a Certificate IV in Teaching a First Nation's Language to help increase the number of Aboriginal language teachers in Victorian kindergartens and schools.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

Preparing the education system for self-determination

Funding is provided to improve educational outcomes and experiences for Aboriginal Victorians and to prepare for the forthcoming self-determination in education reforms. This includes continuing the Strengthening Principals' Professional Capability in Koorie Education program, the Speaking out Against Racism program, and expanding Victorian Aboriginal language learning in schools. In addition, funding supports the continuation of a statewide consultation and co-design process to progress Aboriginal self-determination in education.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Progressing the First Principles Review

Funding is provided to establish a *Traditional Owner Settlement Act 2010* Forum related to the First Principles Review to improve the outcomes of agreements under the Act.

This initiative contributes to the Department of Justice and Community Safety's Justice Policy, Services and Law Reform output.

Progressing Victoria's historic treaty process with First Peoples

Funding is provided to provision for the state to progress key obligations as part of Victoria's ongoing Treaty Process with First Peoples, as required under the *Advancing the Treaty Process with Aboriginal Victorians Act 2018*. Live negotiations continue between the First Peoples' Assembly of Victoria and the State.

This initiative will contribute to the Department of Premier and Cabinet's Self-determination Policy and Reform Advice and Programs output.

Stolen Generations Reparations Package

Funding is provided for a Stolen Generations Reparations Package in partnership with Aboriginal communities and organisations. The reparations package includes financial reparations, access to trauma-informed counselling and healing programs, an opportunity to record and share an applicant's story and experience, and options to access records held by the State.

This initiative contributes to the Department of Justice and Community Safety's Advocacy, Human Rights and Victim Support output.

Strengthening the independence of Lake Tyers and Framlingham Aboriginal Trusts

Funding is provided to support the Lake Tyers and Framlingham Aboriginal Trusts, including additional professional training and initiatives to support future leaders and the social and emotional wellbeing of the communities at both trusts.

This initiative contributes to the Department of Premier and Cabinet's Self-determination Policy and Reform Advice and Programs output.

Supporting Aboriginal youth engagement

Funding is provided to strengthen the Koorie Youth Council partnership with government in the design and delivery of initiatives affecting Aboriginal young people, consistent with Victoria's commitment to Aboriginal self-determination.

This initiative contributes to the Department of Families, Fairness and Housing's Youth output.

Supporting artistic First Peoples across regional and outer-metropolitan Victoria

Funding is provided to support a First Peoples determined touring and engagement package to increase participation by artistic First Peoples and creative workers as well as grow economic opportunities for First Peoples and expand new cultural experiences for Victorian audiences.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Access, Development and Innovation output.

Victorian Aboriginal and Local Government Strategy 2021-2026

Funding is provided to support implementation of the Victorian Aboriginal and Local Government Strategy 2021-2026. This will strengthen engagement between Aboriginal organisations and local councils and support pathways to self-determination for Aboriginal Victorians.

This initiative contributes to the Department of Jobs, Precincts and Regions' Local Government and Suburban Development output.

Water access and ownership for Traditional Owners

Funding is provided to support returning water to Traditional Owners for cultural, spiritual, and economic use. This will deliver on commitments outlined in the Aboriginal Access to Water Roadmap as well as support emerging Traditional Owner capability in water management.

This initiative will be funded from the Environmental Contribution Levy.

This initiative contributes to the Department of Environment, Land, Water and Planning's Effective Water Management and Supply output.

DEPARTMENT OF EDUCATION AND TRAINING

Output initiatives

Table 1.4: Output initiatives – Department of Education and Training ($ million)

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*
Early Childhood Education					
Building inclusive kindergartens	..	2.9	5.8	3.2	..
Continuing early intervention for vulnerable children	..	4.5	5.3	5.2	3.6
Continuing the early childhood language program	..	2.7	2.8	..	..
COVID-19 supports for kindergarten services in 2022	7.0	..	..	..	..
Delivering 15 hours of four-year-old kindergarten	..	8.4	15.2	16.7	10.6
Expanding the Kindergarten Fee Subsidy	..	0.3	0.6	0.6	0.6
Improving outcomes for children with disability	..	4.0	4.2	4.3	4.4
Improving outcomes for culturally and linguistically diverse (CALD) children	..	1.0	2.0	1.0	..
Kinder Kits for three-year-old kinder	..	7.1	7.6	..	..
Maintaining universal access to four-year-old kindergarten	..	10.6	21.6	21.8	22.0
Strengthening Victoria's interface with the National Disability Insurance Scheme	..	2.3	2.9	..	..
School Education					
Active Schools	..	11.2	9.6	..	..
Building equity and excellence for rural and regional students	..	5.2	5.7	8.7	9.1
Connected Learners – cyber safe and secure learners	..	3.7	..	..	..
Continuation of the Student Excellence Program	..	10.5	15.1	7.5	3.9
Digital education – Critical IT supporting every student	..	25.2	25.7	26.2	26.7
Engaging students in learning – The Geelong Project, Northern Centre for Excellence in School Engagement and Project REAL	..	0.6	2.3	1.5	..
English as an Additional Language	..	11.6	11.9	..	..
Enhanced Navigator Program	..	6.7	11.1	11.4	7.7
Essential maintenance and compliance	..	19.0	32.8	32.8	32.8
Excellence in vocational and applied learning	..	18.5	33.1	23.3	13.0
Extension of the Primary Mathematics and Science Specialists initiative	..	4.6	8.3	4.3	..
Head Start apprenticeships and traineeships for all Victorian government school students	..	10.9	18.7	19.4	20.3
Improved vocational and applied learning pathways	..	15.8	12.4	4.5	1.3
Improving teaching quality	0.8	69.5	194.6	254.5	259.6
Lifting student literacy and numeracy outcomes	..	27.1	36.6	33.0	34.4
New schools construction	..	..	15.1	19.4	19.8
Next Generation Victorian Curriculum F-10	..	1.4	0.8	0.5	..
Out-of-field teaching	..	1.8	3.2	3.6	1.5

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*
Primary Care Vaccinations in Schools program	4.0	..	..	..	..
Relocatable Buildings Program	..	8.1	2.9	3.0	3.0
Respectful and safe school communities	0.9	4.8	4.2	1.9	1.5
School enrolment-based funding	14.4	30.1	31.3	32.6	33.9
School upgrades: growth for 2025	..	..	..	0.9	1.8
Software for connected learners	..	3.6	8.5	9.7	9.7
Student health and wellbeing – school nursing and student support services	..	9.0	0.8	0.8	0.8
Sustaining student mental health services for schools	..	9.0	12.5	9.9	10.0
Targeted initiatives to attract more teachers	..	21.9	14.8	15.1	7.1
Targeted investment to improve educational outcomes in youth justice	..	5.6	9.3	9.4	6.0
Universal access to high-quality VET for government school students	..	9.8	24.2	27.3	24.8
Victorian Certificate of Education (VCE) delivery on the Northern Hemisphere timetable	..	1.4	1.5	..	..
Support for Students with Disabilities					
Students with Disabilities Transport Program	..	30.7	..	..	..
Training, Higher Education and Workforce Development					
A coordinated and efficient TAFE system	15.7	39.5	25.9	2.1	..
Adding Auslan courses to the Free TAFE course list	..	1.0	1.0	1.0	1.0
Apprenticeship Support Officers	..	5.9	6.1	..	..
Skills Solutions Partnerships	..	0.2	0.2	..	..
TAFE inclusion	..	0.4	0.4	..	..
Total output initiatives [(a)]	**42.8**	**468.0**	**648.4**	**617.2**	**571.2**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Early Childhood Education

Building inclusive kindergartens

Funding is provided to help kindergartens make facilities and activities more accessible to children of all abilities, and to enhance learning environments for children with disability or additional needs.

Grants will be provided to local government and other eligible providers to upgrade early childhood buildings and playgrounds and purchase equipment.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Continuing early intervention for vulnerable children

Funding is provided to continue early intervention programs, including:

- Early Childhood LOOKOUT to support children in out-of-home care access kindergarten and effectively transition to school
- Access to Early Learning to provide intensive outreach for vulnerable children and their families to support participation in early education.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Continuing the early childhood language program

Funding is provided to continue the early childhood language program. This includes grants to kindergarten services for the delivery of language programs, along with further professional support and training.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

COVID-19 supports for kindergarten services in 2022

Funding is provided to support kindergarten services with the costs of COVIDSafe operations, including increased cleaning, training and staffing. Grants will be provided for Terms 1 and 2 in 2022 to all services with a funded kindergarten program.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Delivering 15 hours of four-year-old kindergarten

Funding is provided for continued delivery of 15 hours of four-year-old kindergarten under the new Preschool Reform Agreement. Funding will supplement the contribution provided by the Commonwealth Government for delivery from 2023 and implement a new data collection system to measure kindergarten attendance.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Expanding the Kindergarten Fee Subsidy

Funding is provided to support children known to child protection and children from a refugee or asylum seeker background to access free or low-cost kindergarten in a sessional service, through expansion of the Kindergarten Fee Subsidy program.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Improving outcomes for children with disability

Funding is provided to continue the Kindergarten Inclusion Support program to assist children with significant disability or complex needs to participate in kindergarten through the provision of tailored supports including specialist training and consultancy for educators, additional staff in the kindergarten setting and minor building modifications.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Improving outcomes for culturally and linguistically diverse (CALD) children

Funding is provided to extend targeted outreach support for children and families from CALD backgrounds to access and engage in kindergarten, including in public housing communities.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Kinder Kits for three-year-old kinder

Funding is provided to continue delivering Kinder Kits for every child enrolled in funded three-year-old kindergarten. Each kit includes books and educational items to support early literacy and help families to engage in children's learning.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Maintaining universal access to four-year-old kindergarten

Funding is provided to continue support for kindergartens to deliver services across Victoria, including continuation of the Ratio Supplement and Small Rural Kindergarten funding. Additional funding is also provided to meet demand for the Early Childhood Teacher Supplement and Kindergarten Fee Subsidy.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

Strengthening Victoria's interface with the National Disability Insurance Scheme

Refer to the Department of Families, Fairness and Housing for a description of this initiative.

School Education

Active Schools

Funding is provided to continue the Active Schools program in government primary, secondary and specialist schools for a further two school years, to ensure that all Victorian students have the skills, confidence and motivation to be active for life. This includes an expert support service for schools, and assistance with the costs of running sport, outdoor education and active recreation programs.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Building equity and excellence for rural and regional students

Funding is provided for initiatives that support rural and regional schools to focus on teaching and to give students access to a broader curriculum, including:

- providing facilities management and occupational health and safety support for clusters of small rural and regional schools
- establishing a regional blended learning hub to provide students with greater place-based curriculum access through a mix of face-to-face and online learning
- establishing partnerships between clusters of rural and regional schools and local Aboriginal communities to strengthen diversity and the teaching of Aboriginal and Torres Strait Islander histories, cultures and perspectives.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Connected Learners – cyber safe and secure learners

Funding is provided to ensure that government schools operate in a digital environment that is safe and secure by implementing a comprehensive IT asset discovery system, a security management plan and advanced event monitoring capability to provide effective alerts for cybersecurity incidents.

This initiative will contribute to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Continuation of the Student Excellence Program

Funding is provided to continue the Student Excellence Program in government schools. High-ability students will continue to be supported to reach their full potential through enrichment opportunities that ensure every government primary and secondary school has access to a high-ability practice leader. This initiative also maintains funding for school resources, professional development for teachers and extension programs delivered with partner organisations.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Digital education – Critical IT supporting every student

Funding is provided to upgrade software tools with improved capabilities for students, school staff and administrators. This will reduce administrative burden and improve resources for digital learning.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Engaging students in learning – The Geelong Project, Northern Centre for Excellence in School Engagement and Project REAL

Funding is provided to continue programs to engage students in learning in the Barwon South West region and the Hume Moreland area. These include The Geelong Project, an early intervention program delivering coordinated interventions across selected schools in the Barwon area, and the Northern Centre for Excellence in School Engagement and Project REAL, a capability building network and flexible learning option for local students with significant behavioural issues in the Hume Moreland area.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

English as an Additional Language

Funding is provided to increase the number of students supported by the English as an Additional Language program for the 2023 school year, in line with growth in enrolments. The program supports government school students who do not speak English at home, including Australian-born students, newly arrived migrants and students from refugee and asylum seeker backgrounds, to become proficient in English.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Enhanced Navigator Program

Funding is provided to increase the number of young people aged 12–17 years supported by the Navigator program. The program provides intensive outreach supports to young people who are at risk of disengaging or are already disengaged from school. The program aims to increase the number of young people connected to school and engaged in learning. This initiative includes funding for a pilot to extend the program to include young people aged 10–11 years.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Essential maintenance and compliance

Funding is provided to government schools for maintenance and compliance programs, including the:

- Student Resource Package (SRP) Maintenance and Minor Works program to fund schools for regular and routine maintenance
- SRP Grounds Allowance to fund schools to maintain outdoor facilities and grounds.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Excellence in vocational and applied learning

Professional learning programs and supported study pathways will support and expand the vocational and applied learning workforce, in particular the availability of suitably skilled and qualified VET teachers and trainers. Additional funding for jobs, skills and pathways coordination in government secondary schools will reduce the administrative and coordination burden on schools and build capacity for excellent programs, supported by an augmented model of regional support for vocational and applied learning.

This initiative contributes to the Department of Education and Training's
School Education – Secondary output.

Extension of the Primary Mathematics and Science Specialists initiative

Funding is provided to extend the Primary Mathematics and Science Specialists initiative to train an additional 100 government primary teachers as mathematics specialists. Twenty-five positions will be filled by rural and regional teachers.

This initiative contributes to the Department of Education and Training's
School Education – Primary output.

Head Start apprenticeships and traineeships for all Victorian government school students

Funding is provided to expand the Head Start school-based apprenticeships and traineeships model to all government secondary schools. This includes cluster directors, Head Start coordinators and learning leaders to support students and increase relationships with employers. Funding will also strengthen data capture, monitoring and compliance.

This initiative contributes to the Department of Education and Training's School Education – Secondary output.

Improved vocational and applied learning pathways

Funding is provided to support the introduction of the new Victorian Certificate of Education (VCE), Vocational Major and Victorian Pathways Certificate in 2023, and to champion vocational and applied learning pathways. This includes professional learning for government school teachers to implement the new curriculum, support to the Victorian Curriculum and Assessment Authority for assessment moderation and to create a student portal, and support for non-school senior secondary providers to transition to the new framework.

This initiative contributes to the Department of Education and Training's School Education – Secondary output.

Improving teaching quality

Funding is provided to hire up to 1 900 new primary and secondary teachers at government schools, which will support more time for teachers to prepare lessons, plan and mark assessments.

The maximum number of weekly face-to-face teaching hours for teachers will initially reduce by one hour for the 2023 school year, and then by a further half-hour in 2024. The total one-and-a-half-hour reduction in maximum weekly face-to-face teaching time will continue in subsequent school years.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Lifting student literacy and numeracy outcomes

Funding is provided to continue targeted literacy and numeracy support for students that need it most, including by:

- providing individual support to students in the middle years who do not meet minimum standards in literacy and numeracy
- providing a range of professional learning resources and supports for teachers and school leaders to improve literacy and numeracy teaching practice
- continuing the Koorie English professional development program to support Koorie students' literacy and numeracy
- supplying a free 'Prep Bag' to children starting prep in a government school that contains books and guidance for families and carers on how to foster literacy and numeracy in the home environment.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

New schools construction

Refer to the asset initiative for a description of this initiative.

Next Generation Victorian Curriculum F-10

Funding is provided to develop the next iteration of the Victorian Curriculum F-10, including alignment with the Australian curriculum. This includes using the Australian curriculum review process findings to map agreed changes to the Victorian curriculum, create new aligned resources and publish new support material.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Out-of-field teaching

Funding is provided to continue the Secondary Mathematics and Science Initiative to train 50 mathematics and 25 science out-of-field teachers in priority curriculum areas and extend into the new Secondary Science, Technologies and Mathematics initiative. Funding also supports the introduction of 50 Graduate Certificates of Secondary Digital Technologies and 50 Graduate Certificates of Secondary Design and Technologies. Half of the program positions will be filled by rural and regional teachers.

This initiative contributes to the Department of Education and Training's
School Education – Secondary output.

Primary Care Vaccinations in Schools program

Funding is provided for primary care and private providers to deliver vaccination services at school-hosted pop-up clinics, to support families to access vaccinations for 5 to 11 year-olds. These grants will cover establishment costs, travel and equipment.

This initiative contributes to the Department of Education and Training's School Education – Primary output.

Relocatable Buildings Program

Refer to the asset initiative for a description of this initiative.

Respectful and safe school communities

Funding is provided to implement the School Community Safety Order Scheme, introduced in May 2021 under the *Education and Training Reform Amendment (Protection of School Communities) Act 2021*, to empower authorised persons to respond to harmful behaviours by parents, carers or other adults towards members of the school community. Funding will support implementation of legislative requirements, including establishment of court and tribunal processes, training and incident reporting platform enhancements.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

School enrolment-based funding

Additional funding is provided to government and non-government schools to meet student enrolment growth in the 2022 school year.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

School upgrades: growth for 2025

Refer to the asset initiative for a description of this initiative.

Software for connected learners

Funding is provided to continue to support a suite of centrally procured educational software for government schools. Professional learning will also be provided to ensure schools and teachers can leverage the educational opportunities provided by the software.

This initiative will contribute to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Student health and wellbeing – school nursing and student support services

Funding is provided to continue enhanced capacity for health and wellbeing services in schools, including through support for additional school nurses and allied health services. The funding will ensure schools can continue to meet student need for nurses, speech pathologists, social workers and psychologists. This initiative also includes funding to maintain the Victorian student health and wellbeing survey.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Sustaining student mental health services for schools

Funding is provided to continue expanded supports to improve the wellbeing and mental health of students. This includes continuing the LOOKOUT program to support engagement of vulnerable children and young people in out-of-home care, continuing the Headspace initiative, which provides mental health counselling and training, and continuing the mental health practitioners in secondary schools initiative in specialist schools.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Targeted initiatives to attract more teachers

Funding is provided to continue attracting and developing quality teachers in Victorian schools, including by:

- continuing and expanding the delivery of innovative, employment-based initial teacher education degrees in partnership with industry organisations
- increasing the supply of casual relief teachers to schools in rural and regional areas through the provision of coordination assistance and expense reimbursements
- supporting a new Go Rural – Education program pilot to facilitate pre-service teachers to undertake placements at rural and regional schools
- continuing delivery of financial incentives and other supports for teachers willing to relocate to work in Victorian schools.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Targeted investment to improve educational outcomes in youth justice

Funding is provided to deliver education and additional supports to improve the educational outcomes of young people involved in, or at risk of involvement with, the youth justice system.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Universal access to high-quality VET for government school students

Funding is provided to support improved access to a core offering of Vocational Education and Training Delivered to Secondary Schools (VDSS) pathways and certificates. A revised funding model will reduce complexity and better reflect the cost of delivery. Local access planning will support place-based solutions and collaboration between cluster schools.

This initiative contributes to the Department of Education and Training's School Education – Secondary output.

Victorian Certificate of Education (VCE) delivery on the Northern Hemisphere timetable

Funding is provided to allow schools to deliver VCE subjects on an August to June timetable.

This initiative contributes to the Department of Education and Training's School Education – Secondary output.

Support for Students with Disabilities

Students with Disabilities Transport Program

Funding is provided to continue transport assistance through the Students with Disabilities Transport Program, supporting eligible students to attend their designated government specialist education setting.

This initiative contributes to the Department of Education and Training's Support for Students with Disabilities output.

Training, Higher Education and Workforce Development

A coordinated and efficient TAFE system

Funding is provided to strengthen the Office of TAFE Coordination and Delivery within the Department of Education and Training, to lead strategic projects and enhance collaboration across the TAFE network. Funding will also support TAFEs to sustainably transition to the new funding model announced in late 2021, and deliver an expansion of the coordination of practical placements for TAFE students.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

Adding Auslan courses to the Free TAFE course list

Free TAFE will be expanded to include the Diploma of Auslan and Advanced Diploma of Interpreting (Auslan) to help increase the number of Auslan interpreters.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

Apprenticeship Support Officers

Funding is provided to continue contemporary, targeted support for Victorians to finish their training through the Apprenticeship Support Officers program. The program provides dedicated supports to learners most at risk of failing to complete their apprenticeship, including women.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

Skills Solutions Partnerships

Refer to the Department of Jobs, Precincts and Regions for a description of this initiative.

TAFE inclusion

Funding is provided to conduct an access audit of all TAFE campuses to identify improvements required across the TAFE network to ensure people with disability can access training and skills.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

Asset initiatives

Table 1.5: Asset initiatives – Department of Education and Training ($ million)

	2021-22	2022-23	2023-24	2024-25	2025-26	TEI
Early Childhood Education						
Delivering 15 hours of four-year-old kindergarten	..	4.3	..	..	..	4.3
School Education						
Essential maintenance and compliance	..	2.4	84.9	31.2	1.5	120.0
Land acquisition for new schools	..	99.7	118.0	19.0	..	236.7
Minor Capital Works Fund	..	12.5	27.2	2.1	..	41.8
New schools construction	..	247.9	249.8	28.0	1.4	527.2
Relocatable Buildings Program	..	92.2	..	..	..	92.2
School upgrades	..	8.0	99.5	119.6	6.6	234.0
School upgrades: growth for 2025	..	2.0	17.4	34.6	2.1	56.4
Support for Students with Disabilities						
Accessible Buildings Program	..	5.0	5.0	..	..	10.0
Special school upgrades	..	7.7	125.6	181.7	10.4	326.0
Total asset initiatives [(a)]	**..**	**481.7**	**727.5**	**416.2**	**22.1**	**1648.5**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding. The TEI includes funding beyond 2025-26.

Early Childhood Education

Delivering 15 hours of four-year-old kindergarten

Refer to the output initiative for a description of this initiative.

School Education

Essential maintenance and compliance

Funding is provided to government schools for maintenance and compliance programs, including the Planned Maintenance Program (PMP) to ensure all priority asset defects are addressed.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

Land acquisition for new schools

Land will be acquired for future new schools in the following municipalities: Cardinia, Casey, Greater Geelong, Hume, Melton, Whittlesea and Wyndham.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output
- Support for Students with Disabilities output.

Minor Capital Works Fund

Funding is provided for the Minor Capital Works Fund for further high-priority projects as assessed in the 2021 round of the program. The Fund provides funding sought by schools for minor capital projects that are a priority for their school.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

New schools construction

The Government will build 13 new schools, contributing to its commitment to open 100 new schools across the state by 2026.

The following additional 13 new schools will be built to open in 2024:

- Aintree Secondary School (Interim Name)
- Aintree Specialist School (Interim Name)
- Alexander Boulevard Primary School (Interim Name)
- Black Forest East Primary School (Interim Name)
- Brookfield Primary School (Interim Name)
- Lockerbie Central Primary School (Interim Name)
- Lollypop Creek Secondary School (Interim Name)
- Lollypop Creek Specialist School (Interim Name)
- Merrifield South Primary School (Interim Name)
- Officer Brunt Road Primary School (Interim Name)
- Riverdale Secondary School (Interim Name)
- Tarneit North Primary School (Interim Name)
- Truganina North Primary School (Interim Name).

An additional stage of the new Truganina North Secondary School (Interim Name), opening in 2024, will also be constructed (at least $41.178 million). Additional stages of new schools will also be constructed at three recently-opened schools:

- Aintree Primary School (at least $11.201 million)
- Aitken Hill Primary School (at least $11.201 million)
- Gaayip-Yagila Primary School (at least $11.201 million)

Funding is also provided for the operating costs associated with new schools.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output
- Support for Students with Disabilities output.

Relocatable Buildings Program

Relocatable buildings will be provided to relieve pressure at schools that are reaching their capacity and to provide additional functional spaces for learning.

Funding is also provided for the operating costs associated with the Relocatable Buildings Program.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

School upgrades

Twenty-nine mainstream schools across Victoria will receive funding for capital upgrades. This will improve educational outcomes through the provision of high-quality classrooms and facilities for learning and community use.

This initiative contributes to the Department of Education and Training's:

- School Education – Primary output
- School Education – Secondary output.

School upgrades	
• Banyan Fields Primary School • Benalla P-12 College • Bentleigh Secondary College • Bittern Primary School • Bundoora Secondary College • Coldstream Primary School • Darley Primary School • Diggers Rest Primary School • Doreen Primary School • East Loddon P-12 College • Grasmere Primary School • Hawthorn West Primary School • Kingston Heath Primary School • Laburnum Primary School • Merri Creek Primary School	• Moonee Ponds West Primary School • Mordialloc Beach Primary School • Mount Pleasant Road Nunawading Primary School • Mount Rowan Secondary College • Pascoe Vale Primary School • Reservoir High School • Sandringham East Primary School • St Albans Heights Primary School • The Patch Primary School • Wantirna College • Wedderburn College • Westgarth Primary School • Yarra Primary School • Yinnar Primary School

School upgrades: growth for 2025

Funding is provided to expand capacity to meet enrolment demand at two established area schools. The expanded capacity will be ready for the 2025 school year at the following schools:

- Kambrya College (at least $18.945 million)
- Staughton College (at least $31.770 million).

This initiative contributes to the Department of Education and Training's School Education – Secondary output.

Support for Students with Disabilities

Accessible Buildings Program

Funding is provided to improve access to school facilities for students with disabilities and additional needs. Facility modifications may include ramps and handrails, alterations to toilet and shower facilities and adjustments for students with vision or hearing impairments.

This initiative contributes to the Department of Education and Training's Support for Students with Disabilities output.

Special school upgrades

Thirty-six special schools across Victoria will receive funding for capital upgrades. This will create modern and safe places for students that attend special schools. This initiative will improve educational outcomes through the provision of high-quality teaching spaces.

This initiative contributes to the Department of Education and Training's Support for Students with Disabilities output.

Special school upgrades

- Ashwood School (at least $9.737 million)
- Aurora School (at least $1.800 million)
- Bass Coast Specialist School (at least $1.934 million)
- Belvoir Wodonga Special Developmental School (at least $4.032 million)
- Bendigo Special Developmental School (at least $8.874 million)
- Berendale School and Katandra School (merger) (at least $12.188 million)
- Broadmeadows Special Developmental School (at least $17.107 million)
- Burwood East Special Developmental School (at least $8.697 million)
- Cobram and District Specialist School (at least $3.914 million)
- Croydon Special Developmental School (at least $11.747 million)
- Dandenong Valley Special Developmental School (at least $14.775 million)
- East Gippsland Specialist School (at least $6.777 million)
- Eastern Ranges School (at least $5.701 million)
- Glenroy Specialist School (at least $1.877 million)
- Hamlyn Views School (at least $1.274 million)
- Hampden Specialist School (at least $4.308 million)
- Hume Valley School (at least $8.523 million)
- Jennings Street School (at least $9.419 million)
- Merriang Special Developmental School (at least $5.316 million)
- Mildura Specialist School (at least $12.657 million)
- Montague Continuing Education Centre (at least $2.700 million)
- Mornington Special Developmental School (at least $6.769 million)
- Naranga School (at least $7.612 million)
- Nelson Park School (at least $6.404 million)
- Northern School for Autism (at least $26.339 million)
- Officer Specialist School (at least $3.717 million)
- Peninsula Specialist College (at least $9.479 million)
- Skene Street School Stawell (at least 2.106 million)
- South Gippsland Specialist School (at least 3.682 million)
- Springvale Park Special Developmental School (at least $8.886 million)
- Swan Hill Specialist School (at least $6.348 million)
- Verney Road School (at least $23.782 million)
- Waratah Special Developmental School (at least $6.805 million)
- Warragul & District Specialist School (at least $6.589 million)
- Warringa Park School - Warringa Crescent & Bethany Road Campuses (at least $14.659 million)
- Western Autistic School (at least $6.833 million)

DEPARTMENT OF ENVIRONMENT, LAND, WATER AND PLANNING

Output initiatives

Table 1.6: Output initiatives – Department of Environment, Land, Water and Planning **($ million)**

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*
Building					
Building reforms to secure Victoria's economic recovery	..	19.7	5.9	..	..
Effective Water Management and Supply					
Bendigo mine-impacted groundwater long-term management	..	0.3	3.7	3.4	..
Implementation of the Central and Gippsland Region Sustainable Water Strategy	..	30.0	26.6	..	..
Energy					
$250 Power Saving Bonus	..	250.0	..	..	..
Cheaper electricity for Victorians	..	4.5	4.5	..	..
Decarbonising freight with hydrogen	0.4	3.1	3.8	3.7	0.8
Driving down gas bills for businesses and households	..	1.2	..	..	..
Energy Resilience solutions and Community Microgrid Program	2.5	7.5	..	..	..
Improving Energy Safety and Skills	0.3	1.9	1.9	1.9	1.9
Powerline Bushfire Safety Program	..	2.4	..	..	..
Unlocking offshore wind, renewable hydrogen and new energy manufacturing to create jobs	..	3.4	3.4	..	..
Victorian Renewable Energy Target	..	4.2	..	..	..
Environment and Biodiversity					
Environment protection and air quality	..	5.9	1.8	..	..
Wildlife care and protection	..	3.4	1.9	..	..
Fire and Emergency Management					
Aerial firefighting	14.9	..	..	..	..
Bushfire prevention and protection	4.5	21.4	7.0	7.0	7.0
Critical capital works to keep Victorians safe from fire and other emergencies	..	6.3	..	..	..
Emergency access to roads and trails	..	6.0	..	..	..
Securing Victoria's energy supply	..	1.7	..	..	..
Management of Public Land and Forests					
Great Ocean Road management reforms and erosion preparedness	..	0.6	1.2	1.1	..
Keeping the public safe	..	2.4	2.4	1.7	..
Securing Victoria's alpine future	..	5.0	..	..	..
Strengthening the Victorian Forestry Plan	0.4	9.2	9.2	4.4	4.4
VicCoasts: Building a safe, healthier and more resilient marine and coastal environment for the community	..	7.0	..	..	..

	2021-22	2022-23	2023-24	2024-25	2025-26
Planning and Heritage					
Delivering sustainable growth for a resilient Victoria	..	1.6	..	..	..
Protecting heritage at Jacksons Hill	..	2.2	..	..	..
Unlocking new communities and affordable housing	..	6.0	..	..	..
Solar Victoria					
Solar Homes boost	..	26.3	..	..	..
Statutory Activities and Environment Protection					
Sustaining the EPA's strengthened regulatory functions	..	15.0	15.0	15.0	15.0
Waste and Recycling					
Recycling Victoria – Household Chemical Collection program	..	2.0	2.0	..	..
Total output initiatives [(a)]	**23.0**	**450.4**	**90.3**	**38.2**	**29.1**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Building

Building reforms to secure Victoria's economic recovery

Funding is provided for the Victorian Building Authority to implement automatic mutual recognition, a national initiative to boost occupational mobility that will make it easier for interstate practitioners to work in Victoria. Additional measures will also be introduced to strengthen the building approvals process, including a risk-based targeted inspection audit program. The Office of the State Building Surveyor will be established, ensuring buildings are consistently well-built, safe and fit for purpose.

A Building Monitor will also be established, supported by staff from the Department of Environment, Land, Water and Planning, to improve the consumer experience by advocating for domestic building consumers and reporting on emerging issues.

This initiative contributes to the Department of Environment, Land, Water and Planning's Building output.

Effective Water Management and Supply

Bendigo mine-impacted groundwater long-term management

Refer to the asset initiative for a description of this initiative.

Implementation of the Central and Gippsland Region Sustainable Water Strategy

Funding is provided to begin implementation of the Sustainable Water Strategy for the Central and Gippsland region, in partnership with Traditional Owners. Funding will implement the strategy through a range of projects to commence in 2022-23, including co-investment in place-based Integrated Water Management projects, support for business and councils to be more water efficient, waterway and catchment health projects in Lower Latrobe, Maffra, Moorabool and Werribee as well as investment to enable adaptation to a drying climate.

This initiative will be funded from the Environmental Contribution Levy.

This initiative contributes to the Department of Environment, Land, Water and Planning's Effective Water Management and Supply output.

Energy

$250 Power Saving Bonus

Funding is provided for a one-off $250 Power Saving Bonus for all Victorian households that use the Victorian Energy Compare website to search for the cheapest electricity deal. The program will operate for 12 months from 1 July 2022 to 30 June 2023.

This initiative contributes to the Department of Environment, Land, Water and Planning's Energy output.

Cheaper electricity for Victorians

Funding is provided to ensure the Victorian Energy Compare website continues to assist consumers in searching for the cheapest electricity deal. The Energy Assistance Program will also be funded to support energy customers experiencing vulnerability to navigate the energy market.

This initiative contributes to the Department of Environment, Land, Water and Planning's Energy output.

Decarbonising freight with hydrogen

Funding is provided for a renewable hydrogen refuelling network demonstration project for freight vehicles between Melbourne and Sydney. This initiative will be co-delivered in collaboration with the New South Wales Government and delivers on the renewable hydrogen industry development plan.

This initiative contributes to the Department of Environment, Land, Water and Planning's Energy output.

Driving down gas bills for businesses and households

Funding is provided to support gas reliability and affordability while reducing carbon emissions through regulatory reform. This includes promoting electrification and supporting the deployment of renewable gases.

This initiative contributes to the Department of Environment, Land, Water and Planning's Energy output.

Energy Resilience solutions and Community Microgrid Program

Funding is provided for the design and deployment of energy resilience solutions such as microgrids to improve the supply of electricity at locations at high risk of bushfires and extreme weather.

This initiative contributes to the Department of Environment, Land, Water and Planning's Energy output.

Improving Energy Safety and Skills

Funding is provided for mandatory skills maintenance training to ensure continuing professional development and improved safety skills for electrical workers.

This initiative contributes to the Department of Environment, Land, Water and Planning's Energy output.

Powerline Bushfire Safety Program

Funding is provided to continue the Powerline Bushfire Safety Program for the Victorian community, including critical risk reduction modelling and consequence mapping tool updates.

This initiative contributes to the Department of Environment, Land, Water and Planning's Energy output.

Unlocking offshore wind, renewable hydrogen and new energy manufacturing to create jobs

Funding is provided to support planning and policy development for Victoria's first offshore wind development, securing the State's position as a powerhouse for renewable energy innovation. Support will also be provided for further policy development to deliver renewable hydrogen projects.

This initiative contributes to the Department of Environment, Land, Water and Planning's Energy output.

Victorian Renewable Energy Target

Funding is provided to maintain engagement in national energy market decision-making that supports the interests of all Victorians and to deliver the second Victorian Renewable Energy Target auction.

This initiative contributes to the Department of Environment, Land, Water and Planning's Energy output.

Environment and Biodiversity

Environment protection and air quality

Funding is provided to establish two air quality precincts to implement actions to reduce localised air pollution and to support regulatory implementation of recent environment protection reforms.

This initiative will be partly funded from the Sustainability Fund.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Wildlife care and protection

Funding is provided for a package of initiatives that seek to protect Victorian wildlife. These include on-ground koala management programs for overabundant populations, which encompass health checks and fertility controls, and protection of grey-headed flying fox colonies across the State by managing heat stress events and avoiding human wildlife conflicts. Funding is also provided to support Victorian wildlife centres and shelters rehabilitate injured and orphaned wildlife, including support for the Amaroo Wildlife Shelter, Ballarat koalas, Friends of Bats Geelong and Surf Coast Wildlife Rescue.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Fire and Emergency Management

Aerial firefighting

Funding is provided for additional firefighting aviation resources that supported the State's firefighting capability during the 2021-22 bushfire season.

This initiative contributes to the Department of Environment, Land, Water and Planning's Fire and Emergency Management output.

Bushfire prevention and protection

Funding is provided to continue an expanded risk-based integrated land and fuel management program, including a greater level of mechanical fuel treatments year-round. In addition, funding is provided for preparedness activities for the 2021-22 bushfire season, including increased fire prevention activities and acquitting COVIDSafe plan requirements.

This initiative contributes to the Department of Environment, Land, Water and Planning's Fire and Emergency Management output.

Critical capital works to keep Victorians safe from fire and other emergencies

Refer to the asset initiative for a description of this initiative.

Emergency access to roads and trails

Funding is provided to ensure the safety of the strategic fire network and public land roads and crossings impacted by the storm and flood events from 2021.

This initiative contributes to the Department of Environment, Land, Water and Planning's Fire and Emergency Management output.

Securing Victoria's energy supply

Funding is provided to coordinate and manage the ongoing energy emergency recovery work at Yallourn Power Station to strengthen Victoria's energy supply security following the destabilisation of the Morwell River Diversion.

This initiative contributes to the Department of Environment, Land, Water and Planning's Fire and Emergency Management output.

Management of Public Land and Forests

Great Ocean Road management reforms and erosion preparedness

Refer to the asset initiative for a description of this initiative.

Keeping the public safe

Funding is provided to address public safety and environmental risks associated with abandoned and legacy mines and quarries on public land.

This initiative contributes to the Department of Environment, Land, Water and Planning's Management of Public Land and Forests output.

Securing Victoria's alpine future

Funding is provided to assist in the sustainable management of Victoria's alpine resorts, ensuring they can continue to be enjoyed by the community.

This initiative contributes to the Department of Environment, Land, Water and Planning's Management of Public Land and Forests output.

Strengthening the Victorian Forestry Plan

Funding is provided for eucalyptus seed collection, upgrades to storage facilities and seed viability testing. These investments will support forest contractors and ensure that forests can be reseeded after major fires. Funding is also provided to develop new procedures for forest coupe regeneration that will ensure compliance to the standards required in the *Code of Practice for Timber Production 2014*. This includes continued vital regulation of native timber harvesting through forest protection surveys and regulatory prescriptions. The Conservation Regulator will also be resourced to ensure ongoing active enforcement.

This initiative contributes to the Department of Environment, Land, Water and Planning's Management of Public Land and Forests output.

VicCoasts: Building a safe, healthier and more resilient marine and coastal environment for the community

Refer to the asset initiative for a description of this initiative.

Planning and Heritage

Delivering sustainable growth for a resilient Victoria

Funding is provided to develop a framework to ensure consistency in planning and decision-making within Melbourne's metropolitan and major activity centres, meeting Plan Melbourne objectives. In addition, regional growth plans will be updated to support the population growth that occurred during COVID-19, developing an integrated approach to associated changes in infrastructure provision, jobs growth and regional city development.

This initiative contributes to the Department of Environment, Land, Water and Planning's Planning and Heritage output.

Protecting heritage at Jacksons Hill

Funding is provided to maintain the land and buildings at Jacksons Hill, Sunbury, while the associated master plan and land divestment strategy are delivered.

This initiative contributes to the Department of Environment, Land, Water and Planning's Planning and Heritage output.

Unlocking new communities and affordable housing

Funding is provided to the Victorian Planning Authority (VPA) to continue to support precinct planning for high-priority areas to maintain the pipeline of land supply in metropolitan Melbourne and regional Victoria.

This initiative contributes to the Department of Environment, Land, Water and Planning's Planning and Heritage output.

Solar Victoria

Solar Homes boost

Funding is provided for Solar Victoria to provide rebates to eligible households, including renters, to install solar panels and battery storage systems on their homes. Interest-free loans are available to support eligible households.

This initiative contributes to the Department of Environment, Land, Water and Planning's Solar Victoria output.

Statutory Activities and Environment Protection

Sustaining the EPA's strengthened regulatory functions

Funding is provided for the Environment Protection Authority (EPA) to ensure it can continue to protect Victoria's environment from pollution and waste and fulfil its obligations under the *Environment Protection Act 2017*.

This initiative will be funded from the Municipal and Industrial Landfill Levy.

This initiative contributes to the Department of Environment, Land, Water and Planning's Statutory Activities and Environment Protection output.

Waste and Recycling

Recycling Victoria – Household Chemical Collection program

Funding is provided for the Household Chemical Collection program to continue to make it easier for Victorians to safely dispose of household hazardous chemicals and hard-to-recycle products, such as batteries and fluorescent lights.

This initiative will be funded from the Sustainability Fund.

This initiative contributes to the Department of Environment, Land, Water and Planning's Waste and Recycling output.

Asset initiatives

Table 1.7: Asset initiatives – Department of Environment, Land, Water and Planning **($ million)**

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*	*TEI*
Building						
Building reforms to secure Victoria's economic recovery	..	2.2	..	..	..	2.2
Effective Water Management and Supply						
Bendigo mine-impacted groundwater long-term management	..	5.7	15.3	23.4	..	44.4
Environment and Biodiversity						
Protecting Victoria's park heritage icons	..	0.7	2.8	6.3	6.6	16.5
Safeguarding Victoria's critical seed and botanical collection	..	1.0	2.4	1.4	..	4.8
Safer public dams	..	0.7	1.9	7.0	..	9.6
Victoria's great outdoors program	..	1.0	..	..	..	1.0
Fire and Emergency Management						
Critical capital works to keep Victorians safe from fire and other emergencies	..	18.3	..	..	..	18.3
Emergency access to roads and trails	..	1.6	..	..	..	1.6
Management of Public Land and Forests						
Community infrastructure accessibility and sustainability	..	8.6	0.9	..	..	9.5
Great Ocean Road management reforms and erosion preparedness	..	4.0	2.5	0.5	..	7.0
New and improved suburban parks	..	1.5	2.3	3.0	3.0	9.8
VicCoasts: Building a safe, healthier and more resilient marine and coastal environment for the community	..	9.9	..	..	..	9.9
Planning and Heritage						
Revitalising Central Geelong	..	0.4	1.9	..	..	2.3
Total asset initiatives [(a)]	**..**	**55.6**	**30.0**	**41.7**	**9.6**	**136.9**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Building

Building reforms to secure Victoria's economic recovery

Refer to the output initiative for a description of this initiative.

Effective Water Management and Supply

Bendigo mine-impacted groundwater long-term management

Funding is provided to implement a permanent solution to manage mine-impacted groundwater in central Bendigo, in the vicinity of the Central Deborah Gold Mine. This includes construction of a treatment facility and infrastructure changes to manage and prevent discharge of contaminated groundwater and odour in central Bendigo and decommissioning of the current interim solution.

This initiative contributes to the Department of Environment, Land, Water and Planning's Effective Water Management and Supply output.

Environment and Biodiversity

Protecting Victoria's park heritage icons

Funding is provided for building repairs to improve safety and enhance public access to iconic Victorian heritage sites including the Werribee Park Mansion, Point Nepean Forts and Lighthouses at Cape Otway, Cape Schanck, Point Hicks and Wilsons Promontory.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Safeguarding Victoria's critical seed and botanical collection

Funding is provided for critical building works at the Royal Botanical Gardens National Herbarium and to further develop a business case for long-term options to house and safeguard the State's botanic collection.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Safer public dams

Funding is provided for infrastructure works to improve public safety at the Expedition Pass Dam near Castlemaine and to decommission the Upper Teddington Dam in Kara Kara National Park.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Victoria's great outdoors program

Funding is provided to further establish the Yallock-Bulluk Marine and Coastal Park including enhanced visitor facilities and linkages between existing parks and reserves along the coastline between San Remo and Inverloch.

This initiative contributes to the Department of Environment, Land, Water and Planning's Environment and Biodiversity output.

Fire and Emergency Management

Critical capital works to keep Victorians safe from fire and other emergencies

Funding is provided to replace and renew critical fire and emergency assets to support the State's preventative bushfire services and rapid response to emergency events. This includes urgent renewals and repairs for fire and emergency assets.

This initiative contributes to the Department of Environment, Land, Water and Planning's Fire and Emergency Management output.

Emergency access to roads and trails

Refer to the output initiative for a description of this initiative.

Management of Public Land and Forests

Community infrastructure accessibility and sustainability

Funding is provided for works to improve access to community infrastructure and reduce the energy footprint of public buildings. This includes energy efficient infrastructure upgrades at the Albert Park Reserve, building restoration and accessibility upgrades at Point Lonsdale Lighthouse Reserve, improvements and access upgrades at Farm Vigano, and master planning and improvements to community spaces and facilities at the Patterson River Launching Way and the Patterson River National Water Sports Centre.

This initiative contributes to the Department of Environment, Land, Water and Planning's Management of Public Land and Forests output.

Great Ocean Road management reforms and erosion preparedness

Funding is provided to complete the transfer of land management to the Great Ocean Road Coast and Parks Authority (the Authority). Investments in heavy plant and equipment will also be made to build the Authority's capacity to respond to erosion events.

This initiative contributes to the Department of Environment, Land, Water and Planning's Management of Public Land and Forests output.

New and improved suburban parks

Funding is provided for new and improved parks and activating local parks to increase access to safe and contemporary park and recreation facilities. This includes upgrades at Dandenong Police Paddocks Reserve and Jells Park sports fields and the establishment of a dog park in Gowanbrae.

This initiative contributes to the Department of Environment, Land, Water and Planning's Management of Public Land and Forests output.

VicCoasts: Building a safe, healthier and more resilient marine and coastal environment for the community

Funding is provided to address critical erosion and flood risks, protect marine and coastal assets and support the adaptation and resilience of coastal communities.

This initiative contributes to the Department of Environment, Land, Water and Planning's Management of Public Land and Forests output.

Planning and Heritage

Revitalising Central Geelong

Funding is provided to deliver the second laneways strategy breakthrough project at Market Street South, to improve connection between the nearby health and education precincts and the commercial heart of the city.

This initiative contributes to the Department of Environment, Land, Water and Planning's Planning and Heritage output.

DEPARTMENT OF FAMILIES, FAIRNESS AND HOUSING

Output initiatives

Table 1.8: Output initiatives – Department of Families, Fairness and Housing ($ million)

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*
Child Protection and Family Services					
Civil claims costs for historical institutional child abuse	..	25.3	..	..	..
Emergency accommodation for children of COVID-19 positive parents or guardians	1.8	..	..	..	..
Establishing the Social Services Regulator	..	0.3	..	..	..
Funding for statutory bodies and reforms	..	4.9	4.9	..	..
Improving the capacity and mix of care services	..	77.9	6.7	..	..
Improving the safety of children and young people in out-of-home care	..	4.8	4.3	..	..
Justice system costs associated with the extension of court programs	..	0.5	0.5	0.5	0.5
Responding to demand for child protection and family services	..	16.4	24.3	16.9	..
Strengthening the community services workforce	3.4	3.5	3.5	..	..
Supporting community sector jobs	..	18.6	16.9	15.1	13.2
Community Participation					
Emerging with stronger communities	..	10.1	6.2	..	..
Victorian Social Recovery Support program	..	0.7	..	..	..
Concessions to Pensioners and Beneficiaries					
State Trustees – Community Service Agreement	..	5.8	7.9	8.1	8.3
Disability Services					
Strengthening Victoria's interface with the National Disability Insurance Scheme	..	16.5	19.4	..	..
Victorian State Disability Plan	..	14.6	0.5	..	..
Family Violence Service Delivery					
Implementing a sustainable Central Information Point	..	13.4	15.0	..	..
Perpetrator responses	..	17.0	12.2	0.9	..
Refuge and crisis accommodation	..	17.6	16.2	3.6	4.8
Supporting victims of sexual violence and harm	..	10.1	13.0	10.2	..
Sustaining family violence reforms	..	19.5	19.5	4.4	..
Housing Assistance					
Community isolation accommodation	12.4	..	..	..	..
High-rise fire upgrade program	..	0.2	0.2	0.2	0.2
High-risk response and recovery model for vulnerable Victorians	3.8	11.5	..	..	..
Investing in a thriving North Richmond	..	2.0	2.2	2.0	1.3
Investing to make homelessness rare, brief and non-recurring	..	8.3	19.1	23.9	..
Sustained support and improved housing outcomes	..	4.6	4.8	..	..

	2021-22	2022-23	2023-24	2024-25	2025-26
LGBTIQ+ Equality Policy and Programs					
LGBTIQ+ Strategy implementation	..	4.3	2.7	2.9	1.7
Multicultural Affairs Policy and Programs					
Continuing COVID-19 support and recovery for multicultural communities	..	3.7	..	..	..
Multicultural community infrastructure	..	6.4	..	..	..
Multicultural Festivals and Events Program	..	1.1	..	..	..
Support for priority newly arrived migrant communities	..	3.3	3.4	..	..
Victorian African Communities Action Plan	..	4.4	..	..	..
Primary Prevention of Family Violence					
Investing in Respect Victoria to prevent family and gendered violence	..	6.2	6.3	6.5	..
Seniors Programs and Participation					
Addressing family violence for older Victorians	..	2.9	..	..	..
Ageing Well in Victoria – Social recovery for older Victorians and carers	..	3.0	..	..	..
Support to Veterans in Victoria					
Support for veteran infrastructure	..	1.4	1.4	..	..
Support for veteran transition and wellbeing	..	0.3	0.3	..	..
Women's Policy					
Investing in Victoria's new gender equality strategy	..	4.6	1.2	1.0	..
Youth					
Empowering young people facing disadvantage	..	1.1	0.6	..	..
Total output initiatives [(a)]	**21.5**	**347.0**	**213.0**	**95.9**	**30.0**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Child Protection and Family Services

Civil claims costs for historical institutional child abuse

Funding is provided for the settlement of civil claims for historical institutional child abuse suffered by former wards of the State while in the State's care.

This initiative will contribute to the Department of Families, Fairness and Housing's Child Protection and Family Services output.

Emergency accommodation for children of COVID-19 positive parents or guardians

Funding is provided to operate emergency accommodation for children of people with COVID-19 requiring hospitalisation. This provides emergency short-term care and support for children until suitable alternative arrangements are made, or the parent or guardian is discharged.

This initiative contributes to the Department of Families, Fairness and Housing's Child Protection and Family Services output.

Establishing the Social Services Regulator

Funding is provided for the Suitability Panel to conclude investigations as part of the transition and implementation of legislative reforms under the new *Social Services Regulation Act 2021*.

This initiative contributes to the Department of Families, Fairness and Housing's Child Protection and Family Services output.

Funding for statutory bodies and reforms

Funding is provided for the implementation of the *Child Wellbeing and Safety (Child Safe Standards Compliance and Enforcement) Amendment Act 2021*. As a result of these legislative reforms, additional support is required to set up information sharing systems and compliance and enforcement frameworks and make necessary organisational changes.

Regulators will also communicate the reforms to around 50 000 regulated entities and community members, providing revised sector guidance and educational information.

Funding is also provided for the Disability Services Commissioner to manage its residual functions related to Transport Accident Commission and State Trustee funded services prior to the establishment of new arrangements for non-National Disability Insurance Scheme (NDIS) disability complaints.

This initiative contributes to the Department of Families, Fairness and Housing's:

- Child Protection and Family Services output
- Disability Services output.

This initiative contributes to the Department of Health's Admitted Services output.

Improving the capacity and mix of care services

Funding is provided to support existing demand for residential care and to continue trialling the Care Hub program, which brings together multidisciplinary teams to provide children and young people entering out-of-home care with specialist services and immediate care placement options.

Funding is also provided to continue the CaringLife app to enable up to 1 500 children in out-of-home care to store photos and other digital documentation important to their identity.

An uplift in base funding for 150 residential care placements is also provided.

This initiative contributes to the Department of Families, Fairness and Housing's Child Protection and Family Services output.

Improving the safety of children and young people in out-of-home care

Funding is provided to continue developing the menu of evidence-informed practices and programs on the Outcomes, Practice and Evidence Network (OPEN) website which enables the child protection and family services sector to share knowledge and build capability. Funding is also provided to boost safety measures for vulnerable children and young people through:

- introducing safety checks for adult household members in kinship care placements
- improving cross-jurisdiction information sharing about children and young people
- enhancing service delivery and security for high-risk children and young people in secure care facilities.

This initiative contributes to the Department of Families, Fairness and Housing's Child Protection and Family Services output.

Justice system costs associated with the extension of court programs

Refer to the Department of Justice and Community Safety initiative for a description of this initiative.

Responding to demand for child protection and family services

Funding is provided to meet increasing demand for targeted and specialised family services and support for up to 1 000 additional vulnerable families. Child protection responses will also be strengthened by increasing support staff capacity and enhancing recruitment programs to attract and retain child protection practitioners. Initiatives to strengthen child protection responses include:

- the introduction of a carer help-desk dedicated to assisting carers
- additional litigation solicitors and administrative support staff to advise and assist child protection practitioners
- additional support workers in the centralised subpoena office
- a new advertising campaign to attract child protection practitioners
- supporting visa and relocation costs for child protection practitioners recruited from overseas
- expansion of the Career Advancement Program to support and promote child protection workers to move into more senior roles
- continuation of the Child Protection Vacation Employment Program
- wellbeing support for the child protection workforce.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to the Department of Families, Fairness and Housing's Child Protection and Family Services output.

Strengthening the community services workforce

Funding is provided for an attraction and recruitment campaign that raises the profile of the community services workforce.

Funding is also provided for scholarships to increase education and training pathways for underemployed cohorts and those with lived experience interacting with social services. These initiatives remove barriers to entry to the community services workforce and increase the pipeline of graduates and diversity in community services.

This initiative contributes to the Department of Families, Fairness and Housing's:

- Child Protection and Family Services output
- Disability Services output
- Family Violence Service Delivery output.

Supporting community sector jobs

Additional funding is provided to help community service organisations that deliver social services on behalf of the Government to cover the impacts of minimum wage and consumer price index cost increases.

This initiative contributes to the Department of Families, Fairness and Housing's:

- Child Protection and Family Services output
- Concessions to Pensioners and Beneficiaries output
- Disability Services output
- Family Violence Service Delivery output
- Housing Assistance output
- Office for Disability output
- Seniors Programs and Participation output.

This initiative contributes to the Department of Health's:

- Community Health Care output
- Drug Treatment and Rehabilitation output
- Health Protection output
- Home and Community Care Program for Younger People output
- Mental Health Community Support Services output
- Non-Admitted Services output
- Small Rural Services – Aged Care output.

Community Participation

Emerging with stronger communities

Funding is provided for a range of initiatives to support the social recovery of Victorian communities. Initiatives include continuation of the funding boost provided to the Neighbourhood House Coordination Program, and a package of food relief support, including continuation of Regional Food Hubs and the Food Relief Taskforce, chilled food freight to regional areas and pop-up food relief markets in vulnerable communities. These initiatives will increase the supply of fresh and frozen foods to Victorians experiencing food insecurity.

Funding is also provided for additional community support, including funding for Sikh Volunteers Australia Incorporated to purchase and operate free food distribution vans and for the improvement of facilities at Uniting Prahran.

This initiative contributes to the Department of Families, Fairness and Housing's Community Participation output.

Victorian Social Recovery Support program

Funding is provided to extend the Victorian Social Recovery Support program to deliver recovery support services to communities affected by the June 2021 flood and storm event. Services include financial counselling and individualised case support to assist people to access housing, health and wellbeing and legal services.

This initiative contributes to the Department of Families, Fairness and Housing's Community Participation output.

Concessions to Pensioners and Beneficiaries

State Trustees – Community Service Agreement

Funding is provided to increase the capacity of State Trustees to ensure compliance with enhanced service standards and requirements under the *Guardian and Administration Act 2019*.

This initiative contributes to the Department of Families, Fairness and Housing's Concessions to Pensioners and Beneficiaries output.

Disability Services

Strengthening Victoria's interface with the National Disability Insurance Scheme

Funding is provided to services and programs to support Victorians with disability who are not eligible for the National Disability Insurance Scheme (NDIS), including:

- support for non-permanent residents
- Home and Community Care Program for Younger People
- youth justice specialist disability advisers
- Office of the Public Advocate's guardianship, investigation and support services
- aids and equipment support.

This initiative will deliver on the Government's commitment to continue to provide support to existing Victorian disability services' clients who have not been able to transition to the NDIS. This will also support non-permanent residents to access Early Childhood Intervention Services.

This initiative contributes to the Department of Families, Fairness and Housing's:

- Child Protection and Family Services output
- Disability Services output.

This initiative contributes to the Department of Education and Training's Early Childhood Education output.

This initiative contributes to the Department of Health's:

- Admitted Services output
- Mental Health Community Support Services output
- Aged Support Services output
- Home and Community Care for Younger People output
- Community Health Care output.

This initiative contributes to the Department of Justice and Community Safety's Protection of Vulnerable People, Human Rights and Victim Support output.

Victorian State Disability Plan

Funding is provided to construct new fully accessible public toilet facilities across Victoria and extend the Changing Places initiative. This builds on previous investment in Changing Places facilities and enables people with disability and high support needs to participate in social, recreational, and cultural activities across Victoria.

Further funding is also provided for the Victorian Disability Advocacy Program. This will support people with disability through increasing access to advocacy and ensuring equitable access to services, including the NDIS. Further funding is also provided for Disability Liaison Officers to identify and address barriers for people with disability in accessing health services.

Funding is also provided for a public education campaign to promote better attitudes and behaviours towards people with autism.

Accessible infrastructure grants to improve access at community facilities will also be provided through the Universal Design Grants program. Grants will be used to improve access, enabling more people to participate in community and social activities.

This initiative contributes to the Department of Families, Fairness and Housing's Disability Services output.

Family Violence Service Delivery

Implementing a sustainable Central Information Point

Funding is provided to expand the impact of the statewide Central Information Point, a multi-agency service that collates and shares relevant information about the risk of harm posed by perpetrators of family violence to inform family violence risk assessment and management.

This initiative contributes to the Department of Families, Fairness and Housing's Family Violence Service Delivery output.

Perpetrator responses

Funding is provided to enable family violence specialists to continue delivering perpetrator interventions and contribute to an increasing evidence base about what works to change behaviour and prevent violence. Specialists will work with perpetrators and their families to deliver interventions and provide accommodation support, as well as continue specialised programs for diverse cohorts.

Funding is also provided for a pilot program to target and evaluate intensive interventions for high-risk and high-harm perpetrators, including strengthened family safety contact.

This initiative contributes to the Department of Families, Fairness and Housing's Family Violence Service Delivery output.

Refuge and crisis accommodation

Funding is provided to consolidate and expand the existing statewide family violence refuge and crisis response that supports victim survivors of family violence, through:

- continuation of funding for family violence refuges, including two Aboriginal community-controlled refuges, to bring funding certainty to core and cluster refuges
- construction and operational funding of two new core and cluster family violence refuges, including land acquisition and additional staff to support implementation
- installation of fire protection systems at core and cluster refuges to meet new compliance requirements
- the purchase of six new Crisis Accommodation Program (CAP) properties to support family violence victim survivors with complex needs while other appropriate housing options become available.

Funding is also provided to partner with three refuge agencies to upgrade and operate agency owned properties and infrastructure, including the:

- McAuley Community Services for Women – to refurbish and operate a facility with an additional seven family suites and seven single units of core and cluster crisis accommodation, with additional staff to assist an enhanced model of support
- Good Samaritan Inn – to develop and operate a 10-unit property of transitional accommodation, with additional staffing to assist an enhanced model of support for residents
- Berry Street – to assist with operating a five-unit residential facility and three-bedroom property by providing additional staffing, therapeutic supports and brokerage for family needs.

This initiative contributes to the Department of Families, Fairness and Housing's:

- Family Violence Service Delivery output
- Housing Assistance output.

Supporting victims of sexual violence and harm

Refer to the Department of Justice and Community Safety initiative for a description of this initiative.

Sustaining family violence reforms

Funding is provided to support crisis case management and therapeutic support for victim survivors of family violence, specialised therapeutic interventions for children and young people who are victims of family violence, financial supports to assist victims of family violence to establish safety and security, support for the state-wide 24/7 crisis service and women on temporary visas. Funding is also provided for crisis case management to meet increasing demand.

This initiative contributes to the Department of Families, Fairness and Housing's Family Violence Service Delivery output.

Housing Assistance

Community isolation accommodation

Funding is provided for alternative accommodation for people with COVID-19 who need to safely isolate but cannot do so in their current residence.

This initiative contributes to the Department of Families, Fairness and Housing's Housing Assistance output.

High-rise fire upgrade program

Refer to the asset initiative for a description of this initiative.

High-risk response and recovery model for vulnerable Victorians

Funding is provided to continue the COVID-19 Isolation and Recovery Facility (CIRF). The CIRF provides temporary accommodation and support to people with multiple complex needs with a suspected or confirmed case of COVID-19 to self-isolate.

Funding is also provided to continue the Children and Young People involved with Child Protection (CERCY) model, which provides care and accommodation for children and young people involved with child protection who are unable to isolate or quarantine using their usual care arrangements.

Further funding is also provided for readiness, response and emergency management in high-risk accommodation settings.

This initiative contributes to the Department of Families, Fairness and Housing's:

- Child Protection and Family Services output
- Community Participation output
- Housing Assistance output.

Investing in a thriving North Richmond

Refer to the Department of Health initiative for a description of this initiative.

Investing to make homelessness rare, brief and non-recurring

Funding is provided to reform elements of the homelessness service system, shifting to a delivery model that provides tailored support and is focused on prevention, early intervention and sustainable housing. Victorians experiencing homelessness and rough sleeping will receive support through intensive flexible case management aimed at addressing a wide range of factors that act as barriers to exiting homelessness, such as substance abuse and poor mental and physical health. Funding is also provided for an uplift in case management and data collection tools.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to the Department of Families, Fairness and Housing's Housing Assistance output.

Sustained support and improved housing outcomes

Funding is provided to continue the Homelessness After-Hours Service operated by the Salvation Army to continue responding to, and supporting, people experiencing homelessness.

The Holmesglen Education First Youth Foyer operated by Launch Housing will also be continued. The Youth Foyer provides an integrated accommodation and education response for young people aged 16 to 24 who are experiencing, or are at risk of, homelessness, and are committed to pursuing education and training.

This initiative contributes to the Department of Families, Fairness and Housing's Housing Assistance output.

LGBTIQ+ Equality Policy and Programs

LGBTIQ+ Strategy implementation

Funding is provided for a range of initiatives aimed at strengthening the health, wellbeing, social and economic outcomes of LGBTIQ+ Victorians, supporting delivery of the Government's 2018 election commitment to develop the first whole of government LGBTIQ+ Strategy. Initiatives include:

- continuation of the LGBTIQ+ Grants Program
- the Pride Events and Festivals Fund
- Melbourne Pride
- specialist LGBTIQ+ legal services at the Victorian Pride Centre
- the Trans and Gender Diverse in Community Health Program
- a trial of Safe Spaces for LGBTIQ+ youth in Western Victoria, including referral services and greater access to targeted medical and emotional supports.

This initiative contributes to the Department of Families, Fairness and Housing's LGBTIQ+ Equality Policy and Programs output.

This initiative contributes to the Department of Health's Community Health Care output.

This initiative contributes to the Department of Justice and Community Safety's Justice Policy, Services and Law Reform output.

Multicultural Affairs Policy and Programs

Continuing COVID-19 support and recovery for multicultural communities

Funding is provided to extend the culturally and linguistically diverse (CALD) Communities Taskforce to continue support for multicultural communities. This will include extending the local partnerships model, providing place-based support for COVID-19 preparedness and response and social and economic recovery support for CALD communities.

Funding is also provided to deliver translated and accessible audio-visual content tailored to CALD communities.

This initiative contributes to the Department of Families, Fairness and Housing's Multicultural Affairs Policy and Programs output.

Multicultural community infrastructure

Funding is provided to support CALD communities to build and upgrade community infrastructure to enhance community cohesion and cultural celebration as well as improve access to critical services and supports. This will include grant funding through the Multicultural Community Infrastructure Fund.

This initiative contributes to the Department of Families, Fairness and Housing's Multicultural Affairs Policy and Programs output.

Multicultural Festivals and Events Program

Funding is provided to continue support for multicultural festivals and events in Victoria. These festivals and events celebrate and promote multicultural diversity and foster social cohesion in the community.

This initiative contributes to the Department of Families, Fairness and Housing's Multicultural Affairs Policy and Programs output.

Support for priority newly arrived migrant communities

Funding is provided to support improved settlement outcomes for Victoria's humanitarian cohorts and emerging migrant communities. These initiatives will build community capacity and extend legal support for asylum seekers and temporary visa holders, and continue to provide case management support and information on employment protections for migrant communities. Funding will also increase the capacity of Regional Community Hubs across metropolitan Melbourne and regional Victoria, supporting enhanced services for new migrants, refugees and asylum seekers.

This initiative contributes to the Department of Families, Fairness and Housing's Multicultural Affairs Policy and Programs output.

Victorian African Communities Action Plan

Funding is provided to continue delivery of education and employment initiatives to improve social and economic outcomes for Victoria's African communities. This includes support for Homework Clubs and school community liaison officers to provide educational and social support to students and parents of African heritage, and an Employment Brokers program in community organisations to facilitate access to specialised and mainstream programs, training and pathways to employment for African communities.

This initiative contributes to the Department of Families, Fairness and Housing's Multicultural Affairs Policy and Programs output.

Primary Prevention of Family Violence

Investing in Respect Victoria to prevent family and gendered violence

Funding is provided to continue the operations of Respect Victoria to deliver statewide behaviour change campaigns and evidence based primary prevention activities. This continues funding to support the delivery of Free from Violence, Victoria's strategy to prevent family violence and all forms of violence against women.

This initiative contributes to the Department of Families, Fairness and Housing's Primary Prevention of Family Violence output.

Seniors Programs and Participation

Addressing family violence for older Victorians

Funding is provided to continue the Elder Abuse Prevention Networks, which raise awareness of elder abuse and deliver primary prevention activities. Funding is also provided to continue elder abuse financial counselling services and other supports in bushfire-affected communities.

This initiative contributes to the Department of Families, Fairness and Housing's Seniors Programs and Participation output.

Ageing Well in Victoria – Social recovery for older Victorians and carers

Funding is provided to continue the reimagined Victorian Seniors Festival including online video entertainment and radio programs, the Recognising Senior Victorians in Aged Care program and COVIDSafe live performances in aged care facilities and in regional towns with high populations of seniors.

Funding is also provided to continue the Career Pathways into Employment for Unpaid Carers program to deliver tailored employment support for carers and create pathways into employment within the targeted disability, community services and aged care sectors.

Funding is also provided for a review into digital connectedness for senior Victorians.

This initiative contributes to the Department of Families, Fairness and Housing's Seniors Programs and Participation output.

Support to Veterans in Victoria

Support for veteran infrastructure

Funding is provided for ex-service organisations to maintain facilities that are safe, accessible and fit-for-purpose for veterans and their families. Funding will support organisations to address issues including lighting and electrical safety and improve accessibility through features including ramps, door widening and handrails.

This initiative contributes to the Department of Families, Fairness and Housing's Support to Veterans in Victoria output.

Support for veteran transition and wellbeing

Funding is provided for a range of initiatives aimed at improving veterans' participation and wellbeing including:

- supporting veterans obtaining a Recognition of Prior Learning certificate, removing a significant barrier for job seeking veterans
- continuation of the Returned and Services League Active program, which aims to reduce social isolation and improve veteran's mental health
- free public transport for veterans, war widows, school students, Australian Defence Force cadets, Girl Guides, and Scouts for veterans-related events and for veterans during Veterans' Health Week.

This initiative contributes to the Department of Families, Fairness and Housing's Support to Veterans in Victoria output.

This initiative contributes to the Department of Transport's:

- Bus Services – Statewide output
- Train Services – Statewide output
- Tram Services output.

Women's Policy

Investing in Victoria's new gender equality strategy

Funding is provided to implement the *Gender Equality Act 2020*, including training, education and resources to support gender impact assessments, upgrading the Gender Equality Act reporting platform and developing a new dispute resolution case management system.

Funding is also provided to deliver the Women of Colour Leadership program, which aims to address structural barriers for diverse women seeking leadership opportunities.

This initiative contributes to the Department of Families, Fairness and Housing's Women's Policy output.

Youth

Empowering young people facing disadvantage

Funding is provided to continue initiatives that support young people at risk of disengagement. The Empower Youth program will be continued, providing early intervention case management to vulnerable young people. Continued support is also provided for young people to participate in Scouts and Girl Guides.

This initiative contributes to the Department of Families, Fairness and Housing's Youth output.

Asset initiatives

Table 1.9: Asset initiatives – Department of Families, Fairness and Housing ($ million)

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*	*TEI*
Disability Services						
Support for people with forensic disability and complex needs	..	0.2	..	..	..	0.2
Family Violence Service Delivery						
Implementing a sustainable Central Information Point	..	1.6	..	..	..	1.6
Refuge and crisis accommodation	..	8.8	6.7	6.9	4.4	26.8
Housing Assistance						
High-rise fire upgrade program	..	5.4	4.9	6.0	5.7	22.1
Investing in a thriving North Richmond	..	2.8	2.2	0.5	..	5.5
Investing to make homelessness rare, brief and non-recurring	..	24.0	..	..	..	24.0
Women's Policy						
Investing in Victoria's new gender equality strategy	..	0.8	0.7	0.1	..	1.6
Total asset initiatives [(a)]	**..**	**43.6**	**14.5**	**13.5**	**10.1**	**81.7**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Disability Services

Support for people with forensic disability and complex needs

Funding is provided to support the planning and design of a new dedicated four-bed secure residential treatment unit and four-bed specialist forensic disability accommodation unit for women with cognitive disabilities requiring residential treatment.

This initiative contributes to the Department of Families, Fairness and Housing's Disability Services output.

Family Violence Service Delivery

Implementing a sustainable Central Information Point

Refer to the output initiative for a description of this initiative.

Refuge and crisis accommodation

Refer to the output initiative for a description of this initiative.

Housing Assistance

High-rise fire upgrade program

Funding is provided to complete fire safety upgrades to 19 high-rise public housing buildings.

This initiative contributes to the Department of Families, Fairness and Housing's Housing Assistance output.

Investing in a thriving North Richmond

Refer to the Department of Health initiative for a description of this initiative.

Investing to make homelessness rare, brief and non-recurring

Refer to the output initiative for a description of this initiative.

Women's Policy

Investing in Victoria's new gender equality strategy

Refer to the output initiative for a description of this initiative.

DEPARTMENT OF HEALTH

Output initiatives

Table 1.10: Output initiatives – Department of Health ($ million)

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*
Admitted Services					
A safe and engaged workforce	..	1.9	1.7	0.6	0.6
Better at Home [(a)]	..	172.6	143.6	174.7	207.2
COVID catch-up plan [(a)]	67.7	564.8	621.6	44.9	46.0
Enabling care and meeting demand for hospital services [(a)(b)]	353.0	942.8	465.1	289.1	294.9
Equitable cancer care and prevention [(a)]	..	11.4	2.8	4.2	5.4
Funding for statutory bodies and reforms	..	1.5	1.5	..	..
Providing additional bed capacity through modular facilities	9.7	35.7	19.5	..	..
Safer digital healthcare for Victorian public health services	..	19.0	..	..	..
Supporting our maternity workforce	..	4.6	5.2	..	..
Supporting the community and health system through the COVID-19 pandemic [(b)]	1331.8	244.0	..	..	..
Aged Support Services					
Completion of Modernisation of Metropolitan Melbourne PSRACS Strategy	..	0.8	..	..	..
Ambulance Emergency Services					
Supporting our frontline ambulance services	2.1	33.4	30.9	27.6	28.3
Community Health Care					
Improving health access and outcomes for refugees and asylum seekers	..	5.7	..	..	..
LGBTIQ+ Strategy implementation	..	0.7	0.7	..	..
Responding to community-based healthcare demand and delivering enhanced service responses	..	6.5	0.8	..	..
Supporting community sector jobs	..	8.1	7.2	6.2	5.3
Dental Services					
Smile Squad: specialist services [(c)]	nfp	nfp	nfp	nfp	nfp
Drug Treatment and Rehabilitation					
Better outcomes for substance use and addiction	..	9.3	2.8	1.4	1.4
Investing in a thriving North Richmond	..	4.2	0.2	0.2	..
Health Protection					
COVID-19 transitional operating model [(b)]	466.5	175.5	..	..	..
Decriminalising the sex work industry	..	1.6	1.4	..	..
Immunising Victorians against COVID-19 [(b)]	257.9	..	..	..	..
Public health and local place-based delivery	..	72.3	11.3	1.7	1.7
Rapid antigen tests [(b)]	1060.3	..	..	..	..
Health Workforce Training and Development					
Jreissati Family Pancreatic Centre at Epworth	..	5.0	..	..	..
Standing with our health workforce – investing in our future health workforce	..	37.8	32.0	0.5	0.5

	2021-22	2022-23	2023-24	2024-25	2025-26
Home and Community Care Program for Younger People					
Strengthening Victoria's interface with the National Disability Insurance Scheme [(a)]	..	41.4	39.3	..	..
Maternal and Child Health and Early Parenting Services					
Closing the gap – universal early years healthcare	..	3.9	2.0	2.1	2.2
Mental Health Clinical Care					
Contemporary information architecture for mental health and wellbeing	..	0.2	0.2	1.2	2.4
Develop and expand high-quality and therapeutic bed-based services [(a)]	..	29.3	57.0	62.5	69.6
Improving safety in mental health intensive care areas	..	..	..	1.1	..
Mental health and alcohol and other drugs emergency department hubs in regional Victoria	..	3.5	..	..	..
Mental health and wellbeing legislative reforms	..	15.7	10.9	1.4	1.4
Promoting good mental health and wellbeing in all communities	..	10.5	7.8	7.2	5.0
Strengthening community-based services [(a)]	..	42.9	23.2	21.1	28.4
Strengthening and supporting the mental health and wellbeing workforce [(a)]	7.8	65.3	94.6	100.6	103.2
Non-Admitted Services					
Strengthening palliative care in the community [(a)]	..	18.4	14.0	..	..
Residential Aged Care					
Future provision of public sector residential aged care	..	29.9	..	..	..
Total output initiatives [(d)]	**3556.9**	**2620.1**	**1597.2**	**748.1**	**803.4**

Source: Department of Treasury and Finance

Notes:

(a) These initiatives contribute to activity that attracts Commonwealth Government funding under the National Health Reform Agreement. Estimates of the Commonwealth Government's contribution are included.

(b) These initiatives contribute to activity that attracts Commonwealth Government funding under the National Partnership on COVID-19 Response. Estimates of the Commonwealth Government's contribution are included.

(c) Funding allocation is not for publication (nfp) at this time as arrangements are commercial in confidence.

(d) Table may not add due to rounding.

Admitted Services

A safe and engaged workforce

Funding is provided to support the health and wellbeing of the Victorian health workforce. This includes the continuation and expansion of Safer Care Victoria's Healthcare Worker Wellbeing Centre to provide programs and training to organisations to create productive and safe workplaces.

This initiative will also expand the Nursing and Midwifery Health Program Victoria to provide access to one-on-one psychological support services for up to 600 additional nurses and midwives.

This initiative contributes to the Department of Health's Admitted Services output.

Better at Home

Funding is provided to continue the delivery of healthcare in the home through use of home-based and virtual care models where clinically appropriate and selected by patients. This includes funding to support sustained activity growth and maturation of new shared service models. This initiative will also fund the expansion of a pilot model between health services providing transitional care in home like settings while patients await National Disability Insurance Scheme (NDIS) packages. Funding is also provided to pilot a virtual specialist clinic model that enables Aboriginal Victorians to access care on Country.

This initiative contributes to the Department of Health's:

- Admitted Services output
- Non-Admitted Services output.

COVID catch-up plan

Funding is provided to increase surgical activity across Victoria to record volumes, exceeding pre-pandemic levels by 25 per cent. Funding will provide 40 000 extra surgeries in the next year, building up to a total of 240 000 surgeries annually by 2024.

This will be achieved through the establishment of Rapid Access Hubs, public use of private surgical capacity, more activity in the public system, including more same-day surgeries and increased twilight and after-hours work, support for the training of an additional 400 perioperative nurses, upskill 1 000 nurses, train additional theatre and sterilisation technicians, and the international recruitment of 2 000 healthcare workers. The Government will also transform Frankston Private Hospital into a public surgery centre to deliver additional capacity.

This initiative contributes to the Department of Health's:

- Admitted Services output
- Health Workforce Training and Development output.

Enabling care and meeting demand for hospital services

Funding is provided to support service delivery and performance in Victoria's hospitals, including more emergency department staff, additional highly specialised therapies, and to support new wards. Funding is also provided to expand the newborn screening program, medicinal cannabis compassionate access scheme for children, and robot assisted surgery.

This initiative contributes to the Department of Health's:

- Admitted Services output
- Emergency Services output
- Health Protection output
- Health Workforce Training and Development output
- Non-Admitted Services output.

Equitable cancer care and prevention

Funding is provided to BreastScreen Victoria (BSV) to deliver additional breast cancer screening across new and existing services. Additional funding is provided to meet increases in demand for cancer treatment following the easing of COVID-19 restrictions. Further investment is provided to replace radiotherapy linear accelerators in Ballarat and Geelong, and install a new radiotherapy linear accelerator in Traralgon. Funding is also provided for catch up vaccination against the Human Papilloma Virus (HPV) for young Victorians at secondary schools.

This initiative contributes to the Department of Health's:

- Admitted Services output
- Non-Admitted Services output.

Funding for statutory bodies and reforms

Refer to the Department of Families, Fairness and Housing for a description of this initiative.

Providing additional bed capacity through modular facilities

Refer to the asset initiative for a description of this initiative.

Safer digital healthcare for Victorian public health services

Refer to the asset initiative for a description of this initiative.

Supporting our maternity workforce

Funding is provided for maternity workforce capacity and support, including new Registered Undergraduate Student of Midwifery positions. Funding is also provided to health services to support the midwifery workforce and meet growing demand for maternity services through flexible approaches.

This initiative contributes to the Department of Health's Admitted Services output.

Supporting the community and health system through the COVID-19 pandemic

Funding is provided to continue support for patients in recovery from COVID-19 and support for the health system in continuing to address Victoria's COVID-19 caseload, including:

- establishing and expanding Urgent Care Centres and expanding General Practitioner Respiratory Clinics
- expanding and continuing the COVID Positive Pathways program
- purchasing personal protective equipment (PPE) for health workers to enable them to work safely and effectively supporting health services to meet additional costs associated with COVID-19
- securing a larger critical care and paramedic workforce.

This initiative contributes to the Department of Health's:

- Admitted Services output
- Ambulance Emergency Services output
- Community Health Care output
- Emergency Services output
- Non-Admitted Services output.

Aged Support Services

Completion of Modernisation of Metropolitan Melbourne PSRACS Strategy

Funding is provided to design and plan a new 60-bed Public Sector Residential Aged Care Services facility, with 30 aged persons mental health (APMH) beds and a 30-bed specialist dementia unit at the Mornington Centre.

This initiative contributes to the Department of Health's Aged Support Services output.

Ambulance Emergency Services

Supporting our frontline ambulance services

Funding is provided for Ambulance Victoria to recruit new paramedics and enhance fleet management, rostering and support functions in order to meet growth in demand for ambulance services. A second Mobile Stroke Unit will also be established to improve access to pre-hospital stroke treatment. Funding will also support Ambulance Victoria to implement recommendations from the Victorian Equal Opportunity and Human Rights Commission's review into workplace equality and deliver innovative strategies to support emergency response.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to the Department of Health's:

- Ambulance Emergency Services output
- Ambulance Non-Emergency Services output.

Community Health Care

Improving health access and outcomes for refugees and asylum seekers

Funding is provided to continue and expand services to asylum seekers in Victoria, addressing gaps in safety net supports and delivering culturally appropriate healthcare to newly arrived and at-risk refugees due to ongoing Commonwealth Government funding cuts. People seeking asylum will be provided with primary health care, mental health support, case coordination, and assistance for basic needs, homelessness and utilities. Funding will also boost refugee nurse and bicultural health worker capacity.

This initiative contributes to the Department of Health's Community Health Care output.

LGBTIQ+ Strategy implementation

Refer to the Department of Families, Fairness and Housing for a description of this initiative.

Responding to community-based healthcare demand and delivering enhanced service responses

Funding is provided to strengthen community-based healthcare, by increasing the delivery of services for people who have deferred care, and supporting the integration of general practitioners into 20 registered community health services. In addition, funding will support the design of a new community-based model of care for people diagnosed with Type 2 diabetes, providing early intervention and care via community health services.

This initiative contributes to the Department of Health's Community Health Care output.

Supporting community sector jobs

Refer to the Department of Families, Fairness and Housing for a description of this initiative.

Dental Services

Smile Squad: specialist services

Funding is provided to deliver additional specialist dental treatment to children referred by Smile Squad. This includes an uplift to specialist capacity, and the development of the public specialist workforce through overseas recruitment and training to upskill generalist dentists.

This initiative contributes to the Department of Health's Dental Services output.

Drug Treatment and Rehabilitation

Better outcomes for substance use and addiction

Funding is provided to support better outcomes for Victorians experiencing substance use and addiction, including continued support for community and forensic treatment services, Aboriginal Metropolitan Ice Partnerships and the Needle and Syringe Program.

This initiative contributes to the Department of Health's:

- Drug Prevention and Control output
- Drug Treatment and Rehabilitation output.

Investing in a thriving North Richmond

Funding is provided to improve access to health and social support services, enhance public amenity and improve experiences and perceptions of safety and security in the North Richmond precinct, including:

- maintaining a homeless outreach worker at the Richmond Medically Supervised Injecting Room (MSIR) to assist clients in accessing housing
- maintaining the operations of the Richmond Youth Hub
- continuing the Supporting Tenancy at Yarra (STAY) program in partnership with St Vincent's
- supporting the operation of the Victoria Street Community space
- upgrading entrances to the MSIR and North Richmond Community Health
- improving the perception of safety around the North Richmond housing estate
- continuing to support community leadership and voice.

Enhanced outreach in the Melbourne CBD will also be continued, providing a multidisciplinary team of alcohol and other drug workers and counsellors, social workers, nursing staff, Aboriginal health workers and peer workers to reduce drug-related harm in the area.

This initiative contributes to the Department of Health's Drug Treatment and Rehabilitation output.

This initiative contributes to the Department of Families, Fairness and Housing's Housing Assistance output.

Health Protection

COVID-19 transitional operating model

Funding is provided to scale down the COVID-19 public health response in 2022-23 to transition from crisis response to a public health stewardship role to minimise harm and support Victorians who are most at risk. This includes targeted outbreak management in high-risk aged care and health settings via local public health units and multidisciplinary mobile teams. Funding is also provided for testing and pathology costs and for support functions including data and intelligence, call centre operations, commissioning and legal capability.

This initiative contributes to the Department of Health's:

- Health Protection output
- Non-Admitted Services output.

Decriminalising the sex work industry

Refer to the Department of Justice and Community Safety for a description of this initiative.

Immunising Victorians against COVID-19

Funding is provided to support delivery of COVID-19 vaccines to Victorians due for a booster shot and 5 to 11-year-olds receiving their first two vaccine doses. Vaccines are distributed through a combination of fixed and mobile clinics and are supported by community engagement, booking systems, and dedicated support for 5 to 11-year-olds.

This initiative contributes to the Department of Health's Health Protection output.

Public health and local place-based delivery

Funding is provided for the continued operation of local public health units and additional public health capacity to support these services, including intelligence, community engagement, digital capability and the design and delivery of Aboriginal-specific initiatives.

Funding will support public health prevention, regulation and response programs, including the establishment of sexual and reproductive health services, increased funding for women's health services, continuing the Healthy Heart Victoria program in the Loddon Mallee region, and increased oversight of Victoria's drinking water supplies.

This initiative contributes to the Department of Health's:

- Health Advancement output
- Health Protection output.

Rapid antigen tests

Funding is provided to purchase more than 200 million rapid antigen tests to support Victoria's testing strategy, and provide tests to healthcare workers, school students, COVID contacts and other critical public sector workforces.

This initiative contributes to the Department of Health's Health Protection output.

Health Workforce Training and Development

Jreissati Family Pancreatic Centre at Epworth

Funding is provided to the Jreissati Family Pancreatic Centre at Epworth to support efforts to diagnose and treat pancreatic cancer. This will include improving treatment pathways, undertaking research and developing education materials for health practitioners, patients and families affected by pancreatic cancer.

This initiative contributes to the Department of Health's Health Workforce Training and Development output.

Standing with our health workforce – investing in our future health workforce

Funding is provided for a review into current clinical placement activity to improve the quantity and quality of clinical placements across healthcare disciplines and expand allied health advanced practice service models in public health services to support the career development of allied health professionals.

Funding is also provided to support newly graduated enrolled nurses to enter health services with additional support to become skilled professionals within their first year of practice, enabling them to provide safe patient care by consolidating their skills and knowledge. This includes additional clinical rotations, additional study time, workshops, support from dedicated clinical educators and career support and planning.

Funding is provided to support the retention and growth of the Aboriginal health workforce to increase the accessibility of culturally safe services and fill essential workforce gaps. This includes additional cadetships, scholarships and traineeships for Aboriginal students and current workers in a range of health disciplines.

To consolidate learning and facilitate the transition to registered graduate practice, a Registered Undergraduate Student of Nursing (RUSON) pilot program will be established to facilitate the appointment of 1 125 RUSONs a year.

This initiative contributes to the Department of Health's Health Workforce Training and Development output.

Home and Community Care Program for Younger People

Strengthening Victoria's interface with the National Disability Insurance Scheme

Refer to the Department of Families, Fairness and Housing for a description of this initiative.

Maternal and Child Health and Early Parenting Services

Closing the gap – universal early years healthcare

Funding is provided to continue support for maternal and child health services delivered by Aboriginal organisations, and the Aboriginal led co-design of Aboriginal early years health services spanning antenatal, maternal and child health, and early parenting.

Additional funding is also provided to support four new Early Parenting Centres becoming operational in 2023.

This initiative contributes to the Department of Health's Maternal and Child Health and Early Parenting Services output.

Mental Health Clinical Care

Contemporary information architecture for mental health and wellbeing

Refer to the asset initiative for a description of this initiative.

Develop and expand high-quality and therapeutic bed-based services

Funding is provided to operationalise 82 new beds in Victoria's mental health system to improve access to acute care for those experiencing mental illness as well as increased bed-based support for people experiencing eating disorders. An expansion of the eating disorder enhanced integrated specialist model into four regional health services will support clinical mental health services to provide multidisciplinary support for the increased presentations of patients with eating disorders in regional Victoria, with services established at Grampians Health, Barwon Health, Bendigo Health and Latrobe Regional Hospital.

Funding will also support the operation of five emergency department mental health and alcohol and other drug hubs within Monash, St Vincent's, Barwon, Western and Melbourne health services. Existing support for consultation and liaison services will also continue.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System final report and the Department of Health's Mental Health Clinical Care output.

Improving safety in mental health intensive care areas

Refer to the asset initiative for a description of this initiative.

Mental health and alcohol and other drugs emergency department hubs in regional Victoria

Refer to the asset initiative for a description of this initiative.

Mental health and wellbeing legislative reforms

Funding is provided to support the implementation of new mental health and wellbeing legislation, including the hiring of expert practitioners within Area Mental Health Services and comprehensive training of staff to ensure a successful transition to the new legislative framework. Funding will also deliver on the Government's commitment to undertake an independent review of compulsory treatment criteria, and support ongoing legislative reform and development of supporting regulations.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System final report and the Department of Health's Mental Health Clinical Care output.

Promoting good mental health and wellbeing in all communities

Funding is provided to foster connection and reduce social isolation in vulnerable groups by establishing ten new social inclusion action groups in local government areas. Mental health training for Auslan and deaf interpreters is also funded to increase the availability of credentialled interpreters.

Funding is also provided for targeted suicide prevention and response programs, including:

- design of new LGBTIQ+ suicide aftercare services
- culturally appropriate prevention and bereavement programs for Aboriginal Victorians
- an 18-month pilot for a peer call-back service for families, carers and supporters caring for people experiencing suicidal behaviour
- place-based mental health programs through mental health and wellbeing services Youth Live4Life and Left and Right Counselling.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System final report and the Department of Health's Mental Health Clinical Care output.

Strengthening community-based services

Funding is provided for a range of initiatives to deliver a mental health and wellbeing system that is reoriented towards community-based treatment, care and support. This includes:

- integrated treatment, care and support for people with a co-occurring mental illness and substance use or addiction to be established in all Adult and Youth Area Mental Health and Wellbeing Services, as well as expansion of addiction services. Funding for this initiative forms part of the Early Intervention Investment Framework
- extension of the TelePROMPT program, connecting paramedics at the scene of a mental health crisis with a mental health clinician to provide care for people experiencing mental health emergencies
- in-person group-based parenting sessions to be delivered in regional Infant, Child and Youth Area Mental Health and Wellbeing Services
- approaches to eating disorder care and support to be enhanced through the development of a new statewide eating disorder strategy. Eating Disorders Victoria and the Centre of Excellence in Eating Disorders will also be supported to provide a range of services for families, carers and patients and to provide workforce support for health services.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System final report and the Department of Health's Mental Health Clinical Care output.

Strengthening and supporting the mental health and wellbeing workforce

Funding is provided to continue building the pipeline of workers required to deliver Victoria's mental health reform agenda in line with the Mental Health and Wellbeing Workforce Strategy. These initiatives cover immediate priority actions to boost workforce supply and capability including new allied health and nursing graduate and transition positions, postgraduate scholarships, piloting new earn and learn models for navigation and wellbeing support roles and a continuation of government funded psychiatry rotations for junior medical officers. Victoria's psychiatry and psychology training pipelines will also be supported through additional registrar positions and the establishment of a statewide psychiatry training consortium to address training barriers and identify opportunities for improvements.

A clinical supervision training program will be established to improve retention of senior allied health and nursing practitioners through improving the skills of supervising educators.

Capability in providing safe and responsive care to culturally and linguistically diverse Victorians and LGBTIQ+ Victorians will also be improved through supporting services to implement capacity uplift strategies. The Mental Health Workforce Capability Framework will also be implemented through the development of educational resources and an interactive web platform, enabling its practical application in the sector.

The Mental Health Workforce Capability Framework will be implemented through the development of educational resources and an interactive web platform, enabling its practical application in the sector.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System final report and the Department of Health's Mental Health Clinical Care output.

Non-Admitted Services

Strengthening palliative care in the community

Funding is provided to continue palliative care services, including regional and rural services and the statewide Palliative Care Advice Service. Additional funding is also provided to enable palliative care providers to respond to increased demand for specialist palliative care throughout the COVID-19 pandemic.

This initiative contributes to the Department of Health's Non-Admitted Services output.

Residential Aged Care

Future provision of public sector residential aged care

Funding is provided to public sector residential aged care services to continue to provide high-quality care to vulnerable aged persons, including those with mental health issues and assist in meeting nurse to patient ratios in public sector residential aged care.

This initiative contributes to the Department of Health's Residential Aged Care output.

Asset initiatives

Table 1.11: Asset initiatives – Department of Health **($ million)**

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*	*TEI*
Admitted Services						
Barwon Women's and Children's Hospital [(a)(b)]	tbc	tbc	tbc	tbc	tbc	500.0–525.0
COVID catch-up plan [(c)]	34.6	32.5	1.0	1.1	1.1	tbc
Emergency Department Expansion Program – Casey Hospital and Werribee Mercy Hospital	..	2.0	3.0	89.6	119.9	236.4
Enabling care and meeting demand for hospital services	..	6.0	..	..	..	6.0
Engineering Infrastructure Replacement Program 2022-23	..	20.0	..	..	..	20.0
Equitable cancer care and prevention	..	6.1	3.7	..	3.9	13.7
Medical Equipment Replacement Program	..	35.0	..	..	..	35.0
Metropolitan Health Infrastructure Fund	..	25.0	..	..	..	25.0
New Melton Hospital [(d)]	tbc	tbc	tbc	tbc	tbc	900.0–1 000.0
Providing additional bed capacity through modular facilities	54.9	..	..	..	..	54.9
Regional Health Infrastructure Fund	..	75.0	75.0	75.0	75.0	300.0
Safer digital healthcare for Victorian public health services	..	15.0	..	..	..	15.0
Supporting the community and health system through the COVID-19 pandemic	..	4.9	..	..	..	4.9
Ambulance Emergency Services						
Supporting our frontline ambulance services	..	1.8	..	..	..	1.8
Drug Treatment and Rehabilitation						
Mental health and alcohol and other drugs residential rehabilitation facility – Mildura	..	10.0	15.0	11.0	..	36.0
Maternal and Child Health and Early Parenting Services						
Early Parenting Centre – Shepparton	..	3.0	8.7	13.3	..	25.0
Mental Health Clinical Care						
Additional acute mental health beds in regional Victoria	..	8.5	27.1	96.8	62.3	195.8
Contemporary information architecture for mental health and wellbeing	..	5.5	13.0	25.3	17.0	60.8
Improving safety in mental health intensive care areas	0.2	19.4	37.9	3.6	..	61.1
Mental health and alcohol and other drugs emergency department hubs in regional Victoria	..	1.0	3.8	1.7	..	6.5
Redevelopment of Thomas Embling Hospital – Stage 2	1.6	44.3	73.5	4.5	..	123.9

	2021-22	2022-23	2023-24	2024-25	2025-26	TEI
Mental Health Community Support Services						
Mental Health and Alcohol and Other Drugs Facilities Renewal Fund	..	10.0	..	..	..	10.0
Victorian Collaborative Centre for Mental Health and Wellbeing	..	5.0	..	..	..	5.0
Total asset initiatives [(e)]	**117.0**	**468.2**	**305.2**	**465.2**	**596.1**	**2885.7**

Source: Department of Treasury and Finance

Notes:

(a) Includes $50 million in funding from the Commonwealth Government under the Community Health and Hospitals Program agreement.
(b) TEI is between a range of $500–$525 million. TEI and cash flows will be disclosed following the outcome of the procurement process.
(c) TEI and full cash flows will be disclosed following the outcome of commercial negotiations regarding leasing Frankston Private Hospital.
(d) TEI is between a range of $900–$1 000 million. TEI and cash flows will be disclosed following the outcome of the procurement process.
(e) Table may not add due to rounding. Totals include estimated expenditure for initiatives with 'tbc'. The TEI includes funding beyond 2025-26.

Admitted Services

Barwon Women's and Children's Hospital

Funding is provided to expand women's and children's services at University Hospital Geelong. In Stage 1, capacity will increase in paediatric outpatient services, operating theatres, birthing suites and Maternity Assessment and Short Stay Unit. Stage 2 will build a new inpatient tower with maternity, women's and paediatric services and Special Care Nursery. This expansion will deliver better access to quality care for people in the Barwon region.

This initiative delivers on the Government's election commitment as published in *Labor's Financial Statement 2018*.

This initiative contributes to the Department of Health's Admitted Services output.

COVID catch-up plan

Refer to the output initiative for a description of this initiative.

Emergency Department Expansion Program – Casey Hospital and Werribee Mercy Hospital

Funding is provided to expand emergency department capacity at Casey Hospital and Werribee Mercy Hospital to address significant demand for emergency services. This investment will increase the performance of the hospitals and Ambulance Victoria by delivering more efficient patient flows and better patient care.

This initiative builds on the *Providing additional bed capacity through modular facilities* investment to provide short-term capacity expansions of the emergency departments at Casey Hospital, Northern Hospital and Werribee Mercy Hospital.

This initiative contributes to the Department of Health's Admitted Services output.

Enabling care and meeting demand for hospital services

Refer to the output initiative for a description of this initiative.

Engineering Infrastructure Replacement Program 2022-23

Funding is provided to upgrade and replace critical engineering infrastructure in selected metropolitan, rural and regional hospitals. This will allow health services to support the successful delivery of high-quality care and ensure continued public confidence in Victorian health services.

Funding covers a range of infrastructure items and can include boilers, air handling units, cardiac electrical body protection systems and fire risk management systems to enable continuity of health service delivery and compliance with regulatory requirements.

This initiative contributes to the Department of Health's Admitted Services output.

Equitable cancer care and prevention

Refer to the output initiative for a description of this initiative.

Medical Equipment Replacement Program

Funding is provided to continue to replace critical medical equipment across Victoria. The equipment supports operating suites, emergency departments, surgical wards, intensive care units, neonatal and maternity services, and specialist areas. This will reduce risks for patients and staff and improve service availability through the introduction of newer, more advanced medical equipment.

This initiative contributes to the Department of Health's Admitted Services output.

Metropolitan Health Infrastructure Fund

Additional funding is provided to the Metropolitan Health Infrastructure Fund to improve the quality and amenity of infrastructure across a range of metropolitan health services. This funding will allow health services to respond to local priorities and maintain and enhance their service delivery capacity.

This initiative contributes to the Department of Health's Admitted Services output.

New Melton Hospital

Funding is provided to construct a new tertiary Melton Hospital in Cobblebank, which will provide 24-hour emergency services supported by over 100 medical and surgical beds, intensive care unit, maternity and neonatal services, mental health services, ambulatory care, and a range of clinical supports.

The new hospital will also be fully electric and will contribute to the Victorian Government's climate policy and renewable energy targets.

This investment will activate the Cobblebank precinct and stimulate further investment and development in the area to drive employment growth and nearby residential developments to improve housing supply. This initiative builds on funding provided in previous years to plan, acquire land and undertake early works for the new hospital.

This initiative contributes to the Department of Health's Admitted Services output.

Providing additional bed capacity through modular facilities

Funding is provided to establish additional capacity at Werribee Mercy Hospital, Northern Hospital and Casey Hospital. This includes the establishment and staffing of modular units to alleviate demand on health service emergency departments by providing triage, assessment, respiratory clinic, and urgent care clinic functions.

This initiative contributes to the Department of Health's Admitted Services output.

Regional Health Infrastructure Fund

Additional funding is provided to the Regional Health Infrastructure Fund to improve the quality and amenity of infrastructure across a range of rural and regional health services. This funding will allow health services to respond to local priorities and maintain and enhance their service delivery capacity. The funding boost takes the investment in this fund to more than $790 million.

This initiative contributes to the Department of Health's Admitted Services output.

Safer digital healthcare for Victorian public health services

Funding is provided to upgrade the network infrastructure needed to support and deliver patient-related services such as pathology, diagnostic imaging and patient management systems. Funding is also provided to strengthen cybersecurity measures for Victorian public health services and Ambulance Victoria. This includes support for next generation anti-virus protections, a security operations centre, and a recovery service in the event of a successful cyber attack.

This initiative contributes to the Department of Health's Admitted Services output.

Supporting the community and health system through the COVID-19 pandemic

Refer to the output initiative for a description of this initiative.

Ambulance Emergency Services

Supporting our frontline ambulance services

Refer to the output initiative for a description of this initiative.

Drug Treatment and Rehabilitation

Mental health and alcohol and other drugs residential rehabilitation facility – Mildura

Funding is provided to construct a 30-bed alcohol and other drugs residential rehabilitation facility including a withdrawal unit in Mildura servicing the Loddon Mallee region. This will reduce wait times and improve treatment outcomes for clients.

This initiative contributes to the Department of Health's Drug Treatment and Rehabilitation output.

Maternal and Child Health and Early Parenting Services

Early Parenting Centre – Shepparton

Funding is provided to construct a 10 bed early parenting centre in Shepparton. It will provide specialist support and deliver flexible, targeted services for families with children up to four years of age to enhance the parent-child relationship and support parents with strategies to achieve their parenting goals.

This initiative contributes to the Department of Health's Maternal and Child Health and Early Parenting Centres output.

Mental Health Clinical Care

Additional acute mental health beds in regional Victoria

Funding is provided to replace and expand the existing mental health facility to increase acute and community mental health services at Goulburn Valley Health in Shepparton. The development will enable improved models of care and will ensure the community has access to safe and high-quality mental health services.

Funding is also provided to undertake land acquisition and further detailed planning and design work to deliver additional acute mental health beds in the future at Northeast Health Wangaratta and the Ballarat Base Hospital.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System final report and the Department of Health's Mental Health Clinical Care output.

Contemporary information architecture for mental health and wellbeing

Funding is provided to implement contemporary mental health information infrastructure comprising an electronic statewide mental health and wellbeing record, mental health information and data exchange, and online portal for Victorians experiencing mental illness or psychological distress to support personalised and integrated mental health and wellbeing services.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System final report and the Department of Health's Mental Health Clinical Care output.

Improving safety in mental health intensive care areas

Funding is provided for a program of works to improve the separation of vulnerable consumers, including gender-based separation, in the intensive care areas of mental health inpatient facilities.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System final report and the Department of Health's Mental Health Clinical Care output.

Mental health and alcohol and other drugs emergency department hubs in regional Victoria

Funding is provided to construct a new emergency department mental health and alcohol and other drug crisis hub at the Latrobe Regional Hospital. Planning funding is provided for future hubs in Ballarat, Bendigo and Shepparton. The hub at Latrobe Regional Hospital will ensure specialist care is provided to people requiring urgent treatment for mental health, alcohol and drug issues and will also relieve pressure on the emergency department to treat other patients.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System final report and the Department of Health's Mental Health Clinical Care output.

Redevelopment of Thomas Embling Hospital - Stage 2

Funding is provided to deliver Stage 2 of the Redevelopment of Thomas Embling Hospital, which will deliver critical supporting infrastructure, including a new gatehouse and sally port, and bed refurbishments for patients.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System final report and the Department of Health's Mental Health Clinical Care output.

Mental Health Community Support Services

Mental Health and Alcohol and Other Drugs Facilities Renewal Fund

Additional funding is provided to the Mental Health and Alcohol and Other Drugs Facilities Renewal Fund to improve the quality and amenity of state-owned infrastructure that assists people with mental health, alcohol, and other drug issues. The works enable enhanced access and improved models of care through targeted improvements to ageing and poor-quality facilities, which will reduce risks for patients and staff.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System final report and the Department of Health's Mental Health Community Support Services output.

Victorian Collaborative Centre for Mental Health and Wellbeing

Funding is provided to progress service and capital planning to establish the Victorian Collaborative Centre for Mental Health and Wellbeing.

This initiative contributes to the Government's response to the Royal Commission into Victoria's Mental Health System interim and final reports and the Department of Health's Mental Health Community Support Services output.

DEPARTMENT OF JOBS, PRECINCTS AND REGIONS

Output initiatives

Table 1.12: Output initiatives – Department of Jobs, Precincts and Regions ($ million)

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*
Agriculture					
Animal Care and Protection	..	13.6	3.1	1.3	0.6
Climate ready agriculture	..	0.5	0.9	..	..
Collective biosecurity	..	0.7	0.8	0.2	0.2
Distillery Door Grants	..	5.0	5.0	..	..
Implementation of the Victorian Forestry Plan	0.3	24.0	48.6	14.8	12.6
Victorian grown	..	2.9	..	..	..
Business Precincts					
Fishermans Bend urban renewal – facilitating investment and jobs	..	0.8	..	..	..
Transforming Western Melbourne	..	2.3	0.5	..	..
Creative Industries Access, Development and Innovation					
Celebrating Diversity through South Asian film	..	1.2	1.2	..	..
Creative spaces and places	..	3.0	3.0	..	..
Creative West	..	2.4	..	..	..
Music Industry Growth Package	..	0.8	0.7	0.7	0.7
NBCUniversal Partnership [(a)]	..	12.5	..	12.6	13.8
Creative Industries Portfolio Agencies					
Creative industries portfolio agencies recovery	89.7	35.4	..	..	..
Sustaining the NGV's successful exhibition model	..	10.7	10.7	10.7	..
Creative Infrastructure and Facilities					
Creative Infrastructure Program	..	17.5	..	..	..
Industry, Innovation, Medical Research and Small Business					
Building a thriving digital economy	..	1.3	1.3	..	..
Childhood regenerative medicine commercialisation facility	..	1.0	..	..	..
Lumos Diagnostics-Planet Innovation – rapid diagnostics manufacturing facility and innovation hub [(b)]	..	..	..	..	..
Medical research addressing health inequalities	..	2.0	..	..	..
Supporting small and medium businesses through the pandemic	164.7	31.5	..	..	..
Supporting Victorian Manufacturing – Advanced manufacturing capability	..	9.5	9.1	0.7	0.7
Supporting Victorian Manufacturing – Moderna mRNA vaccine manufacturing facility [(b)]	..	..	..	..	..
Supporting Victorian Manufacturing – Victorian Industry Investment Fund	..	20.0	20.0	..	..
Transforming small business	..	8.9	..	..	..
Victorian innovation industry partnerships	..	0.9	..	..	..

	2021-22	2022-23	2023-24	2024-25	2025-26
Jobs					
Delivering an inclusive recovery for Victoria	..	0.8	..	..	..
Sick Pay Guarantee	32.9	132.8	80.0	..	..
Skills Solutions Partnerships	..	7.1	2.5	..	..
Test Isolation Payment and Pandemic Leave Disaster Payment	163.2	..	..	..	..
Local Government and Suburban Development					
Growing Suburbs Fund	..	50.0	..	..	..
Our suburbs: Living Local – supporting our suburbs to recover and thrive	..	24.7	..	..	..
Public Libraries Funding Program	..	2.3	..	..	..
Regional Development					
Backing our regional leaders	..	0.9	0.9	1.1	0.9
Living Local – Regional	..	5.0	..	..	..
Regional economic transition – Latrobe Valley Authority	..	7.5	..	..	..
Regional Jobs and Infrastructure Fund	1.0	29.0	..	..	..
Resources					
Developing Victoria's critical minerals	..	1.1	3.4	2.9	..
Mineral Resources Regulatory Reform	..	2.0	..	..	..
Regulating safeguards for gas resources	..	2.5	2.6	2.6	..
Sport, Recreation and Racing					
2026 Victorian Commonwealth Games [(c)]	36.3	222.6	467.1	705.7	1 146.2
Home of Victorian Motorsport – design and planning	0.8	0.8	..	..	..
Meeting Victoria's demand for local sport and active recreation infrastructure	..	88.0	..	..	..
Sporting trusts support	..	15.0	..	..	..
Supporting jobs for young people in sport and recreation	..	0.6	0.7	..	..
Tourism and Major Events					
Emerald Tourist Railway	..	5.6	..	..	..
Events Recovery and Support Program	..	4.4	..	..	..
Major Events Act 2009 administration and enforcement	..	1.0	1.0	..	..
Melbourne Convention and Exhibition Trust	..	32.6	..	..	..
National Business Event Program	..	2.6	..	..	..
Regional Tourism Infrastructure Projects	..	12.6	17.3	..	..
Victoria Back to the World: visitor economy destination marketing	..	5.0	..	..	..
Trade and Global Engagement					
Travel Pass	..	1.1	0.9	..	..
Victoria's trade recovery and global engagement	..	10.0	2.8	..	..
Total output initiatives [(d)]	**488.8**	**875.7**	**684.0**	**753.2**	**1175.7**

Source: Department of Treasury and Finance

Notes:

(a) Additional funding of $15.193 million in 2026-27 is beyond the forward estimates.

(b) Funding allocation is not reported at this time as arrangements are commercial in confidence.

(c) Includes intended contributions from the Commonwealth Government and Local Governments, and potential commercial revenues. Additional funding of $51.527 million in 2026-27 is beyond the forward estimates.

(d) Table may not add due to rounding.

Agriculture

Animal Care and Protection

Funding is provided to protect the welfare of animals through the establishment of regulatory design and compliance education activities associated with the Animal Care and Protection Bill, which will replace the current primary animal welfare legislation, the *Prevention of Cruelty to Animals Act 1986*. This includes a regulatory scheme for the pet rehoming sector.

Animal welfare will be further supported by introducing Victoria's first ever pet census, the development of a cat management strategy to promote responsible cat ownership and support for livestock and domestic animal welfare. It will be further supported by the establishment of a new Ballarat Animal Shelter and support for Cherished Pets, LambCare and Safe Steps – Family Violence Pets in Crisis.

This initiative contributes to the Department of Jobs, Precincts and Regions' Agriculture output.

Climate ready agriculture

Funding is provided to support farm businesses and farm communities to undertake drought specific climate change adaption activities. Victorian farmers and farming communities will be engaged in drought resilience and preparedness activities and have the skills to plan for, build resilience and respond to drought and dry seasonal conditions.

This initiative will contribute to the Department of Jobs, Precincts and Regions' Agriculture output.

Collective biosecurity

Funding is provided to support shared biosecurity action between community, industry and government. This includes funding for community pest and weed management, a Biosecurity Citizen Science Toolkit, joint emergency exercises for biosecurity incursions and behavioural insights research. These activities will ensure Victoria is better prepared to manage and respond to escalating biosecurity risks, minimising impacts on the agricultural sector and the community.

This initiative will contribute to the Department of Jobs, Precincts and Regions' Agriculture output.

Distillery Door Grants

Funding is provided for the Victorian distillery industry to support the visitor experience, export market development and skills development. This funding will support industry development, domestic and international market expansion, and job creation in the industry. This initiative replaces the initiative of the same name announced in the *2021-22 Budget*.

This initiative contributes to the Department of Jobs, Precincts and Regions' Agriculture output.

Implementation of the Victorian Forestry Plan

Funding is provided for VicForests to deliver a range of forest management services to support implementation of the Victorian Forestry Plan, including protection of the Leadbeater's possum and road maintenance. Funding is also provided to enhance the support offered through the Victorian Forestry Plan to businesses, communities and workers affected by the phase out of commercial native timber harvesting in state forests. This includes funding to assist industry and worker transition, funding for a Community Transition and Development Fund and additional funding for the Victorian Timber Innovation Fund.

This initiative contributes to the Department of Jobs, Precincts and Regions' Agriculture output.

Victorian grown

Funding is provided for the promotion of Victorian wine, food and drinks locally and globally. This includes funding for the new Victorian Grown program, Drink Victorian program and wine export initiatives. These activities will showcase Victoria's wine, food and drinks and assist Victoria's agriculture industry to export.

This initiative contributes to the Department of Jobs, Precincts and Regions' Agriculture output.

Business Precincts

Fishermans Bend urban renewal – facilitating investment and jobs

Funding is provided to support the planning processes for Fishermans Bend.

This initiative contributes to the Department of Jobs, Precincts and Regions' Business Precincts output.

Transforming Western Melbourne

Funding is provided to facilitate development in the Werribee National Employment and Innovation Cluster (NEIC) including the development of the East Werribee Roadmap and a fast-track review of the Precinct Structure Plan. This initiative will facilitate economic, social and environmental benefits within the Western suburbs of Melbourne.

This initiative contributes to the Department of Jobs, Precincts and Regions' Business Precincts output.

Creative Industries Access, Development and Innovation

Celebrating Diversity through South Asian film

Funding is provided to support local film makers to tell more diverse stories on our screens through a short film competition and mentorship program for Victorian filmmakers under the guidance of leading South Asian directors. Funding is also provided to position the Indian Film Festival Melbourne awards as a major event, promoting Victoria as a production, tourism, education and trade destination.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Access, Development and Innovation output.

Creative spaces and places

Funding is provided to respond to demand for affordable creative industry spaces and strengthen our creative industries' recovery and future growth by delivering:

- more affordable creative spaces within our cities and towns and helping creative workers to secure fit-for-purpose creative spaces in vacant/underutilised accommodation
- infrastructure projects that activate existing community spaces for creative programming and strengthen the vibrancy of our neighbourhoods supporting placemaking and jobs for local creatives
- small-scale projects in partnership with local governments and non-government organisations to support the local creative sector by unlocking the potential of unused or under-utilised spaces.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Access, Development and Innovation output.

Creative West

Funding is provided for the Go West Festivals Fund to support Victorian festivals to present and commission work from artists in Melbourne's West, in particular those from culturally and linguistically diverse backgrounds. This initiative will support the delivery of new creative development, presentation, and employment opportunities in Melbourne's West.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Access, Development and Innovation output.

Music Industry Growth Package

Funding is provided to support music events for the benefit of regional communities, providing new opportunities and upskilling for regional and rural artists and music workers. This initiative will deliver the Victorian Regional and Rural Touring Circuit boosting cultural tourism, opening up new audiences for musicians and giving regional communities greater access to Victorian contemporary music performances.

Funding is also provided to reform the licensing of music across public sector entities, ensuring payment of appropriate music licensing fees and maximising revenue for Victorian artists and music rightsholders.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Access, Development and Innovation output.

NBCUniversal Partnership

Funding is provided to support a multi-year Government partnership with NBCUniversal to secure a new premium television/streaming series development and the installation of state-of-the-art virtual production infrastructure at Docklands Studios Melbourne.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Access, Development and Innovation output.

Creative Industries Portfolio Agencies

Creative industries portfolio agencies recovery

Funding is provided to continue strengthening and supporting Victoria's cultural and creative agencies impacted by the COVID-19 pandemic, supporting jobs, activation, immediate solvency and business recovery.

This initiative supports the Arts Centre Melbourne's Australian Music Vault program, which celebrates and explores the history and future of Australian music through the iconic people, events and places that define Australian music.

Funding is also provided to the Australian Centre for the Moving Image, State Library Victoria and Geelong Arts Centre to activate their redeveloped spaces, inviting more visitors to explore the new spaces and program offering.

The Melbourne Recital Centre and Museums Victoria will be supported to activate their spaces and attract audiences with new offerings providing more exciting events for visitors to return to the CBD and support its economic recovery.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Portfolio Agencies output.

Sustaining the NGV's successful exhibition model

Funding is provided to continue the National Gallery of Victoria (NGV) Summer Programming and NGV Triennial, supporting the economic recovery of the CBD through blockbuster exhibitions that attract more visitors.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Portfolio Agencies output.

Creative Infrastructure and Facilities

Creative Infrastructure Program

Funding is provided to pilot a creative infrastructure grants program across Victoria. This includes grants towards upgrades to Theatre Works and the National Theatre in St Kilda, Castlemaine Art Museum, and Footscray Community Arts Centre. Funding is also provided towards planning for the Tarneit Performing Arts Centre, and the Dandenong Arts Precinct. These works will help ensure that Victorians have access to facilities that are accessible, innovative and functional.

This initiative contributes to the Department of Jobs, Precincts and Regions' Creative Industries Cultural Infrastructure and Facilities output.

Industry, Innovation, Medical Research and Small Business

Building a thriving digital economy

Funding is provided to extend the SummerTech LIVE work integrated learning program, which facilitates 10 to 12 week studentships for tertiary students over the summer break. The program supports students to gain job-ready skills and employment opportunities through developing innovative technical solutions to digital challenges faced by small and medium enterprises (SMEs).

This initiative contributes to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Childhood regenerative medicine commercialisation facility

Funding is provided to support the development of a comprehensive business plan and investment case to expand stem cell research and translational regenerative medicine capabilities at the Murdoch Children's Research Institute, to support its key role in the new international Novo Nordisk Foundation Center for Stem Cell Medicine (reNEW consortium). With a unique focus on childhood conditions, the business case will consider requirements for Good Manufacturing Practices-certified facilities, cell-line manufacturing and pre-clinical studies.

This initiative contributes to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Lumos Diagnostics-Planet Innovation – rapid diagnostics manufacturing facility and innovation hub

Funding is provided through both a grant and repayable loan to support Lumos Diagnostics to establish a rapid diagnostics manufacturing facility and innovation hub in Victoria. This facility will produce up to 50 million COVID-19 rapid antigen tests per annum from October 2022 and create at least 70 new jobs. This investment will secure sovereign rapid diagnostic test manufacturing capability in Victoria to improve security of supply of COVID-19 and future diagnostic products.

This initiative contributes to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Medical research addressing health inequalities

Funding is provided to establish a new public health stream of the Victorian Medical Research Acceleration Fund. A competitive annual grant round will support public health research into emerging challenges and targeted approaches to help promote better health outcomes for Victoria's most disadvantaged cohorts.

This initiative contributes to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Supporting small and medium businesses through the pandemic

Funding is provided to support Victorian businesses impacted by the Omicron variant of COVID-19 over the summer of 2021-22, including through:

- a third round of Melbourne Money dining vouchers and a new statewide dining program also offering capped rebates on eligible dining expenditure
- a new entertainment voucher program, providing a 25 per cent rebate for eligible expenditure on theatre, live music, museums and galleries, exhibitions and other events
- a new round of 150 000 travel vouchers to support the State's visitor economy, including a dedicated allocation of 10 000 vouchers for Victorian seniors
- $500 vouchers and rebates of up to $5 000 to SMEs operating public-facing commercial premises through a Ventilation Support Program to support businesses to manage and reduce their risk of COVID-19 transmission
- a third round of the Small Business Digital Adaptation Program to assist Victorian businesses to adopt digital tools
- an extension of the Business Recovery and Resilience Mentoring Program to provide mentoring and specialist industry guidance to small businesses
- subsidies to support 1 500 job placements in heavily impacted industries through Jobs Victoria.

This initiative contributes to the Department of Jobs, Precincts and Regions':

- Industry, Innovation, Medical Research and Small Business output
- Tourism and Major Events output.

Supporting Victorian Manufacturing – Advanced manufacturing capability

Funding is provided to assist advanced manufacturing businesses to transition to a highly skilled and low carbon environment by establishing a new Digital Jobs for Manufacturing stream of the Victorian Digital Jobs Program. This initiative will support 300 internships over two years to augment workforce supply and help address specific sector needs. A pilot of the Low-Carbon Manufacturing Grant Program will help manufacturers undertake large scale, productivity enhancing investments to enable them to participate in global supply chains for renewable energy and low-carbon components, supporting Victoria's transition to net zero.

Additional funding is provided to support the growth of Victoria's defence industry, including funding for the Defence Science Institute to facilitate additional defence research and development in Victoria. Funding is also provided for the Victorian Defence Industry Workforce Development program to deliver an expansion of existing internship programs and provide defence-specific professional development training. A business case to co-locate CSIRO agrifood research and development capabilities with AgriBio at La Trobe University will also be developed.

This initiative contributes to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Supporting Victorian Manufacturing – Moderna mRNA vaccine manufacturing facility

Funding is provided to secure Moderna's Australian pharmaceutical manufacturing facility, Australian Headquarters and Regional Research Centre in Victoria, as part of a 10-year strategic partnership between Moderna and the Victorian and Commonwealth Governments. Coupled with the establishment of a dedicated fill and finish facility, the State's investment will support the production up to 100 million mRNA vaccine doses in Victoria every year from 2024, as well as the creation of new highly skilled jobs.

This strategic partnership will ensure that Australia can meet its ongoing COVID-19 vaccine needs, and will promote the development of new and innovative respiratory mRNA vaccines, supporting future pandemic preparedness and enhancing Victoria's status as a critical regional hub for mRNA technology development and production.

This initiative will contribute to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Supporting Victorian Manufacturing – Victorian Industry Investment Fund

Funding is provided to establish a new Victorian Industry Investment Fund (VIIF) stream of the Victorian Jobs and Investment Fund. Grants provided through the VIIF will support fast growing and expanding businesses, including in supply chains that underpin economic resilience. The program will focus on investments that are strategically important to economic recovery and growth, generating capital investment and new jobs for Victoria.

This initiative contributes to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Transforming small business

The Government will continue supporting small and medium-sized Victorian businesses through grants for specialist advisory services to provide business operators with greater access to expert advice on business strategy and innovation, financial planning, and risk and compliance.

Funding to extend the Wellbeing and Mental Health Support for Victorian Small Businesses initiative is also provided to support Victorian business operators, including sole traders, through access to financial advice and mental health support services.

This initiative contributes to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Victorian innovation industry partnerships

Funding is provided to continue the Victorian Prize for Science & Innovation, Victorian Fellowships and Inspiring Women programs. This initiative implements a key priority action area under the Victorian Innovation Statement by recognising outstanding research capabilities and outcomes. It also supports young Victorian researchers to undertake a short-term overseas study mission to undertake specialist training and career development not available in Australia, benefitting the broader research and innovation ecosystem.

This initiative contributes to the Department of Jobs, Precincts and Regions' Industry, Innovation, Medical Research and Small Business output.

Jobs

Delivering an inclusive recovery for Victoria

Funding is provided to extend the Government's partnership with the Kinaway Aboriginal Chamber of Commerce to support the Aboriginal Procurement Target and the Social Procurement Framework.

Funding is also provided to grow the social enterprise sector as part of the Social Enterprise Strategy. The Government will partner with social finance providers to create investment opportunities for social enterprises. Work will also be undertaken to measure the economic impact of the social enterprise sector.

This initiative contributes to the Department of Jobs, Precincts and Regions' Jobs output.

Sick Pay Guarantee

Funding is provided towards program design and implementation of the Sick Pay Guarantee. The two-year pilot will support casual and contract workers in eligible occupations across priority industries by providing a payment of up to five days of sick or carer's pay at the national minimum wage. It is anticipated that more than 150 000 workers will be eligible in the first phase of the Sick Pay Guarantee.

This initiative contributes to the Department of Jobs, Precincts and Regions' Jobs output.

Skills Solutions Partnerships

Funding is provided to Skills Solutions Partnerships, a collaboration between the Victorian Government, industry, TAFEs and dual sector universities to pilot new training approaches that address skills shortages in priority areas, including short courses and work placements.

This initiative contributes to the Department of Jobs, Precincts and Regions' Jobs output.

This initiative contributes to the Department of Education and Training's Training, Higher Education and Workforce Development output.

Test Isolation Payment and Pandemic Leave Disaster Payment

Funding is provided for Test Isolation Payments in 2021-22 to support people without leave entitlements or existing financial support to self-isolate while awaiting COVID-19 test results, or those caring for someone awaiting their test results.

Funding is also provided for Pandemic Leave Disaster Payments to recipients who are not Australian citizens or permanent residents.

This initiative contributes to the Department of Jobs, Precincts and Regions' Jobs output.

Local Government and Suburban Development

Growing Suburbs Fund

Funding is provided to extend the Growing Suburbs Fund to deliver critical local infrastructure projects that support economic participation across Melbourne's interface councils and regional Victoria's peri-urban shires, which are experiencing population growth and changing demographics.

The fund will provide grants for new and upgraded local community infrastructure such as health and wellbeing hubs, community centres, arts and cultural facilities, parks and reserves, early education and learning centres and sport and recreation facilities that have dedicated community space and support multi-use purposes.

This initiative contributes to the Department of Jobs, Precincts and Regions' Local Government and Suburban Development output.

Our suburbs: Living Local – supporting our suburbs to recover and thrive

Funding is provided to continue supporting our Suburban Revitalisation Boards in Boronia, Broadmeadows, Frankston, Lilydale, Melton, Noble Park, Reservoir and Tarneit. Suburban Revitalisation Boards support local communities by delivering improvements to amenities, addressing social disadvantage through youth and family engagement programs, and facilitating new economic development opportunities.

Victoria's suburbs will be further supported through the Living Local Fund, which will provide funding for local community-building projects that promote social connections, enhance liveability, and revitalise suburban shopping strips. The Living Local Fund will also provide grants to community not-for-profit organisations to support local communities.

This initiative contributes to the Department of Jobs, Precincts and Regions' Local Government and Suburban Development output.

Public Libraries Funding Program

Funding is provided to public libraries across Victoria to maintain the quality of resources and services. This will ensure that these facilities continue to deliver free and universal access to education, resources and other programs to Victorian communities.

This initiative contributes to the Department of Jobs, Precincts and Regions' Local Government and Suburban Development output.

Regional Development

Backing our regional leaders

Funding is provided to support regional communities by continuing the role of the Victorian Cross Border Commissioner to reduce the barriers border communities face when accessing services and programs. The Country Women's Association will also receive support to continue assisting women, children, and families across regional Victoria, particularly those experiencing hardship or disadvantage.

This initiative is partially funded through the Community Support Fund.

This initiative contributes to the Department of Jobs, Precincts and Regions' Regional Development output.

Living Local – Regional

Funding is provided to support rural and regional communities to build social cohesion and community connection. This will be achieved through grants for:

- community infrastructure projects
- local community grants for equipment and other community projects.

This initiative contributes to the Department of Jobs, Precincts and Regions' Regional Development output.

Regional economic transition – Latrobe Valley Authority

Funding is provided to continue the Latrobe Valley Authority's (LVA) operations, support the management of economic transition, identify future opportunities through a transition plan and facilitate business concierge services specific to the Latrobe Valley. Funding is also provided for the Ladder Step-Up program to provide employment support for young people in the Latrobe Valley and for delivery of the Inclusive Employment Program by the Gippsland Trades and Labour Council. This investment will mitigate the impacts of industry closures and ensure that communities and workers have the required skills and support to capture emerging opportunities in future growth sectors.

This initiative contributes to the Department of Jobs, Precincts and Regions' Regional Development output.

Regional Jobs and Infrastructure Fund

Funding is provided to continue supporting economic growth and development in rural and regional Victoria through the Regional Jobs and Infrastructure Fund, with $1 million of new funding for the fast-track stream available in 2021-22. Funding is provided to continue the Regional Infrastructure Fund, Regional Jobs Fund and Investment Fast-Track Fund streams.

This investment will continue to create and retain jobs, leverage private sector investment, grow and diversify the regional economy, and improve economic and social outcomes for regional Victorians.

This initiative contributes to the Department of Jobs, Precincts and Regions' Regional Development output.

Resources

Developing Victoria's critical minerals

Funding is provided to support development of a Victorian critical minerals prospectus. This prospectus will draw from new geoscience data to identify favourable geology and early exploration investment opportunities for priority critical minerals. A competitive critical minerals development grants program will also be established, and policy and investment facilitation functions will be strengthened to support project delivery. This will improve investor confidence, foster diversification and economic growth, and lay the foundations for an industry that will grow in importance in a decarbonised economy.

This initiative contributes to the Department of Jobs, Precincts and Regions' Resources output.

Mineral Resources Regulatory Reform

Funding is provided to support Victoria to reform the regulatory framework for mining and extractives activities. This will encourage investment by industry, reduce the cost of extractive materials and support additional employment in the resources sector.

This initiative contributes to the Department of Jobs, Precincts and Regions' Resources output.

Regulating safeguards for gas resources

Funding is provided towards Earth Resources Regulation to protect public safety, agriculture and the environment. This supports the Government's commitment to regulate the restart of the onshore conventional gas sector and existing offshore gas activity.

This initiative contributes to the Department of Jobs, Precincts and Regions' Resources output.

Sport, Recreation and Racing

2026 Victorian Commonwealth Games

Funding is provided to enable the organisation and hosting of the 2026 Commonwealth Games in Victoria. The Games will offer a world-class sports and tourism experience and provide significant economic opportunities and benefits, with the Games to be held throughout regional Victoria, centred in four hubs in Ballarat, Bendigo, Geelong and Gippsland. The Government is currently undertaking further scoping and due diligence of the proposed competition venues. Additional sports and competition venues in regional Victoria, outside of the four hubs, are under consideration. Costs may be updated to reflect the final athletic program for Victoria 2026.

This initiative contributes to the Department of Jobs, Precincts and Regions' Sport, Recreation and Racing output.

Home of Victorian Motorsport – design and planning

Funding is provided to undertake detailed design, master planning and site due diligence activities for the Home of Victorian Motorsport at a location to be identified.

This initiative contributes to the Department of Jobs, Precincts and Regions' Sport, Recreation and Racing output.

Meeting Victoria's demand for local sport and active recreation infrastructure

Funding is provided for grants programs that deliver new and upgraded community sport and recreation infrastructure. This will include local community sport and recreation projects and competitive grant funding. The following existing local sports infrastructure programs will be continued including the:

- Local Sports Infrastructure Fund
- Female Friendly Facilities Fund
- Country Football and Netball Program.

Together, these programs will develop community sport and recreation infrastructure, increasing participation opportunities and improving accessibility for the community.

This initiative contributes to the Department of Jobs, Precincts and Regions' Sport, Recreation and Racing output.

Sporting trusts support

Funding is provided to support the State Sport Centres Trust and the Kardinia Park Stadium Trust to continue operations and undertake asset renewals in 2022-23.

This initiative contributes to the Department of Jobs, Precincts and Regions' Sport, Recreation and Racing output.

Supporting jobs for young people in sport and recreation

Funding is provided to subsidise accreditation for more than 2 000 young people, supporting their employment in the sport and recreation sector.

This initiative contributes to the Department of Jobs, Precincts and Regions' Sport, Recreation and Racing output.

Tourism and Major Events

Emerald Tourist Railway

Funding is provided to support the operation of the Emerald Tourist Railway, including implementation of the *Puffing Billy Railway Master Plan.*

This initiative contributes to the Department of Jobs, Precincts and Regions' Tourism and Major Events output.

Events Recovery and Support Program

Funding is provided to continue government engagement with Victoria's events sector on the safe coordination and management of events in response to COVID-19. Funding is also provided to support small to medium community events in Greater Melbourne.

This initiative contributes to the Department of Jobs, Precincts and Regions' Tourism and Major Events output.

Major Events Act 2009 administration and enforcement

Funding is provided to support sporting and cultural events through anti-ticket scalping provisions, new amendments, and crowd management protection.

This initiative contributes to the Department of Jobs, Precincts and Regions' Tourism and Major Events output.

Melbourne Convention and Exhibition Trust

Funding is provided to the Melbourne Convention and Exhibition Centre to support its operations following the impacts of the COVID-19 pandemic on the events sector. This will help keep the organisation active, retain its workforce, ensure its immediate solvency and enable the business to undertake recovery and relaunch activities through to the end of 2022-23.

This initiative contributes to the Department of Jobs, Precincts and Regions' Tourism and Major Events output.

National Business Event Program

Funding is provided to continue to attract a strong pipeline of national business events to Melbourne and regional Victoria. Business events provide a pipeline of visitors during the off-peak and shoulder seasons and will continue to support the State's economic recovery.

This initiative contributes to the Department of Jobs, Precincts and Regions' Tourism and Major Events output.

Regional Tourism Infrastructure Projects

Funding is provided to support the growth of regional tourism through funding for the following regional tourism infrastructure projects:

- Croajingolong Coastal Wilderness Walk
- Mildura 'Trail of Lights'
- Murray to Mountains Rail Trail
- Wycheproof Wetlands Precinct
- Central Goldfields Art Gallery – Indigenous Interpretive Garden – Stages 2 & 3
- Bald Hill Activation – Stage 3 Summit Trail
- Budj Bim – Development of visitor experiences at Lake Condah and the Tae Rak Traps
- Kittyhawk Museum Business Case
- Lorne Sea Baths Wellness Centre.

This initiative contributes to the Department of Jobs, Precincts and Regions' Tourism and Major Events output.

Victoria Back to the World: visitor economy destination marketing

Funding is provided to support Victoria's visitor economy through international marketing campaigns to encourage tourism visitation in the short-haul, long-haul, growth and emerging international flight market segments. These initiatives will assist in rebuilding the Victorian visitor economy brand following the re-opening of international borders.

This initiative contributes to the Department of Jobs, Precincts and Regions' Tourism and Major Events output.

Trade and Global Engagement

Travel Pass

Funding is provided to support the recovery and growth of Victoria's international education sector through the International Student Travel Pass. This will support transport accessibility for international students.

This initiative contributes to the Department of Jobs, Precincts and Regions' Trade and Global Engagement output.

Victoria's trade recovery and global engagement

Funding is provided for the Trade Mission Program to help exporters remain connected to international markets. As part of this initiative, the Government will establish a new trade and investment office in Paris to generate and capture opportunities for Victorian businesses to further expand into European markets in key trade sectors. This initiative also supports the continuation of key trade facilities that strengthen Victoria's international engagement efforts. These initiatives will assist in supporting Victoria's trade and exports in response to the impacts of the COVID-19 pandemic.

This initiative contributes to the Department of Jobs, Precincts and Regions' Trade and Global Engagement output.

Asset initiatives

Table 1.13: Asset initiatives – Department of Jobs, Precincts and Regions ($ million)

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*	*TEI*
Agriculture						
Horsham alternative proteins glasshouse complex and incubation hub	..	3.8	8.3	..	..	12.0
Creative Industries Portfolio Agencies						
Creative industries portfolio agencies recovery	..	2.3	..	..	..	2.3
Sport, Recreation and Racing						
Sporting trusts support	..	9.8	..	..	..	9.8
Tourism and Major Events						
Emerald Tourist Railway	..	2.7	..	..	..	2.7
Total asset initiatives [(a)]	**..**	**18.6**	**8.3**	**..**	**..**	**26.8**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Agriculture

Horsham alternative proteins glasshouse complex and incubation hub

Funding is provided for a research glasshouse complex and incubation hub at the Horsham Grains Innovation Precinct. This will deliver crop and pasture innovations for traditional and alternative proteins that are climate resilient and targeted at emerging market and consumer preferences.

This initiative contributes to the Department of Jobs, Precincts and Regions' Agriculture output.

Creative Industries Portfolio Agencies

Creative industries portfolio agencies recovery

Refer to the output initiative for a description of this initiative.

Sport, Recreation and Racing

Sporting trusts support

Refer to the output initiative for a description of this initiative.

Tourism and Major Events

Emerald Tourist Railway

Refer to the output initiative for a description of this initiative.

DEPARTMENT OF JUSTICE AND COMMUNITY SAFETY

Output initiatives

Table 1.14: Output initiatives – Department of Justice and Community Safety ($ million)

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*
Advocacy, Human Rights and Victim Support					
A new financial assistance scheme for victims of crime	..	2.3	12.0	12.0	13.2
Decriminalising the sex work industry	..	5.2	3.2	..	..
Responding to historical forced adoptions in Victoria	1.3	3.6	..	..	..
Strengthening Victoria's interface with the National Disability Insurance Scheme	..	6.7	6.4	..	..
Supporting oversight and scrutiny of the victim service system	..	1.2	1.2	1.2	1.2
Community Crime Prevention					
Early intervention to counter violent extremism	..	2.4	0.8	0.8	0.8
Preventing youth crime through early intervention	..	4.5	..	..	..
Emergency Management Capability					
COVID-19 Quarantine Victoria	839.7	120.3	..	..	..
Critical emergency management reforms	..	1.2	1.0	..	..
Emergency response capability uplift	..	2.7	2.2	1.4	0.8
Emergency Services Telecommunications Authority	12.9	108.4	65.5	70.7	76.0
Our future Victoria marine search and rescue service	..	0.1	0.3	0.3	0.8
Public water safety initiatives	..	9.4	2.6	..	..
State Control Centre workforce	..	2.0	11.2	11.4	11.6
Upskilling and protecting our firefighters	..	2.2	2.3	2.3	2.1
VICSES facilities and fleet maintenance and volunteer health and safety	..	9.5	7.4	..	..
VICSES volunteer training	..	2.7	..	..	..
Fines and Road Safety Enforcement					
Implementing a COVID fines concessional scheme	..	1.0	..	..	..
Forensic Justice Services					
Supporting victims of sexual violence and harm	..	3.3	3.8	3.1	3.1
Gambling and Liquor Regulation					
Responding to the Royal Commission into the Casino Operator and Licence and enhancing gambling and liquor regulation	23.6	23.4	8.5	..	..
Justice Policy, Services and Law Reform					
LGBTIQ+ Strategy implementation	..	0.6	1.0	..	..
Royal Commission into the Management of Police Informants	..	3.2	..	..	..
Wellbeing support for frontline justice workers	..	0.3	..	..	..

	2021-22	2022-23	2023-24	2024-25	2025-26
Policing and Community Safety					
Better mental healthcare for police	..	2.5	2.5	..	..
Equipping frontline police officers with conducted energy devices	..	39.0	39.6	50.6	39.6
Increasing policing capacity to meet current and future demand	..	40.0	87.3	100.9	105.7
Royal Commission into the Management of Police Informants – human source management and disclosure obligations	..	1.9	3.3	1.8	1.9
Victoria Police death and disability benefits	..	3.2	3.5	3.9	4.3
Prisoner Supervision and Support					
Providing aged care health services for people in prison	..	2.5	..	..	..
Reducing future justice demand and keeping the community safe	..	22.7	24.5	14.5	11.9
Responding to COVID-19 in corrections and youth justice	54.3	..	..	..	..
Royal Commission into Victoria's Mental Health System	..	1.4	0.1	..	..
Western Plains Correctional Centre	..	39.5	..	..	..
Protection of Children, Personal Identity and Screening Services					
Digital future of the Registry of Births, Deaths and Marriages	2.3	3.9	2.5	..	..
Working with Children Check and National Disability Insurance Scheme worker screening	..	3.6	..	..	..
Public Prosecutions and Legal Assistance					
Delivery of prosecution services	..	7.5	7.5	..	..
Expanding the Assessment and Referral Court	..	..	1.1	2.1	2.7
Helping Courts respond to the impacts of the pandemic	..	9.1	1.9	..	..
Justice system costs associated with the extension of court programs	..	20.2	16.3	11.3	11.1
Legal assistance	..	21.3	28.7	..	..
Supporting community legal centres	..	7.0	..	..	..
Public Sector Information Management, Privacy and Integrity					
Supporting the Office of the Victorian Information Commissioner	..	0.2	..	..	..
Regulation of the Victorian Consumer Marketplace					
Contact service harmonisation and digital uplift	..	0.8	1.0	0.1	..
Youth Justice Community Based Services					
Diverting children from youth justice	..	5.0	6.0	..	..
Youth Justice Custodial Services					
Improving Custodial Services for Youth Justice	..	90.1	107.6	95.1	97.8
Total output initiatives [(a)]	**934.0**	**637.0**	**462.7**	**383.4**	**384.6**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Advocacy, Human Rights and Victim Support

A new financial assistance scheme for victims of crime

Funding is provided to prepare for the commencement of the new financial assistance scheme for victims of crime, to become operational in the second half of 2023.

This initiative contributes to the Department of Justice and Community Safety's Advocacy, Human Rights and Victim Support output.

Decriminalising the sex work industry

Funding is provided to continue reforms relating to the decriminalisation of sex work in Victoria. This includes support for WorkSafe to establish a dedicated Sex Work Safety Team to develop guidance, training, industry support and awareness campaigns, Victoria Police to manage the transition to decriminalisation, the Victorian Equal Opportunity and Human Rights Commission to develop supports for sex workers facing discrimination under the *Equal Opportunity Act 2010*, and the St Kilda Legal Service to provide legal advice and assistance. Funding is also provided to further develop a peer-led agency to embed the reforms within the sex worker community.

This initiative contributes to the Department of Justice and Community Safety's:

- Advocacy, Human Rights and Victim Support output
- Regulation of the Victorian Consumer Marketplace output
- Policing and Community Safety output.

This initiative contributes to the Department of Health's Health Protection output.

Responding to historical forced adoptions in Victoria

Funding is provided to implement priority activities to support Victorians affected by historical forced adoptions, including the scoping and design of a redress scheme, discretionary payments to affected mothers with exceptional circumstances (including terminal illness), crisis counselling, integrated birth certificates and financial support to community groups that assist affected people.

This initiative contributes to the Department of Justice and Community Safety's Advocacy, Human Rights and Victim Support output.

Strengthening Victoria's interface with the National Disability Insurance Scheme

Refer to the Department of Families, Fairness and Housing for a description of this initiative.

Supporting oversight and scrutiny of the victim service system

Funding is provided to support the Victims of Crime Commissioner to hold justice agencies to account and improve victims' experiences in the justice system.

This initiative contributes to the Department of Justice and Community Safety's Advocacy, Human Rights and Victim Support output.

Community Crime Prevention

Early intervention to counter violent extremism

Funding is provided to continue programs to counter violent extremism.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to the Department of Justice and Community Safety's Community Crime Prevention output.

Preventing youth crime through early intervention

Funding is provided to prevent youth crime before it occurs by continuing critical programs aimed at engaging young people in the community and addressing the key drivers of crime.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to the Department of Justice and Community Safety's Community Crime Prevention output.

Emergency Management Capability

COVID-19 Quarantine Victoria

Funding is provided for the operation of COVID-19 Quarantine Victoria for costs associated with operating 17 hotel quarantine sites and for the new Centre for National Resilience at Mickleham. The Centre provides a purpose-built facility and quarantine program with strict infection and prevention controls, and ventilation standards, encompassing a range of services including accommodation, catering, transport and health which can be scaled up and down depending on public health and other requirements.

The Victorian Government has offered the use of the Centre for National Resilience at Mickleham to the Commonwealth Government to assist to temporarily accommodate Ukrainian refugees, should this be required.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Critical emergency management reforms

Funding is provided for Emergency Management Victoria's strategic planning, assurance and reform capability to deliver on key internal reviews and government responses to inquiries undertaken by the Inspector-General for Emergency Management and the Royal Commission into National Natural Disaster Arrangements.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Emergency response capability uplift

Refer to the asset initiative for a description of this initiative.

Emergency Services Telecommunications Authority

Funding is provided for increased call-taking and dispatch capacity in all emergency call-taking lines, as well as increased capability and leadership, wellbeing support, ICT maintenance, additional trainers, additional support and surge capability, additional workforce support – and for a whole of government strategy to manage non-emergency demand.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Our future Victoria marine search and rescue service

Refer to the asset initiative for a description of this initiative.

Public water safety initiatives

Funding is provided to support lifesaving services, continue safety programs at public pools, and maintain and improve Life Saving Victoria clubhouses.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

State Control Centre workforce

Funding is provided for the State Control Centre's 24/7 workforce capability, data analytics, ICT support and rostering system.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Upskilling and protecting our firefighters

Funding is provided to the Country Fire Authority (CFA) for volunteer driver training, licensing and related emergency vehicle fleet.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

VICSES facilities and fleet maintenance and volunteer health and safety

Refer to the asset initiative for a description of this initiative.

VICSES volunteer training

Funding is provided to deliver Victoria State Emergency Service (VICSES) training and a professional development program to strengthen capability, including training in land based swift water rescue, rope rescue, landslides, incident management team development and leadership development.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Fines and Road Safety Enforcement

Implementing a COVID fines concessional scheme

Funding is provided to Fines Victoria to implement a COVID Fines Concessional Scheme, enabling vulnerable Victorians to apply for a reduced penalty.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to the Department of Justice and Community Safety's Fines and Road Safety Enforcement output.

Forensic Justice Services

Supporting victims of sexual violence and harm

Funding is provided to improve services for victims of sexual violence and harm, in line with the recent Victorian Law Reform Commission's recommendations in *Improving the Justice System Response to Sexual Offences* through:

- supporting the Victorian Institute of Forensic Medicine (VIFM) to deliver Clinical Forensic Medicine (CFM) services for victim survivors of sexual violence and harm
- supporting specialist sexual assault services to deliver therapeutic support to adults, children and young people who have experienced sexual assault and abuse
- supporting the after-hours Sexual Assault Crisis Line (SACL) to respond to increased demand
- expanded crisis brokerage for victim survivors of sexual assault
- continuing support for Sexually Abusive Behaviour Treatment services for children and young people demonstrating harmful sexual behaviours
- supporting the work of Sexual Assault Services Victoria, the peak body in Victoria for sexual assault and harmful sexual behaviour services
- designing an alternative online reporting model for reporting sexual offences
- working with local organisations and specialist services to deliver community-based consent education
- supporting legal assistance for families of deceased victims of sexual offences under the new victim privacy order scheme
- developing written materials and delivering judicial education on integrated jury directions in sexual offences trials.

This initiative contributes to the Department of Justice and Community Safety's

- Forensic Justice Services output
- Advocacy, Human Rights and Victim Support output.

This initiative contributes to the Department of Families, Fairness and Housing's Family Violence Service Delivery output.

This initiative contributes to Court Services Victoria's Courts output.

Gambling and Liquor Regulation

Responding to the Royal Commission into the Casino Operator and Licence and enhancing gambling and liquor regulation

Funding is provided to support the Government's response to recommendations from the Royal Commission into the Casino Operator and Licence and to introduce tough new measures and strict oversight of Melbourne's casino operator. This includes:

- establishing an Office of the Special Manager with unprecedented powers to oversee casino operations and hold Melbourne's casino operator to account
- supplementing the Victorian Gambling and Casino Control Commission (VGCCC) to support its oversight of all gambling and gaming activities within Victoria, and resource its dedicated casino division, which will focus solely on the casino operator
- appointing a new VGCCC Chair and dedicated casino commissioners to strengthen oversight over casino operations
- supporting the Department of Justice and Community Safety to respond to Royal Commission recommendations.

Funding is also provided to modernise Victoria's liquor regulator, which will improve regulatory outcomes and reduce compliance costs for liquor licence holders.

This initiative contributes to the Department of Justice and Community Safety's Gambling and Liquor Regulation output.

Justice Policy, Services and Law Reform

LGBTIQ+ Strategy implementation

Refer to the Department of Families, Fairness and Housing for a description of this initiative.

Royal Commission into the Management of Police Informants

Funding is provided to the Office of the Special Investigator and the Victorian Inspectorate to support the Government's response to the Royal Commission into the Management of Police Informants. This builds on funding for the Government's response provided in the *2021-22 Budget*.

This initiative contributes to Department of Justice and Community Safety's:

- Justice Policy, Services and Law Reform output
- Parliament's Victorian Inspectorate output.

Wellbeing support for frontline justice workers

Funding is provided to support the development of new workforce wellbeing tools and training for the justice workforce.

This initiative contributes to the Department of Justice and Community Safety's Justice Policy, Services and Law Reform output.

Policing and Community Safety

Better mental healthcare for police

Funding is provided to Victoria Police to continue initiatives focused on mental health early intervention and prevention to increase mental health awareness and improve the wellbeing of police officers.

This initiative contributes to the Department of Justice and Community Safety's Policing and Community Safety output.

Equipping frontline police officers with conducted energy devices

Funding is provided to Victoria Police to equip frontline police officers and protective service officers (PSOs) across the state with conducted energy devices. This includes integration with body worn cameras and training for police and PSOs. The rollout will ensure police and PSOs have additional non-lethal options to safely resolve violent or dangerous situations.

This initiative contributes to the Department of Justice and Community Safety's Policing and Community Safety output.

Increasing policing capacity to meet current and future demand

Funding is provided to Victoria Police to recruit an additional 502 police and 50 PSOs over the next two years to meet service demand and provide high visibility and proactive policing in the community.

This initiative contributes to the Department of Justice and Community Safety's Policing and Community Safety output.

Royal Commission into the Management of Police Informants – human source management and disclosure obligations

Funding is provided to Victoria Police to support the Government's response to the Royal Commission into the Management of Police Informants, including enhanced governance and operational procedures for human source management and disclosure obligations, additional support staff for investigations in the Court of Appeals and enhancements to information systems.

This initiative contributes to the Department of Justice and Community Safety's Policing and Community Safety output.

Victoria Police death and disability benefits

Funding is provided to Victoria Police for group death and disability cover for operational members aged 55 to 60 years old.

This initiative contributes to the Department of Justice and Community Safety's Policing and Community Safety output.

Prisoner Supervision and Support

Providing aged care health services for people in prison

Funding is provided for services to support ageing people in the prison system, ensuring they receive necessary assistance, such as personal care and daily living needs, as well as specialist transition and reintegration assistance.

This initiative contributes to the Department of Justice and Community Safety's Prisoner Supervision and Support output.

Reducing future justice demand and keeping the community safe

Funding is provided for a range of initiatives to address offending and improve outcomes for over-represented cohorts in contact with the justice system, including:

- continued operation of the Maribyrnong Community Residential Facility, which provides short term accommodation and transitional support for men exiting the prison system who would otherwise be at risk of homelessness
- expanding the family visits support program for prisoners to help repair relationships and assist with reunification of family units
- enhanced rehabilitation and reintegration support services for sentenced prisoners to support their successful transition back into the community
- bolstering the Women and Mentoring Program, which matches women at risk of offending with supportive female mentors
- improved oversight of high-risk offenders on Community Corrections Orders.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to the Department of Justice and Community Safety's:

- Prisoner Supervision and Support output
- Community-Based Offender Supervision output
- Justice Policy, Services and Law Reform output.

Responding to COVID-19 in corrections and youth justice

Funding is provided to further support Victoria's corrections and youth justice operations to respond to COVID-19. Funding is provided for measures to prevent and control COVID-19 transmission in custodial facilities, including isolation units, cleaning, personal protective equipment (PPE) and extending the vaccination program. Funding is also provided to help mitigate the impacts of COVID-19 restrictions on prisoner's and young people's mental health and wellbeing.

This initiative contributes to the Department of Justice and Community Safety's:

- Prisoner Supervision and Support output
- Youth Justice Custodial Services output.

Royal Commission into Victoria's Mental Health System

Funding is provided for the planning and design of a youth forensic mental health service in adult prisons as part of the whole of government response to recommendations from the Royal Commission into Victoria's Mental Health System.

This initiative contributes to the Department of Justice and Community Safety's Prisoner Supervision and Support output.

Western Plains Correctional Centre

Funding is provided for commissioning systems at the facility and maintaining the facility.

This initiative contributes to the Department of Justice and Community Safety's Prisoner Supervision and Support output.

Protection of Children, Personal Identity and Screening Services

Digital future of the Registry of Births, Deaths and Marriages

Funding is provided to continue the call taking capability of the Registry of Births, Deaths and Marriages, as well as scoping and developing a proof-of-concept pilot for delivering front-end Births, Deaths and Marriages services as a function of Service Victoria.

This initiative contributes to the Department of Justice and Community Safety's Protection of Children, Personal Identity and Screening Services output.

Working with Children Check and National Disability Insurance Scheme worker screening

Funding is provided to support Working with Children Check Victoria to deliver efficient, effective and sustainable worker screening for child-related work and the National Disability Insurance Scheme.

This initiative contributes to the Department of Justice and Community Safety's Protection of Children, Personal Identity and Screening Services output.

This initiative contributes to the Department of Premier and Cabinet's Digital Strategy and Transformation output.

Public Prosecutions and Legal Assistance

Delivery of prosecution services

Funding is provided to support the Office of Public Prosecutions (OPP) to prosecute offenders and support victims and witnesses. Funding is also provided to assist the OPP to adopt a modern electronic document and records management system and upgrade its audio-visual systems, which will increase the OPP's productivity and streamline evidence production, reducing court delays.

This initiative contributes to Department of Justice and Community Safety's Public Prosecutions and Legal Assistance output.

Expanding the Assessment and Referral Court

Refer to Court Services Victoria for a description of this initiative.

Helping Courts respond to the impacts of the pandemic

Funding is provided to increase the justice system's capacity to reduce court delays caused by COVID-19 public health restrictions, build a stronger and more accessible justice system and improve the safety of family violence victims. The funding will:

- continue the Magistrates' Court Pre-Court Engagement service, which assists clients to resolve their family violence-related matters prior to a court hearing
- pilot a specialist OPP County Court Team, which will work exclusively on cases in the County Court's trial division to facilitate early resolution of matters and help reduce the County Court's backlog of jury trials
- continue the VLA Help Before Court program so that more people charged with summary crime offences can resolve their matter at their first hearing, relieving pressure on the court system.

This initiative contributes to the Department of Justice and Community Safety's:

- Policing and Community Safety output
- Public Prosecutions and Legal Assistance output.

Justice system costs associated with the extension of court programs

Funding is provided for additional resources across the justice system to ensure justice agencies have sufficient capacity to meet increased demands associated with matters moving through the courts, and to ensure the benefits of additional investments in Victoria's court network are fully realised.

This initiative contributes to the Department of Justice and Community Safety's:

- Public Prosecutions and Legal Assistance output
- Prisoner Supervision and Support output
- Policing and Community Safety output.

This initiative contributes to the Department of Families, Fairness and Housing's Child Protection and Family Services output.

Legal assistance

Funding is provided to support Victoria Legal Aid (VLA) to deliver legal services, including duty lawyers and grants of legal aid, helping to address court delays caused by COVID-19 public health restrictions.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to Department of Justice and Community Safety's Public Prosecutions and Legal Assistance output.

Supporting community legal centres

Funding is provided to community legal centres to ensure that they continue to provide legal services and improve access to justice for Victorians who need support.

Funding for this initiative forms part of the Early Intervention Investment Framework.

Funding is also provided to continue the Office of the Public Advocate's Independent Third Person Program.

This initiative contributes to Department of Justice and Community Safety's Public Prosecutions and Legal Assistance output.

Public Sector Information Management, Privacy and Integrity

Supporting the Office of the Victorian Information Commissioner

Funding is provided to support the Office of the Victorian Information Commissioner in carrying out its legislative functions.

This initiative contributes to Department of Justice and Community Safety's Public Sector Information Management, Privacy and Integrity output.

Regulation of the Victorian Consumer Marketplace

Contact service harmonisation and digital uplift

Funding is provided to harmonise processes across multiple consumer contact services to reduce call wait times and ensure Victorians can contact the services they need when they need them.

This initiative contributes to Department of Justice and Community Safety's Regulation of the Victorian Consumer Marketplace output.

Youth Justice Community Based Services

Diverting children from youth justice

Funding is provided for key initiatives to divert children from the youth justice system, including expansion of the central after-hours assessment and bail service, an after-hours Children's Court service, and additional Aboriginal youth justice hubs.

This initiative contributes to the Department of Justice and Community Safety's Youth Justice Community Based Services output.

Youth Justice Custodial Services

Improving Custodial Services for Youth Justice

Funding is provided for opening the Cherry Creek Youth Justice facility, behaviour support specialists, remand beds, and safe and stable workforce initiatives.

This initiative contributes to the Department of Justice and Community Safety's Youth Justice Custodial Services output.

Asset initiatives

Table 1.15: Asset initiatives – Department of Justice and Community Safety ($ million)

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*	*TEI*
Emergency Management Capability						
Emergency response capability uplift	..	5.0	2.0	2.0	..	9.0
Our future Victoria marine search and rescue service	..	1.4	..	..	..	1.4
Upskilling and protecting our firefighters	..	2.2	..	..	..	2.2
VICSES facilities and fleet maintenance and volunteer health and safety	..	5.8	3.1	..	..	8.9
Policing and Community Safety						
Critical police infrastructure	..	1.7	10.5	32.0	2.8	46.9
Equipping frontline police officers with conducted energy devices	..	20.1	12.9	12.9	..	45.9
Increasing policing capacity to meet current and future demand	..	3.9	4.0	..	..	7.9
Prisoner Supervision and Support						
Reducing future justice demand and keeping the community safe	..	1.2	0.4	..	..	1.5
Public Prosecutions and Legal Assistance						
Delivery of prosecution services	..	3.8	1.8	0.5	0.6	6.7
Public Sector Information Management, Privacy and Integrity						
Supporting the Office of the Victorian Information Commissioner	..	0.2	..	..	..	0.2
Youth Justice Community Based Services						
Diverting children from youth justice	..	0.1	..	..	..	0.1
Total asset initiatives [(a)]	**..**	**45.2**	**34.7**	**47.5**	**3.3**	**130.7**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Emergency Management Capability

Emergency response capability uplift

Funding is provided for improvements to CFA stations and Victorian Emergency Management Training Centres that support increased gender diversity, including new changing facilities. Funding is also provided for the assessment and management of environment legacy issues.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Our future Victoria marine search and rescue service

Funding is provided to support marine search and rescue units service delivery including the purchase of digital radios and access to the Victorian Radio Network to ensure interoperability with other emergency services and essential fleet maintenance.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Upskilling and protecting our firefighters

Refer to the output initiative for a description of this initiative.

VICSES facilities and fleet maintenance and volunteer health and safety

Funding is provided to undertake condition assessments of VICSES facilities and priority maintenance and to replace vehicles including rescue trucks. Funding is also provided to support volunteers dealing with complex people and behaviours.

This initiative contributes to the Department of Justice and Community Safety's Emergency Management Capability output.

Policing and Community Safety

Critical police infrastructure

Funding is provided to build a replacement fit-for-purpose 24-hour South Melbourne police station and to build a new police station in Point Cook to serve the growing local community.

This initiative contributes to the Department of Justice and Community Safety's Policing and Community Safety output.

Equipping frontline police officers with conducted energy devices

Refer to the output initiative for a description of this initiative.

Increasing policing capacity to meet current and future demand

Refer to the output initiative for a description of this initiative.

Prisoner Supervision and Support

Reducing future justice demand and keeping the community safe

Refer to the output initiative for a description of this initiative.

Public Prosecutions and Legal Assistance

Delivery of prosecution services

Refer to the output initiative for a description of this initiative.

Public Sector Information Management, Privacy and Integrity

Supporting the Office of the Victorian Information Commissioner

Refer to the output initiative for a description of this initiative.

Youth Justice Community Based Services

Diverting children from youth justice

Refer to the output initiative for a description of this initiative.

DEPARTMENT OF PREMIER AND CABINET

Output initiatives

Table 1.16: Output initiatives – Department of Premier and Cabinet ($ million)

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*
Digital Strategy and Transformation					
Data integration to support the Government's Early Intervention Investment Framework	..	0.6	..	..	..
Service Victoria – enhancing customer experience with more digital services for Victorians	..	63.2	23.3	..	..
Whole of Government Data – meeting the demand for data and insights	..	4.4	..	..	..
Working with Children Check and National Disability Insurance Scheme worker screening	..	0.2	..	..	..
Executive Government Advice and Support					
Effective public sector management of COVID-19 communications	..	3.9	..	..	..
Industrial Relations					
Better supports for on-demand workers in Victoria	..	5.6	..	..	..
Construction industry safety training	..	2.0	..	..	..
Wage Inspectorate Victoria – Compliance and enforcement of wage theft laws	..	6.0	..	..	..
Workplace Gender Pay Equity initiatives	..	0.9	0.1	..	..
Public Sector Administration Advice and Support					
Supporting public sector diversity, capability, and integrity	..	11.3	..	..	..
Social Policy and Intergovernmental Relations					
Floods victims in QLD and NSW – Red Cross donation	2.0	..	..	..	..
Total output initiatives [(a)]	**2.0**	**98.1**	**23.4**	**..**	**..**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Digital Strategy and Transformation

Data integration to support the Government's Early Intervention Investment Framework

Funding is provided to support the Government's Early Intervention Investment Framework through increased data integration capability and governance for the Victorian Social Investment Integrated Data Resource (VSIIDR). This will help to ensure that benefits from early interventions are accurately measured.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to the Department of Premier and Cabinet's Digital Strategy and Transformation output.

Service Victoria – enhancing customer experience with more digital services for Victorians

Funding is provided to continue Service Victoria's operations and improve public access to services by creating new channels for simple and fast interactions with government.

This initiative contributes to the Department of Premier and Cabinet's Digital Strategy and Transformation output.

Whole of Government Data – meeting the demand for data and insights

Funding is provided to continue the Insights Victoria platform, supporting monitoring and reporting of public health and mobility trends, and use of cross-portfolio data and analytics to track the rollout and progress of key economic recovery initiatives.

This initiative contributes to the Department of Premier and Cabinet's Digital Strategy and Transformation output.

Working with Children Check and National Disability Insurance Scheme worker screening

Refer to the Department of Justice and Community Safety for a description of this initiative.

Executive Government Advice and Support

Effective public sector management of COVID-19 communications

Funding is provided to support effective public sector management of COVID-19 communications across the public sector to ensure Victorians get the health information they need to keep them and their loved ones safe.

This initiative contributes to the Department of Premier and Cabinet's Executive Government Advice and Support output.

Industrial Relations

Better supports for on-demand workers in Victoria

Funding is provided to continue the implementation of the Government's response to the Inquiry into the Victorian On-Demand Workforce. This includes provision of support services for on-demand workers including advice in relation to their entitlements and work status and administration of the Fair Conduct and Accountability Standards.

This initiative contributes to the Department of Premier and Cabinet's Industrial Relations output.

Construction industry safety training

Funding is provided to provide grants to employer and employee organisations to support occupational health and safety and other training in the construction industry.

This initiative contributes to the Department of Premier and Cabinet's Industrial Relations output.

Wage Inspectorate Victoria – Compliance and enforcement of wage theft laws

Funding is provided to continue the operations of Wage Inspectorate Victoria, as legislated under the *Wage Theft Act 2020*. The Authority's wage theft compliance, enforcement and education activities will continue to assist in protecting workers from exploitation and to recover employees' lawful workplace entitlements.

This initiative contributes to the Department of Premier and Cabinet's Industrial Relations output.

Workplace Gender Pay Equity initiatives

Funding is provided to promote gender pay equity workplace initiatives and the functions of the Equal Workplaces Advisory Council, and to undertake relevant research. The focus will be on gender pay equity in all Victorian workplaces through advice on issues relating to pay equity, equality and productivity.

This initiative contributes to the Department of Premier and Cabinet's Industrial Relations output.

Public Sector Administration Advice and Support

Supporting public sector diversity, capability, and integrity

Funding is provided to support the operations of the Victorian Public Service Commission to ensure a highly effective public service that continues to deliver the Government's priorities and high-quality services to the community.

This initiative contributes to the Department of Premier and Cabinet's Public Sector Administration Advice and Support output.

Social Policy and Intergovernmental Relations

Floods victims in QLD and NSW – Red Cross donation

A donation was provided to the Red Cross Flood Appeal for volunteers and staff to help with evacuation and relief centres, and deliver vital humanitarian support to the people and communities affected by the recent floods in New South Wales and Queensland. This will complement assistance being provided to affected individuals, communities and businesses by Natural Disaster Relief and Recovery Arrangements.

This initiative contributes to the Department of Premier and Cabinet's Social Policy and Intergovernmental Relations output.

Asset initiatives

Table 1.17: Asset initiatives – Department of Premier and Cabinet ($ million)

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*	*TEI*
Digital Strategy and Transformation						
Service Victoria – enhancing customer experience with more digital services for Victorians	..	5.2	8.1	..	..	13.3
Total asset initiatives	**..**	**5.2**	**8.1**	**..**	**..**	**13.3**

Source: Department of Treasury and Finance

Digital Strategy and Transformation

Service Victoria – enhancing customer experience with more digital services for Victorians

Refer to the output initiative for a description of this initiative.

DEPARTMENT OF TRANSPORT

Output initiatives

Table 1.18: Output initiatives – Department of Transport ($ million)

	2021-22	2022-23	2023-24	2024-25	2025-26
COVID-19 impacts on the transport network	650.9	215.4	..	..	..
Switching on the Big Build	169.2	191.5	5.0	7.4	7.7
Bus Services					
Delivering Victoria's Bus Plan	..	11.6	20.7	23.2	24.0
Ports and Freight					
Local ports critical maintenance works	..	..	1.5	..	..
Mode Shift Incentive Scheme	..	3.5	..	..	..
Ports Victoria start-up	..	2.2	1.3	..	..
Road Asset Management					
Maintaining Victoria's road network	..	103.5	..	..	..
West Gate Bridge maintenance	..	1.9	1.8	..	..
Road Operations					
Active transport	0.5	5.5	0.8	0.1	..
Delivering the Road Safety Action Plan [(a)(b)]	6.8	9.6	1.2	..	..
Metropolitan road upgrades	..	9.4	9.5	4.9	1.1
Mickleham Road Upgrade – Stage 1	..	2.5	4.0	..	..
Regional road upgrades	..	7.5	0.2	0.1	1.8
Smarter roads – Phase 2	..	1.1	1.1	..	..
Train Services					
Bairnsdale train stabling upgrades	..	..	..	0.2	0.2
Capacity improvements to Melton and Ballarat	..	23.8	..	..	..
Caulfield Station Interchange Project – planning	..	2.0	..	..	..
Comeng train disposal program	..	8.6	12.0	3.3	..
Flemington Racecourse train stabling upgrades	..	..	0.2	0.3	0.3
Personal safety on the transport network	..	..	0.1	0.1	0.1
Pre-paid public transport tickets for school students in crisis	..	0.3	0.3	0.3	..
Regional rail sustainability	2.0	29.7	6.9	2.2	2.2
Regional rolling stock service improvements	..	..	23.5	27.6	19.3
Support for veteran transition and wellbeing	..	0.3	0.3	..	..
Train radio system upgrade	..	13.4	13.6	..	..
Tram Services					
Delivering the Tram Plan	..	4.0	2.3	0.3	0.6
Transport Infrastructure					
Detailed Northern Corridor Transport and Land Use Plan	..	0.3	1.3	1.3	..
Train station accessibility and amenity	..	7.6	..	0.3	0.4
Western Interstate Freight Terminal	..	6.1	..	..	..
Total output initiatives [(c)]	**829.4**	**661.1**	**107.5**	**71.7**	**57.8**

Source: Department of Treasury and Finance

Notes:

(a) This initiative includes funding from the Transport Accident Commission.

(b) This initiative includes Commonwealth Government funding of $12.4 million.

(c) Table may not add due to rounding.

COVID-19 impacts on the transport network

Funding is provided to address the impacts of the COVID-19 pandemic on the transport network. This includes offsetting the impact of lower revenue for public transport operators to continue service delivery, additional cleaning to support public health and ensure that users are safe using public transport, and compliance and monitoring of the commercial passenger vehicle industry.

This initiative contributes to the Department of Transport's:

- Bus Services – Statewide output
- Regulation of Commercial Passenger Vehicle Services output
- Train Services – Metropolitan output
- Train Services – Regional output
- Train Services – Statewide output
- Tram Services output.

Switching on the Big Build

Funding is provided for additional services and to operate new transport infrastructure that is being delivered as part of the Big Build.

Train timetable service upgrades are being introduced across both regional and metropolitan rail networks following the completion of major projects including the Cranbourne Line Upgrade, Waurn Ponds Station upgrade, Wyndham Vale corridor upgrades, and the Pakenham level crossing removals. An additional Maryborough shuttle service will also be introduced.

Preparation activities for day one operations of the Metro Tunnel will be progressed, including recruitment and training of train drivers and other critical staff, maintenance of new assets and the development of wayfinding and customer information.

Funding is also provided to operate and maintain new assets across the transport network including level crossing removals, rail extensions, train station upgrades and road upgrades.

This initiative contributes to the Department of Transport's:

- Bus Services – Statewide output
- Ports and Freight output
- Road Asset Management output
- Train Services – Metropolitan output
- Train Services – Regional output
- Train Services – Statewide output
- Tram Services output
- Transport Infrastructure output.

Bus Services

Delivering Victoria's Bus Plan

Funding is provided to deliver bus service improvements and accessibility upgrades that align with Victoria's Bus Plan including:

- service changes and operating funding for the Bulleen Park and Ride which will open in 2022 as part of the North East Link Busway
- a first phase roll-out of wheelchair restraint systems on metropolitan buses
- accessibility and amenity upgrades at 80 bus stops
- network changes to deliver Flexiride services in Greensborough and St Helena
- network changes in Heatherton to complement Suburban Rail Loop works
- improvements to bus routes connecting Kilmore residents to the town centre
- improvements and service uplifts to Gisborne town bus services
- service uplifts for bus routes between Torquay and Armstrong Creek to Geelong
- a high frequency weekday shuttle bus between the Donnybrook and Craigieburn Stations as well as upgrades to the Craigieburn Station Bus Interchange
- new services for communities in Sunbury and Diggers Rest
- expansion of bus routes in Cranbourne West and Narre Warren
- improvements to bus routes and services between Box Hill, Oakleigh and Southland
- new and uplifted school services across Victoria targeted towards growth areas
- development funding for the Footscray Station Bus Interchange.

This initiative contributes to the Department of Transport's:

- Bus Services – Metropolitan output
- Bus Services – Regional output
- Bus Services – Statewide output.

Ports and Freight

Local ports critical maintenance works

Refer to the asset initiative for a description of this initiative.

Mode Shift Incentive Scheme

The Mode Shift Incentive Scheme will be maintained in 2022-23 to encourage the transfer of freight from road to rail.

This initiative contributes to the Department of Transport's Ports and Freight output.

Ports Victoria start-up

Funding is provided to expand Ports Victoria's role in port sector planning, governance and maritime operation and safety management, supporting delivery of the Government's response to the Independent Review of the Victorian Ports System.

This initiative contributes to the Department of Transport's Ports and Freight output.

Road Asset Management

Maintaining Victoria's road network

Refer to the asset initiative for a description of this initiative.

West Gate Bridge maintenance

Refer to the asset initiative for a description of this initiative.

Road Operations

Active transport

Refer to the asset initiative for a description of this initiative.

Delivering the Road Safety Action Plan

Refer to the asset initiative for a description of this initiative.

Metropolitan road upgrades

Refer to the asset initiative for a description of this initiative.

Mickleham Road Upgrade – Stage 1

Refer to the asset initiative for a description of this initiative.

Regional road upgrades

Refer to the asset initiative for a description of this initiative.

Smarter roads – Phase 2

Refer to the asset initiative for a description of this initiative.

Train Services

Bairnsdale train stabling upgrades

Refer to the asset initiative for a description of this initiative.

Capacity improvements to Melton and Ballarat

Funding is provided to undertake detailed works on infrastructure and service solutions to increase current rail network capacity on the Melton and Ballarat corridor.

This initiative contributes to the Department of Transport's:

- Train Services – Metropolitan output
- Train Services – Regional output.

Caulfield Station Interchange Project – planning

Additional funding is provided to plan for future upgrades at Caulfield Station to improve customer amenity and passenger flows, with Caulfield Station to become a key interchange point following completion of the Metro Tunnel.

This initiative contributes to the Department of Transport's:

- Train Services – Metropolitan output
- Transport Infrastructure output.

Comeng train disposal program

Funding is provided to continue the disposal of decommissioned Comeng trains, which will free up stabling capacity on the metropolitan network.

This initiative contributes to the Department of Transport's Train Services – Metropolitan output.

Flemington Racecourse train stabling upgrades

Refer to the asset initiative for a description of this initiative.

Personal safety on the transport network

Refer to the asset initiative for a description of this initiative.

Pre-paid public transport tickets for school students in crisis

Students in crisis will be provided with free public transport travel passes. The 30-day travel passes will be provided to students experiencing crisis such as family violence or sudden financial hardship to ensure they can continue to travel to school and support services.

Funding for this initiative forms part of the Early Intervention Investment Framework.

This initiative contributes to the Department of Transport's:

- Train Services – Statewide output
- Tram Services output.

Regional rail sustainability

Refer to the asset initiative for a description of this initiative.

Regional rolling stock service improvements

Funding is provided to increase maintenance capacity to support the growing regional train fleet and improve reliability and punctuality of regional passenger rail services.

This initiative contributes to the Department of Transport's Train Services – Regional output.

Support for veteran transition and wellbeing

Refer to the Department of Families, Fairness and Housing initiative for a description of this initiative.

Train radio system upgrade

Refer to the asset initiative for a description of this initiative.

Tram Services

Delivering the Tram Plan

Refer to the asset initiative for a description of this initiative.

Transport Infrastructure

Detailed Northern Corridor Transport and Land Use Plan

Funding is provided for development of a Northern Corridor Transport and Land Use Plan to support integrated land use and transport planning for the northern metropolitan Melbourne growth area.

This initiative contributes to the Department of Transport's Transport Infrastructure output.

Train station accessibility and amenity

Refer to the asset initiative for a description of this initiative.

Western Interstate Freight Terminal

Funding is provided to progress planning and development activities for the Western Interstate Freight Terminal and its associated rail connection to the interstate rail freight network via the Outer Metropolitan Ring Southern corridor.

This initiative contributes to the Department of Transport's Transport Infrastructure output.

Asset initiatives

Table 1.19: Asset initiatives – Department of Transport **($ million)**

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*	*TEI*
Switching on the Big Build	..	2.3	..	..	..	2.3
Bus Services						
Delivering Victoria's Bus Plan	..	13.5	15.5	..	..	29.0
Ports and Freight						
Local ports critical maintenance works	..	9.2	2.0	5.7	..	16.9
Road Asset Management						
Maintaining Victoria's road network	..	119.4	..	..	..	119.4
West Gate Bridge maintenance	..	24.0	..	..	..	24.0
Road Operations						
Active transport	..	8.9	6.0	..	..	14.9
Delivering the Road Safety Action Plan [(a)(b)]	29.3	187.9	26.5	1.8	..	245.6
Metropolitan road upgrades [(c)]	..	6.6	32.6	55.8	5.8	100.8
Mickleham Road Upgrade – Stage 1 [(d)]	..	40.7	90.1	64.3	11.8	206.8
Regional road upgrades [(e)]	..	13.2	54.3	23.8	..	91.4
Smarter roads – Phase 2	..	3.6	8.9	..	..	12.5
Train Services						
Bairnsdale train stabling upgrades	..	7.2	23.7	..	..	30.9
Flemington Racecourse train stabling upgrades	..	18.7	23.9	16.2	..	58.8
More VLocity trains [(f)]	..	122.1	36.0	50.1	29.9	250.0
Personal safety on the transport network	..	3.4	8.0	..	..	11.4
Public Transport Ticketing Asset Renewal [(g)]	..	tbc	tbc	tbc	tbc	tbc
Regional rail sustainability	0.8	74.1	109.1	16.9	3.7	204.6
Train radio system upgrade [(f)]	..	95.0	30.0	12.0	10.0	173.0
Tram Services						
Critical tram works	..	9.8	4.0	1.3	..	15.1
Delivering the Tram Plan	..	7.4	21.6	52.1	..	81.1
Transport Infrastructure						
Arden Precinct redevelopment [(h)]	..	tbc	tbc	tbc	tbc	tbc
Train station accessibility and amenity	..	13.8	35.4	0.3	..	49.5
Total asset initiatives [(i)]	**30.2**	**780.7**	**527.6**	**300.4**	**61.2**	**1737.9**

Source: Department of Treasury and Finance

Notes:

(a) This initiative includes funding from the Transport Accident Commission.

(b) This initiative includes Commonwealth Government funding of $142.5 million.

(c) This initiative includes funding from local council.

(d) This initiative excludes funding of $14.851 million announced in the 2021-22 Budget*. This initiative includes Commonwealth Government funding of $109.540 million.*

(e) This initiative includes Commonwealth Government funding of $39.802 million to be accessed from the Roads of Strategic Importance program and the Princes Highway program.

(f) The TEI includes funding beyond 2025-26.

(g) The funding for this initiative is not disclosed at this time due to the commercial sensitivity of the procurement process.

(h) The TEI is not disclosed to ensure negotiations with affected landholders are not prejudiced.

(i) Table may not add due to rounding. Totals exclude estimated expenditure for initiatives with a 'tbc'.

Switching on the Big Build

Refer to the output initiative for a description of this initiative.

Bus Services

Delivering Victoria's Bus Plan

Refer to the output initiative for a description of this initiative.

Ports and Freight

Local ports critical maintenance works

Funding is provided to undertake critical works on Hampton Jetty, Rye Pier, Mornington Fishermans Jetty, Old Flinders Jetty, Lakes Entrance Fishing Cooperative Ltd South Jetty, Raymond Island Public Jetty and McLoughlins Beach Jetty, and install fenders at Gem Pier. Planned asset maintenance will be undertaken on marine assets, including piers, jetties, breakwaters, seawalls and navigation aids. This work will improve user safety and accessibility at these facilities, while supporting local businesses and employment.

This initiative contributes to the Department of Transport's Ports and Freight output.

Road Asset Management

Maintaining Victoria's road network

Funding is provided to undertake road pavement works across metropolitan Melbourne and regional Victoria. This will include routine maintenance, road resurfacing and rehabilitation, bridge strengthening and replacement works, and asset data collection.

These works will improve road safety and help maximise the productivity of the Victorian road network.

This initiative contributes to the Department of Transport's:

- Road Asset Management output
- Road Network Performance output.

West Gate Bridge maintenance

Funding is provided to deliver a program of maintenance work and upgrades to improve user safety and accessibility, while supporting Victoria's economic growth, freight movement and employment.

This initiative contributes to the Department of Transport's Road Asset Management output.

Road Operations

Active transport

Funding is provided for a package of priority projects to improve connections and safety on Victoria's walking and cycling network, including:

- development of upgraded cycling facilities along the Capital City Trail and Merri Creek Trail Strategic Cycling Corridor
- cycling infrastructure on the Bendigo City Centre Strategic Cycling Corridor
- bicycle parking facilities at train stations
- delivery and construction of a new shared use path between Greensborough and Montmorency
- pedestrian infrastructure development at Elgar Road, Mont Albert; Gaffney Street, Pascoe Vale; Howard Street, Epsom and East Boundary Road, Bentleigh East.

This initiative contributes to the Department of Transport's Road Network Performance output.

Delivering the Road Safety Action Plan

Funding is provided for construction of projects under tranches four and five of the Commonwealth Road Safety Program, including Commonwealth contributions to tranches two and three. Funding is also provided for implementation of a project to reform heavy vehicle licensing and improve driver safety, and continuation of the School Crossing Supervisor Program.

Funding supports the continued delivery of *Victoria's 2021-2030 Road Safety Strategy* and the first three-year Road Safety Action Plan.

This initiative contributes to the Department of Transport's Road Safety output.

Metropolitan road upgrades

Funding is provided to upgrade key roads and intersections in metropolitan Melbourne in order to improve network efficiency, travel times and road safety. Projects will be developed and delivered across Melbourne, including:

- Ryan Road, Pakenham East, sealing works
- Canterbury Road, Waterloo Street to Sunset Drive, Heathmont, safety improvements
- South Gippsland Highway and Clyde-Five Ways Road, Clyde, intersection signalisation
- Derrimut-Hopkins Road and Boundary Road, Tarneit, intersection signalisation
- Melton Highway, Plumpton, infill duplication
- McIntyre Road and Phoenix Street, Sunshine North, signals upgrade
- Burwood Highway and McMahons Road, Ferntree Gully, intersection signalisation.

This initiative contributes to the Department of Transport's:

- Road Network Performance output
- Road Safety output.

Mickleham Road Upgrade – Stage 1

Funding is provided to upgrade Mickleham Road between Somerton Road and Dellamore Boulevard, including intersection upgrades, bus priority infrastructure and a shared user path.

Funding is also provided for the development of a business case for Mickleham Road Upgrade Stage 2 between Dellamore Boulevard and Craigieburn Road.

This initiative is supported by co-funding from the Commonwealth Government.

This initiative contributes to the Department of Transport's:

- Road network performance output
- Transport Infrastructure output.

Regional road upgrades

Funding is provided for a number of upgrades on regional roads in order to improve network efficiency and road safety, and to develop high priority projects for future consideration. Projects will be developed and delivered across regional Victoria, including:

- Bellarine Highway at Moolap Station Road, Moolap, intersection improvements
- Bass Highway, Kilcunda, infrastructure improvements
- Strzelecki Highway, between Morwell and Mirboo North, overtaking lane
- Melrose Drive Hume Freeway overpass, West Wodonga, pedestrian safety barriers
- Six Ways, Lara, intersection upgrade
- Barwon Heads, Black Rock and Staceys roads intersection, Connewarre, roundabout construction
- Goulburn Valley Highway and Graham Street, Shepparton, intersection improvements
- Princes Highway at Lookout Road, Kalimna, intersection improvements
- Princes Highway and Bairnsdale-Dargo Road, Bairnsdale, intersection improvements
- Bridgewater Road and Portland Ring Road, Portland, intersection upgrade
- Princes Highway West at Timboon-Colac Road, roundabout construction
- Midland Highway and Howard Street, Epsom, intersection upgrade development
- High Street and Urquhart Street, Woodend, intersection and access development
- Ballarat-Carngham Road from Dyson Drive to Wiltshire Lane, Ballarat, duplication development.

This initiative contributes to the Department of Transport's:

- Road Network Performance output
- Road Safety output.

Smarter roads – Phase 2

Funding is provided to build upon Phase 1 of the smarter roads program and improve transport outcomes for freight, on-road public transport, general traffic, pedestrians, and cyclists.

This initiative contributes to the Department of Transport's:

- Road Network Performance output
- Road Safety output.

Train Services

Bairnsdale train stabling upgrades

Funding is provided to facilitate stabling of VLocity trains at Bairnsdale station to enable the full service of VLocity trains on the Gippsland Line, which will improve reliability, accessibility, and passenger experience.

This initiative contributes to the Department of Transport's Train Services – Regional output.

Flemington Racecourse train stabling upgrades

Funding is provided to increase stabling capacity at Flemington Racecourse to support the operational reliability and efficiency of the metropolitan rail network.

This initiative contributes to the Department of Transport's Train Services – Metropolitan output.

More VLocity trains

Twelve new VLocity trains will be built in Victoria to support planned service improvements on the Shepparton and Warrnambool lines.

The new trains will be manufactured in Victoria, supporting a significant number of local manufacturing and supply chain jobs. These new trains will continue the replacement of the classic fleet and improve reliability, accessibility, and passenger experience on the regional network.

This initiative will contribute to the Department of Transport's Train Services – Regional output.

Personal safety on the transport network

Funding is provided to install suicide prevention fencing in key locations on the metropolitan train network and install help seeking signage across the network.

This initiative will contribute to the Department of Transport's Train Services – Metropolitan output.

Public Transport Ticketing Asset Renewal

Funding is provided to renew ticketing assets at the end of useful life across the public transport network to ensure service continuity.

This contributes to the Department of Transport's:

- Train Services output
- Tram Services output
- Bus Services output.

Regional rail sustainability

A package of organisational improvement projects will be delivered to support the reliability and efficiency of V/Line operations. This includes upgrades to the V/Line rostering system, staff facilities, information management, compliance and asset management systems.

Funding is also provided to deliver major periodic maintenance and routine maintenance works on freight rail corridors across Victoria to ensure safety standards are maintained and to support the sustainability of rail freight in regional Victoria.

This initiative contributes to the Department of Transport's Train Services – Regional output.

Train radio system upgrade

Funding is provided to replace ageing equipment to maintain the availability of the digital train radio system, which is critical to operate the metropolitan train network.

This initiative contributes to the Department of Transport's Train Services – Metropolitan output.

Tram Services

Critical tram works

Funding is provided for structural repairs and to maintain CCTV services on trams to continue safe and reliable operations on the network.

This initiative contributes to the Department of Transport's Tram Services output.

Delivering the Tram Plan

Funding is provided to deliver a package of critical tram infrastructure works to improve safety, prepare for the Metro Tunnel opening and Next Generation Trams, and support the State to comply with Commonwealth Disability Standards for Accessible Public Transport (DSAPT). The package includes:

- seven DSAPT-compliant tram stops along La Trobe Street and at Park Street, South Melbourne to provide safe and accessible connections to the Metro Tunnel
- an enhanced track renewal at Melbourne University terminus to futureproof for Next Generation Trams
- various critical safety works and new driver toilet facilities to provide safe infrastructure and facilities for the community, maintenance staff and tram drivers
- development of further corridors of tram stop upgrades to support the State to progressively meet DSAPT requirements and ensure Victorians with accessibility needs can use the network.

This initiative contributes to the Department of Transport's Tram Services output.

Transport Infrastructure

Arden Precinct redevelopment

Funding is provided to acquire sites within the Arden Precinct to enable future development in accordance with the Arden Structure Plan. Funding is also provided for working capital to progress critical precinct planning activities for future enabling works.

This initiative contributes to the Department of Transport's Transport Infrastructure output.

Train station accessibility and amenity

Funding is provided for a package of works to deliver accessibility and amenity improvements across the metropolitan and regional railway network including:

- improvements at priority train stations to address DSAPT compliance, and improve safety and amenity including Glen Waverley, Jacana, Lalor, Merri, Thornbury, Victoria Park, Warrnambool, and Woodend
- delivery of platform modifications to improve accessibility of stations along the Dandenong corridor
- development and design of future safety accessibility and amenity improvements across the rail network.

This initiative contributes to the Department of Transport's:

- Transport Infrastructure output
- Transport Safety and Security output.

DEPARTMENT OF TREASURY AND FINANCE

Output initiatives

Table 1.20: Output initiatives – Department of Treasury and Finance ($ million)

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*
Budget and Financial Advice					
Embedding gender responsive budgeting in Victoria's legislation	..	1.1	..	..	..
Commercial and Infrastructure Advice					
Office of Projects Victoria	..	2.5	..	..	..
Economic and Policy Advice					
Business Acceleration Fund	..	10.0	..	..	..
Unlocking the potential of loans and guarantees to support more housing	..	1.3	1.0	..	..
Economic Regulatory Services					
Supporting better customer protections in essential services	..	3.9	..	..	..
Invest Victoria					
Supporting Victorian Manufacturing – Equity investment attraction	..	0.5	0.4	0.4	0.5
Supporting Victorian Manufacturing – International investment attraction	..	20.0	20.0	..	..
Victorian Government Trade and Investment Network resourcing	..	2.5	2.5	..	..
Services to Government					
Centralised fleet management – accelerating transition to Zero Emissions Vehicles	..	0.6	..	..	..
Improving governance of State Purchase Contracts	..	1.0	..	..	..
Language services procurement	..	0.3	..	..	..
Total output initiatives [(a)]	**..**	**43.7**	**24.0**	**0.4**	**0.5**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Budget and Financial Advice

Embedding gender responsive budgeting in Victoria's legislation

Funding is provided to embed gender responsive budgeting in Victoria through legislative reform to secure the practice across public sector entities.

This initiative contributes to the Department of Treasury and Finance's Budget and Financial Advice output.

Commercial and Infrastructure Advice

Office of Projects Victoria

Funding is provided to continue the enhanced role of the Office of Projects Victoria in providing independent advice and technical assurance to government and delivery agencies on social and economic infrastructure.

This initiative contributes to the Department of Treasury and Finance's Commercial and Infrastructure Advice output.

Economic and Policy Advice

Business Acceleration Fund

Funding is provided to extend the Regulatory Reform Incentive Fund, to be renamed the Business Acceleration Fund (BAF), to continue to support projects that modernise and streamline regulatory processes across the State's regulators and local councils. This includes replacing cumbersome paper-based processes, reducing duplicate requests for information and with a particular focus on helping to lower the overall regulatory burden for businesses.

This initiative contributes to the Department of Treasury and Finance's Economic and Policy Advice output.

Unlocking the potential of loans and guarantees to support more housing

Up to a further $1 billion will be made available in low interest loans and government guarantees to community housing agencies to deliver social and affordable housing. This will facilitate up to 6 000 new social and affordable housing dwellings, providing accommodation for some of the most vulnerable Victorians as well as key workers.

This initiative contributes to the Department of Treasury and Finance's Economic and Policy Advice output.

Economic Regulatory Services

Supporting better customer protections in essential services

Funding is provided to the Essential Services Commission (ESC) to improve protections for Victorian residential customers in dealing with businesses participating in the Victorian Energy Upgrades (VEU) program and to support the ESC's economic regulatory oversight of the Port of Melbourne, including ensuring compliance with the Port of Melbourne's newly created port customer charter.

This initiative contributes to the Department of Treasury and Finance's Economic Regulatory Services output.

Invest Victoria

Supporting Victorian Manufacturing – Equity investment attraction

Funding is provided to establish a $20 million equity investment pilot fund to attract Victorian, interstate and international companies that align with Victoria's priority strengths, bolstering the State's start-up ecosystem and supporting sovereign manufacturing capabilities.

This initiative contributes to the Department of Treasury and Finance's Invest Victoria output.

Supporting Victorian Manufacturing – International investment attraction

Funding is provided for targeted financial incentives to attract business investment in Victoria, in line with the Government's *International Investment Strategy*. This aims to attract strategic investments that will enhance the future prosperity of the Victorian economy including through supporting domestic supply chain capability.

This initiative contributes to the Department of Treasury and Finance's Invest Victoria output.

Victorian Government Trade and Investment Network resourcing

Funding is provided to support the continued operations of the Victorian Government Trade and Investment Network in strategic markets to stimulate foreign direct investment flows and talent attraction in key sectors of the Victorian economy.

This initiative contributes to the Department of Treasury and Finance's Invest Victoria output.

Services to Government

Centralised fleet management – accelerating transition to Zero Emissions Vehicles

Funding is provided to commence the transition to a centralised fleet management model, improving fleet utilisation and efficiency to support the ongoing uptake in the government fleet of zero emission vehicles.

This initiative contributes to the Department of Treasury and Finance's Services to Government output.

Improving governance of State Purchase Contracts

Funding is provided to begin a reform program to ensure effective oversight and assurance of the rapid growth in transactions through State Purchase Contracts (SPCs). The expanded use of SPCs, and improvements to SPC governance and oversight will deliver the value for money benefits that are expected to flow from greater utilisation of SPCs across government.

This initiative contributes to the Department of Treasury and Finance's Services to Government output.

Language services procurement

Funding is provided to support the establishment of a State Purchasing Contract (SPC) for language services to improve CALD communities' access to government services.

This initiative contributes to the Department of Treasury and Finance's Services to Government output.

Asset initiatives

Table 1.21: Asset initiatives – Department of Treasury and Finance ($ million)

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*	*TEI*
Economic Regulatory Services						
Supporting better customer protections in essential services	..	4.1	..	..	..	4.1
Total asset initiatives	**..**	**4.1**	**..**	**..**	**..**	**4.1**

Source: Department of Treasury and Finance

Economic Regulatory Services

Supporting better customer protections in essential services

Refer to the output initiative for a description of this initiative.

PARLIAMENT

Output initiatives

Table 1.22: Output initiatives – Parliament **($ million)**

	2021-22	2022-23	2023-24	2024-25	2025-26
Independent Broad-based Anti-corruption Commission					
IBAC: Increase to base operational funding	..	7.0	7.9	8.6	8.6
Parliamentary Services					
Administration of VIRTIPS Act	0.8	3.1	2.3	2.3	2.4
Protective security upgrades and service enhancements	..	1.9	1.7	1.8	1.8
Victorian Inspectorate					
Victorian Inspectorate base funding	..	1.3	4.3	4.6	4.7
Total output initiatives [(a)]	**0.8**	**13.3**	**16.2**	**17.3**	**17.5**

Source: Department of Treasury and Finance

Note:

(a) Table may not add due to rounding. Totals do not include expenditure associated with a Treasurer's Advance of $0.700 million in 2022-23 to be approved for the Victorian Ombudsman to meet increases in demand for its services and effectively meet the needs and expectations of the community.

Independent Broad-based Anti-corruption Commission

IBAC: Increase to base operational funding

Funding is provided to increase the base operational capacity of the Independent Broad-based Anti-corruption Commission (IBAC) to ensure it operates effectively and efficiently into the future.

This initiative will contribute to Parliament's Public Sector Integrity Output.

Parliamentary Services

Administration of VIRTIPS Act

Funding is provided to enable the Department of Parliamentary Services to administer the requirements of the *Victorian Independent Remuneration Tribunal and Improving Parliamentary Standards Act 2019* (VIRTIPS Act) for the Parliament of Victoria. This also includes implementing the Victorian Independent Remuneration Tribunal's guidelines for Electorate Office fit out and maintenance costs.

The Electorate Office and communication budgets for Members of Parliament are calculated based on the number of voters enrolled in their electorate as at the last day of February of the previous financial year, as per the determination of the Victorian Independent Remuneration Tribunal. In accordance with the most recent determination of the Tribunal, Parliament will also receive additional funding for Electorate Office and communication budgets.

This initiative contributes to Parliament's:

- Legislative Assembly output
- Legislative Council output
- Parliamentary Services output.

Protective security upgrades and service enhancements

Funding is provided to upgrade and improve Parliament's security controls at the Parliamentary Precinct and Electorate Offices, engage additional security advisors and contracted security guards, and develop and deliver workplace violence and aggression management programs. This will assist with the implementation of Parliament's Protective Security Framework and enhance overall security at the Parliamentary Precinct and Electorate Offices.

This initiative contributes to Parliament's Parliamentary Services output.

Victorian Inspectorate

Victorian Inspectorate base funding

Additional funding is provided to ensure the Victorian Inspectorate continues to fulfil its legislative remit and operate as an independent integrity agency. This will allow front line staff to continue to respond to complaints and disclosures in a timely manner and deliver more proactive integrity activity. The Victorian Inspectorate will investigate serious issues and produce special reports where appropriate, and target key risks on issues to drive systemic improvements across all integrity bodies under its oversight.

This initiative contributes to Parliament's Public Sector Integrity Output.

Asset initiatives

Table 1.23: Asset initiatives – Parliament **($ million)**

	2021-22	2022-23	2023-24	2024-25	2025-26	TEI
Parliamentary Services						
Parliamentary sitting resilience	..	1.5	..	..	..	1.5
Protective security upgrades and service enhancements	..	3.0	0.6	..	..	3.6
Total asset initiatives [(a)]	**..**	**4.5**	**0.6**	**..**	**..**	**5.1**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Parliamentary Services

Parliamentary sitting resilience

Funding is provided to upgrade Parliament's legacy and end-of-life broadcasting equipment for both Houses of Parliament. Updated technologies will be implemented to enable members and their staff to remotely participate in Parliamentary proceedings in emergency situations.

This initiative contributes to Parliament's Parliamentary Services output.

Protective security upgrades and service enhancements

Refer to the output initiative for a description of this initiative.

COURT SERVICES VICTORIA

Output initiatives

Table 1.24: Output initiatives – Court Services Victoria **($ million)**

	2021-22	2022-23	2023-24	2024-25	2025-26
Courts					
Continuing therapeutic court programs	..	5.4	..	..	..
Expanding the Assessment and Referral Court	..	1.3	2.2	4.9	6.1
Improving access to justice for children and their families	..	2.4	2.4	1.6	1.6
Helping Courts respond to the impacts of the pandemic	..	12.8	14.7	8.1	5.4
New federal jurisdiction matters in the Magistrates' Court of Victoria	..	0.1	0.2	..	..
Operationalising Bendigo Law Courts	..	2.7	6.1	5.4	5.5
Specialist Weekend Online Children's Court	..	0.8	0.8	..	..
Supporting victims of sexual violence and harm	..	0.1	0.1	0.1	..
Total output initiatives [(a)]	**..**	**25.5**	**26.5**	**20.0**	**18.6**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Courts

Continuing therapeutic court programs

Funding is provided to continue the Magistrates' Court of Victoria's (MCV) Ballarat and Shepparton Drug Court programs to provide participants with targeted support, address their drug use and break the cycle of offending. Funding is also provided to continue the County Court of Victoria's (CCV) Court Integrated Support Program pilot, which supports eligible accused persons to access services and reduces recidivism rates.

This initiative contributes to Court Services Victoria's Courts output.

Expanding the Assessment and Referral Court

Funding is provided to progressively expand the Assessment and Referral Court (ARC) to the Ballarat, Broadmeadows, Dandenong, Geelong, Heidelberg, Ringwood, Shepparton and Sunshine Magistrates' Courts. The ARC provides intensive pre-sentence support and judicial supervision to accused persons with a mental illness and/or cognitive impairment and assists address underlying factors that contribute to offending behaviours.

This initiative contributes to Court Services Victoria's Courts output.

This initiative contributes to the Department of Justice and Community Safety's:

- Policing and Community Safety output
- Public Prosecutions and Legal Assistance output.

Helping Courts respond to the impacts of the pandemic

Funding is provided to establish an integrated MCV Service Centre that will manage digital public enquiries, provide contact centre services and case triaging, improve online access and automation, reduce pressure on in-person services at individual court locations and increase court throughput. Funding is also provided to continue operating the Supreme Court's eCourt program, which is delivering a more efficient and accessible justice system, and additional resources for the CCV's Active Case Management Program.

Funding is also provided for Victorian Civil and Administrative Tribunal (VCAT) members to address delays caused by COVID-19 public health restrictions.

This initiative contributes to Court Services Victoria's Courts output.

Improving access to justice for children and their families

Funding is provided to continue the Youth Control Order program, which provides the Children's Court of Victoria with an intensive and targeted supervision sentencing option. Funding is also provided to continue the Intensive Bail Order program, which provides a supervision and support service for young people awaiting trial and for registry staff to maintain delivery of the successful Children's Court of Victoria's active case management program.

This initiative contributes to Court Services Victoria's Courts output.

New federal jurisdiction matters in the Magistrates' Court of Victoria

Funding is provided to support the MCV's transition to hearing federal jurisdiction matters previously heard by the VCAT. This initiative supports the legislative change passed by the Victorian Parliament that requires the MCV to hear these matters.

This initiative contributes to Court Services Victoria's Courts output.

Operationalising Bendigo Law Courts

Funding is provided to operationalise the new Bendigo Law Court and to support delivery of specialist court services to the Loddon Mallee region. The modern and inclusive new facility will be the first regional court in Victoria to provide specialist courts for the Koorie community. Funding is also provided for an ARC in Bendigo.

This initiative contributes to Court Services Victoria's Courts output.

Specialist Weekend Online Children's Court

Funding is provided to establish an after-hours online Children's Court of Victoria service to support children who have offended and help divert young people from custody.

This initiative contributes to Court Services Victoria's Courts output.

Supporting victims of sexual violence and harm

Refer to the Department of Justice and Community Safety for a description of this initiative.

Asset initiatives

Table 1.25: Asset initiatives – Court Services Victoria **($ million)**

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*	*TEI*
Courts						
Keeping courts open	..	10.0	..	..	..	10.0
New federal jurisdiction matters in the Magistrates' Court of Victoria	..	1.5	2.3	..	..	3.8
Total asset initiatives [(a)]	**..**	**11.5**	**2.3**	**..**	**..**	**13.8**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Courts

Keeping courts open

Funding is provided to undertake critical asset maintenance, repairs and renewal works to Victoria's court buildings.

This initiative contributes to the Court Service Victoria's Courts output.

New federal jurisdiction matters in the Magistrates' Court of Victoria

Refer to the output initiative for a description of this initiative.

REVENUE INITIATIVES

Table 1.26: Revenue initiatives **($ million)**

	2021-22	*2022-23*	*2023-24*	*2024-25*	*2025-26*
Equalise gambling tax rates for electronic gaming machine operators	..	..	27.2	28.5	29.9
Exempt wheelchair accessible commercial passenger vehicles that provide unbooked services from motor vehicle duty	..	(0.6)	(0.7)	(0.7)	(0.7)
Total output initiatives [(a)]	**..**	**(0.6)**	**26.5**	**27.8**	**29.2**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding

Equalise gambling tax rates for electronic gaming machine operators

From 1 July 2023, electronic gaming machines operated by the casino licence operator will be subject to the same tax structure as electronic gaming machines operated by venue operators with club entitlements. This initiative is expected to increase the maximum marginal tax rate for electronic gaming machines operated at the casino from 31.57 per cent to 60.67 per cent (plus the 1 per cent Community Benefit Levy). The change will improve the equity of electronic gaming machine taxation by ensuring taxes paid by the largest gambling venue in the State are not lower than rates at smaller, not-for-profit, community-based venues. Commission-based play on gaming machines will continue to be taxed at 10 per cent.

Exempt wheelchair accessible commercial passenger vehicles that provide unbooked services from motor vehicle duty

From 1 July 2022, the sale or transfer of wheelchair accessible commercial passenger vehicles that provide unbooked services will be exempt from motor vehicle duty. The exemption will only apply to the sale or transfer of eligible vehicles that are less than two years old. This initiative will support wheelchair users by encouraging investment in wheelchair accessible transportation.

CHAPTER 2 – DEPARTMENT PERFORMANCE STATEMENTS

This chapter presents departmental performance statements that describe the objectives and associated performance indicators departments seek to achieve over the medium term. This chapter also describes the outputs (goods and services) that departments are funded to deliver to achieve these objectives.

Budget Paper No. 3, Chapter 1 *Service Delivery* describes the new initiatives that will be funded in 2022-23 and makes links with the base funding departments receive for ongoing programs. The departmental performance statements published in this chapter describe the services provided by the Government and, where relevant, have been updated to reflect the new initiatives in Chapter 1.

Performance measures for each output are divided into Quality, Quantity, Timeliness and Cost categories. The performance measures collectively describe the goods and services delivered, and how they are measured. The 2022-23 targets represent what the Government seeks or expects to achieve in the coming year. For each measure, targets and expected outcomes from 2021-22 and actual outcomes from 2020-21 will allow a comparison of departmental performance from previous years.

The Government is continuing to improve its performance reporting framework to provide more meaningful specification of the outputs delivered by departments, measures of successful delivery of these outputs, and a clear alignment with departmental objectives.

Output movements as a result of machinery of government changes

In 2021-22 there was one machinery of government change implemented, which was the transfer of aged support services from the Department of Health to the Department of Fairness, Families and Housing. The departmental performance statements published in this chapter are organised according to the new structure of the Victorian public service.

Footnotes for outputs and performance measures that have moved as a result of the machinery of government changes indicate which department was previously responsible for delivering the service described.

The table below provides an overview of the movement of outputs between departments, including outputs split between departments.

Table 2.1: Movement of outputs as a result of machinery of government changes in 2021-22

Outputs	*Old department*	*New department*
Outputs moved between departments		
Aged Support Services	Department of Health	Department of Families, Fairness and Housing [(a)]

Source: Department of Treasury and Finance

Note:

(a) The two measures relating to the provision of pension-level beds and services provided to residents in supported residential facilities has been transferred directly from the Department of Health 'Aged Support Services' output to reflect the impact of machinery of government changes

Other matters to note

Appendix A *Output performance measures for review by the Public Accounts and Estimates Committee* identifies performance measures that are proposed to be substantially changed or discontinued in 2022-23.

Situations where it is appropriate to substantially change or discontinue a performance measure include:

- a current measure can be replaced by a more appropriate measure and the new measure will provide more meaningful information to the Parliament and the public
- it is no longer relevant due to a change in policies or priorities of the Government and/or departmental objectives
- milestones, projects or programs have been completed, substantially changed, or discontinued
- funding is not provided in the current budget for the continuation of initiatives.

Changed or discontinued measures have been amended or replaced by new measures in instances where they can provide a stronger basis for evaluating the outcomes of performance of services to the community.

When reading the performance statements, 'nm' refers to a new performance measure and 'na' refers to measures that are either not applicable in the specified year or data is not available. Where a department has included a new measure in 2022-23, historical performance data has been provided, where available, to assist with analysis of the department's performance over time.

The impact of the COVID-19 pandemic on 2021-22 performance outcomes and 2022-23 performance statements

In the *2021-22 Budget*, performance targets were set for what was considered a standard year. This approach allows this budget to show the full anticipated impact of the COVID-19 pandemic on government performance through the 2020-21 actual outcomes as well as the 2021-22 expected outcomes.

In 2022-23, some government services are expected to continue to be impacted by the ongoing effects of the COVID-19 pandemic. Continuing the approach from previous years, the *2022-23 Budget* will set performance targets for a standard year. That is, where performance measures and targets have been changed or measures have been updated it is due to:

- annual routine movements, which exclude the impact of the COVID-19 pandemic (e.g., target adjustments that are dependent on output costs)
- new performance measures being added, and targets being revised, to reflect new initiatives in Chapter 1 *Output, asset investment, savings and revenue initiatives*.

This approach applies to both updating existing measures and where new measures have been added because of funding decisions in 2022-23.

The standard year approach remains the most efficient and transparent way to set performance targets and measures in a COVID-19 setting.

Removal of the Capital Assets Charge from output costs

The Capital Assets Charge (CAC) policy was discontinued from the *2021-22 Budget* and the CAC has been removed from all output costs in the 2021-22 Budget Paper No. 3 *Service Delivery*. In previous years, CAC has been used to demonstrate the opportunity costs of utilising government assets.

While the inclusion of the CAC was reflected in the output cost, it did not reflect the real distribution of funds to departments and public sector agencies. This is because departments were funded from the budget for their CAC expense, and departments then immediately paid the same amount back into the Consolidated Fund.

Removing the CAC does not disadvantage departments.

The removal of the CAC creates more meaningful departmental financial information, generates administrative efficiency, and brings Victoria in line with budgeting practices of other Australian jurisdictions.

In the *2021-22 Budget*, output costs were represented as both inclusive and exclusive of the CAC for demonstrative purposes. From the *2022-23 Budget*, output costs will be represented exclusive of the CAC only.

DEPARTMENT OF EDUCATION AND TRAINING

Ministerial portfolios

The Department supports the ministerial portfolios of early childhood, education, higher education, and training and skills.

Departmental mission statement

> 'Together we give every Victorian the best learning and development experience, making our state a smarter, fairer and more prosperous place.'

The Department is responsible for delivering and regulating statewide learning and development services to approximately one-third of all Victorians, across the early childhood education, school education, and training and skills sectors.

We support Victorians to reach their potential, regardless of their background, postcode or circumstance, and to develop the knowledge, skills and attributes they need to participate and thrive in a complex economy and society, as well as engage as global citizens.

The goals we set, changes we implement, systems we support and services we offer are all focused on improving outcomes and opportunities for Victorians. We are committed to supporting Victorians to build happy, healthy and rewarding lives.

Departmental objectives

Achievement

Raise standards of learning and development achieved by Victorians using education and training.

Engagement

Increase the number of Victorians actively participating in education and training.

Wellbeing

Increase the contribution that education and training make to quality of life for all Victorians, particularly children and young people.

Productivity

Increase the productivity of our services.

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives and outputs, together with their key performance indicators, are presented in subsequent tables.

($ millions)

	2021-22 budget	*2021-22 expected outcome*	*2022-23 budget*	*Variation [(a)] %*
Strategy, Review and Regulation	117.8	115.1	110.9	(5.9)
Early Childhood Education	973.4	922.0	984.9	1.2
School Education – Primary	5 765.9	5 504.6	5 942.9	3.1
School Education – Secondary	4 713.1	4 669.1	5 026.9	6.7
Training, Higher Education and Workforce Development	2 599.8	2 598.7	2 482.7	(4.5)
Support Services Delivery	389.1	447.6	440.4	13.2
Support for Students with Disabilities	1 363.6	1 323.9	1 522.3	11.6
Total	**15 922.8**	**15 580.9**	**16 510.9**	**3.7**

Source: Department of Education and Training

Note:

(a) Variation between the 2021-22 budget and the 2022-23 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant output cost.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.2 outlines the Department's income from transactions and Table 2.3 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base and payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.2 Income from transactions **($ million)**

	2020-21 actual	*2021-22 budget*	*2021-22 revised*	*2022-23 budget*
Output appropriations	16 133.9	15 120.5	15 101.9	15 782.3
Special appropriations	5.8	6.2	6.2	5.6
Interest	7.0	14.8	5.1	6.4
Sale of goods and services	637.0	872.4	528.1	607.8
Grants	69.1	33.2	34.1	12.6
Fair value of assets and services received free of charge or for nominal consideration	6.3	..	4.7	..
Other income	320.9	409.9	409.1	526.9
Total income from transactions [(a)]	**17 179.9**	**16 456.9**	**16 089.2**	**16 941.5**

Source: Department of Education and Training

Note:

(a) Table may not add due to rounding.

Table 2.3 Parliamentary authority for resources **($ million)**

	2021-22 budget	*2021-22 revised*	*2022-23 budget*
Annual appropriations	**15 883.9**	**15 734.6**	**17 128.6**
Provision of outputs	14 473.9	14 425.6	15 199.3
Additions to the net asset base	1 409.9	1 309.0	1 929.3
Payments made on behalf of the State	..	..	..
Receipts credited to appropriations	**615.4**	**628.2**	**582.9**
Unapplied previous years appropriation	**31.2**	**90.5**	**..**
Provision of outputs	31.2	69.2	..
Additions to the net asset base	..	21.3	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**16 530.4**	**16 453.3**	**17 711.6**
Special appropriations	**6.2**	**6.2**	**5.6**
Trust funds	**4 221.9**	**4 329.5**	**4 508.8**
State Grants (School Funding Reform framework) Non-government programs [(a)]	4 197.3	4 304.4	4 507.5
Other [(b)]	24.6	25.1	1.4
Total parliamentary authority [(c)]	**20 758.5**	**20 789.0**	**22 226.0**

Source: Department of Education and Training

Notes:

(a) The purpose of this trust primarily relates to recurrent Commonwealth funding provided to the non-government school sector under the School Funding Reform framework as part of the Australian Education Act 2013*.*

(b) Includes inter-departmental transfers.

(c) Table may not add due to rounding.

Departmental performance statement

Strategy Review and Regulation

The Strategy Review and Regulation output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 4: Productivity

The departmental objective indicators are:

- $ per primary school student per year[(a)]
- $ per secondary school student per year[(a)]
- $ per vocational education and training (VET) student contact hour.

Note:
(a) These indicators refer to government and non-government schools.

Outputs

Strategy Review and Regulation (2022-23: $110.9 million)

This output develops, plans and monitors strategic policy settings across all stages of learning. It also includes inter-governmental negotiations as well as research, data and performance evaluations. This output also supports regulation that ensures quality education and training is delivered.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of Registered Training Organisation (RTO) quality audits and school reviews undertaken annually	number	100	134	102	78
This performance measure relates to the school cyclical review program for independent schools only. The 2021-22 expected outcome is higher than the 2021-22 target due to the school cyclical review program for independent schools being reconfigured to deal with the backlog arising from COVID-19. The lower 2022-23 target reflects the resumption of the normal cyclical review program.					
Quality					
Education peak bodies that rate the Victorian Registration and Qualifications Authority (VRQA) effective or highly effective in performing its regulatory function	per cent	90	93	90	94
This performance measure relates to the calendar year.					
Regulated schools and RTOs that rate the VRQA effective or highly effective in performing its regulatory function	per cent	90	93	90	94
This performance measure relates to the calendar year.					
Percentage of government schools where an enrolment audit is conducted	per cent	32.5	32.5	32.5	11.3
This performance measure relates to the calendar year. This performance measure refers to government schools only.					
Cost					
Total output cost	$ million	110.9	115.1	117.8	114.6
The lower 2022-23 target primarily reflects efficiency in the Department's delivery of strategic policy functions.					

Source: Department of Education and Training

Early Childhood Education

The Early Childhood Education output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 1: Achievement

The departmental objective indicators are:

- Children developmentally 'on track' on the Australian Early Development Census[(a)] (AEDC) in the language and cognitive skills domains
- Proportion of early childhood services meeting or exceeding National Quality Standard Area 1 (NQSA1–Educational program and practice).

Objective 2: Engagement

The departmental objective indicators are:

- Participation in a kindergarten service in the year before school
- Proportion of early childhood education and care services meeting or exceeding National Quality Standard Area 6 (NQSA6–Collaborative partnerships with families and communities).

Objective 3: Wellbeing

The departmental objective indicators are:

- Proportion of children who have no behavioural issues on entry into Prep
- Proportion of children who have no general development issues on entry into Prep
- Children developmentally 'on track' on the AEDC social competence and emotional maturity domains[(a)].

Objective 4: Productivity

The departmental objective indicator is:

- $ per kindergarten student per year.

Note:
(a) These indicators refer to government and non-government schools.

Early Childhood Education (2022-23: $984.9 million)

This output delivers kindergarten and related programs and services to improve quality, and to support participation for disadvantaged children and children with additional needs. This includes four-year-old kindergarten and the rollout of three-year-old kindergarten. Services also include workforce and infrastructure development and the monitoring of licensed early childhood education and care services.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Children funded to participate in kindergarten in the year before school	number	79 000	80 928	80 000	79 850
This performance measure relates to the calendar year. This performance measure includes first- and second-year kindergarten participants. *The lower 2022-23 target reflects the latest Victoria in the Future (VIF) 2021 population estimates which predict a small decrease in population from 2021 to 2022.*					
Aboriginal children funded to participate in kindergarten in the year before school	number	1 550	1 492	1 550	1 653
This performance measure relates to the calendar year. This performance measure includes first- and second-year Aboriginal kindergarten participants.					
Kindergarten participation rate in the year before school	per cent	96.0	92.9	96.0	89.1
This performance measure relates to the calendar year and excludes children who participate in a second year of the four-year-old kindergarten program.					
Kindergarten participation rate for Aboriginal children in the year before school	per cent	96.0	92.6	96.0	100.0
This performance measure relates to the calendar year. This performance measure excludes children who participate in a second year of the four-year-old kindergarten program.					
Children funded to participate in kindergarten in the year two years before school	number	47 000	5 800	5 000	2 673
This performance measure relates to the calendar year. This performance measure includes children in Early Start Kindergarten (ESK) and the phased rollout of the three-year-old kindergarten program. *The 2021-22 expected outcome is higher than the 2021-22 target due to the ongoing roll out of three-year-old kindergarten.* *The higher 2022-23 target reflects expansion of the staged implementation statewide from 2022.*					
Children funded to participate in Early Start Kindergarten or Access to Early Learning in the year two years before school	number	3 500	3 325	3 000	nm
This performance measure relates to the calendar year. *The 2021-22 expected outcome is higher than the 2021-22 target due to the benefits of outreach and other engagement work to support the enrolment and ongoing participation of children eligible for Access to Early Learning (AEL) and ESK.* *The higher 2022-23 target reflects the recent increase in uptake of AEL and ESK.*					
Average number of inspections per service	number	0.85	0.73	0.85	0.58
This performance measure relates to the calendar year. *The 2021-22 expected outcome is lower than the 2021-22 target due to inspection rates being impacted by COVID-19 restrictions in February and May-October 2021, resulting in postponement of visits to premises.*					
Number of Early Years Management (EYM) funded services	number	1 030	995	1 000	nm
This performance measure relates to the calendar year. *The higher 2022-23 target reflects the number of kindergarten services anticipated to receive EYM funding in the reference period, based on current demand trends for EYM services.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Proportion of approved eligible services assessed and rated	per cent	25.0	14.0	25.0	6.2
This performance measure relates to the calendar year. *The 2021-22 expected outcome is lower than the 2021-22 target due to lower than expected assessment and ratings visits conducted in the period of COVID-19 restrictions in February and May to October 2021.*					
Proportion of allied health sessions offered through School Readiness Funding accessed by funded kindergarten services	per cent	80	nm	nm	nm
New performance measure for 2022-23 to reflect allied health service provision through School Readiness Funding. *This performance measure relates to the calendar year.*					
Number of kindergarten services supported through the Kindergarten Inclusion Support program for children with a disability or complex medical needs	number	600	nm	nm	nm
New performance measure for 2022-23 to reflect delivery of kindergarten inclusion services. This performance measure relates to the calendar year.					
Number of Kinder Kits delivered to services for distribution to children commencing their three-year-old kindergarten program	number	47 000	nm	nm	nm
New performance measure for 2022-23 to reflect provision of the Kinder Kit to families with children commencing kindergarten in the year two years before school. This performance measure relates to the calendar year.					
Quality					
Education and care services offering a funded kindergarten program assessed as exceeding the National Quality Standard	per cent	46.0	38.4	46.0	43.0
This performance measure relates to the calendar year. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions on assessment and ratings visits.*					
Education and care services offering a funded kindergarten program assessed as meeting or exceeding the National Quality Standard	per cent	91.0	91.5	91.0	91.0
This performance measure relates to the calendar year.					
Parent satisfaction with kindergarten services	per cent	90	90	90	nm
This performance measure relates to the calendar year. The performance measure includes funded kindergarten providers.					
Cost					
Total output cost	$ million	984.9	922.0	973.4	807.6
The lower 2021-22 expected outcome primarily reflects operating rephases into 2022-23.					

Source: Department of Education and Training

School Education – Primary

The School Education–Primary output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 1: Achievement

The departmental objective indicators are:

- primary students meeting the expected standard in national and international literacy and numeracy assessment[(a)]
- percentage of positive responses to teacher collaboration within primary schools[(b)].

Objective 2: Engagement

The departmental objective indicators are:

- mean number of primary student absent days per full-time equivalent (FTE) a year[(c)]
- mean number of unapproved student absence days per FTE per year in primary schools[(c)]
- primary students with a positive opinion about their school providing a stimulating learning environment[(c)].

Objective 3: Wellbeing

The departmental objective indicators are:

- primary students feeling connected to their school[(c)]
- primary students with a positive opinion about their school providing a safe and orderly environment for learning[(c)].

Objective 4: Productivity

The departmental objective indicator is:

- $ per primary school student per year[(c)].

Notes:

(a) This indicator refers to government schools for the national assessments and both government and non-government schools for the international assessments.

(b) These indicators refer to government schools.

(c) These indicators refer to government and non-government schools.

School Education – Primary (2022-23: $5 942.9 million)

The School Education – Primary output provides services to develop essential skills and learning experiences to engage young minds and improve the quality of learning of students in Prep to Year 6 in government and non-government schools.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Investment in non-government schools (primary)	$ million	519.5	523.8	524.6	469.8
Percentage of government primary school students receiving equity funding	per cent	24	25	25	25
This performance measure relates to the calendar year. This performance measure refers to government schools only. The lower 2022-23 target reflects the percentage of eligible students for 2022 calendar year funding based on parental education and occupation data.					
Number of teachers participating in the Primary Mathematics and Science Specialist (PMSS) initiative	number	100	209	200	201
This performance measure relates to the calendar year. This performance measure refers to government schools only. The lower 2022-23 target reflects a smaller PMSS cohort.					
Number of assistant principals participating in leadership development programs	number	700	1 348	700	388
This performance measure relates to the calendar year. This performance measure refers to government schools only. The 2021-22 expected outcome is higher than the 2021-22 target because (a) it is likely that an increased number of participants enrolled in 2021 programs as a result of postponed enrolments in 2020 due to the impact of COVID-19 restrictions, and (b) the former Bastow leadership development programs offered in 2021 supported additional assistant principals to participate.					
Number of principals participating in leadership development programs	number	1 100	1 255	1 100	671
This performance measure relates to the calendar year. This performance measure refers to government schools only. The 2021-22 expected outcome is higher than the 2021-22 target because (a) it is likely that an increased number of participants enrolled in 2021 programs as a result of postponed enrolments in 2020 due to the impact of COVID-19 restrictions, and (b) the former Bastow leadership development programs offered in 2021 supported additional principals to participate.					
Number of school staff who are not principals or assistant principals participating in leadership development programs	number	3 000	3 226	3 000	2 470
This performance measure relates to the calendar year. This performance measure refers to government schools only. This performance measure includes all school staff (teaching and education support). The 2021-22 expected outcome is higher than the 2021-22 target because (a) it is likely that an increased number of participants enrolled in 2021 programs as a result of postponed enrolments in 2020 due to the impact of COVID-19 restrictions, and (b) the former Bastow leadership development programs offered in 2021 supported additional other school-based staff (such as teachers) to participate.					
Number of participants in the Teacher Excellence Program	number	200	nm	nm	nm
New performance measure for 2022-23 to reflect participation in the Teacher Excellence Program through the Victorian Academy of Teaching and Learning. This performance measure relates to the calendar year.					
Number of teachers completing mentoring training	number	925	1 033	900	835
The performance measure relates to the calendar year. This performance measure includes early childhood teachers. The 2021-22 expected outcome is higher than the 2021-22 target due to greater accessibility to the Effective Mentoring Program (EMP) seminars, which were predominantly delivered online, and scheduling of three additional seminars to meet Career Start pilot demands. The higher 2022-23 target reflects stronger forecast demand in light of increased awareness of the program, which will assist in increasing registrations and attendances.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Number of Victorian schools participating as a 'lead school' for the Respectful Relationships initiative	number	382	402	382	382
This performance measure relates to primary and secondary schools. *The 2021-22 expected outcome is higher than the 2021-22 target due to a higher-than-expected number of schools that expressed interest and were assessed as suitable to participate as a 'lead school'.*					
Number of school-based staff who have participated in the whole-school Respectful Relationships professional learning initiative	number	37 500	35 000	35 000	30 000
This performance measure relates to the calendar year. This performance measure relates to primary and secondary schools. *The higher 2022-23 target reflects the expected number of staff participating in Respectful Relationships training in 2022.*					
Number of schools able to access the Digital Assessment Library	number	2 413	2 413	2 413	2 413
This performance measure relates to the calendar year.					
Number of schools supported with strategic business and financial support	number	750	745	700	859
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The 2021-22 expected outcome is higher than the target due to greater uptake of support services by schools.* *The higher 2022-23 target reflects the greater uptake.*					
Number of school staff attending strategic business and financial support training	number	2 500	2 520	2 500	1 167
This performance measure relates to the calendar year. This performance measure refers to government schools only.					
Proportion of eligible schools in receipt of funding for the Swimming in Schools program	per cent	100	100	100	100
This performance measure relates to the calendar year. This performance measure refers to government schools only.					
Number of schools utilising the Local Administrative Bureau	number	105	58	88	nm
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The 2021-22 expected outcome is lower than the 2021-22 target due to COVID-19 impacts resulting in longer than anticipated project initiation and recruitment activities.* *The higher 2022-23 target reflects the increased level of service available to schools.*					
Number of schools working with School-wide Positive Behaviour Support	number	400	428	400	nm
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The 2021-22 expected outcome is higher than the 2021-22 target due to additional area coaches supporting a higher number of schools than initially forecast.*					
Utilisation of annual hours allocated to schools for onsite IT technical support	per cent	99	100	99	nm
This performance measure relates to the calendar year. This performance measure refers to government schools only.					
Quality					
Average days lost due to absence at Year 5	number	14.1	14.9	14.1	13.6
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The 2021-22 expected outcome is higher than the 2021-22 target due to the impact of COVID-19. This includes parent choice on student attendance (reflecting the characteristics of and risks for families), and the resumption of on-site learning resulting in increased absences due to illness. The rate covers all absences, including those due to illness and parent choice.*					
Average days lost due to absence at Year 6	number	14.5	15.7	14.5	13.8
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The 2021-22 expected outcome is higher than the 2021-22 target due to the impact of COVID-19. This includes parent choice on student attendance (reflecting the characteristics of and risks for families), and the resumption of on-site learning resulting in increased absences due to illness. The rate covers all absences, including those due to illness and parent choice.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Average days lost due to absence for Aboriginal students in Years Prep to 6	number	24.0	28.4	24.0	26.7
This performance measure relates to the calendar year. This performance measure refers to government schools only. The 2021-22 expected outcome is higher than the 2021-22 target due to the impact of COVID-19. This includes parent choice on student attendance (reflecting the characteristics of and risks for Koorie families), and the resumption of on-site learning resulting in increased absences due to illness. The rate covers all absences, including those due to illness and parent choice. This cohort is small and data is subject to volatility.					
Proportion of positive responses to school satisfaction by parents of government primary school students	per cent	85.0	83.8	85.0	85.0
This performance measure relates to the calendar year. This performance measure refers to government schools only.					
Percentage of Aboriginal students above the bottom three bands for numeracy in Year 3 (National Assessment Program Literacy and Numeracy – NAPLAN testing)	per cent	46.7	39.1	46.7	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in a confidence interval of ± 2.88 percentage points which is specific to the measure in 2021.					
Percentage of Aboriginal students above the bottom three bands for numeracy in Year 5 (NAPLAN testing)	per cent	35.2	33.6	35.2	nm
This performance measure relates to the calendar year. The 2021-22 actual is within the margin of error associated with NAPLAN testing for this cohort. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in a confidence interval of ± 3.25 percentage points which is specific to the measure in 2021.					
Percentage of Aboriginal students above the bottom three bands for reading in Year 3 (NAPLAN testing)	per cent	58.2	55.6	58.2	nm
This performance measure relates to the calendar year. The 2021-22 actual is within the margin of error associated with NAPLAN testing for this cohort. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in a confidence interval of ± 3.09 percentage points which is specific to the measure in 2021.					
Percentage of Aboriginal students above the bottom three bands for reading in Year 5 (NAPLAN testing)	per cent	44.6	45.9	44.6	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in a confidence interval of ± 2.90 percentage points which is specific to the measure in 2021.					
Percentage of students above the bottom three bands for numeracy in Year 3 (NAPLAN testing)	per cent	73.8	68.2	73.8	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in an estimated confidence interval of ± 1.02 percentage points which is specific to the measure in 2021.					
Percentage of students above the bottom three bands for numeracy in Year 5 (NAPLAN testing)	per cent	66.0	64.3	66.0	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in an estimated confidence interval of ± 1.01 percentage points which is specific to the measure in 2021.					
Percentage of students above the bottom three bands for reading in Year 3 (NAPLAN testing)	per cent	82.0	81.3	82.0	nm
This performance measure relates to the calendar year. The 2021-22 actual is within the margin of error associated with NAPLAN testing for this cohort. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in a confidence interval of ± 0.73 percentage points which is specific to the measure in 2021.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Percentage of students above the bottom three bands for reading in Year 5 (NAPLAN testing)	per cent	74.0	73.8	72.5	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in an estimated confidence interval of ± 0.90 percentage points which is specific to the measure in 2021. *The higher 2022-23 target reflects the ambition of the Education State against targets for Learning for life and Breaking the link.*					
Percentage of students in the top two bands for numeracy in Year 3 (NAPLAN testing)	per cent	46.7	40.0	46.7	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in an estimated confidence interval of ± 1.07 percentage points which is specific to the measure in 2021.					
Percentage of students in the top two bands for numeracy in Year 5 (NAPLAN testing)	per cent	35.3	33.0	35.3	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in an estimated confidence interval of ± 1.12 percentage points which is specific to the measure in 2021.					
Percentage of students in the top two bands for reading in Year 3 (NAPLAN testing)	per cent	62.2	61.9	60.7	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in an estimated confidence interval of ± 0.99 percentage points which is specific to the measure in 2021. *The higher 2022-23 target reflects the ambition of the Education State against targets for Learning for life and Breaking the Link.*					
Percentage of students in the top two bands for reading in Year 5 (NAPLAN testing)	per cent	45.1	44.8	45.1	nm
This performance measure relates to the calendar year. The 2021-22 actual is within the margin of error associated with NAPLAN testing for this cohort. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in a confidence interval of ± 1.08 percentage points which is specific to the measure in 2021.					
Years 5 to 6 students' opinion of their connectedness with the school	number (1-5)	4.4	4.1	4.4	4.1
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The 2021-22 expected outcome is lower than the 2021-22 target likely due to the impact of changes to survey timing, structure and delivery to account for the impacts of COVID-19, reducing the comparability of results for 2021.*					
Proportion of identified schools that subsequently improved their performance	per cent	67.0	62.0	67.0	nm
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The 2021-22 expected outcome is lower than the 2021-22 target due to the schools identified to receive additional school improvement practices during 2020 and 2021 experiencing a lower level of support compared to schools in previous years. This was due to the school improvement workforce being redeployed to support agile COVID-19 regional operating models.*					
Proportion of participants rating (all programs) the impact of the Victorian Academy of Teaching and Leadership's professional learning on their own development and practice at or above 'significant'	per cent	78.0	82.0	78.0	93.0
This performance measure relates to the calendar year. *The 2021-22 expected outcome is higher than the 2021-22 target due to continuous improvement in the Academy's professional learning design and delivery.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Proportion of participants (all programs) who are satisfied with the Victorian Academy of Teaching and Leadership's professional learning and development training	per cent	82.0	77.0	82.0	90.0
This performance measure relates to the calendar year. *The 2021-22 expected outcome is lower than the 2021-22 target as a result of some programs being delivered online and in hybrid settings for the first time. The Academy responded to this feedback by implementing continuous improvement plans.*					
Timeliness					
Percentage of government schools compliant with the Child Safety Standards three months after review	per cent	100	99	100	98
This performance measure relates to the calendar year. This performance measure refers to government schools only.					
Cost					
Total output cost	$ million	5 942.9	5 504.6	5 765.9	5 410.8

Source: Department of Education and Training

School Education – Secondary

The School Education – Secondary output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 1: Achievement

The departmental objective indicators are:

- secondary students meeting the expected standard in national and international literacy and numeracy assessment[(a)]
- percentage of positive responses to teacher collaboration within secondary schools[(b)]
- average score in science (Programme for International Student Assessment 15-year-olds) in Victoria compared to global top performers[(a)]
- Year 12 or equivalent completion rates of young people[(b)].

Objective 2: Engagement

The departmental objective indicators are:

- mean number of secondary student absent days per FTE per year[(b)]
- mean number of unapproved student absence days per FTE per year in secondary schools[(b)]
- secondary students with a positive opinion about their school providing a stimulating learning environment[(b)].

Objective 3: Wellbeing

The departmental objective indicators are:

- secondary students feeling connected to their school[(b)]
- secondary students with a positive opinion about their school providing a safe and orderly environment for learning[(b)].

Objective 4: Productivity

The departmental objective indicator is:

- $ per secondary school student per year[(c)].

Notes:

(a) This indicator refers to government schools for the national assessments and both government and non-government schools for the international assessments.

(b) These indicators refer to government schools.

(c) These indicators refer to government and non-government schools.

School Education – Secondary (2022-23: $5 026.9 million)

The School Education – Secondary output involves provision of education and support services designed to improve student learning, development and wellbeing in Years 7 to 12 in government and non-government schools. These seek to consolidate literacy and numeracy competencies including creative and critical thinking, as well as physical, social, emotional and intellectual development in adolescence. It also covers the provision of services to improve pathways to further education, training and employment.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Investment in non-government schools (secondary)	$ million	556.7	561.3	541.2	490.2
Number of school students enrolled in the Victorian Certificate of Applied Learning (VCAL)	number	27 018	27 624	21 650	22 888
The performance measure relates to the calendar year. *The 2021-22 expected outcome is higher than the 2021-22 target due to an increasing proportion of students undertaking VCAL as it becomes more established as an alternative qualification to the VCE.* *The higher 2022-23 target reflects the new single senior certificate which will be introduced in 2023.*					
Number of school students participating in accredited vocational programs	number	50 500	49 560	48 500	48 561
This performance measure relates to the calendar year. *The higher 2022-23 target reflects recent strong participation in vocational programs.*					
Number of school-based apprentices/trainees	number	3 700	3 172	3 700	3 520
The performance measure relates to the calendar year. *The 2021-22 expected outcome is lower than the 2021-22 target due to the reduction in school-based apprentices/traineeships enrolments in light of disruption to industry and schools as a result of COVID-19 restrictions.*					
Proportion of all secondary schools offering vocational options to students as part of their secondary school certificate	per cent	96.0	96.3	96.0	94.5
The performance measure relates to the calendar year.					
Number of students for which government secondary schools are funded to 'catch up'	number	10 500	10 700	10 700	10 700
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The lower 2022-23 target reflects fewer students being below the national average for NAPLAN Year 5 reading which impacts eligibility for program funding.*					
Percentage of government secondary school students receiving equity funding	per cent	30.0	30.5	30.5	31.0
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The lower 2022-23 target reflects the percentage of eligible students for 2022 calendar year funding based on parental education and occupation data.*					
Number of students participating in the Victorian Young Leaders program	number	460	325	325	280
The higher 2022-23 target reflects additional student focussed programs being delivered onshore and online given continued uncertainty of international travel.					
Number of partner secondary schools accessing a Tech School	number	165	157	160	168
This performance measure relates to the calendar year. This performance measure refers to government and non-government schools who are partners to a Tech School. *The higher 2022-23 target reflects the expected level of demand in 2022.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Proportion of employment-based pathways-qualified teachers retained in Victorian government school workforce (within two years) after completing the pathway	per cent	70	70	65	nm
This performance measure relates to the calendar year. This performance measure refers to government schools only. The 2021-22 expected outcome is higher than the 2021-22 target due to a higher than forecast number of 2018 Teach for Australia teacher graduate cohort remaining employed in Victorian government schools as at 2021. The higher 2022-23 target reflects the aim of the investment to stabilise retention over time.					
Number of industry professionals supported to commence qualifications needed to become a VDSS trainer	number	50	nm	nm	nm
New performance measure for 2022-23 to reflect professional development in Vocational Education and Training Delivered to Secondary Students (VDSS).					
Number of teachers and VDSS trainers who have been supported to strengthen their teaching/training practice through professional learning	number	80	nm	nm	nm
New performance measure for 2022-23 to reflect professional development in VDSS.					
Quality					
Average days lost due to absence in Years 11 and 12	number	16.1	16.8	16.1	14.8
This performance measure relates to the calendar year. This performance measure refers to government schools only. The 2021-22 expected outcome is higher than the 2021-22 target due to the impact of COVID-19. This includes parent choice on student attendance (reflecting the characteristics of and risks for families), and the resumption of on-site learning resulting in increased absences due to illness. The rate covers all absences, including those due to illness and parent choice.					
Average days lost due to absence in Years 7 to 10	number	19.0	22.7	19.0	18.9
This performance measure relates to the calendar year. This performance measure refers to government schools only. The 2021-22 expected outcome is higher than the 2021-22 target due to the impact of COVID-19. This includes parent choice on student attendance (reflecting the characteristics of and risks for families), and the resumption of on-site learning resulting in increased absences due to illness. The rate covers all absences, including those due to illness and parent choice.					
Average days lost due to absence for Aboriginal students in Years 7 to 12	number	35.0	41.3	35.0	37.0
This performance measure relates to the calendar year. This performance measure refers to government schools only. The 2021-22 expected outcome is higher than the 2021-22 target due to the impact of COVID-19. This includes parent choice on student attendance (reflecting the characteristics of and risks for Koorie families), and the resumption of on-site learning resulting in increased absences due to illness. The rate covers all absences, including those due to illness and parent choice. This cohort is small and data is subject to volatility.					
Median VCE study score	number	29	29	29	29
This performance measure relates to the calendar year. This performance measure refers to government schools only.					
Proportion of positive responses to school satisfaction by parents of government secondary school students	per cent	80.0	78.2	80.0	81.0
This performance measure relates to the calendar year. This performance measure refers to government schools only.					
Percentage of Aboriginal students above the bottom three bands for numeracy in Year 7 (NAPLAN testing)	per cent	29.7	28.4	29.7	nm
This performance measure relates to the calendar year. The 2021-22 actual is within the margin of error associated with NAPLAN testing for this cohort. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in a confidence interval of ± 3.13 percentage points which is specific to the measure in 2021.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Percentage of Aboriginal students above the bottom three bands for numeracy in Year 9 (NAPLAN testing)	per cent	27.9	21.9	27.9	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in a confidence interval of ± 2.58 percentage points which is specific to the measure in 2021.					
Percentage of Aboriginal students above the bottom three bands for reading in Year 7 (NAPLAN testing)	per cent	30.6	29.9	29.2	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in a confidence interval of ± 3.05 percentage points which is specific to the measure in 2021. *The higher 2022-23 target reflects the ambition of the Education State against targets for Learning for life and Breaking the link.*					
Percentage of Aboriginal students above the bottom three bands for reading in Year 9 (NAPLAN testing)	per cent	26.3	20.7	26.3	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in a confidence interval of ± 2.65 percentage points which is specific to the measure in 2021.					
Percentage of school leavers completing a VCE VET program in a school progressing to further education, training or work	per cent	95.0	95.2	95.0	92.2
This performance measure relates to the calendar year.					
Percentage of school leavers completing an intermediate or senior VCAL in a school progressing to further education, training or work	per cent	85.0	87.0	85.0	79.5
This performance measure relates to the calendar year.					
Percentage of students above the bottom three bands for numeracy in Year 7 (NAPLAN testing)	per cent	64.7	62.3	64.7	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in an estimated confidence interval of ± 1.65 percentage points which is specific to the measure in 2021.					
Percentage of students above the bottom three bands for numeracy in Year 9 (NAPLAN testing)	per cent	57.9	51.9	57.9	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in an estimated confidence interval of ± 1.91 percentage points which is specific to the measure in 2021.					
Percentage of students above the bottom three bands for reading in Year 7 (NAPLAN testing)	per cent	62.4	61.7	61.1	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in an estimated confidence interval of ± 1.61 percentage points which is specific to the measure in 2021. *The higher 2022-23 target reflects the ambition of the Education State against targets for Learning for life and Breaking the link.*					
Percentage of students above the bottom three bands for reading in Year 9 (NAPLAN testing)	per cent	53.3	49.7	53.3	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in an estimated confidence interval of ± 1.69 percentage points which is specific to the measure in 2021.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Percentage of students in the top two bands for numeracy in Year 7 (NAPLAN testing)	per cent	36.7	34.3	36.7	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in an estimated confidence interval of ± 1.67 percentage points which is specific to the measure in 2021.					
Percentage of students in the top two bands for numeracy in Year 9 (NAPLAN testing)	per cent	27.6	21.4	27.6	nm
This performance measure relates to the calendar year. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in an estimated confidence interval of ± 1.74 percentage points which is specific to the measure in 2021.					
Percentage of students in the top two bands for reading in Year 7 (NAPLAN testing)	per cent	31.4	30.7	31.2	nm
This performance measure relates to the calendar year. The 2021-22 actual is within the margin of error associated with NAPLAN testing for this cohort. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in a confidence interval of ± 1.53 percentage points which is specific to the measure in 2021. *The higher 2022-23 target reflects the ambition of the Education State against targets for Learning for life and Breaking the link.*					
Percentage of students in the top two bands for reading in Year 9 (NAPLAN testing)	per cent	23.0	21.8	23.0	nm
This performance measure relates to the calendar year. The 2021-22 actual is within the margin of error associated with NAPLAN testing for this cohort. NAPLAN results, as with any assessment measure, are subject to a small margin of error. This is reflected in a confidence interval of ± 1.45 percentage points which is specific to the measure in 2021.					
Percentage of students who remain at school from Year 7 to Year 12	per cent	93.0	91.5	93.0	91.0
This performance measure relates to the calendar year.					
Percentage of VCAL certificates satisfactorily completed by school students	per cent	77.0	69.2	77.0	74.5
This performance measure relates to the calendar year. *The 2021-22 expected outcome is lower than the 2021-22 target due to a higher than usual proportion of students enrolled in the VCAL Foundation and Intermediate levels finding studies challenging in light of COVID-19 restrictions.*					
Years 7–9 students' opinion of their connectedness with the school	number (1-5)	3.7	3.4	3.7	3.6
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of changes to survey timing, structure and delivery to account for the impacts of COVID-19, reducing the comparability of results for 2021.*					
Percentage of students in out of home care receiving targeted supports in school (LOOKOUT Education Support Centres)	per cent	85.0	83.0	85.0	84.0
This performance measure relates to the calendar year.					
Proportion of Navigator program participants re-engaged in schooling	per cent	70.0	60.0	70.0	64.0
This performance measure relates to the calendar year. *The 2021-22 expected outcome is lower than 2021-22 target due to COVID-19 restrictions and long periods of remote and disrupted learning in 2020 and 2021, which made returning disengaged young people to education significantly more challenging.*					
Percentage of Year 9 students in government schools that complete an online assessment using a career diagnostic tool	per cent	86.0	82.0	86.0	nm
This performance measure relates to the calendar year. This performance measure refers to government schools only.					
Proportion of Year 10 to 12 students with a Career Action Plan	per cent	86.0	83.1	86.0	nm
This performance measure relates to the calendar year. This performance measure refers to government schools only.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Cost					
Total output cost	$ million	5 026.9	4 669.1	4 713.1	4 422.7
The higher 2022-23 target primarily reflects new funding announced as part of the 2022-23 Budget*, funding approved after the release of the* 2021-22 Budget *and indexation.*					

Source: Department of Education and Training

Training, Higher Education and Workforce Development

The Training, Higher Education and Workforce Development output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 1: Achievement

The departmental objective indicators are:

- VET course completions
- Certificate III or above completions
- proportion of graduates with improved employment status after training.

Objective 2: Engagement

The departmental objective indicators are:

- VET enrolments by age and gender
- VET enrolments by administrative regions
- VET enrolments by skills shortage category courses
- VET enrolments by specialised category courses
- VET participation by learners facing barriers
- VET participation by unemployed learners
- proportion of VET students satisfied with the teaching in their course.

Objective 3: Wellbeing

The departmental objective indicator is:

- level of student satisfaction with VET.

Objective 4: Productivity

The departmental objective indicator is:

- $ per VET student contact hour.

Training, Higher Education and Workforce Development

(2022-23: $2 482.7 million)

The Training, Higher Education and Workforce Development output supports Victorians to gain the skills and capabilities essential for success in employment and further training or study. The Department works with the TAFE and training sector to deliver quality training that strongly supports industry to meet the evolving needs of the economy, promotes equity and addresses disadvantage, with an emphasis on growth sectors of the economy. This output includes the functions of training system design, industry engagement, contracting and monitoring of quality and training services including accredited and pre-accredited vocational education and training through to adult community education.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of government subsidised course enrolments *This performance measure relates to the calendar year.*	number	317 500	328 811	317 500	297 253
Number of government subsidised course enrolments in the TAFE Network *This performance measure relates to the calendar year.* *The 2021-22 expected outcome is higher than the 2021-22 target due to the higher continuing enrolments from 2020 students who were not able to complete their studies due to COVID-19.*	number	145 000	157 626	145 000	146 843
Number of government subsidised pre-accredited module enrolments funded through the Adult Community and Further Education (ACFE) Board *This performance measure relates to the calendar year.* *The 2021-22 expected outcome is lower than the 2021-22 target due to the continuing impact of COVID-19 on training activity in 2021.* *The lower 2022-23 target reflects lapsing of one-off funding of 1,000 places provided in the* 2020-21 Budget *which was contracted for delivery in 2021-22.*	number	47 400	42 645	48 400	35 744
Number of government subsidised apprenticeship course enrolments *This performance measure relates to the calendar year.* *The 2021-22 expected outcome is higher than the 2021-22 target due to higher continuing enrolments from 2020 students who were not able to complete their studies due to COVID-19.*	number	49 900	52 841	49 900	47 153
Proportion of government subsidised enrolments related to qualifications that will lead to jobs and economic growth *This performance measure relates to the calendar year.*	per cent	83.0	86.3	83.0	87.1
Number of government subsidised course enrolments by students living in regional Victoria *This performance measure relates to the calendar year.*	number	81 300	84 811	81 300	77 758
Number of students without Year 12, or Certificate II or above, enrolled in a government subsidised course at Certificate III or above *This performance measure relates to the calendar year.*	number	58 000	58 296	58 000	53 291

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Number of government subsidised foundation module enrolments	number	150 000	108 505	150 000	123 515
This performance measure relates to the calendar year. *The 2021-22 expected outcome is lower than the 2021-22 target due to the continuing impact of COVID-19 in 2021 and the substitution from accredited foundation training to other types of training.*					
Number of government subsidised course enrolments by students eligible for fee concession	number	60 000	63 299	67 500	55 940
This performance measure relates to the calendar year. *The 2021-22 expected outcome is lower than the 2021-22 target due to the continuing impact of COVID-19 in 2021 as well as the increasing proportion of training delivered through Free TAFE and JobTrainer programs, where students are not required to report fee concession eligibility.* *The lower 2022-23 target reflects the increasing proportion of training delivered through programs where students are not required to report fee concession eligibility as observed in 2021-22.*					
Number of enrolments in the Free TAFE for priority courses initiative	number	50 000	54 965	50 000	nm
This performance measure relates to the calendar year. *The 2021-22 expected outcome is higher than the 2021-22 target due to higher continuing enrolments from 2020 students who were not able to complete their studies due to COVID-19.*					
Quality					
Proportion of employers of apprentices and trainees who are satisfied with training	per cent	78.1	75.3	78.1	79.1
This performance measure relates to the calendar year. Data for 2021-22 outcomes relate to the 2021 Victorian Employer Satisfaction Survey of 2020 training experiences.					
Proportion of VET completers who are satisfied with their training	per cent	85.7	86.5	85.7	86.7
This performance measure relates to the calendar year. Data for 2021-22 outcomes relate to the 2021 Victorian Student Satisfaction Survey of 2020 training experiences.					
Proportion of VET completers with an improved employment status after training	per cent	54.4	55.7	54.4	55.4
This performance measure relates to the calendar year. Data for 2021-22 outcomes relate to the 2021 Victorian Student Satisfaction Survey of 2020 training experiences.					
Proportion of VET completers who achieved their main reason for training	per cent	84.1	85.3	84.1	85.1
This performance measure relates to the calendar year. Data for 2021-22 outcomes relate to the 2021 Victorian Student Satisfaction Survey of 2020 training experiences.					
Two-year completion rate for non-apprentice commencements in government subsidised Australian Qualifications Framework (AQF) qualifications	per cent	46.3	46.0	46.3	48.4
This performance measure relates to the calendar year. Data for the 2021-22 outcome is the proportion of enrolments which commenced in 2020 that completed at the end of 2021.					
Six-year completion rate for apprentice commencements in government subsidised AQF qualifications	per cent	58.0	62.8	58.0	nm
This performance measure relates to the calendar year. *The 2021-22 expected outcome is higher than the 2021-22 target due to higher completions by apprentices who were not able to complete their studies due to COVID-19.* *Data for the 2021-22 outcome is the proportion of enrolments which commenced in 2016 that complete by the end of 2021.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Cost					
Total output cost	$ million	2 482.7	2 598.7	2 599.8	2 284.5

The 2021-22 and 2022-23 targets include funding for selected public sector workforce training and development initiatives, reflecting their contribution to outcomes and government priorities related to this output.
The lower 2022-23 target predominantly reflects the funding profile for the Victorian Higher Education State Investment Fund, a time limited initiative to support Victorian universities during economic recovery, and other COVID-19 related initiatives.

Source: Department of Education and Training

Support Services Delivery

The Support Services Delivery output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 4: Productivity

The departmental objective indicators are:

- $ per primary school student per year[(a)]
- $ per secondary school student per year[(a)].

Note:
(a) These indicators refer to government and non-government schools.

Support Services Delivery (2022-23: $440.4 million)

The Support Services Delivery output primarily provides student welfare and support, student transport (excluding transport for special needs students) and health services.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Eligible primary school students in receipt of Camps, Sports and Excursions Fund	number	130 000	128 086	135 400	127 876
This performance measure relates to the calendar year. *The 2021-22 expected outcome is lower than the 2021-22 target due to a decrease in the number of eligible students in the primary cohort and lower than expected applications from parents, in light of COVID-19 restrictions and extended periods of learning from home.* *The lower 2022-23 target reflects the outcomes observed in 2021-22.*					
Eligible secondary school students in receipt of Camps, Sports and Excursions Fund	number	100 000	99 741	91 800	95 700
This performance measure relates to the calendar year. *The 2021-22 expected outcome is higher than the 2021-22 target due to an increase in the number of eligible students in the secondary cohort and more parents submitting applications for their children than expected.* *The higher 2022-23 target reflects the increase in recent years in eligible secondary students.*					
Investment in student welfare and support	$ million	394.2	402.1	343.2	342.4
The 2021-22 expected outcome is higher than the 2021-22 target, primarily reflecting funding approved after the release of the 2021-22 Budget. *The higher 2022-23 target primarily reflects new funding announced as part of the* 2022-23 Budget*, funding approved after the release of the* 2021-22 Budget *and indexation.*					
Investment in travelling allowances and transport support (not including special needs students)	$ million	46.2	45.5	45.9	45.3
Health assessments of prep-aged students by school nurses	number	70 500	60 256	70 500	54 138
This performance measure relates to the calendar year. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restricting school nursing operations.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
School students (government) supported by conveyance allowance	number	9 849	9 849	9 255	8 655
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The 2021-22 expected outcome is higher than the 2021-22 target due to a greater than anticipated number of applications, particularly from students at newly established government schools.* *The higher 2022-23 target reflects the anticipated higher number of applications from students at newly established government schools.*					
School students (non-government) supported by conveyance allowance	number	29 471	29 471	28 922	28 636
This performance measure relates to the calendar year. *The higher 2022-23 target reflects the anticipated higher number of applications from students at newly established non-government schools and/or extension of study levels in already established schools.*					
Schools allocated a nurse through the Secondary School Nursing Program	number	198	198	198	196
This performance measure relates to the calendar year. This performance measure refers to government schools only.					
Schools funded for primary welfare officers	number	800	803	803	802
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The lower 2022-23 target reflects the expected number of schools eligible for funding in that year.*					
Number of schools supported by the Schools Mental Health Fund	number	680	nm	nm	nm
New performance measure for 2022-23 to reflect government priorities and initiatives relating to student mental health. This performance measure relates to the calendar year. This performance measure refers to government schools only.					
Number of Active Schools grants provided to schools	number	600	nm	nm	nm
New performance measure for 2022-23 to reflect the Active Schools Fund. This performance measure relates to the calendar year.					
Quality					
School satisfaction with student support services	per cent	80.0	67.9	80.0	75.0
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The 2021-22 expected outcome is lower than the 2021-22 target due to schools' competing priorities regarding flexible and remote teaching and learning, and constrained resource support.*					
Cost					
Total output cost	$ million	440.4	447.6	389.1	387.4
The 2021-22 expected outcome is higher than the 2021-22 target, primarily reflecting funding approved after the release of the 2021-22 Budget. *The higher 2022-23 target primarily reflects new funding announced as part of the* 2022-23 Budget*, funding approved after the release of the* 2021-22 Budget *and indexation.*					

Source: Department of Education and Training

Support for Students with Disabilities

The Support for Students with Disabilities output contributes to all the Department's objectives of achievement, engagement, wellbeing and productivity.

Objective 4: Productivity

The departmental objective indicators are:

- $ per primary school student per year[(a)]
- $ per secondary school student per year[(a)].

Note:
(a) These indicators refer to government and non-government schools.

Support for Students with Disabilities (2022-23: $1 522.3 million)

The Support for Students with Disabilities output covers programs and funding to support students with disabilities as well as transport, welfare and support services for students with special needs.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Eligible special school students provided with appropriate travel	number	8 950	8 925	8 925	8 895
This performance measure relates to the calendar year. *The higher 2022-23 target reflects projected enrolment growth.*					
Proportion of government school students who receive adjustments to support their access and participation in learning because of disability as defined in the *Disability Discrimination Act 1992* (Cth)	per cent	21.0	24.6	17.0	nm
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The 2021-22 expected outcome is higher than the 2021-22 target due to stronger than forecast program demand for targeted engagement with schools.* *The higher 2022-23 target reflects the recent five-year average proportion in eligible students.*					
Proportion of total government schools resourced through the Disability Inclusion funding and support model	per cent	50.0	38.0	30.0	nm
This performance measure relates to the calendar year. This performance measure refers to government schools only. *The 2021-22 expected outcome is higher than the 2021-22 target due to faster than anticipated implementation.* *The higher 2022-23 target reflects increased funding allocations in light of implementation.*					
Proportion of positive responses to school satisfaction by parents of government special school students	per cent	85.0	85.1	85.0	84.0
This performance measure relates to the calendar year. This performance measure refers to government schools only.					
Quality					
Opinion of connectedness to schooling for government school students who receive an adjustment due to disability (mean score)	number (1-5)	3.6	nm	nm	nm
New performance measure for 2022-23 to monitor engagement of students with disability in school. This new measure aligns with reporting for all government school students. This performance measure relates to the calendar year. This performance measure refers to government schools only.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Cost					
Total output cost	$ million	1 522.3	1 323.9	1 363.6	1 126.0

The higher 2022-23 target primarily reflects new funding announced as part of the 2022-23 Budget*, a higher 2022-23 funding profile from previous budget decisions and indexation.*

Source: Department of Education and Training

DEPARTMENT OF ENVIRONMENT, LAND, WATER AND PLANNING

Ministerial portfolios

The Department supports the ministerial portfolios of Energy, Environment and Climate Change, Solar Homes, Water, and Planning.

Departmental mission statement

The Department of Environment, Land, Water and Planning's mission is to shape and support liveable, inclusive and sustainable communities, and thriving natural environments across Victoria by:

- listening, working alongside and partnering with the community in everything we do
- leveraging the connectivity between our portfolios to respond to the impacts of climate change in a productive, collaborative and coordinated way
- maximising opportunities for attracting investment and jobs through supporting the development of new, environmentally sustainable industries
- protecting, enhancing and strengthening the State's liveability and protecting our natural environment, infrastructure and heritage for future generations.

The Department contributes to the Government's commitment to a stronger, fairer, better Victoria by supporting our natural and built environment, to ensure economic growth and liveable, sustainable and inclusive communities that are resilient to the impacts of climate change.

Departmental objectives

Net zero emission, climate-ready economy and community

The Department leads the Government's response to climate change, in line with the *Climate Change Act 2017*. The Government's response includes reducing greenhouse gas emissions, adapting to the impacts of climate change, and supporting the economic and social transition to a net zero emissions and climate-resilient future.

The Climate Change output contributes to this objective by leading the development and implementation of strategic, whole of government climate change policy and programs that contribute to Victoria's 2050 target of net zero greenhouse gas emissions and build the State's resilience to climate change.

Healthy, resilient and biodiverse environment

The Department leads the development and implementation of strategic regulation and investment in environmental and natural resource programs across Victoria.

The Environment and Biodiversity output contributes to this objective by developing and implementing environmental policy and delivering investment, regulatory and research functions.

The Waste and Recycling output delivers investment into reducing waste, transforming recycling services and increasing value from recycled materials. These activities support industry, innovation, research and development and clean technologies to create new markets and business opportunities for recycled materials.

The Statutory Activities and Environment Protection output protects the environment and people by preventing and reducing harm from pollution and waste through better regulation, conducting research and gathering intelligence to inform compliance and enforcement activities, collaboration and the provision of advice.

Reliable, sustainable and affordable energy services

The Department delivers programs on renewable energy, improving energy efficiency and productivity, and provides policy advice to government on the delivery of reliable, sustainable and affordable energy services to households and business consumers.

The Energy output contributes to this objective through state-based energy programs, including renewable energy development, energy efficiency and affordability improvements, and facilitation of new investment.

Victoria is transitioning to a lower emissions future, reducing fossil fuel usage and air pollution, and allowing independence from conventional energy supplies. The Solar Victoria output will, over 10 years, provide 778 500 households with either solar panel energy systems, solar hot water systems, or battery storage for homes with existing solar energy systems. The program also provides solar panels rebates for small businesses and financial subsidies to vulnerable and low-income households to upgrade heating and install high-efficiency reverse cycle air conditioners. Solar Victoria will also deliver the Victorian Government's Zero Emissions Vehicle Subsidy, enabling residents and businesses to transition to cleaner, greener, and more affordable transport.

Productive and effective land management

The Department delivers effective management and governance of Victoria's public and private land to protect its social, economic and environmental values and maximise its use by all Victorians.

The Land Use Victoria output delivers high quality and authoritative land administration and property information services, including the registration of land, survey, valuation and land information services. Land Use Victoria also incorporates the State's foundational spatial data services and government land policies.

The Management of Public Land and Forests output contributes to this objective by providing stewardship of Victoria's forests, coasts and Crown land reserves, to ensure that natural, built and historic assets are managed responsibly.

The Parks Victoria output contributes to this objective by managing the development and protection of Victoria's natural, cultural and community assets.

Safe and sustainable water resources

The Department increases the efficiency of supply and use of water in cities and towns, and improves environmental conditions of waterways to ensure that Victoria has safe and sustainable water resources to meet future urban, rural and environmental needs.

The Effective Water Management and Supply output contributes to this objective by developing policies, providing strategic advice and overseeing regulatory systems and institutional arrangements to effectively manage Victoria's water resources.

A safe and quality built environment

The Department plans for the future growth and transformation of Victoria's cities and regions, and provides leadership and advice on heritage protection and the built environment.

The Planning and Heritage output contributes to this objective by delivering programs to address the future growth and transformation of cities and regions.

The Building output contributes to this objective by addressing risks associated with combustible cladding and ensuring Victoria's building system delivers a safe and quality built environment and strong consumer protection.

Reduced impact of major bushfires and other emergencies on people, property and the environment

The Department delivers an integrated approach to reducing the risk of bushfires and other emergencies to protect people, property and the environment.

The Fire and Emergency Management output contributes to this objective by planning and delivering integrated bushfire management, and the provision of emergency response.

Changes to the output structure

The Department has made changes to its output structure for 2022-23 as shown in the table below:

2021-22 output	*Reason*	*2022-23 outputs*
Solar Homes	This output has been renamed in 2022-23 to reflect the expansion of deliverables within the portfolio.	Solar Victoria
Planning, Building and Heritage	This output has been disaggregated into two outputs in 2022-23 to enhance transparency.	Planning and Heritage Building

Source: Department of Environment, Land, Water and Planning

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives and outputs, together with key performance indicators, are presented in subsequent tables.

($ million)

	2021-22 budget	*2021-22 revised*	*2022-23 budget*	*Variation [(a)] %*
Net zero emission, climate-ready economy and community				
Climate Change	32.9	46.0	27.6	(16.0)
Healthy, resilient and biodiverse environment				
Environment and Biodiversity	162.3	280.0	159.8	(1.6)
Statutory Activities and Environment Protection	236.5	235.0	196.4	(17.0)
Waste and Recycling	55.9	83.9	57.4	2.8
Reliable, sustainable and affordable energy services				
Energy	278.3	368.6	485.7	74.6
Solar Victoria	322.2	367.1	204.7	(36.5)
Productive and effective land management				
Land Use Victoria	255.4	289.4	273.2	7.0
Management of Public Land and Forests	294.0	399.8	336.0	14.3
Parks Victoria	207.6	208.4	216.5	4.3
Safe and sustainable water resources				
Effective Water Management and Supply	317.7	323.4	332.8	4.7
A safe and quality built environment				
Planning and Heritage	182.1	237.5	160.3	(12.0)
Building	139.1	160.1	106.8	(23.2)
Reduced impact of major bushfires and other emergencies on people, property and the environment				
Fire and Emergency Management	406.4	476.8	411.1	1.2
Total [(b)]	**2 890.2**	**3 475.9**	**2 968.3**	**2.7**

Source: Department of Environment, Land, Water and Planning

Notes:

(a) Variation between the 2021-22 budget and the 2022-23 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant output cost.

(b) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.4 outlines the Department's income from transactions and Table 2.5 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.4: Income from transactions **($ million)**

	2020-21 actual	*2021-22 budget*	*2021-22 revised*	*2022-23 budget*
Output appropriations	2 354.7	2 081.1	2 410.4	2 307.2
Special appropriations	122.6	181.7	139.7	182.2
Interest	8.9	21.6	19.2	22.0
Sale of goods and services	84.6	81.2	101.1	109.7
Grants	100.5	6.1	37.3	13.9
Other income	483.6	515.1	640.9	576.6
Total income from transactions [(a)]	**3 154.8**	**2 886.8**	**3 348.6**	**3 211.5**

Source: Department of Environment, Land, Water and Planning

Note:
(a) Table may not add due to rounding.

Table 2.5: Parliamentary authority for resources **($ million)**

	2021-22 budget	*2021-22 revised*	*2022-23 budget*
Annual appropriations	**2 802.1**	**3 084.3**	**3 062.8**
Provision of outputs	1 879.4	2 126.4	2 054.6
Additions to the net asset base	238.5	279.7	292.5
Payments made on behalf of the State [(a)]	684.2	678.1	715.8
Receipts credited to appropriations	**240.9**	**319.5**	**335.2**
Unapplied previous years appropriation	**..**	**50.7**	**..**
Provision of outputs	..	50.7	..
Additions to the net asset base	..	..	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**3 042.9**	**3 454.5**	**3 398.0**
Special appropriations	**201.9**	**160.1**	**193.9**
Trust funds	**1 068.5**	**1 190.7**	**1 258.0**
Municipal and Industrial Landfill Levy Trust [(b)]	374.5	374.5	441.5
Parks and Reserves Trust [(c)]	208.5	208.5	216.7
Other [(d)]	485.6	607.8	599.8
Total parliamentary authority [(e)]	**4 335.2**	**4 835.2**	**4 882.2**

Source: Department of Environment, Land, Water and Planning

Notes:
(a) Includes contributions by the state under agreements pursuant to section 25 of the Murray Darling Basin Act 1993.
(b) The purpose of this trust primarily relates to the collection and distribution of the General Landfill Levy as required under section 70E of the Environment Protection and Sustainability Victoria Amendment Act 2014.
(c) The purpose of this trust primarily holds the park charge collected to support ongoing core operations of Parks Victoria throughout the metropolitan area, the Royal Botanic Gardens, Zoos Victoria and the Shrine of Remembrance.
(d) Includes inter-departmental transfers.
(e) Table may not add due to rounding.

Departmental performance statement

Objective 1: Net zero emission, climate-ready economy and community

This objective involves leading a whole of government response to climate change, including reducing greenhouse gas emissions, adapting to the impacts of a changing climate, and supporting the economic and social transition to a net zero emissions and climate resilient future.

The Department leads the modernisation of legislative, regulatory and governance arrangements in the environment portfolio, and uses economic, research and scientific expertise to develop policy responses to harness Victoria's current and emerging opportunities, in the context of climate change.

The foundation for the Department's work on these issues is the *Climate Change Act 2017*.

The departmental objective indicators are:

- reduction in Victoria's greenhouse gas emissions relative to 2005
- reduction in greenhouse gas emissions for Victorian schools participating in the ResourceSmart Schools program[(a)].

Note:
(a) This objective indicator replaces 'Reduction in annual energy costs for Victorian schools participating in the ResourceSmart Schools program'. The new indicator better reflects progress towards the objective of net zero emission, climate ready economy and community.

Outputs

Climate Change (2022-23: $27.6 million)

This output leads the development and implementation of strategic, whole of government climate change policy and programs that contribute to Victoria's 2050 target of net zero greenhouse gas emissions and building the State's resilience to climate change.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Victorian schools participating in the ResourceSmart Schools program	number	700	650	700	583
The 2021-22 expected outcome is lower than the 2021-22 target due to remote learning arrangements and delivery partners being unable to access school sites as a result of COVIDSafe settings.					
Annual energy saved by Victorian schools participating in the ResourceSmart Schools program	kWh	8 500 000	11 000 000	8 500 000	13 433 957
The 2021-22 expected outcome is higher than the 2021-22 target due to remote learning arrangements as a result of COVIDSafe settings.					
Quality					
Stakeholder satisfaction with climate change engagement events	per cent	75	75	75	nm

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Timeliness					
Delivery of agreed milestones for climate change policy, advice and research within agreed timeframes	per cent	80	80	80	100
Completion of Annual Greenhouse Gas Emissions Report	date	Oct 2022	Oct 2021	Oct 2021	nm
Cost					
Total output cost	$ million	27.6	46.0	32.9	35.7

The 2021-22 expected outcome is higher than the 2021-22 target predominantly due to the funding profile of Protecting Port Phillip Bay and its Beaches and Taking Decisive Action On Climate Change.

The lower 2022-23 target is predominantly due to the funding profile of the Climate Change Community Action and Volunteers Protecting The Coast initiatives.

Source: Department of Environment, Land, Water and Planning

Objective 2: Healthy, resilient and biodiverse environment

This objective involves leading the development and implementation of strategic regulation and investment in environmental and natural resource programs across Victoria.

The Department works with portfolio partners, local communities and external stakeholders to develop effective, evidence-based policies, programs and regulatory responses for: environment protection; waste resource recovery and recycling; ecosystem resilience; native vegetation management; threatened species; and land management practices.

The departmental objective indicators are:

- participation in community-based environmental programs
- reduction in pollutants from priority hotspots
- Environment Protection Authority prosecutions result in a finding of guilt or a clarification of the law[(a)]
- reduction in waste generation per person
- increase in diversion of municipal and industrial waste from landfill[(b)].

Notes:

(a) New indicator to reflect that matters commenced by the EPA have a sound legal basis and are in the public interest.

(b) New indicator to reflect progress towards reducing waste and increasing resource recovery and recycling.

Outputs

Environment and Biodiversity (2022-23: $159.8 million)

This output leads the development and implementation of strategic, whole of government environmental policy and delivers investment, regulatory and research functions that support Victoria's diverse and resilient ecosystems.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Hours volunteered across all government-funded environmental volunteering programs	number	965 350	709 650	965 350	nm
The 2021-22 expected outcome is lower than the 2021-22 target due to a reduction in the number of events and opportunities for volunteering as a result of COVIDSafe settings.					
New permanently protected native vegetation on private land	hectares	800	900	800	560
The 2021-22 expected outcome is higher than the 2021-22 target reflecting the completion of covenant registrations on title delayed from 2020-21 due to the impact of COVID-19 and the 2019-20 bushfires on landowner engagement.					
Hectares of weed control in priority locations	hectares	140 000	140 000	140 000	65 552
Hectares of pest predator control in priority locations	hectares	400 000	700 000	400 000	694 859
The 2021-22 expected outcome is higher than the 2021-22 target as a result of increased pest predator control through bushfire recovery activity.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Hectares of pest herbivore control in priority locations	hectares	500 000	750 000	500 000	905 151
The 2021-22 expected outcome is higher than the 2021-22 target due to increased pest herbivore control through bushfire recovery activity and the deer control program.					
Hectares of revegetation in priority locations for habitat connectivity	hectares	1 000	250	1 000	249
The 2021-22 expected outcome is lower than the 2021-22 target due to the need to prioritise resources to bushfire recovery pest and herbivore control activities, and additional time required for consultation to plan the implementation of large-scale revegetation programs.					
Strategic compliance and enforcement operations implemented by the Conservation Regulator	number	6	6	6	nm
This performance measure renames the 2021-22 performance measure 'Strategic compliance operations implemented by the Conservation Regulator'. The new measure reports on the same activity as the previous measure, however it has been amended for increased clarity.					
Quality					
Presentations made and scientific publications in peer reviewed journals	number	60	60	60	70
Annual Arthur Rylah Institute Client Survey respondents rank the level of overall satisfaction with ARI's research as good, very good or excellent	per cent	95	95	95	nm
Preharvest surveys of areas planned for timber harvesting completed	per cent	64	80	80	93
The lower 2022-23 target reflects the funding profile of the Forest Protection Survey Program and forecasted coupe selection capacity.					
Timeliness					
Native Vegetation Credit Extracts processed within 10 days	per cent	96	95	95	98
The higher 2022-23 target reflects the average level of performance in recent years.					
Planning referrals relating to native vegetation processed within statutory timeframes	per cent	80	80	80	84
Wildlife Licence renewals processed by target dates	per cent	96	96	96	96
Cost					
Total output cost	$ million	159.8	280.0	162.3	187.6
The 2021-22 expected outcome is higher than the 2021-22 target predominantly due to release of contingency funding for the Bushfire Biodiversity Response and Recovery initiative and Commonwealth funding for the Regional Fund for Wildlife and Habitat Bushfire Recovery initiative.					

Source: Department of Environment, Land, Water and Planning

Statutory Activities and Environment Protection (2022-23: $196.4 million)

This output involves protecting the environment and people by preventing and reducing harm from pollution and waste through better regulation, conducting research and gathering intelligence to inform compliance and enforcement activities, collaboration and the provision of advice. These activities support a liveable and prosperous state by leveraging good environmental performance and a shared responsibility among all Victorians to maintain clean air, water and land, and minimal disturbance from noise and odour.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Inspections that assess premises whose operations could represent a significant risk to the environment and human health	number	360-400	400	400-450	336
This performance measure renames the 2021-22 performance measure 'Inspections that assess premises compliance, including licenced premises, whose operations represent a significant risk to the environment and human health'. The new measure reports on the same activity as the previous measure, however it has been amended to reflect that EPA is authorised to inspect all premises that could represent a significant risk to the environment and human health. *The lower 2022-23 target is based on EPA prioritising its resources on ensuring appropriate risk management systems are in place at high risk sites consistent with the General Environmental Duty, and well as broader compliance with the requirements of the* Environment Protection Act 2017.					
Environment condition notifications provided to Victorians	number	>800	1 000	> 1 000	1037
This performance measure renames the 2021-22 performance measure 'Environment condition notifications provided to Victorians via digital channels.' The new measure reports on the same activity as the previous measure, however it has been simplified because all environment condition notifications are delivered via digital channels. *The lower 2022-23 target is based on EPA having implemented a new operating model to deliver its broader responsibilities under the* Environment Protection Act 2017 *and reflects risk-based prioritisation of EPA's resources.*					
Quality					
Community and duty holder trust in EPA	scale 1–100	70	nm	nm	nm
This new performance measure replaces the 2021-22 performance measure 'Events and activities that engage business and community in environment protection'. The replacement better measures the quality of EPA's performance in meeting its regulatory responsibilities as assessed by community and duty holders (businesses issued a license, permit or registration by EPA). This performance measure uses survey data and the 2022-23 target will provide a benchmark to measure improvement in trust over time.					
Timeliness					
Environmental audits and preliminary risk screening assessment reports are reviewed to ensure administrative compliance with legislation and guidelines within 14 days of submission	per cent	80	90	90	nm
This performance measure renames the 2021-22 performance measure 'Environmental audits reviewed to ensure compliance with statutory requirements and guidelines'. The new measure reports on the same activity as the previous measure and now also includes preliminary risk screening assessments, a new tool under the Environment Protection Act 2017. *The measure has been reclassified from quality to timeliness to more accurately reflect the service being delivered.* *The lower 2022-23 target reflects the inclusion of the preliminary risk screening assessments.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
EPA confirms duty holder compliance with remedial notice requirements, or escalates for further action, within 14 days of the compliance due date	per cent	80	90	90	94
This performance measure renames the 2021-22 performance measure 'Remedial notices complied with by due date or escalated in line with EPA's Compliance and Enforcement policy'. The new measure reports on the same activity as the previous measure, however it has been amended for increased clarity. *The measure has been reclassified from quality to timeliness to more accurately reflect the service being delivered.* *The lower 2022-23 target is based on a greater number of duty holders and new forms of remedial notice under the* Environment Protection Act 2017.					
Pollution reporters requesting follow up by EPA receive contact within three working days	per cent	75	85	85	96
The lower 2022-23 target is based on EPA having implemented a new operating model to deliver its broader responsibilities under the Environment Protection Act 2017 *and reflects risk-based prioritisation of EPA's resources.*					
Applications for licences, permits and registrations completed within statutory timelines	per cent	70	96	96	90
This performance measure renames the 2021-22 performance measure 'Applications for permissions completed within statutory timelines'. The new measure reports on the same activity as the previous measure, however it has been amended for increased clarity. *The lower 2022-23 target is based on EPA having implemented a new operating model to deliver its broader responsibilities under the* Environment Protection Act 2017 *and reflects risk-based prioritisation of EPA's resources.*					
Planning matters responded to within agreed timeframes	per cent	65	80	80	nm
The lower 2022-23 target is based on EPA having implemented a new operating model to deliver its broader responsibilities under the Environment Protection Act 2017 *and reflects risk-based prioritisation of EPA's resources.*					
Applications for internal review of remedial notices completed within statutory timeframes	per cent	100	90	90	nm
The higher 2022-23 target reflects EPA's commitment to the efficient review where requested of remedial notices for environmental improvements, prohibitions, actions, and investigations.					
EPA provides technical advice to lead agencies within agreed timelines during emergency incidents	per cent	90	90	90	95
EPA responds to priority waste incidents within one day of notification	per cent	90	90	90	nm
This performance measure renames the 2021-22 performance measure 'EPA responds within one day of notification to waste crime incidents identified for priority response'. The new measure reports on the same activity as the previous measure but has been renamed to distinguish waste incidents necessitating immediate response and the time required to determine whether a waste incident is criminal in nature.					
Cost					
Total output cost	$ million	196.4	235.0	236.5	271.3
The lower 2022-23 target predominantly relates to EPA's new operating model to deliver its broader responsibilities under the Environment Protection Act 2017 *and the funding profile of the Lara Waste Stockpile Site Rehabilitation and Sustaining the EPA's strengthened regulatory functions initiatives.*					

Source: Department of Environment, Land, Water and Planning

Waste and Recycling (2022-23: $57.4 million)

This output delivers investment into reducing waste, transforming recycling services and increasing value from recycled materials. These activities support industry, innovation, research and development and clean technologies to create new markets and business opportunities for recycled materials.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Proportion of Victorian households with access to organic food and garden waste recycling services	per cent	47	33	16	26
The 2021-22 expected outcome is higher than the 2021-22 target due to strong council participation in organic food and garden waste services. *The higher 2022-23 target reflects progress towards Victoria's target of all households having access to organic food and garden waste recycling services by 2030.*					
Proportion of Victorian households with access to separated glass recycling services	per cent	14	11	11	nm
The higher 2022-23 target reflects progress towards Victoria's target of all households having access to kerbside glass recycling services by 2027.					
Victorian local council sites supported to upgrade infrastructure to safely collect and sort e-waste for recovery	number	140	137	140	125
Quality					
Cumulative increase in the capacity of Victoria's resource recovery infrastructure	tonnes	1 500 000	1 350 000	1 000 000	957 354
The 2021-22 expected outcome is higher than the 2021-22 target due to additional capacity achieved through the installation of larger equipment with higher processing capacity than originally planned at some sites. *The higher 2022-23 target reflects the cumulative nature of this measure.*					
Timeliness					
Average assessment time (calendar days) for major investment grants from application closure to recommendation	days	75	80	60	nm
The 2021-22 expected outcome is higher than the 2021-22 target due to higher than expected demand for grants. *The higher 2022-23 target reflects the required financial and environmental due diligence checks for high-value and complex grants.*					
Cost					
Total output cost	$ million	57.4	83.9	55.9	25.0
The 2021-22 expected outcome is higher than the 2021-22 target predominantly due to release of contingency funding for the Fast Tracking Waste and Recycling Infrastructure, Facilitating Innovative Remediation Solutions and Lemon Springs Remediation initiatives.					

Source: Department of Environment, Land, Water and Planning

Objective 3: Reliable, sustainable and affordable energy services

This objective is focused on delivering a comprehensive suite of energy programs that will improve energy efficiency, strengthen consumer protections and improve affordability. The Department also provides policy advice to government on how to deliver clean, reliable, sustainable and affordable energy services to Victorians.

The Department works with a range of stakeholders to provide energy services to consumers, attract investment in renewable energy and low emissions technologies, and support local jobs and communities as Victoria's energy system transitions.

The Department also provides a 10-year program for households to install solar energy technologies.

The departmental objective indicators are:

- relative share of Victoria's energy sourced from renewables
- percentage of surveyed users of the Victorian Energy Compare website who report that they plan to switch offers after using the website
- electricity generating capacity installed under the Solar Homes program
- solar systems installed under the Solar Homes program.

Outputs

Energy (2022-23: $485.7 million)

This output advocates for the provision of reliable, sustainable and affordable energy services through state-based energy programs, including renewable energy development, energy efficiency and affordability improvements, and facilitation of new investment.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Victorian Energy Efficiency Certificates (each representing one tonne of greenhouse gas emissions avoided) surrendered by energy retailers to meet their liabilities under the Victorian Energy Efficiency Target	million certificates	13.2	0	6.5	6.5

This performance measure renames the 2021-22 measure 'Certificates surrendered to meet energy saving targets under the Victorian Energy Upgrades program' to provide clarity on the meaning of 'certificate'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.

The 2021-22 expected outcome is lower than the 2021-22 target due to COVIDSafe settings limiting professional installations of energy efficiency upgrades in households and businesses. This resulted in some certificate providers not being able to meet their contracts with energy retailers. While sufficient energy efficiency certificates have been created to meet the target, the liability surrender date has been delayed until 31 July 2022 to allow more time for contracts to be renegotiated or retailers to source certificates from elsewhere.

The higher 2022-23 target reflects the Victorian Energy Efficiency Target for 2022 and the delayed surrender of the 2021 target.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Annual Melbourne tram network demand offset by solar generated large-scale generation certificates	per cent	100	100	100	100
This performance measure renames the 2021-22 performance measure 'Solar energy purchases sufficient to meet annual Melbourne tram network demand'. The new measure reports on the same activity as the previous measure, however it has been amended for increased clarity.					
Share of Victoria's electricity generation from renewable sources	per cent	38	35	31	29
The 2021-22 expected outcome is higher than the 2021-22 target due to record high solar output and lower than expected coal output. *The higher 2022-23 target reflects progress towards Victoria's renewable energy target of 40 per cent by 2025.*					
Renewable Energy Certificates procured under the Renewable Certificate Purchasing initiative sufficient to meet Renewable Energy Target liability associated with annual electricity demand of participating government sites	per cent	100	100	100	100
This performance measure renames the 2021-22 measure 'Large-scale Generation Certificate procured under the Renewable Certificate Purchasing initiative sufficient to meet annual electricity demand of participating government sites'. The new measure reports on the same activity as the previous measure, however it has been amended for increased clarity.					
Total renewable electricity generation capacity from the Victorian Renewable Energy Target 2017 Auction projects	MW	650	689	650	519
This performance measure renames the 2021-22 measure 'Cumulative renewable energy generation capacity under the Victorian Renewable Energy Target 2017 Auction'. The new measure reports on the same activity as the previous measure, however it has been amended for increased clarity. *The 2021-22 expected outcome is higher than the 2021-22 target reflecting current scheduling information and the anticipated operational capacity of commissioned projects at 30 June 2022.* *The 2022-23 target reflects the Victorian Government's objective to support up to 650 MW of new renewable energy capacity through the VRET 2017 Auction.*					
New Energy Jobs Fund projects completed	number	2	13	15	4
The 2021-22 expected outcome is lower than the 2021-22 target due to one project requiring additional time to attain a planning permit and navigate barriers to grid connection, and one project requiring additional time to amend its technical design to facilitate the grid connection process. *The lower 2022-23 target reflects the number of projects remaining in the program.*					
Government-supported events that engage business and supply chains regarding the energy sector	number	10	10	10	13
Microgrids established	number	4	nm	nm	nm
New performance measure for 2022-23 to demonstrate the delivery of energy resilience solutions. Energy resilience solutions are designed to increase the sustainability and availability of electricity supply through grid independent energy generation and storage at a local level. They include stand-alone power systems (solar panels, battery and/or generator for residential or commercial premises), microgrids, virtual power plants and community scale battery storage solutions.					
Vulnerable Victorian energy consumers reached through consumer support programs	number	50 000	25 000	10 000	20 573
The 2021-22 expected outcome is higher than the 2021-22 target reflecting the significant reach of the Victorian Government's $250 Power Saving Bonus program. *The higher 2022-23 target reflects specific targeting of hard-to-reach energy consumers who have not engaged recently with the energy retail market and extension of the Power Saving Bonus Program.*					

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quality					
Relative reduction in statewide powerline-related bushfire risk	per cent	48.1	44.1	45	44.1
The higher 2022-23 target reflects the expected level of risk reduction following completion of the final tranche of the Rapid Earth Fault Current Limiter rollout. As the rollout will reach completion in 2022-23, no change in risk reduction is expected in 2021-22.					
Users of the Victorian Energy Compare website who report a better understanding of their usage costs after using the website.	per cent	65	65	65	63.2
Timeliness					
Delivery of key Australian Energy Market Commission funding milestones, in line with funding agreements and agreed project deliverables	per cent	100	100	100	100
Cost					
Total output cost	$ million	485.7	368.6	278.3	457.2
The 2021-22 expected outcome is higher than the 2021-22 target predominantly due to the fair value adjustment for derivative financial instruments. *The higher 2022-23 target predominantly relates to the funding profile of the Power Savings Bonus initiative.*					

Source: Department of Environment, Land, Water and Planning

Solar Victoria (2022-23: $204.7 million)

This output will, over 10 years, provide up to 775 800 households with either solar panel energy systems, solar hot water systems, or battery storage for homes with existing solar energy systems, as Victoria transitions to a lower emissions future, reducing fossil fuel usage and air pollution, and allowing independence from conventional energy supplies.

The program also includes solar photovoltaic panels rebates for small businesses and provides financial subsidies to vulnerable and low-income households to upgrade heating and install high-efficiency reverse-cycle air conditioners. Solar Victoria will also deliver the Victorian Government's Zero Emissions Vehicle Subsidy, enabling residents and businesses to transition to cleaner, greener, and more affordable transport.

Through this output, Solar Victoria supports investment in household energy technology innovation to find new and improved ways to meet future energy demand.

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quantity					
Applications for Solar PV rebates for owner-occupied and rental households approved	number	64 000	46 860	75 000	61 473
The 2021-22 expected outcome is lower than the 2021-22 target due to a scheduled reduction in rebate and loan value from 1 July 2021, softening consumer demand and COVID-19 impacts on the solar industry. *The lower 2022-23 target reflects the number of rebates available, in line with the phasing of the program.*					
Applications for home battery rebates approved	number	5 200	7 000	7 000	2841
The lower 2022-23 target reflects the number of rebates available, in line with the phasing of the program.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Applications for solar hot water rebates approved	number	6 000	620	6 000	639
The 2021-22 expected outcome is lower than the 2021-22 target reflecting demand for solar hot water units. A review of the Solar Hot Water rebate program has been completed and actions to facilitate increased uptake are being implemented.					
Applications for Solar PV rebates for small businesses approved	number	5 000	1 525	5 000	373
The 2021-22 expected outcome is lower than the 2021-22 target due to COVID-19 impacts on small business cashflow and business confidence.					
Applications for Home Heating and Cooling Upgrade rebates for reverse cycle air conditioning units to replace inefficient heating systems approved	number	6 000	12 100	70 000	nm
The 2021-22 expected outcome is lower than the 2021-22 target due to COVIDSafe settings limiting installations, availability of reverse cycle air conditioning units and financial impacts of COVID-19 on the consumer target group. *The lower 2022-23 target reflects the number of rebates available, in line with the phasing of the program.*					
Applications for Zero Emissions Vehicle subsidies approved	number	8 600	nm	nm	nm
New performance measure for 2022-23 to reflect the adoption of zero emission vehicles by households and businesses through a subsidy program.					
Rebated installations audited by the Solar Homes Audit Program to be conducted in accordance with the Solar Homes Assurance Framework plan	per cent	5	5	5	5
This performance measure has been reclassified from 'quality' to 'quantity' to more accurately reflect the type of service being delivered.					
Quality					
Solar Homes Program customers who rate the overall performance of Solar Victoria as 'Good' or 'Very Good' in post-approval surveys	per cent	75	nm	nm	nm
New performance measure for 2022-23 to reflect customer satisfaction with the Solar Homes Program.					
Timeliness					
Average number of weeks for Solar Victoria to process completed eligibility applications	weeks	2	2	4	2
This performance measure renames the 2020-21 performance measure 'Average number of weeks to process completed eligibility applications'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity. *The 2021-22 expected outcome is better than the 2021-22 target, reflecting portal enhancements that reduced manual processing and improved the online application experience for customers.* *The lower target for 2022-23 reflects the expectation that this trend will continue.*					
Rebate payments for Solar retailers processed within five business days	per cent	80	nm	nm	nm
New performance measure for 2022-23 to reflect the timeliness of Solar Victoria in providing an efficient payment service to the solar retailers.					
Cost					
Total output cost	$ million	204.7	367.1	322.2	234.9
The 2021-22 expected outcome is higher than the 2021-22 target predominantly due to a rephase of funding from 2020-21 for the Energy Efficiency Upgrades for Homes and Cheaper Clean Energy For Small Business initiatives. *The lower 2022-23 target is predominantly due to the funding profile for the Solar Homes initiatives and the cessation of a number of initiatives.*					

Source: Department of Environment, Land, Water and Planning

Objective 4: Productive and effective land management

This objective delivers effective management and governance of Victoria's public and private land to protect its social, economic and environmental values and maximise its use by all Victorians.

The Department works with statutory agencies, committees and local governments to ensure that: land is productive and is used in a sustainable manner; infrastructure on public land and in coastal environments is appropriate and well managed; the condition of marine, coastal and estuarine environments is protected, maintained and improved; and key biodiversity assets, priority habitats and ecological processes are healthy and secure.

The Department also provides authoritative, comprehensive and accessible land data and services, including the Victorian land registry, valuations, surveying and innovative spatial information, to support integrated, evidence-based decision making and ensure confidence in the integrity and efficiency of the Victorian property system. The Department also leads implementation of the Victorian Government Land Use policy to deliver greater value from government-owned land and works with agencies to ensure land is transacted in accordance with legislation, policy and probity standards, through the Victorian Government Land Monitor.

The departmental objective indicators are:

- level of park visitor satisfaction across the Parks Victoria estate[(a)]
- bay and park assets rated in average to excellent condition
- increase in utilisation of Land Use Victoria's mapping and spatial data products relative to 2016-17[(b)]
- Traditional Owner satisfaction with DELWP's progress in enabling self-determination[(c)]

Notes:

(a) This objective indicator replaces 'Number of visits to the public land estate managed by the Department's portfolio agencies (Parks Victoria)'. The replacement indicator is better aligned to the objective of productive and effective land management.

(b) This objective indicator replaces the previous indicators 'Consistent and timely provision of government land transaction approvals and advice' and 'Efficient provision of timely and authoritative land administration and property information services'. The new indicator better reflects progress towards achieving the objective, representing DELWP's product offering in spatial services.

(c) This objective indicator replaces the previous indicator 'Traditional Owner satisfaction with progress on the Pupangarli Marnmarnepu Implementation Action Plan endorsed by the statewide Caring for Country Partnership Forum'. The new indicator better represents and assesses DELWP's progress in enabling self-determination more broadly across program areas.

Outputs

Land Use Victoria (2022-23: $273.2 million)

This output delivers high-quality and authoritative land administration and property information services, including the registration of land titles, survey, valuation and land information services. Land Use Victoria also incorporates the State's foundational spatial data services and government land policies. The probity of the Government's property transactions is overseen by the Government Land Monitor.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Land Utilisation Program assessments completed	number	40	40	40	49
This performance measure renames the 2021-22 performance measure 'Rapid Land Use Assessments completed' to better represent the activity of the entire program. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.					
Quality					
Audited Vicmap digital map base not requiring correction	per cent	98	98	98	99.49
Government-owned properties sold, bought or leased within 10 per cent of valuation	per cent	80	80	80	80
Land dealings accurately registered	per cent	99	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Property transfers, discharge of mortgages and registration of new mortgages' to better reflect activity within the Department's control.					
Successful objection rate for rating authority valuations	per cent	< 0.2	nm	nm	nm
New performance measure for 2022-23 to demonstrate the quality of the rating and taxing valuation service in line with the International Valuation Standards benchmark.					
Timeliness					
Delivery of updated Vicmap foundation data within one week	per cent	98	98	98	100
Land dealings registered within five days	per cent	99	99	99	99.49
New titles (subdivisions) created within 15 business days	per cent	95	95	95	84.58
This performance measure renames the 2021-22 performance measure 'New titles (subdivisions) created within three weeks'. The new measure reports on the same activity as the previous measure, however it has been amended for clarity.					
Update transactions for the Vicmap digital map base processed within the required timeframes	per cent	98	98	98	94.6
Decisions made on submissions to the Victorian Government Land Monitor within 10 business days	per cent	85	nm	nm	nm
New performance measure for 2022-23 to reflect the Victorian Government Land Monitor's requirement to provide timely land transactions advice, in line with the requirements set out in the Victorian Government Land Transaction Policy.					
Cost					
Total output cost	$ million	273.2	289.4	255.4	250.6
The 2021-22 expected outcome and 2022-23 target are higher than the 2021-22 target predominantly due to Victoria's positive housing market boom. This has caused an increase in Land Registry Services revenue with a reciprocal increase in payments to the private operator.					

Source: Department of Environment, Land, Water and Planning

Management of Public Land and Forests (2022-23: $336.0 million)

This output provides for the improved stewardship of Victoria's forests, coasts and Crown land reserves. Through this output, the Department manages the natural, built and historic assets on public land responsibly, and incorporates management of public land in partnership with statutory agencies, committees of management and local government.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Crown land leases directly managed by the Department	number	678	678	720	689
The 2021-22 expected outcome and the 2022-23 target are lower than the 2021-22 target reflecting the transfer of some leases from the department to other agencies for management.					
Crown land licenses directly managed by the Department	number	45 000	45 000	45 000	45 000
Native Title and *Traditional Owner Settlement Act 2010* negotiations the Department supports with data and information services	number	3	6	4	6
The 2021-22 expected outcome is higher than the 2021-22 target due to the commencement of two new agreement negotiations with Traditional Owner groups.					
The lower 2022-23 target reflects the anticipated completion of negotiations with three Traditional Owner groups that have existing agreements.					
Native Title and *Traditional Owner Settlement Act 2010* agreements being implemented by the Department	number	6	6	6	6
Participants in Coastcare activities	number	10 000	9 120	10 000	2 233
The 2021-22 expected outcome is lower than the 2021-22 target due to COVIDSafe settings impacting face to face delivery of Coastcare activities.					
Visitors to the Royal Botanic Gardens in Melbourne and Cranbourne	number (million)	2.2–2.4	2.0	2.0–2.2	1.5
The higher 2022-23 target reflects planned activities to increase visitation through major events and learning programs.					
Specimens curated in the State Botanical Collection	number	30 000	30 000	30 000	25 015
Visitors to Zoos Victoria at Melbourne, Werribee and Healesville	number (million)	2.85	1.64	2.85	1.53
The 2021-22 expected outcome is lower than the 2021-22 target due to closure of zoos and visitor number caps under COVIDSafe settings.					
Contaminated Crown land sites assessed/prepared for remediation	number	1	5	5	3
The lower 2022-23 target reflects program being ahead of schedule and a higher number of sites being completed in 2021-22.					
Off-leash dog parks completed	number	31	nm	nm	nm
New performance measure for 2022-23 to disaggregate and replace the 2021-22 measure 'Suburban dog parks and pocket parks under development'. The new measure provides clarity on the number of parks being established in each category and demonstrates the department's progress in delivering the Suburban Parks Program and the Building Works Package.					
Suburban pocket parks completed	number	29	nm	nm	nm
New performance measure for 2022-23 to disaggregate and replace the 2021-22 measure 'Suburban dog parks and pocket parks under development'. The new measure provides clarity on the number of parks being established in each category and demonstrates the department's progress in delivering the Suburban Parks Program.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quality					
Publicly elected Committees of Management that have a current statutory appointment	per cent	90	90	90	91
Recreational facilities in state forests maintained to have a life expectancy greater than five years.	per cent	75	78	75	77
This performance measure renames the 2021-22 performance measure 'Recreational facilities in state forests with a life expectancy greater than five years'. The new measure reports on the same activity as the previous measure however has been amended to better reflect work undertaken by the department.					
Timeliness					
Rent reviews of Department-managed Crown land leases undertaken within specified time frames	per cent	95	95	95	93
Investigations of alleged non-compliance with the Code of Practice for Timber Production 2014 and other relevant laws are completed within the statute of limitations of two years	per cent	100	100	100	nm
Cost					
Total output cost	$ million	336.0	399.8	294.0	356.2
The 2021-22 expected outcome is higher than the 2021-22 target predominantly due to additional funding for Flood and Storm recovery, release of contingency funding for the Enhanced Communications During Emergencies Creating a Safer Victoria initiative and a reallocation of costs from asset to output for the Great Ocean Road Management Reforms and Coastal Trail initiative.					
The 2022-23 target is higher than the 2021-22 target predominantly due to the release of contingency funding for the Enhanced Communications During Emergencies Creating a Safer Victoria initiative and additional funding announced as part of the 2022-23 Budget*. This is partially offset by the funding profile for the Enhancing Victoria's liveability through improvements to the parks and reserves estate initiative.*					

Source: Department of Environment, Land, Water and Planning

Parks Victoria (2022-23: $216.5 million)

This output provides for the improved stewardship of Victoria's parks. Through this output, Parks Victoria manages the development and protection of natural, cultural and community assets for safe enjoyment and sustainable use by all Victorians. Parks Victoria works to ensure the State's park assets are managed efficiently and effectively.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Area treated to minimise the impact of pest plants, pest animals and over abundant native animals in parks managed by Parks Victoria	hectares (000)	1 600	2 200	2 200	2 250
The lower 2022-23 target reflects the completion of State and Commonwealth bushfire recovery programs.					
Visits to national, state, urban and other terrestrial parks	number (million)	82	na	80	86
The 2021-22 expected outcome is not available as the biennial visitor number survey is not being conducted in 2021-22. The 2022-23 target is higher than the 2021-22 target due to an expected increase in domestic tourism and more Victorians connecting with nature under eased COVIDSafe settings.					
Visits to piers and jetties	number (million)	37	na	35	33.3
The 2021-22 expected outcome is not available as the biennial visitor number survey is not being conducted in 2021-22. The 2022-23 target is higher than the 2021-22 target due to an expected increase in domestic tourism and more Victorians connecting with nature under eased COVIDSafe settings.					
Total area of estate managed by Parks Victoria	hectares (000)	4 120	4 120	4 120	4 120
Quality					
Significant built bay assets managed by Parks Victoria rated in average to excellent condition	per cent	80	70	80	67
The 2021-22 expected outcome is lower than the 2021-22 target due to the decline of maritime assets from age and storm impacts.					
Significant built park assets managed by Parks Victoria rated in average to excellent condition	per cent	88	88	88	86
Cost					
Total output cost	$ million	216.5	208.4	207.6	165.7

Source: Department of Environment, Land, Water and Planning

Objective 5: Safe and sustainable water resources

This objective increases the security of supply and the efficient use of water in cities and towns and improves the environmental condition of waterways to ensure Victoria has safe and sustainable water resources to meet future urban, rural and environmental needs.

The Department works in partnership with water corporations, catchment management authorities, government agencies, industry, traditional owners and the community to balance the economic, environmental and social values of water. This helps to deliver secure water supplies, greener and liveable cities and towns, and healthy waterways and aquifers.

The departmental objective indicators are:

- proportion of intended properties (or equivalent) in the Goulburn Murray, Macalister, Werribee and Bacchus Marsh irrigation districts connected to a modernised irrigation delivery system
- number of river reaches/wetlands with maintained or improved environmental condition.

Outputs

Effective Water Management and Supply (2022-23: $332.8 million)

This output develops policies, provides strategic advice and oversees regulatory systems and institutional arrangements to effectively manage Victoria's water resources. Through this output, the Department delivers on-ground environmental programs to improve the health of waterways; water industry reform, governance and performance oversight; integrated water management; sustainable irrigation programs; and makes water resource information accessible to enable informed decision making.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Area of waterway vegetation works undertaken to improve the health and resilience of waterways	hectares	9 000	9 000	9 000	9 400
Cumulative water savings (permanent reduction in irrigation distribution system delivery losses) realised through water recovery projects	megalitres	910 028	902 128	909 902	893 893
The 2021-22 expected outcome is lower than the 2021-22 target due to delays in DELWP receiving final water recovery estimates for some of the planned audits. It is anticipated that final estimates will be provided in 2022-23 to allow audits to proceed. Water savings are not granted to water corporations until savings have been formally verified and recognised through an independent water audit process. *The higher 2022-23 target reflects the cumulative nature of this measure.*					
Climate and hydrology research activities underway that focus specifically on Victoria	number	7	2	1	2
The 2021-22 expected outcome is higher than the 2021-22 target due to two research activities developed under the Victorian Water and Climate Initiative. As implementation progressed, it was found that two funding agreements would deliver a better outcome for this investment. *The higher 2022-23 target reflects an additional five funded research studies underway in line with the program plan.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Long-term water monitoring site parameters maintained	number	1 495	1 167	1 167	1 167
This performance measure renames the 2021-22 performance measure 'Long-term water monitoring sites maintained'. The new measure reports on the same activity as the previous measure, however it has been amended for increased clarity to better reflect the work being undertaken in relation to both surface water and groundwater monitoring, and that a water monitoring site can have multiple parameters being measured at that site. *The higher 2022-23 target reflects the number of parameters that will become long term parameters over 2022-23.*					
Interactions with Water Markets reporting and transparency information, including visits to the Water Register webpage and other digital information, per month	number	2 500	2 100	2 000	1 503
This performance measure renames the 2021-22 performance measure 'Interactions with Water Markets reporting and transparency information, including visits to the Water Markets insights webpage and other digital information, per month'. The new measure reports on the same activity as the previous measure, however it has been amended to include broader water market information, rather than the narrow information provided on water insights webpages. *The 2021-22 expected outcome is higher than the 2021-22 target reflecting high demand for water market information.* *The higher 2022-23 target reflects the expectation for increased interactions following the inclusion of additional web pages.*					
Schools signed up to Schools Water Efficiency Program (SWEP)	number	1 550	1 375	1 500	1 277
The 2021-22 expected outcome is lower than the 2021-22 target to account for reduced recruitment during periods of remote learning as a result of COVIDSafe settings. *The higher 2022-23 target reflects the cumulative nature of this measure.*					
Place-based plans and actions underway for healthier communities and environments that encompass multiple values (Aboriginal, social, environmental and economic)	number	8	8	8	8
Households or community housing assisted in the Community Rebate and Housing Retrofit Program	number	1 100	1 555	1 555	600
The lower 2022-23 target reflects that the housing retrofit component of the program will be completed in 2021-22.					
Area of active stewardship to improve catchment health and resilience through broadacre management	hectares	19 500	6 000	12 000	3 711
This performance measure renames the 2021-22 performance measure 'Area of active stewardship for catchment health and resilience'. The new measure reports on the same activity as the previous measure, however it has been amended for increased clarity. *The 2021-22 expected outcome is lower than the 2021-22 target due to COVIDSafe settings limiting staff ability to meet with landholders and contractors, and undertake work. Further, wet conditions during 2021-22 made sites inaccessible and unsuitable for works.* *The higher 2022-23 target reflects the program's delivery stage in line with the project plan and new funding received in 2022-23 under the 'Implementation of the Central and Gippsland Region Sustainable Water Strategy' initiative.*					
New flood studies underway to ensure communities understand flood risk and to inform investment in flood warning and mitigation measures	number	12	9	6	0
The 2021-22 expected outcome is higher than the 2021-22 target due to nine submissions fully meeting the Risk and Resilience Grants criteria. *The higher 2022-23 target reflects the increased number of studies being undertaken during the year in line with the program plan.*					
Environmental watering actions achieved at planned sites	per cent	90	90	90	89.6

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quality					
Compliance with the salinity management actions agreed in the Murray Darling Basin Agreement	per cent	100	100	100	100
Victorian Water Register system availability per annum	per cent	95.8	95	95.8	99
Waterway and catchment health priority projects delivered involving community and sector partners	per cent	95	90	90	80
The higher 2022-23 target reflects expected increases in line with the program plan as it reaches its third year of a four-year program, under the fifth tranche of the Environmental Contribution and new funding received in 2022-23 under the 'Implementation of the Central and Gippsland Region Sustainable Water Strategy' initiative.					
Timeliness					
Waterway licenses and permits processed within statutory timeframes	per cent	90	90	90	93
Cost					
Total output cost	$ million	332.8	323.4	317.7	334.2
The higher 2022-23 target predominately relates to Commonwealth contributions for the Sustainable Rural Water Use and Infrastructure program and additional funding announced as part of the 2022-23 Budget*. This is partially offset by the funding profile for the Waterway Environmental Works initiative and reallocation of costs from output to asset for the Goulburn-Murray Water Efficiency initiative.*					

Source: Department of Environment, Land, Water and Planning

Objective 6: A safe and quality built environment

This objective plans for the future growth and transformation of cities and regions, and provides leadership and advice on heritage protection and the built environment. It delivers streamlined, fair and transparent planning, building and heritage systems.

The department recognises the link between the natural and built environment in the quality of our lives and works to accommodate population growth while maintaining world-class liveability and protecting our heritage for future generations.

The departmental objective indicators are:

- improved liveability, sustainability and inclusiveness of public spaces and neighbourhoods
- effective protection of cultural and natural heritage.

Outputs

Planning and Heritage (2022-23: $160.3 million)

This output delivers programs to address the future growth and transformation of cities and regions through: strategic and integrated land use planning; urban development, design and renewal; land supply; heritage conservation and management; and regulatory reform. Through this output, the Department administers the statutory responsibilities of the Minister for Planning and provides for fair and transparent planning and heritage systems.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Local governments undertaking work to support strategic planning for coastal settlements and areas	number	15	15	15	15
This performance measure has been transferred directly from the former Planning, Building and Heritage output.					
Places or objects assessed for the Victorian Heritage Register	number	40	40	40	42
This performance measure has been transferred directly from the former Planning, Building and Heritage output.					
Conservation projects funded for 'at risk' State significant heritage places and objects	number	20	19	20	15
The 2021-22 expected outcome is lower than the 2021-22 target, reflecting the number of projects funded through Round 6 of the Living Heritage Program. These successful projects scored highest against the program criteria and were assessed as providing the strongest community and heritage conservation benefits. *This performance measure has been transferred directly from the former Planning, Building and Heritage output.*					
Regional Victoria plans where preparation is complete	number	3	nm	nm	nm
This new performance measure replaces the 2021-22 performance measure 'Planning projects initiated in regional cities and towns to unlock and deliver zoned land supply'. The new measure reflects the work undertaken by the Victorian Planning Authority in fulfilling its legislated obligations in delivering precinct structure plans, which is a subsequent milestone of the process previously measured.					

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Metropolitan Greenfield plans where preparation is complete	number	3	nm	nm	nm
This new performance measure replaces the 2021-22 performance measure 'Planning projects initiated to deliver zoned land supply for new 20-minute neighbourhoods in Greenfields Melbourne'. The new measure reflects the work undertaken by the Victorian Planning Authority in fulfilling its legislated obligations in delivering precinct structure plans, which is a subsequent milestone of the process previously measured.					
Quality					
Environment effects statements, referrals and assessments are completed effectively and within the timeframes necessary to meet targets in the Ministerial Guidelines	per cent	70	70	70	69
This performance measure has been transferred directly from the former Planning, Building and Heritage output.					
Council grant applications that meet relevant objectives of the Streamlining for Growth guidelines	per cent	96	nm	nm	nm
This new performance measure replaces the 2021-22 performance measure 'Projects approved through the Streamlining for Growth program that benefit councils'. The new measure is a more meaningful indicator of performance, as it provides information on councils' ability to develop submissions that meet the objectives of the Streamlining for Growth program which in turn reflects the quality of support and guidance provided by the department to councils during the application process.					
Timeliness					
Average number of days to issue an archaeological consent	days	20	20	20	17
This performance measure has been transferred directly from the former Planning, Building and Heritage output.					
Average number of days to issue heritage certificates	days	7	7	7	7
This performance measure has been transferred directly from the former Planning, Building and Heritage output.					
Heritage permits issued within initial 60-day statutory timeframes	per cent	90	90	90	79
This performance measure has been transferred directly from the former Planning, Building and Heritage output.					
Median number of days taken by the Department to assess a planning scheme amendment	days	40	45	35	71
The 2021-22 expected outcome is higher than the 2021-22 target due to an increased number of prescribed and ministerial amendments, which added to the overall number of amendments for processing. Additional delays were experienced due to COVID-19. *The higher 2022-23 target reflects the changing profile of amendments and the appropriate number of days to complete an assessment under Ministerial Direction 15 for Planning Scheme Amendments.* *This performance measure has been transferred directly from the former Planning, Building and Heritage output.*					
Urban Development Program Report on analysis of supply, consumption and adequacy of residential and industrial land completed	date	Jun 2023	Jun 2022	Jun 2022	Jun 2021
This performance measure has been transferred directly from the former Planning, Building and Heritage output.					
State population projections completed to inform State Budget delivery	date	Feb 2023	Feb 2022	Feb 2022	Feb 2021
This performance measure has been transferred directly from the former Planning, Building and Heritage output.					
Victoria in Future population projection data to support infrastructure and service delivery planning completed	date	Jun 2023	Jun 2022	Jun 2022	Jun 2021
This performance measure has been transferred directly from the former Planning, Building and Heritage output.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Planning permit applications for new renewable energy facilities (excluding call ins) prepared for determination within 45 days after completion of public notice and receipt of council response to public notice	per cent	70	60	70	57
The 2021-22 expected outcome is lower than the 2021-22 target due to some applicants failing to prepare a Cultural Heritage Management Plan within the prescribed timeframe, and other applicants requiring additional time to provide supporting information.					
This performance measure has been transferred directly from the former Planning, Building and Heritage output.					
Cost					
Total output cost	$ million	160.3	237.5	182.1	nm
The 2021-22 expected outcome is higher than the 2021-22 target predominantly due to the funding profile for initiatives funded through the Growth Areas Infrastructure Contribution Fund: Berwick station bus interchange, bus interchange and cycle access to Tarneit station, Cranbourne station car parking and the future police station Wollert project.					
The lower 2022-23 target is predominantly due to the transfer of funding to the new Building output as well as the funding profile for the Cladding Rectification Program and Big Housing Build: Implementing the Commissioner For Better Regulation's planning reforms.					

Source: Department of Environment, Land, Water and Planning

Building (2022-23: $106.8 million)

The Building output contributes to this objective by addressing risks associated with combustible cladding and ensuring Victoria's building system delivers a safe and quality built environment. Cladding Safety Victoria was established to rectify combustible cladding on the highest risk private residential buildings and support Government departments to rectify their buildings across Victoria. In addition, the Victorian Building Authority's proactive inspection program identifies and addresses high risk building and plumbing works across the State. Through this output, the Department administers the statutory responsibilities of the Minister for Planning and provides for fair, transparent and safe building systems, and strong consumer protection.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
New building permits inspected by the Victorian Building Authority	per cent	10	10	10	10
This performance measure renames the 2021-22 performance measure 'Building permits inspected by the Victorian Building Authority'. The new measure reports on the same activity as the previous measure, however it has been amended for increased clarity.					
This performance measure has been transferred directly from the former Planning, Building and Heritage output.					
In-scope government buildings that have completed cladding rectification works	number	18	35	31	nm
The 2021-22 expected outcome is higher than the 2021-22 target due to additional buildings brought into the program in 2021-22. These buildings were identified as meeting program criteria based on risk rating and were funded within the available budget.					
The lower 2022-23 target reflects continued investigation of risk-mitigation measures. This performance measure has been transferred directly from the former Planning, Building and Heritage output.					
In-scope privately owned residential buildings that have commenced cladding rectification works	number	80	80	150	nm
The 2021-22 expected outcome is lower than the 2021-22 target due to continued investigation of risk-mitigation measures. The 70 remaining buildings will be completed in 2022-23 and are included in the 2022-23 target.					
The lower 2022-23 target reflects continued investigation of risk-mitigation measures.					
This performance measure has been transferred directly from the former Planning, Building and Heritage output.					
In-scope privately-owned residential buildings that have completed cladding rectification works	number	90	150	150	nm
The lower 2022-23 target reflects continued investigation of risk-mitigation measures.					
This performance measure has been transferred directly from the former Planning, Building and Heritage output.					
Cost					
Total output cost	$ million	106.8	160.1	139.1	nm
The 2021-22 expected outcome is higher than the 2021-22 target predominantly due to the release of contingency for the Cladding Rectification Program.					
The lower 2022-23 target is predominantly due to the funding profile of the Cladding Rectification Program.					

Source: Department of Environment, Land, Water and Planning

Objective 7: Reduced impact of major bushfires and other emergencies on people, property and the environment

This objective delivers an integrated approach to reducing the risk of bushfires and other emergencies to protect people, property and the environment.

The Department works together with land and fire managers and with the community to plan and deliver bushfire management across public and private land, and uses world-leading science to manage fire and ecosystems.

The departmental objective indicators are:

- percentage of bushfires contained at first attack and/or under five hectares to suppress bushfires promptly, keep bushfires small and minimise loss
- area treated through planned burning and other treatments to maintain the statewide bushfire risk at or below 70 per cent
- percentage of agreed departmental emergency management obligations met on time and to standard
- the economic impact of fire prevention and preparedness investment.

Output

Fire and Emergency Management (2022-23: $411.1 million)

This output plans and delivers integrated bushfire management. Through this output, the Department works with land and fire managers to plan and deliver bushfire management across public and private land; involves local communities in decision-making, drawing on local values and insights to promote resilience; invests in science and partnerships to build knowledge of the relationship between fire and the environment to better manage risk; monitors and assesses the impact and effectiveness of fire management operations; ensures its workforce is effectively trained and prepared; and maintains a strategic road network to facilitate fire and emergency related activities and provide access for the community, timber and tourism industries.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Strategic fuel breaks built or upgraded	km	152	750	963	545
The 2021-22 expected outcome is lower than the 2021-22 target due to works brought forward at the end of 2020-21, seasonal factors that delayed works commencing in 2021-22 and COVID-19 impacts on contractor availability. *The lower 2022-23 target reflects the remaining activities required to complete the Building Strategic Fuel Breaks program target of 1 447 kilometres of fuel breaks over the life of the program.*					
Strategic fire access roads improved	km	2 000	2 000	2 000	3 791
Bridges or crossings on the strategic fire access road network replaced or upgraded	number	10	10	10	15

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Personnel with accreditation in a fire and emergency management role	number	2 450	2 873	2 400	2 761
The 2021-22 expected outcome is higher than the 2021-22 target due to a proactive approach to ensuring staff progress to accreditation as soon as practicable, strong engagement in the training programs and an intake of seasonal Project Fire Fighters and fixed term Forest Fire Operating Officers. *The higher 2022-23 target reflects this trend while accounting for natural attrition.*					
State forests roads (Category 1) and bridges (on Category 1 roads) with documented inspections and/or maintenance programs to meet regulatory obligations	per cent	100	100	100	100
Statewide bushfire risk is maintained at or below the target	per cent	70	67	70	64
Stakeholder and community forums on bushfire management and planned burning held	number	12	22	12	12
The 2021-22 expected outcome is higher than the 2021-22 target due to a requirement for stakeholder and community engagement on the impact of storm debris on bushfire management following the June 2021 storm and flood event.					
Quality					
Fires contained at less than five hectares to suppress fires before they become established, minimising impact	per cent	80	95	80	97
The 2021-22 expected outcome is higher than the 2021-22 target due to a benign bushfire season. In addition to cooler weather conditions, contract extensions for seasonal workers and additional Forest, Fire Operations Officers allowed for increased staff to increase patrols and conduct preparedness works.					
Personnel accredited to serve in a senior capacity (level 2 or 3) in a fire and emergency management role	number	340	390	330	384
The 2021-22 expected outcome is higher than the 2021-22 target due to a proactive approach to ensuring staff progress to accreditation as soon as practicable after completing training and demonstrating their ability to perform the role, strong engagement in the senior emergency management development and accreditation programs, proactive identification of future leaders and a high success rate of participants. *The higher 2022-23 target reflects this trend, which will be partly offset by natural attrition.*					
Proportion of Community-Based Bushfire Management partnerships rated as high functioning	per cent	80	80	80	80
Timeliness					
Assessment of model of cover completed to assess resource requirements and availability	date	Dec 2022	Dec 2021	Dec 2021	Dec 2020
100 per cent of burns identified in the Joint Fuel Management Program prepared for delivery	date	Sep 2022	Oct 2021	Sep 2021	Sep 2020
This performance measure renames the 2021-22 performance measure 'Joint Fuel Management Program Plans completed'. The new measure reports on the same activity as the previous measure, however it has been amended for increased clarity. *The 2021-22 target date of September 2021 was not met due to additional time required to finalise fire history spatial data.*					
Fires contained at first attack to suppress fires before they become established, minimising impact	per cent	80	98	80	95
The 2021-22 expected outcome is higher than the 2021-22 target due to a benign bushfire season. In addition to cooler weather conditions, contract extensions for seasonal workers and additional Forest, Fire Operations Officers allowed for increased staff to increase patrols and conduct preparedness works.					
Readiness and response plans completed prior to the upcoming fire season	date	Oct 2022	Oct 2021	Oct 2021	Oct 2020

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Cost					
Total output cost	$ million	411.1	476.8	406.4	517.4
The 2021-22 expected outcome is higher than the 2021-22 target predominantly due to additional funding provided to augment Victoria's aviation firefighting fleet, support necessary bushfire emergency management preparation activities and undertake bushfire recovery activities.					

Source: Department of Environment, Land, Water and Planning

DEPARTMENT OF FAMILIES, FAIRNESS AND HOUSING

Ministerial portfolios

The Department supports the ministerial portfolios of Housing, Disability, Ageing and Carers, Child Protection and Family Services, Equality, Multicultural Affairs, Veterans, Women, Youth and the Prevention of Family Violence.

Departmental mission statement

The Department of Families, Fairness and Housing's vision is to empower communities to build a fairer and safer Victoria.

Departmental objectives

Children, young people and families are safe, strong and supported

- Victorian families, carers and individuals have supportive and respectful relationships
- Victorians are safe from harm, fear and neglect in their homes.

Victorian communities are safe, fair, inclusive and resilient

- Victorians are socially involved in their community and participation helps their wellbeing
- communities foster social inclusion and participation, and diversity is celebrated and enabled
- Victorians from intersectional communities can safely identify with their culture, express their identity and build support networks with people they trust
- communities are strong and resilient in times of emergency.

All Victorians have stable, affordable and appropriate housing

- Victorians have safe homes that provide emotional and physical sanctuary
- Victorians have security of tenure in housing that is accessible, appropriate, affordable and tailored to them.

Departmental services are high performing and responsive, and informed by Aboriginal voice, knowledge and cultural leadership

- Aboriginal self-determination underpins everything the department does, and Aboriginal knowledge and evidence informs service development and delivery
- services are person centred, inclusive and effective, supported by a culture of safety, a skilled workforce, and strong leadership.

Changes to the output structure

The Department has made changes to its output structure for 2022-23 as shown in the table below.

2021-22 outputs	*Reason*	*2022-23 outputs*
Victorian Contribution to National Disability Insurance Scheme	Output removed due to changed funding arrangements. Funding will continue be reported in Budget Paper No. 5, along with the performance measure target for 2022-23 and expected outcome for 2021-22.	na

Source: Department of Families, Fairness and Housing

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2021-22 budget	*2021-22 revised*	*2022-23 budget*	*Variation [(a)] %*
Children, young people and families are safe, strong and supported				
Child Protection and Family Services	1 811.4	1 858.0	1 824.0	0.7
Primary Prevention of Family Violence	27.5	28.5	27.1	(1.5)
Family Violence Service Delivery	555.1	529.8	585.9	5.5
Victorian communities are safe, fair, inclusive and resilient				
Disability Services	458.1	461.0	490.1	7.0
Community Participation	108.7	155.8	65.9	(39.4)
Office for Disability	15.6	15.4	7.8	(50.0)
Seniors Programs and Participation	27.4	68.4	68.4	149.6
Support to veterans in Victoria	12.6	13.5	11.5	(8.6)
LGBTIQ+ equality policy and programs	5.7	7.6	10.1	76.5
Women's policy	15.7	16.6	13.4	(14.8)
Youth	33.7	34.5	32.6	(3.4)
Multicultural affairs policy and programs	54.7	103.3	51.2	(6.4)
Victorian Contribution to National Disability Insurance Scheme [(b)]	1 693.3	1 693.3	na	na
All Victorians have stable, affordable and appropriate housing				
Housing Assistance	1 019.6	936.1	821.1	(19.5)
Concessions to Pensioners and Beneficiaries	625.6	648.5	641.3	2.5
Total [(c)]	**6 464.7**	**6 570.4**	**4 650.4**	**(28.1)**

Source: Department of Families, Fairness and Housing

Notes:

(a) Variation between the 2021-22 budget and the 2022-23 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant output cost.

(b) Variance between the 2021-22 budget and the 2022-23 budget is due to the reclassification for reporting purposes of National Disability Insurance Scheme (NDIS) payments from output appropriation to payments made on behalf of the State appropriation as a result of changes in the related financial administration arrangements effective from 1 July 2022.

(c) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.6 outlines the Department's income from transactions and Table 2.7 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.6: Income from transactions **($ million)**

	2020-21 actual	*2021-22 budget*	*2021-22 revised*	*2022-23 budget*
Output appropriations	2 540.2	6 478.1	6 545.0	4 710.4
Special appropriations	26.6	63.9	66.2	72.0
Interest	..	..	..	..
Sale of goods and services	6.0	..	..	..
Grants	53.7	84.8	155.6	58.2
Fair value of assets and services received free of charge or for nominal consideration	0.2	..	..	..
Other income	0.8	..	..	..
Total income from transactions [(a)(b)]	**2 627.6**	**6 626.8**	**6 766.8**	**4 840.6**

Source: Department of Families, Fairness and Housing

Notes:

(a) Variance between the 2021-22 budget and the 2022-23 budget is due to the reclassification for reporting purposes of National Disability Insurance Scheme (NDIS) payments from output appropriation to payments made on behalf of the State appropriation as a result of changes in the related financial administration arrangements effective from 1 July 2022.

(b) Table may not add due to rounding.

Table 2.7: Parliamentary authority for resources **($ million)**

	2021-22 budget	*2021-22 revised*	*2022-23 budget*
Annual appropriations	**6 222.6**	**6 963.9**	**7 773.4**
Provision of outputs [(a)]	6 012.6	6 053.5	4 247.6
Additions to the net asset base	140.9	841.3	784.8
Payments made on behalf of the State [(a)]	69.1	69.1	2 741.0
Receipts credited to appropriations	**492.6**	**491.9**	**489.9**
Unapplied previous years appropriation	**..**	**40.2**	**..**
Provision of outputs	..	26.8	..
Additions to the net asset base	..	13.4	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**6 715.2**	**7 496.0**	**8 263.3**
Special appropriations	**65.4**	**66.4**	**73.3**
Trust funds	**850.1**	**934.9**	**59.7**
Total parliamentary authority [(b)]	**7 630.6**	**8 497.3**	**8 396.3**

Source: Department of Families, Fairness and Housing

Notes:

(a) The variance between the 2021-22 budget and 2022-23 budget is primarily due to the reclassification for reporting purposes of National Disability Insurance Scheme (NDIS) payments from output appropriation to payments made on behalf of the State appropriation as a result of changes in the related financial administration arrangements effective from 1 July 2022.

(b) Table may not add due to rounding.

Departmental performance statement

Objective 1: Children, young people and families are safe, strong and supported

This objective aims to ensure that Victorian families, carers and individuals have supportive and respectful relationships and are safe from harm, fear and neglect in their homes. This includes addressing the compounding effects of abuse and violence; improving support and recovery for both victim-survivors and perpetrators; and ensuring the wellbeing of children and young people in care.

To succeed we will:

- reduce abuse and neglect of children and young people
- increase safe, respectful family relationships
- improve development and wellbeing for children and young people
- increase stability of care services placements
- increase connections to culture, family and kinship systems for Aboriginal families including for Aboriginal children in care
- reduce over-representation of Aboriginal children and young people in care services
- increase safety for victim-survivors of family violence
- reduce family violence
- reduce family violence and abuse against Aboriginal women and children.

Outputs

Child Protection and Family Services **(2022-23: $1 824.0 million)**

The Child Protection and Family Services output, through the funding of statutory child protection services, family support and parenting services, adoption and placement care services and specialist support services, aims to ensure the safety and wellbeing of adolescents and children at risk of harm, abuse and neglect. This output aims to make a positive difference to Victorians experiencing disadvantage by providing excellent community services to meet clients' needs.

This output provides:

- child protection services to ensure the safety and wellbeing of children and young people at risk of harm, abuse and neglect
- specialist support and placement services to ensure the safety and wellbeing of children and young people who require support to remain with their family or are placed in out-of-home care
- a range of early intervention and support services to ensure the safety and wellbeing of children, young people and families.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected*	*2021-22 target*	*2020-21 actual*
Quantity					
Daily average number of children in care placements	number	10 625	9 749	9 801	9 678
The higher 2022-23 target reflects a new methodology of target setting aligned with capacity, as opposed to projected demand.					
Daily average number of children in foster care placements	number	1 773	1 599	1 681	1 673
The higher 2022-23 target reflects a new methodology of target setting aligned with capacity, as opposed to projected demand.					
Daily average number of children in residential care placements	number	514	466	455	455
The higher 2022-23 target reflects a new methodology of target setting aligned with capacity, as opposed to projected demand.					
Daily average number of children in kinship care placements	number	8 338	7 670	7 665	7 546
The higher 2022-23 target reflects a new methodology of target setting aligned with capacity, as opposed to projected demand.					
Daily average number of children subject to permanent care orders	number	3 555	3 555	3 225	3 360
The 2021-22 expected outcome is higher than target, due to the 2016 amendments to the Children Youth and Families Act 2005 *(permanency amendments) having created significant changes to permanency planning for children and to the timeliness for decision making, leading to increases in the number of permanent care orders made annually.* *The higher 2022-23 target reflects these increases.*					
Number of families receiving an intensive support service	number	3 107	2 314	2 361	2 372
The higher 2022-23 target reflects reforms to the range of services and an improved approach to counting cases.					
Number of investigations from reports to Child Protection Services about the wellbeing and safety of children	number	39 100	35 612	39 100	33 320
The 2021-22 expected outcome is lower than target primarily due to fewer reports as a result of the impact of COVID-19 restrictions and due to strengthened early support and intervention services reaching vulnerable children.					
Number of intensive support services provided to Aboriginal families	number	839	nm	nm	nm
New performance measure for 2022-23 to reflect Government priorities regarding family supports provided to Aboriginal families to prevent entry to care or support reunification.					
Number of family services cases provided to Aboriginal families	number	1 909	2 314	3 281	3 253
The lower 2022-23 target reflects the transition of Child FIRST targets to The Orange Door and an improved approach to counting cases. *The 2021-22 expected outcome is lower than the 2021-22 target due to data collection system issues in 2021-22, resulting in under-reporting of the number of Aboriginal families supported.*					
Reports to Child Protection Services about the wellbeing and safety of children	number	136 677	119 489	136 677	121 715
The 2021-22 expected outcome is lower than target, due to less oversight of children in school settings during COVID-19 lockdown periods.					
Total number of family services cases provided	number	21 548	29 507	32 486	40 088
The 2021-22 expected outcome is lower than the 2021-22 target due to data collection system issues in 2021-22 that resulted in under-reporting of the number of families supported. *The lower 2022-23 target reflects the transition of Child FIRST targets to The Orange Door and an improved approach to counting cases.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected*	*2021-22 target*	*2020-21 actual*
Quality					
Children and young people in care who have had two or less placements in the past 12 months (not including time at home in parental care)	per cent	90	93	90	92.6
This performance measure renames the 2021-22 performance measure 'Children and young people in care who have had two or less placements in the past 12 months (not including placements at home)'. The new measure reports on the same activity as the previous measure but has been amended for increased clarity.					
Children and young people who were the subject of a substantiated report within 12 months of the closure of a previous substantiated report	per cent	17.5	15.8	17.5	17.4
Children and young people who were the subject of an investigation which led to a decision not to substantiate, who were subsequently the subject of a substantiation within three months of case closure	per cent	3	3.1	3	3.3
Proportion of Aboriginal children placed with relatives/kin, other Aboriginal carers or in Aboriginal residential care	per cent	77	74.5	75	75.6
The higher 2022-23 target reflects reforms to the range of services and an improved approach ensuring Aboriginal children are placed with family.					
Organisations that have successfully completed a certification review (specialist support and placement services)	per cent	95	95	95	100
In 2022-23 the Human Services Regulator will transition to become the Social Services Regulator (SSR). As part of this transition, the current requirement that gives rise to the BP3 measures will be ceased in preparation for the implementation of new Social Services Standards. This is likely to impact on whether the BP3 measures for 2022-23 are achieved. The transition process ensures that the gap that organisations will have between their last certification review and the start of the SSR will not be any longer than the normal gap that would occur between certification reviews.					
Organisations that have successfully completed a certification review (family and community services)	per cent	95	95	95	100
In 2022-23 the Human Services Regulator will transition to become the Social Services Regulator (SSR). As part of this transition, the requirement that gives rise to the BP3 measures will be ceased in preparation for the implementation of new Social Services Standards. This is likely to impact on whether the BP3 measures for 2022-23 are achieved. The transition process ensures that the gap that organisations will have between their last certification review and the start of the SSR will not be longer than the normal gap that would occur between certification reviews.					
Timeliness					
Percentage of child protection investigations assessed as urgent, that were visited, or where attempts were made to visit, within two days of receipt of the report	per cent	97	96	97	94.6
Cost					
Total output cost	$ million	1 824.0	1 858.0	1 811.4	1 705.0

Source: Department of Families, Fairness and Housing

Primary Prevention of Family Violence (2022-23: $27.1 million)

This output provides initiatives that support primary prevention of family violence and all forms of violence against women.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of people participating in funded primary prevention programs	number	10 000	11 338	3 400	nm
The 2021-22 expected outcome is higher than the 2021-22 target due to the move to online program delivery during the COVID-19 pandemic which has enabled a greater number of people to participate in online primary prevention programs. The higher 2022-23 target reflects the change in performance measure from women participating to people participating, and to account for programs pivoting from in-person delivery to online delivery.					
Quality					
Prevention of family violence grant recipients who met or exceeded contractually agreed outcomes	per cent	95	95	95	nm
Timeliness					
Prevention of family violence projects and programs delivered on time	per cent	100	100	100	nm
Cost					
Total output cost	$ million	27.1	28.5	27.5	27.3

Source: Department of Families, Fairness and Housing

Family Violence Service Delivery (2022-23: $585.9 million)

This output will lead and coordinate whole of government family violence policy and implement and deliver the Government's family violence reform agenda. This will include establishing and operating The Orange Door Network; delivering victim survivor support services; sexual assault support services; and perpetrator interventions; implementing information sharing legislation; and delivering risk assessment and management programs.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected*	*2021-22 target*	*2020-21 actual*
Quantity					
Workers trained in the Family Violence Risk Assessment and Risk Management Framework	number	10 000	10 000	10 000	23 603
Support and Safety Hubs established	number	18	16	14	8
The expected outcome for 2021-22 is higher than target, which reflects the updated implementation schedule, and efficiencies in the implementation program. The target of 16 sites includes an additional site for the Wimmera South West area, which has two primary premises (South West – Warrnambool; Wimmera – Horsham). *The higher 2022-23 target reflects the expected implementation schedule as new Orange Door Network sites open in 2022-23.*					
Total assessments undertaken at the Support and Safety Hubs	number	75 370	65 539	34 839	31 072
The expected outcome for 2021-22 is higher than target, due to a change in counting rules for child well-being assessments. The previous rule counted one assessment for all children on a referral, and has been amended to include all individual child well-being assessments. *The higher 2022-23 target reflects the new counting rules for child safety and well-being assessments introduced in 2021-22, and increases to reflect The Orange Door establishment in new areas.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected*	*2021-22 target*	*2020-21 actual*
Total assessments undertaken for children in the Support and Safety Hubs/The Orange Door	number	49 093	42 690	10 453	nm
The expected outcome for 2021-22 is higher than target, due to a change in counting rules for child wellbeing assessments. The previous rule counted one assessment for all children on a referral, and has been amended to include all individual child well-being assessments. *The higher 2022-23 target reflects the new counting rules for child safety and well-being assessments introduced in 2021-22.*					
Number of cases referred to and assisted by a Risk Assessment and Management Panel	number	450	469	650	461
This performance measure renames the 2021-22 performance measures 'Number of clients assisted by a Risk Assessment and Management Panel'. The new measure reports on the same activity as the previous measure, but has been amended for increased clarity. *The lower 2022-23 target reflects the success in diverting cases away from a Risk Assessment and Management Panel (RAMP) response through collaborative cross-agency work. RAMP case referrals are counted in an additional measure.* *The 2021-22 expected outcome is lower than the 2021-22 target in part due to collaboration between RAMP coordinators and specialist family violence services, which diminishes risk and addresses cases through cross-agency collaboration.* *An additional measure is being introduced in 2022-23 to capture the number of cases which are referred where the RAMP coordinator facilitates cross agency collaboration and the target for the RAMP meeting measure will be reduced.*					
Number of cases referred to Risk Assessment and Management Panels and managed by the coordinators	number	200	nm	nm	nm
New performance measure for 2022-23 to capture the number of cases where RAMP coordinators facilitate cross-agency collaboration to manage the case. This complements the measure that counts the number of cases both referred to and assisted by a Risk Assessment and Management Panel.					
Number of sexual assault services provided to adults, children and young people	number	14 890	14 890	14 890	nm
Number of children who receive a Sexually Abusive Behaviours Treatment Service response	number	1 182	1 182	1 182	868
Number of episodes of support provided to adolescents using violence in the home	number	1 040	800	800	nm
The higher 2022-23 target includes targets against base level funding not included in the 2021-22 target.					
Number of calls responded to by the statewide telephone helpline for men regarding family violence	number	6 500	7 240	6 000	7 433
The 2021-22 expected outcome is higher than the 2021-22 target due to increasing demand for the helpline. *The higher 2022-23 target reflects the expected increase in the number of calls.*					
Number of men participating in the Men's Behaviour Change program	number	4 400	2 266	4 400	2 400
The 2021-22 expected outcome is lower than the 2021-22 target due to the COVID-19 pandemic as services transitioned between delivery of services in-person, online or via telephone. Online and telephone services were provided where it was assessed as safe to do so.					
Number of case management responses provided to perpetrators of family violence including those that require individualised support	number	1 300	1 567	1 300	1 495
The 2021-22 expected outcome is higher than the 2021-22 target due to clients, who would otherwise have undertaken a group Men's behaviour change program, transferring to an individual case management response during the COVID-19 lockdowns.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected*	*2021-22 target*	*2020-21 actual*
Quality					
Satisfaction of workers with the information sharing and family violence risk assessment and risk management training	per cent	90	97	80	98.5
The 2021-22 expected outcome is higher than the 2021-22 target due to the high quality of information sharing and family violence risk assessment and risk management training. *The higher 2022-23 target reflects consistent higher performance.*					
Satisfaction of clients with Support and Safety Hubs services	per cent	80	80	80	0
Timeliness					
Assessments undertaken within seven days	per cent	80	73	80	67
The 2021-22 expected outcome is lower than the 2021-22 target due to increasing demand, and reduced workforce availability as a result of unplanned leave during periods of COVID-19 restrictions.					
Sexual assault support services clients receiving an initial response within five working days of referral	per cent	98	98	98	99
Cost					
Total output cost	$ million	585.9	529.8	555.1	363.2
The higher 2022-23 target primarily reflects additional funding provided for Government policy commitments.					

Source: Department of Families, Fairness and Housing

Objective 2: Victorian communities are safe, fair, inclusive and resilient

This objective aims to ensure Victorians are socially involved in their community and participation helps their wellbeing. Communities foster social inclusion and participation, and diversity is celebrated and enabled. Victorians from intersectional communities can safely identify with their culture, express their identity and build support networks with people they trust. Communities are strong and resilient in times of emergency.

To succeed we will:

- increase social, economic and community inclusion and participation, including for women, people with disability, Aboriginal Victorians and other communities
- decrease experiences of discrimination and racism
- increase safety where people live, work, learn and play
- increase wellbeing for Aboriginal Victorians, including safety to connect with and express culture
- increase capacity for senior Victorians to age well
- increase supports for people with complex needs
- increase social capital and community connection
- increase community resilience
- improve social recovery following emergencies.

Outputs

Disability Services (2022-23: $490.1 million)

The Disability Services output, through the provision of continuing care and support services for people with disabilities, their carers and their families, aims to make a positive difference for Victorians experiencing disadvantage and provide excellent community services to meet clients' needs.

This output provides:

- specialised support for people with a disability and resources and programs that build capacity to respond to the needs of people with disability
- bed and facility-based services characterised by the bundling of accommodation services and disability support.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Clients receiving forensic disability service	number	750	750	750	789
Quality					
Forensic disability residents participating in community reintegration activities	per cent	80	80	80	82
Organisations that have successfully completed a certification review (accommodation supports)	per cent	95	95	95	100
In 2022-23 the Human Services Regulator will transition to become the Social Services Regulator (SSR). As part of this transition, the current requirement that gives rise to the BP3 measures will be ceased in preparation for the implementation of new Social Services Standards. This is likely to impact on whether the BP3 measures for 2022-23 are achieved. The transition process ensures that the gap that organisations will have between their last certification review and the start of the SSR will not be any longer than the normal gap that would occur between certification reviews.					
Organisations that have successfully completed a certification review (client services and capacity)	per cent	95	95	95	100
In 2022-23 the Human Services Regulator will transition to become the Social Services Regulator (SSR). As part of this transition, the current requirement that gives rise to the BP3 measures will be ceased in preparation for the implementation of new Social Services Standards. This is likely to impact on whether the BP3 measures for 2022-23 are achieved. The transition process ensures that the gap that organisations will have between their last certification review and the start of the SSR will not be any longer than the normal gap that would occur between certification reviews.					
Organisations that have successfully completed a certification review (individualised supports)	per cent	95	95	95	100
In 2022-23 the Human Services Regulator will transition to become the Social Services Regulator (SSR). As part of this transition, the current requirement that gives rise to the BP3 measures will be ceased in preparation for the implementation of new Social Services Standards. This is likely to impact on whether the BP3 measures for 2022-23 are achieved. The transition process ensures that the gap that organisations will have between their last certification review and the start of the SSR will not be any longer than the normal gap that would occur between certification reviews.					
Timeliness					
Forensic disability Target Group Assessments completed within six weeks	per cent	80	80	80	82.4
Cost					
Total output cost	$ million	490.1	461.0	458.1	556.4
The higher 2022-23 target primarily reflects funding provided for Government policy commitments and indexation.					

Source: Department of Families, Fairness and Housing

Community Participation (2022-23: $65.9 million)

Community participation programs include the Neighbourhood House Coordination Program and Men's Sheds. These programs support the social participation of Victorian communities, particularly vulnerable populations.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Hours of coordination funding provided to Neighbourhood Houses	number	561 896	554 798	561 896	560 908
Timeliness					
Grants acquitted within the timeframe specified in the terms and conditions of the funding agreement	per cent	92	92	92	92
Cost					
Total output cost	$ million	65.9	155.8	108.7	132.6
The 2021-22 expected outcome is higher than the 2021-22 target due to funding provided for Government policy commitments related to COVID-19 support.					
The lower 2022-23 target primarily reflects completion of Government policy commitments including the Future of Public Health: local place-based delivery with central support and Alternative COVID-19 Accommodation and High-Risk Accommodation and Response program–Housing.					

Source: Department of Families, Fairness and Housing

Office for Disability (2022-23: $7.8 million)

The Office for Disability leads and coordinates whole of government policy, disability action planning and funding, and support to disability advocacy and self-advocacy organisations so that people with a disability experience reduced disadvantage, can fully participate in the community and have their rights upheld.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of Disability Advocacy clients	number	2 500	2 500	2 500	2 722
Timeliness					
Departments report progress to Office for Disability on state disability plan responsibilities within agreed time frames	per cent	100	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Annual reporting against the State disability plan within agreed timeframes'.					
Cost					
Total output cost	$ million	7.8	15.4	15.6	9.6
The lower 2022-23 target primarily reflects completion of Government policy commitments including building inclusive and safe communities for Victorians with disability.					

Source: Department of Families, Fairness and Housing

Seniors Programs and Participation (2022-23: $68.4 million)

Support broader community planning processes to facilitate an integrated community planning and response approach aimed at enabling older Victorians to fully participate and engage in the community.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Pension-level beds available in assisted Supported Residential Services facilities	number	1 633	1 633	1 736	1 667
This performance measure has been transferred directly from the Department of Health 'Aged Support Services' output to reflect the impact of machinery of government changes.					
The 2021-22 expected outcome is lower than the 2021-22 target due to closures of pension-level Supported Residential Services during 2021-22.					
The lower 2022-23 target is due to recent closures of some pension-level Supported Residential Services.					
Pension-level Supported Residential Services residents provided with service coordination and support/brokerage services	number	775	775	775	775
This performance measure has been transferred directly from the Department of Health 'Aged Support Services' output to reflect the impact of machinery of government changes.					
Individuals provided with respite and support services	number	13 250	13 250	13 250	15 637
Number of hours of respite and support services	number	261 250	261 250	261 250	348 125
New University of the Third Age membership growth	per cent	5	5	5	-11
Open rates for Seniors Card eNewsletters	per cent	48	40	48	48
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19.					
Quality					
Eligible seniors in the Seniors Card program	per cent	90	90	90	89.1
Senior satisfaction with Victorian Seniors Festival events	per cent	90	90	90	90
Cost					
Total output cost	$ million	68.4	68.4	27.4	27.7
The 2021-22 expected outcome is higher than the 2021-22 target due to additional program funding transferring from the Department of Health.					
The higher 2022-23 target primarily reflects additional program funding transferring from the Department of Health which includes the support for carers program and the supporting accommodation for vulnerable Victorians program.					

Source: Department of Families, Fairness and Housing

Support to veterans in Victoria (2022-23: $11.5 million)

This output provides coordination of veteran-related issues at a state level, especially in relation to commemoration, education programs, grant programs, employment initiatives, research and veteran welfare. This output supports the Shrine of Remembrance and the Victorian Veterans Council.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Entries received – Premier's Spirit of Anzac Prize	number	250	85	250	0
The 2021-22 expected outcome is lower than the 2021-22 target as entries were lower due to the impacts of COVID-19 restrictions on schools.					
Community engagement – Shrine ceremonial activities, public and student education programs, tours and general visitation	number	750 000	759 758	750 000	725 022
Number of veterans employed in the Victorian Public Sector	number	750	188	750	766
The 2021-22 expected outcome is lower than the 2021-22 target, but in line with the target of employing 750 veterans in the Victorian Public Sector by June 2025.					
Quality					
Commemorative and educative projects meet agreed project objectives	per cent	100	100	100	100
Timeliness					
Deliver an annual program of grants within agreed, published timelines	per cent	100	100	100	100
Cost					
Total output cost	$ million	11.5	13.5	12.6	9.4
The 2021-22 expected outcome is higher than the 2021-22 target due to funding provided for veterans trust funds.					
The lower 2022-23 target primarily reflects the lapsing of the Shrine of Remembrance grant program and the lapsing of the additional funding provided for the ANZAC Day Proceeds Fund.					

Source: Department of Families, Fairness and Housing

LGBTIQ+ equality policy and programs (2022-23: $10.1 million)

This output provides programs and services to promote equality for LGBTIQ+ Victorians and to support the economic, social and civic participation of these communities.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of people who have attended government supported pride events and festivals	number	100 000	75 000	90 000	nm
The 2021-22 expected outcome is lower than the 2021-22 target due to a delay in delivery of government-funded pride events and festivals due to the impacts of COVID-19. *The higher 2022-23 target reflects increased attendance at pride events and festivals, due to a funding increase to the Pride Events and Festivals Fund program.*					
Number of people engaged through a Trans and Gender Diverse Peer Support Program	number	250	nm	nm	nm
This performance measure replaces the discontinued measure, 'Number of organisations engaged through the establishment of a Trans and Gender Diverse Peer Support Program', to more accurately measure engagement in the program.					
Proportion of LGBTIQ+ grant program recipients who are located in regional and rural areas	per cent	30	30	30	25.4
Number of community leaders completing the LGBTIQ+ Leadership Program	number	25	28	25	30
The 2021-22 expected outcome is higher than the 2021-22 target reflecting strong interest due to the program theme attracting a broader group of emerging LGBTIQ+ leaders.					
Timeliness					
Percentage of payments for events made within agreed timeframes	per cent	85	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Payments for events made in accordance with department milestones'.					
Cost					
Total output cost	$ million	10.1	7.6	5.7	11.1
The 2021-22 expected outcome is higher than the 2021-22 target due to funding provided for Government policy commitments *The higher 2022-23 target primarily reflects funding provided for Government policy commitments.*					

Source: Department of Families, Fairness and Housing

Women's policy (2022-23: $13.4 million)

This output provides initiatives that support gender equality and better outcomes for women across all areas of their lives including economic security, safety, leadership, health and wellbeing.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of people participating in funded gender equality programs	number	7 000	16 955	3 400	nm
The 2021-22 expected outcome is higher than the 2021-22 target due to programs pivoting from in person delivery to online delivery due to COVID-19 resulting in increased digital engagement. *The higher 2022-23 target reflects the continuation of online delivery of some programs, while most programs that were delivered online in 2021-22 will pivot back to in person delivery in 2022-23.*					
Percentage of women on Victorian Government boards.	per cent	50	55	50	56
The refreshed women on boards commitment came into effect in March 2022, and requires that boards and portfolios that already have at least 50 per cent women are now required to maintain at least 50 per cent women. Those boards which have not reached at least 50 per cent women will still be required to have women comprise 50 per cent of appointments, as per the existing commitment.					
Quality					
Gender equality grant recipients who met or exceeded contractually agreed outcomes	per cent	95	95	95	nm
Timeliness					
Women's Portfolio projects and programs delivered on time	per cent	100	95	100	nm
The 2021-22 expected outcome is lower than the 2021-22 target due to some minor delays to program delivery due to the COVID-19 pandemic.					
Tools, resources and guidelines to support the *Gender Equality Act 2020* implementation are completed within agreed timeframes	per cent	100	100	100	100
Cost					
Total output cost	$ million	13.4	16.6	15.7	11.5
The 2021-22 expected outcome is higher than the 2021-22 target due to funding provided for Government policy commitments and trust funds. *The lower 2022-23 target is due to the completion of Government policy commitments including improving the health, wellbeing and safety of women. Also, contributing to the lower 2022-23 target is the lapsing of funding for the Bushfire Recovery Trust Fund and the Women and Equality Trust Fund.*					

Source: Department of Families, Fairness and Housing

Youth (2022-23: $32.6 million)

This output leads and coordinates whole of government policy advice and delivers a range of initiatives for young people aged between 12 and 25 years to gain a range of skills and experiences and to actively participate in their local communities.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Participation by young people in programs that provide opportunities to be involved in social and economic life in their communities	number	245 000	235 664	240 000	261 560
The higher 2022-23 target reflects increased participation of young people due to funding increases to the Engage! and FReeZA programs.					
Participation by young people in programs that support young people to be involved in decision making in their community	number	2 300	3 492	2 300	2 844
The 2021-22 expected outcome is higher than the 2021-22 target due to higher participation rates of young people involved in Victorian Youth Week and activities funded through the Centre for Multicultural Youth and Youth Affairs Council of Victoria.					
Number of Scout Hall Capital Projects Completed	number	6	5	2	6
The 2021-22 expected outcome is higher than the 2021-22 target due to an acceleration in completed projects from year one and two following completion of the project planning stages. *The higher 2022-23 target reflects the alignment to the four-year capital works program, in anticipation of the acceleration in projects following completion of the project planning stages.*					
Quality					
Participants reporting development of transferrable skills supporting positive outcomes for young people	per cent	75	75	75	92
Timeliness					
Percentage of programs delivered within agreed timeframes	per cent	90	94	90	98
Cost					
Total output cost	$ million	32.6	34.5	33.7	34.1

Source: Department of Families, Fairness and Housing

Multicultural affairs policy and programs (2022-23: $51.2 million)

This output provides policy advice on multicultural affairs and social inclusion in Victoria, including settlement coordination for newly arrived migrants and refugees and delivers a range of programs to directly support Victoria's multicultural communities. It also supports Victoria's whole of government approach to multiculturalism. The output includes monitoring of government departments' responsiveness to Victorians from culturally, linguistically and religiously diverse backgrounds.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Consultations with communities on issues relevant to culturally and linguistically diverse (CALD) communities	number	75	85	75	110
The 2021-22 expected outcome is higher than the 2021-22 target due to increased consultation on multicultural affairs priorities, including anti-racism policy.					
Number of projects delivered in partnerships with CALD communities	number	30	31	30	55
Community participation in multicultural events (attendance at Multicultural Affairs events)	number (millions)	1.3	1.07	1.3	nm
The 2021-22 expected outcome is lower than the 2021-22 target as a result of decreased attendance at events due to COVID-19.					
Number of people engaged through Cultural Diversity Week events and engagement	number	25 000	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Attendance at Cultural Diversity Week flagship event, Victoria's Multicultural Festival' to enable capture of engagement via online means, rather than solely in-person. Engagement through more focused and/or tailored events is expected to deliver stronger connections with those it reaches.					
Quality					
Proportion of approved grant funding provided to organisations in regional/rural areas	per cent	20	15	20	13.6
The 2021-22 expected outcome is lower than the 2021-22 target due to the Multicultural Seniors Support program representing a significant portion of overall funding allocated in 2021-22 and the overwhelming majority of multicultural seniors organisations being located in metropolitan Melbourne.					
Cost					
Total output cost	$ million	51.2	103.3	54.7	107.0
The 2021-22 expected outcome is higher than the 2021-22 target due to funding provided for Government policy commitments related to the COVID-19 response. *The lower 2022-23 target primarily reflects the rephasing of budget from 2020-21 into 2021-22 to align with program delivery.*					

Source: Department of Families, Fairness and Housing

Objective 3: All Victorians have stable, affordable and appropriate housing

This objective aims to ensure Victorians have safe homes that provide emotional and physical sanctuary. Victorians have security of tenure in housing that is accessible, appropriate, affordable and tailored to them. This outcome includes supports to address and reduce housing insecurity and homelessness, to enable suitable housing for all.

To succeed we will:

- increase the supply and availability of affordable and high-quality housing
- improve the quality, environmental sustainability, appropriateness and accessibility of existing housing
- increase housing stability for people experiencing or at risk of rough sleeping, homelessness, and other insecure housing arrangements
- increase financial ability to access and maintain housing and utility services
- increase Aboriginal residents' connection to community, culture and place
- increase the proportion of Aboriginal people living in appropriately sized (not overcrowded) housing
- improve transitions to independent living arrangements.

Outputs

Housing Assistance (2022-23: $821.1 million)

The Housing Assistance output aims to make a difference for Victorians experiencing disadvantage by providing homelessness services; crisis and transitional accommodation; and long-term adequate affordable and accessible housing assistance. These services are coordinated with support services, home renovation assistance, and the management of the home loan portfolio where required. This output provides:

- housing assistance for low-income families, older people, singles, youth and other households. It responds to the needs of clients through the provision of appropriate accommodation, including short-term and long-term properties that assist in reducing and preventing homelessness
- housing support services to people who are homeless or at risk of homelessness, in short-term housing or crisis situations. Support will assist clients in accessing and maintaining tenancies in appropriate accommodation. Services provided will assist in preventing and reducing homelessness.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of bonds issued to low-income Victorians to assist access to the private rental market	number	10 000	7 630	10 000	6 630
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the continued economic impact of COVID-19 on the private rental market.					
Number of clients assisted to address and prevent homelessness	number	107 000	109 000	107 000	105 304
The 2021-22 expected outcome is higher than the 2021-22 target due to additional homelessness service delivery required as a result of economic conditions, including the rollback of JobKeeper and additional JobSeeker.					
Number of clients provided with accommodation	number	30 000	32 000	30 000	31 207
The 2021-22 expected outcome is higher than the 2021-22 target due the Government providing additional funding to accommodate people in hotels in response to COVID-19.					
Number of households assisted with long-term social housing (public, Aboriginal and community long-term tenancies at end of year)	number	77 900	77 900	77 900	77 900
Number of public housing dwellings upgraded during year	number	2 665	2 665	2 665	2 519
Total number of social housing dwellings	number	89 832	87 515	87 515	85 969
The higher 2022-23 target reflects significant government investment in new social housing.					
Total social housing dwellings acquired during the year	number	2 775	2 287	1 901	1 889
The 2021-22 expected outcome is higher than the 2021-22 target due to some social housing projects being completed earlier than originally scheduled including property settlements under the Big Housing Build. *The higher 2022-23 target reflects the scheduled additional activity of Big Housing Build program.*					
Total number of affordable housing dwellings	number	340	nm	nm	nm
New performance measure for 2022-23 to reflect government priorities regarding the Affordable Housing Rental Scheme. The Affordable Housing Rental Scheme is the Government's response to the growing gap in housing affordability and supply for many low- to moderate-income households.					
Number of clients assisted to address and prevent homelessness due to family violence	number	49 000	50 000	49 000	50 855
Number of family violence victims who receive a refuge response	number	1 061	800	1 061	819
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of the COVID-19 public health restrictions reducing the number of families that could be accommodated in communal refuges.					
Number of nights of refuge accommodation provided to victims of family violence	number	54 109	49 959	54 109	43 674
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of the COVID-19 public health restrictions reducing the number of families that could be accommodated in communal refuges.					
Number of calls responded to by the statewide 24/7 family violence victim/survivor crisis service	number	60 000	74 858	60 000	67 355
The 2021-22 expected outcome is higher than the 2021-22 target due to increased demand for the service during the COVID-19 pandemic.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quality					
Proportion of homelessness services clients that engage with support services and access or maintain housing	per cent	77	77	72	75.6
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to a correction in how the counting rules for the measure were implemented after the target was set. *The higher 2022-23 target reflects a correction in how the counting rules for this new measure were implemented in 2021-22.*					
Social housing tenants satisfied with completed urgent maintenance works	per cent	85	89.8	85	87.9
The 2021-22 expected outcome is higher than the 2021-22 target due to COVID-19 restrictions prohibiting non-urgent works to be undertaken, creating more capacity for urgent maintenance works.					
Social housing tenants satisfied with completed non-urgent maintenance works	per cent	80	65	80	69.9
The 2021-22 expected outcome is lower than the 2021-22 target due to non-urgent works being unable to be undertaken while COVID-19 restrictions were in place.					
Timeliness					
Average waiting time for public rental housing for those clients who have received priority access housing allocation or a priority transfer	months	10.5	13.9	10.5	12.4
The 2021-22 expected outcome is higher than the 2021-22 target due to a decrease in tenants moving out of public housing which has provided fewer opportunities to allocate properties to people on the register.					
Average waiting time for public rental housing for clients who have received a priority access housing or priority transfer allocation due to family violence	months	10.5	16.1	10.5	11.1
The 2021-22 expected outcome is higher than the 2021-22 target due to a decrease in tenants moving out of public housing, which has provided fewer opportunities to allocate properties to people on the register.					
Proportion of clients where support to sustain housing tenure was provided or referred	per cent	88	89	85	88.4
The higher 2022-23 target reflects improved performance for this measure over the past several years, most likely due to an increased focus on earlier intervention.					
Cost					
Total output cost	$ million	821.1	936.1	1 019.6	1 366.9
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the change of funding source from provision of output to capital to align with the nature of the expenditure for the Big Housing Build. The decrease is however partially offset by the Government's new investments in the Housing sector. *The lower 2022-23 target primarily reflects the lapsing of the Building Works stimulus package.*					

Source: Department of Families, Fairness and Housing

Concessions to Pensioners and Beneficiaries (2022-23: $641.3 million)[a]

The Concessions to Pensioners and Beneficiaries output, through the development and coordination of the delivery of concessions and relief grants to eligible consumers and concession card holders, aims to make a positive difference for Victorians experiencing disadvantage by providing excellent community services to meet clients' needs.

This output provides reductions in the price of energy, water, and municipal rates to eligible consumers and concession card holders. It also provides trustee services for people on a low income or those who are subject to an order by the Victorian Civil and Administrative Tribunal, and other social and community services, including the provision of emergency relief for individuals or families who are experiencing immediate and personal distress due to a financial or domestic crisis.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Households receiving mains electricity concessions	number	943 617	924 888	1 006 929	1 006 842
The 2021-22 expected outcome is lower than the 2021-22 target due to the ending of COVID-19 restrictions reducing the number of concession cardholders eligible for this concession. *The lower 2022-23 target reflects the most current data regarding the uptake of concessions in Victoria and the past growth trend.* *The 2020-21 actual updates the preliminary result in the Department's* 2020-21 Annual Report.					
Households receiving mains gas concessions	number	665 040	658 831	679 823	704 468
The lower 2022-23 target reflects the most current data regarding the uptake of concessions in Victoria and the past growth trend. *The 2020-21 actual updates the preliminary result in the Department's 2020-21 Annual Report.*					
Households receiving non-mains energy concessions	number	24 848	24 534	24 123	24 224
The higher 2022-23 target reflects the most current data regarding the uptake of concessions in Victoria and the past growth trend. *The 2020-21 actual updates the preliminary result in the Department's* 2020-21 Annual Report.					
Households receiving pensioner concessions for municipal rates and charges	number	434 997	434 701	432 143	435 257
The higher 2022-23 target reflects the most current data regarding the uptake of concessions in Victoria and the past growth trend. *The 2020-21 actual updates the preliminary result in the Department's 2020-21 Annual Report.*					
Households receiving water and sewerage concessions	number	680 209	680 191	709 495	727 250
The lower 2022-23 target reflects the most current data regarding the uptake of concessions in Victoria and the past growth trend. *The 2020-21 actual updates the preliminary result in the Department's* 2020-21 Annual Report.					
Number of Utility Relief Grants granted to households	number	92 801	84 220	72 421	77 385
The 2021-22 expected outcome is higher than the 2021-22 target due to significant increase in hardship resulting from the COVID-19 pandemic. *The higher 2022-23 target reflects the most current data regarding the uptake of concessions in Victoria and the past growth trend.* *The 2020-21 actual updates the preliminary result in the Department's* 2020-21 Annual Report.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quality					
Percentage of customers satisfied with State Trustees Limited services	per cent	75	65	75	81
Percentage of Community Service Agreement performance targets that have been achieved by State Trustees	per cent	90	90	90	93
Percentage of customer requests answered by State Trustees within the timelines set in the Community Service Agreement	per cent	90	90	90	92
Cost					
Total output cost	$ million	641.3	648.5	625.6	637.1

Source: Department of Families, Fairness and Housing

Note:
(a) This excludes funding for transport concessions transferred to the Department of Transport.

DEPARTMENT OF HEALTH

Ministerial portfolios

The Department supports the ministerial portfolios of Health, Ambulance Services, Disability, Ageing and Carers, and Mental Health.

Departmental mission statement

The Department of Health's mission is to achieve the best health, wellbeing and safety of all Victorians so that they can live a life they value.

The Department contributes to the Government's commitment to a stronger, fairer, better Victoria by developing and delivering policies, programs and services that support, protect and enhance the health, wellbeing and safety of all Victorians.

Departmental objectives

The Department is focused on delivering the following outcomes:

- Victorians are healthy and well
- Victorians have good physical health
- Victorians have good mental health
- Victorians act to protect and promote health.

The Department will deliver services that are person centred and sustainable.
Our services will:

- be appropriate and available in the right place, at the right time
- respond to choice, culture, identity, circumstances and goals
- be efficient and sustainable
- be safe, high quality and provide a positive experience.

Changes to the output structure

The Department has made changes to its output structure for 2021-22 as shown in the table below:

2021-22 outputs	*Reason*	*2022-23 outputs*
Acute Training and Development	Renamed to clarify given abolition of output groups	Health Workforce Training and Development
Aged Support Services	Partially transferred to the Department of Families, Fairness and Housing	Aged Support Services

Source: Department of Health

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2021-22 budget	*2021-22 revised*	*2022-23 budget*	*Variation [(a)] %*
Victorians are healthy and well				
Admitted Services	12 903.4	15 193.0	14 132.6	9.5
Non-Admitted Services	2 208.8	2 356.1	2 189.7	(0.9)
Emergency Services	838.3	907.7	882.0	5.2
Health Workforce Training and Development	352.3	339.1	439.9	24.9
Residential Aged Care	436.1	445.5	439.5	0.8
Aged Care Assessment	59.6	59.5	59.7	0.2
Aged Support Services	108.8	102.4	67.6	(37.8)
Home and Community Care Program for Younger People	202.2	203.2	189.7	(6.2)
Ambulance Emergency Services	1 166.5	1 199.4	1 212.8	4.0
Ambulance Non-Emergency Services	197.0	181.7	180.0	(8.6)
Drug Prevention and Control	44.8	44.5	40.8	(9.1)
Drug Treatment and Rehabilitation	285.4	308.6	272.5	(4.5)
Mental Health Clinical Care	2 177.0	2 178.6	2 594.7	19.2
Mental Health Community Support Services	166.3	173.7	155.2	(6.7)
Community Health Care	381.0	507.7	401.2	5.3
Dental Services	351.9	294.1	327.7	(6.9)
Maternal and Child Health and Early Parenting Services	150.6	148.6	155.0	2.9
Health Protection	555.0	1 592.6	446.2	(19.6)
Health Advancement	81.5	87.0	103.1	26.5
Emergency Management	15.0	17.1	12.9	(13.8)
Small Rural Services – Acute Health	431.5	440.8	429.5	(0.5)
Small Rural Services – Aged Care	243.9	245.6	250.3	2.6
Small Rural Services – Home and Community Care Services	5.3	5.3	11.5	116.2
Small Rural Services – Primary Health	24.5	24.4	24.7	0.7
Total [(b)]	**23 386.6**	**27 055.9**	**25 018.9**	**7.0**

Source: Department of Health

Notes:

(a) Variation between the 2021-22 budget and the 2022-23 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant output cost.

(b) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.8 outlines the Department's income from transactions and Table 2.9 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.8: Income from transactions **($ million)**

	2020-21 actual	*2021-22 budget*	*2021-22 revised*	*2022-23 budget*
Output appropriations	19 011.4	12 095.3	15 051.3	12 565.6
Special appropriations	1 072.3	1 989.8	1 836.1	2 751.7
Interest	19.8	47.4	16.6	48.6
Sale of goods and services	1 798.2	1 923.8	1 743.0	2 012.1
Grants	8 706.5	8 181.4	9 391.0	8 650.6
Fair value of assets and services received free of charge or for nominal consideration	5.4	..	..	..
Other income	775.3	774.8	807.2	819.1
Total income from transactions [(a)]	**31 388.8**	**25 012.5**	**28 845.1**	**26 847.7**

Source: Department of Health

Note:
(a) Table may not add due to rounding.

Table 2.9: Parliamentary authority for resources **($ million)**

	2021-22 budget	*2021-22 revised*	*2022-23 budget*
Annual appropriations	**11 826.0**	**15 016.0**	**12 307.0**
Provision of outputs	11 670.9	14 576.6	12 175.4
Additions to the net asset base	155.1	439.4	131.6
Payments made on behalf of the State	..	..	..
Receipts credited to appropriations	**426.8**	**445.2**	**450.0**
Unapplied previous years appropriation	**49.1**	**65.8**	**14.3**
Provision of outputs	49.1	65.8	14.3
Additions to the net asset base	..	..	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**12 301.9**	**15 527.1**	**12 771.3**
Special appropriations	**2 077.5**	**1 967.0**	**2 809.3**
Trust funds	**6 661.0**	**7 761.6**	**7 108.0**
National Health Funding Pool–Victorian State Pool Account [(a)]	6 526.9	7 570.4	6 951.8
Other [(b)]	134.2	191.3	156.2
Total parliamentary authority [(c)]	**21 040.4**	**25 255.8**	**22 688.6**

Source: Department of Health

Notes:
(a) The purpose of this trust primarily relates to receiving all Commonwealth public hospital funding under the National Health Reform Agreement.
(b) Includes inter-departmental transfers.
(c) Table may not add due to rounding.

Departmental performance statement

Objective: Victorians are healthy and well

This objective aims for Victorians to have good physical health, good mental health and act to protect and promote health.

The departmental objective indicators are:

- reduce obesity and increase physical activity across Victoria
- increase the proportion of children with healthy birth weight–with a focus on reducing smoking during pregnancy
- reduce infant mortality
- reduce inequalities in premature death
- reduce the suicide rate
- improve rates of self-reported health and wellbeing
- reduce deaths resulting from misuse of prescription medicine
- increase immunisation coverage rates at two years of age and at school entry.

Outputs

Admitted Services (2022-23: $14 132.6 million)

Acute and sub-acute patient services (elective and non-elective) provided at Victorian metropolitan and rural public hospitals.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Palliative separations	number	7 816	8 100	7 700	7 500
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to the impact of the COVID-19 pandemic. The higher 2022-23 target reflects the funding provided in the 2022-23 Budget.					
Sub-acute care separations	number	39 600	32 638	39 600	31 180
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Total separations – all hospitals	number (thousand)	2 073	1 919	2 034	1 868
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.. The higher 2022-23 target reflects the funding provided in the 2022-23 Budget.					
NWAU funded separations – all hospitals except small rural health services	number (thousand)	1 879	1 646	1 840	nm
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic. The higher 2022-23 target reflects the funding provided in the 2022-23 Budget.					
Perinatal mortality rate per 1 000 of babies of Aboriginal mothers, using rolling 3-year average	rate per 1 000	8.7	11	8.7	12.6
The 2021-22 expected result is higher than the 2021-22 target which means a higher perinatal mortality rate.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Number of patients admitted from the elective surgery waiting list	number	230 100	164 168	208 800	163 628
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic. The higher 2022-23 target reflects the funding provided in the 2022-23 Budget.					
NWAU funded emergency separations – all hospitals	number (thousand)	771	603	759	nm
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.. The higher 2022-23 target reflects the funding provided in the 2022-23 Budget.					
Quality					
Eligible newborns screened for hearing deficit before one month of age	per cent	98	97	98	97.3
Hand hygiene compliance	per cent	85	87	85	86.4
Healthcare worker immunisation – influenza	per cent	92	77	92	93
Intensive Care Unit central line associated blood stream infections (CLABSI) per 1 000 device days	rate	0	0	0	0.6
Major trauma patients transferred to a major trauma service	per cent	88	91	88	90.5
Percentage of patients who reported positive experiences of their hospital stay	per cent	95	91	95	na
Perinatal and child mortality reports received, reviewed and classified	per cent	100	100	100	95.5
Public hospitals accredited	per cent	100	100	100	100
Patient reported hospital cleanliness	per cent	70	80	70	na
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to the impact of the COVID-19 pandemic. Survey results not available for 2020-21.					
Staphylococcus aureus bacteraemias (SAB) infections per 10 000 patient days	rate	1	1	1	0.7
Unplanned readmission after treatment for acute myocardial infarction	per cent	4	4	4	1.8
Unplanned readmission after treatment for heart failure	per cent	11.3	11	11.3	7.5
Unplanned readmission after hip replacement surgery	per cent	6.0	6.0	6.0	3.4
Unplanned readmission after paediatric tonsillectomy and adenoidectomy	per cent	3.7	3.7	3.7	2.5
Unplanned readmission after knee replacement surgery	per cent	5.5	5	5.5	4.5
The 2021-22 expected result is outcome is lower than the 2021-22 target which means fewer people are being readmitted to hospital following knee replacement surgery.					
Timeliness					
Non-urgent (Category 3) elective surgery patients admitted within 365 days	per cent	95	85	95	80.4
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Semi-urgent (Category 2) elective surgery patients admitted within 90 days	per cent	83	65	83	61.6
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Urgent (Category 1) elective surgery patients admitted within 30 days	per cent	100	99	100	100
Cost					
Total output cost	$ million	14 132.6	15 193.0	12 903.4	14 751.8
The higher 2021-22 expected outcome and 2022-23 target reflect funding provided for government policy commitments					

Source: Department of Health

Non-Admitted Services (2022-23: $2 189.7 million)

Non-admitted acute services provide planned non-admitted services that require an acute setting to ensure the best outcome for a patient. These services provide access to: medical, nursing, midwifery and allied health professionals for assessment, diagnosis and treatment; ongoing specialist management of chronic and complex conditions in collaboration with community providers; pre- and post-hospital care; maternity care; and related diagnostic services, such as pathology and imaging.

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quantity					
Community palliative care episodes	number	24 133	nm	nm	nm
New performance measure for 2022-23 to enhance the measurement of access to community palliative care.					
Health Independence program direct contacts	number (thousand)	1 599	1 307	1 599	1 396
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic..					
Patients treated in Specialist Outpatient Clinics – unweighted	number (thousand)	1 975	1 824	1 975	1 791
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Quality					
Post-acute clients not readmitted to acute hospital	per cent	90	90	90	93.8
Timeliness					
Health Independence program clients contacted within three days of referral	per cent	85	90	85	91.4
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to a shift in hospital practices during COVID-19 to free up inpatient beds and minimise infection risk. The Health Independence program focused on early follow up and review of treatment options.					
Cost					
Total output cost	$ million	2 189.7	2 356.1	2 208.8	2 074.3
The 2021-22 expected outcome is higher than the 2021-22 target due to funding provided for government policy commitments and associated Commonwealth funding under the COVID-19 Response National Partnership Agreement. The lower 2022-23 target reflects the bring forward of funding from 2022-2023 into 2021-22 for the Better at Home initiative.					

Source: Department of Health

Emergency Services (2022-23: $882.0 million)

This output relates to emergency presentations at reporting hospitals with emergency departments. It aims to provide high-quality, accessible health and community services, specifically in improving waiting times for emergency services.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Emergency presentations	number (thousand)	1 973	1 791	1 944	1 773
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic. The higher 2022-23 target reflects additional funding provided in the 2022-23 Budget.					
Quality					
Emergency patients that did not wait for treatment	per cent	<5	4.9	<5	4.6
Emergency patients re-presenting to the emergency department within 48 hours of previous presentation	per cent	<6	6.0	<6	6.1
Patients' experience of emergency department care	per cent	85	78.6	85	na
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Timeliness					
Emergency Category 1 treated immediately	per cent	100	100	100	100
Emergency patients treated within clinically recommended 'time to treatment'	per cent	80	65.7	80	68
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to impacts arising from the COVID-19 pandemic including changes in patient complexity, heightened infection control practices and significant workforce impacts.					
Emergency patients with a length of stay of less than four hours	per cent	75	57.4	75	62
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to impacts arising from the COVID-19 pandemic including changes in patient complexity, heightened infection control practices and significant workforce impacts.					
Proportion of ambulance patient transfers within 40 minutes	per cent	90	66	90	74
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to higher health system demand, a higher proportion of complex patients, and heightened infection control practices during the COVID-19 pandemic.					
Cost					
Total output cost	$ million	882.0	907.7	838.3	804.2
The higher 2021-22 expected outcome and 2022-23 target reflect funding provided for government policy commitments.					

Source: Department of Health

Health Workforce Training and Development (2022-23: $439.9 million)

This output relates to grants provided to Victorian health services to support the training and development of the health workforce. This output aims to provide career pathways and contribute towards a stable, ongoing accredited workforce in the health sector in Victoria.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Additional student clinical placement days	number	80 000	67 756	80 000	nm
The 2021-22 expected outcome is lower than the 2021-22 target primarily as a result of the impact of the COVID-19 pandemic.					
Clinical placement student days (medicine)	number	385 000	356 278	385 000	332 282
The 2021-22 expected outcome is lower than the 2021-22 target primarily as a result of the impact of the COVID-19 pandemic.					
Clinical placement student days (nursing and midwifery)	number	385 000	385 000	385 000	445 987
Clinical placement student days (allied health)	number	160 000	127 809	160 000	142 126
The 2021-22 expected outcome is lower than the 2021-22 target primarily as a result of the impact of the COVID-19 pandemic.					
Number of filled Victorian Rural Generalist Year 3 positions	number	38	15	15	39.5
The higher 2022-23 target reflects the impact of counting additional procedural positions as part of this revised measure. This target has been revised from 'Number of filled rural generalist GP procedural positions' to specify more clearly the measured activity and to encapsulate a broader range of procedural positions in rural areas.					
Funded post graduate nursing and midwifery places at Diploma and Certificate level	number	954	887	954	877
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Total funded FTE (early graduate) allied health positions in public system	number	700	595	700	697
The 2021-22 expected outcome is lower than the 2021-22 target primarily as a result of changes to the graduate model and the impact of the COVID-19 pandemic on the capacity of services to support student placements.					
Total funded FTE (early graduate) medical positions in public system	number	1 525	1 525	1 525	1 584
Total funded FTE (early graduate) nursing and midwifery positions in public system	number	1 889	1 800	1 889	1 956
Quality					
Learner satisfaction about their feeling of safety and wellbeing while undertaking their program of study at health services	per cent	80	80	80	94
Cost					
Total output cost	$ million	439.9	339.1	352.3	299.4
The higher 2022-23 target reflects funding provided for government policy commitments.					

Source: Department of Health

Residential Aged Care (2022-23: $439.5 million)

This output includes delivery of services for older Victorians requiring ongoing care and support in a residential aged care setting.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Available bed days	days	1 153 718	1 153 718	1 153 718	1 134 481
Quality					
Residential care services accredited	per cent	100	100	100	100
Cost					
Total output cost	$ million	439.5	445.5	436.1	405.0
The higher 2022-23 target reflects funding provided for government policy commitments.					

Source: Department of Health

Aged Care Assessment (2022-23: $59.7 million)

This output includes delivery of comprehensive assessment of older Victorians' requirements for treatment and residential aged care services.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Aged care assessments	number	59 000	54 176	59 000	51 636
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic on activities.					
Timeliness					
Average waiting time (calendar days) from referral to assessment	day	16	13	16	15
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Percentage of high-priority clients assessed within the appropriate time in all settings	per cent	90	92	90	100
Percentage of low priority clients assessed within the appropriate time in all settings	per cent	90	82	90	84.67
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic on activities.					
Percentage of medium priority clients assessed within the appropriate time in all settings	per cent	90	98.4	90	98.27
The 2021-22 expected result is higher than the 2021-22 target which means most medium priority clients were assessed within the appropriate time in all settings.					
Cost					
Total output cost	$ million	59.7	59.5	59.6	64.3
The higher 2022-23 target reflects a reallocation of budget to Aged Care Assessment.					

Source: Department of Health

Aged Support Services (2022-23: $67.6 million)

This output includes delivery of a range of community services that support Victorians, such as, eye care services, Personal Alert Victoria services, and pension-level Supported Residential Services.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Personal alert units allocated	number	29 121	29 121	29 121	29 121
Victorian Eyecare Service (occasions of service)	number	75 800	56 782	75 800	57 395
Clients accessing aids and equipment	number	24 881	22 658	22 658	25 702
The higher 2022-23 target reflects funding provided in the 2022-23 Budget.					
Quality					
Funded research and service development projects for which satisfactory reports have been received	per cent	100	100	100	100
Clients satisfied with the aids and equipment services system	per cent	90	90	90	96
Timeliness					
Applications for aids and equipment acknowledged in writing within 10 working days	per cent	95	99	90	100
The 2021-22 expected outcome is higher than the 2021-22 target which means most people who apply for aids and equipment have a written acknowledgement in writing within 10 working days. *The higher 2022-23 target reflects funding provided in the* 2022-23 Budget.					
Cost					
Total output cost	$ million	67.6	102.4	108.8	140.6
The 2021-22 expected outcome is lower than the 2021-22 target due to a reallocation of budget to Residential Aged Care. *The lower 2022-23 target reflects additional program funding transfers to the Department of Families, Fairness and Housing.*					

Source: Department of Health

Home and Community Care Program for Younger People

(2022-23: $189.7 million)

This output includes delivery of a range of community-based nursing, allied health and support services enabling younger people who have difficulties with the activities of daily living to maintain their independence and to participate in the community.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Home and Community Care for Younger People – number of clients receiving a service	number	60 000	60 000	60 000	59 750
Home and Community Care for Younger People – hours of service delivery	hours (thousand)	1 000	860	1 000	877
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of COVID-19 pandemic.					
Cost					
Total output cost	$ million	189.7	203.2	202.2	222.1
The lower 2022-23 target reflects additional program funding transfers to the Department of Families, Fairness and Housing.					

Source: Department of Health

Ambulance Emergency Services

(2022-23: $1 212.8 million)

Emergency road, rotary and fixed air wing patient treatment and transport services provide timely and high-quality emergency ambulance services. Timely and high-quality emergency ambulance services contribute to high-quality, accessible health and community services for all Victorians.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Community Service Obligation emergency road and air transports	number	295 810	286 275	283 447	299 047
The higher 2022-23 target reflects funding provided in the 2022-23 Budget.					
Statewide emergency air transports	number	5 274	3 669	5 071	4 208
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic. The higher 2022-23 target reflects funding provided in the 2022-23 Budget.					
Statewide emergency road transports	number	527 101	527 101	506 828	518 498
The higher 2022-23 target reflects funding provided in the 2022-23 Budget.					
Treatment without transport	number	92 130	90 987	88 587	81 819
The higher 2022-23 target reflects funding provided in the 2022-23 Budget.					
Quality					
Audited cases attended by Community Emergency Response Teams (CERT) meeting clinical practice standards	per cent	90	100	90	100
The 2021-22 expected result is higher than the 2021-22 target which means most of the audited cases attended by the Community Emergency Response Teams are meeting clinical practice standards.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Audited cases statewide meeting clinical practice standards	per cent	95	100	95	100
The 2021-22 expected result is higher than the 2021-22 target which means most of the audited cases are meeting clinical practice standards.					
Proportion of adult patients suspected of having a stroke who were transported to a stroke unit with thrombolysis facilities within 60 minutes	per cent	95	98.3	95	98.5
Proportion of patients experiencing severe cardiac or traumatic pain whose level of pain is reduced significantly	per cent	90	92.6	90	92.5
Proportion of patients very satisfied or satisfied with overall services delivered by paramedics	per cent	95	97.1	95	97.1
Timeliness					
Proportion of emergency (Code 1) incidents responded to within 15 minutes – statewide	per cent	85	70.1	85	77.2
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Proportion of emergency (Code 1) incidents responded to within 15 minutes in centres with more than 7 500 population	per cent	90	74	90	82.5
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Cost					
Total output cost	$ million	1 212.8	1 199.4	1 166.5	1 012.6
The higher 2022-23 target reflects funding provided for government policy commitments.					

Source: Department of Health

Ambulance Non-Emergency Services (2022-23: $180.0 million)

Non-emergency road, rotary and fixed air wing patient treatment and transport services provide access to timely, high-quality non-emergency ambulance services. High-quality non-emergency ambulance services contribute to high-quality, accessible health and community services for all Victorians. The output supports departmental priorities through provision of patient transport officers to service non-emergency, pre and post hospital patients.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Community Service Obligation non-emergency road and air transports	number	240 738	236 129	240 569	237 864
The higher 2022-23 target reflects funding provided in the 2022-23 Budget.					
Statewide non-emergency air transports	number	2 617	2 349	2 538	2 650
The 2021-22 expected outcome is higher than the 2021-22 target as a result of higher demand.					
The higher 2022-23 target reflects funding provided in the 2022-23 Budget.					
Statewide non-emergency road transports	number	316 214	310 134	295 925	313 367
The 2021-22 expected outcome is higher than the 2021-22 target as a result of higher demand.					
The higher 2022-23 target reflects funding provided in the 2022-23 Budget.					
Quality					
Audited cases statewide meeting clinical practice standards	per cent	95	100	95	100
The 2021-22 expected outcome is higher than the 2021-22 target which means most of the audited cases are meeting clinical practice standards.					
Cost					
Total output cost	$ million	180.0	181.7	197.0	176.6
The lower 2021-22 expected outcome is due to government policy commitment rephase due to COVID-19 response.					
The lower 2022-23 target reflects fixed term funding provided in 2021-22 during the peak of the COVID-19 response					

Source: Department of Health

Drug Prevention and Control (2022-23: $40.8 million)

Encourages all Victorians to minimise the harmful effects of alcohol and other drugs by providing a comprehensive range of strategies, which focus on enhanced community and professional education, targeted prevention and early intervention programs, community and residential treatment services, and the use of effective regulation.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of phone contacts from family members seeking support	number	10 682	10 682	10 682	10 498
Needles and syringes provided through the Needle and Syringe program	number (thousand)	10 170	9 508	10 170	10 047
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the disruptions to the supply of needle and syringes.					
Number of telephone, email, website contacts and requests for information on alcohol and other drugs	number (thousand)	4 200	5 858	4 200	5 291
The 2020-21 expected outcome is higher than the 2020-21 target primarily due to the impact of the COVID-19 pandemic.					
Quality					
Pharmacotherapy permits processed within designated timeframe	per cent	100	100	100	100
Timeliness					
Percentage of new licences and permits issued to health services or businesses for the manufacture, use or supply of drugs and poisons within six weeks following receipt of full information	per cent	100	100	100	100
Percentage of treatment permits for medical practitioners or nurse practitioners to prescribe Schedule 8 drugs assessed within four weeks	per cent	80	100	80	100
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to transitioning to a new IT system for processing and assessing Schedule 8 permit applications in Q2/Q3 which is likely to affect the expected outcome for those quarters.					
Cost					
Total output cost	$ million	40.8	44.5	44.8	37.1
The lower 2022-23 target reflects fixed term funding provided in 2021-22.					

Source: Department of Health

Drug Treatment and Rehabilitation (2022-23: $272.5 million)

Assists the community and individuals to control and reduce the harmful effects of illicit and licit drugs, including alcohol, in Victoria through the provision of community-based non-residential and residential treatment services, education and training, and support services.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Clients on the Pharmacotherapy program	number	14 000	14 776	14 000	14 776
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to the continued increase in demand for pharmacotherapy supports driven by disruptions to the illicit drug market.					
Commenced courses of treatment – community-based drug treatment services	number	10 189	11 982	10 189	11 578
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to increased availability of online supports throughout the pandemic.					
Number of drug treatment activity units – residential services	number	78 535	59 878	78 535	51 701
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the implementation of COVID-19 control measures, enabling social distancing, including conversion of twin rooms to single rooms significantly reducing capacity, and therefore admissions, during Q2 and Q3 of 2021-22.					
Number of drug treatment activity units – community-based services	number	97 855	89 610	97 855	96 937
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic on activities.					
Workers complying with Alcohol and Other Drug (AOD) Minimum Qualification Strategy requirements	per cent	85	85	85	93
Quality					
Percentage of new clients to existing clients	per cent	50	59	50	56.1
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to increased complexity and impacts of the COVID-19 pandemic.					
Percentage of residential rehabilitation clients remaining in treatment for ten days or more	per cent	80	81	80	81.7
Successful courses of treatment (episodes of care) – community-based drug treatment services	number	7 385	11 360	7 385	10 966
The 2021-22 expected outcome is higher than the 2021-22 target primarily due more people with issues relating to AOD and mental health completing their treatment with support services.					
Percentage of residential withdrawal clients remaining in treatment for two days or more	per cent	80	96	80	95.5
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to impacts of the COVID-19 pandemic.					
Timeliness					
Median wait time between intake and assessment	days	10	7.3	10	7.4
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to increased demand for AOD services.					
Median wait time between assessment and commencement of treatment	days	20	12.9	20	13.1
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to increased demand for AOD services.					

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Cost					
Total output cost	$ million	272.5	308.6	285.4	268.1
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to additional government policy commitments.					
The lower 2022-23 target primarily reflects fixed term funding provided in 2021-22 to respond to the impacts of COVID-19.					

Source: Department of Health

Mental Health Clinical Care (2022-23: $2 594.7 million)

Provides a range of inpatient residential and community-based clinical services to people with mental illness, and their families so that those experiencing mental health problems can access timely, high-quality care and support to recover and live successfully in the community. Measures will be updated ahead of the 2023-24 budget to reflect investment into the training and development of the mental health and wellbeing workforce.

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quantity					
Clinical inpatient separations	number	29 616	27 470	28 747	27 361
The higher 2022-23 target reflects additional funding provided in the 2022-23 Budget *for additional acute beds.*					
Total community service hours (child and adolescent)	number (thousand)	340	266	266	235
The higher 2022-23 target reflects the impact of funding provided in the 2021-22 *and* 2022-23 Budgets.					
Total community service hours (adult)	number (thousand)	1 304	864	1 185	958
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of Mental Health EBA 2020 negotiations on the reporting of adult clinical community hours, resulting in a reduced result.					
The higher 2022-23 target reflects the impact of funding provided in the 2021-22 *and* 2022-23 Budgets.					
Total community service hours (aged)	number (thousand)	196	112	154	119
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of Mental Health EBA 2020 negotiations on the reporting of adult clinical community hours, resulting in a reduced result.					
The higher 2022-23 target reflects the impact of funding provided in the 2021-22 *and* 2022-23 Budgets.					
New case index	per cent	50	50	50	50.8
Registered community clients	number	90 362	85 863	85 863	75 397
The higher 2022-23 target reflects the impact of funding provided in the 2021-22 *and* 2022-23 Budgets.					
Occupied residential bed days	number	153 574	149 574	153 574	151 201
Occupied Sub-acute bed days	number	198 094	195 288	186 771	196 034
The higher 2022-23 target reflects additional funding provided in the 2022-23 Budget *for additional sub-acute beds.*					
Quality					
Clients readmitted (unplanned) within 28 days	per cent	14	15	14	15
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
New client index	per cent	45	45	45	44.3
Number of designated mental health services achieving or maintaining accreditation under the National Safety and Quality in Health Service Standards	number	19	18	18	18
The higher 2022-23 target reflects an expected increase in designated mental health services.					
Post-discharge community care (child and adolescent)	per cent	88	86	88	86.4
Post-discharge community care (adult)	per cent	88	79	88	84
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of Mental Health EBA 2020 negotiations on the reporting of post-discharge contact for adult consumers, resulting in a reduced result.					
Post-discharge community care (aged)	per cent	88	83	88	88
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of Mental Health EBA 2020 negotiations on the reporting of post-discharge contact for adult consumers, resulting in a reduced result.					
Pre-admission community care	per cent	61	58	61	59
Mental health consumers who report a positive experience of care	per cent	80	nm	nm	nm
New performance measure for 2022-23 to reflect recommendations of the Royal Commission into Victoria's Mental Health System to better measure government investment in mental health.					
Mental health carers who report a positive experience of care	per cent	80	nm	nm	nm
New performance measure for 2022-23 to reflect recommendations of the Royal Commission into Victoria's Mental Health System to better measure government investment in mental health.					
Consumers who report they usually or always felt the service was safe	per cent	90	nm	nm	nm
New performance measure for 2022-23 to reflect recommendations of the Royal Commission into Victoria's Mental Health System to better measure government investment in mental health.					
Carers who report they usually or always felt their opinions as a carer were respected	per cent	90	nm	nm	nm
New performance measure for 2022-23 to reflect recommendations of the Royal Commission into Victoria's Mental Health System to better measure government investment in mental health.					
Acute mental health inpatients readmitted (unplanned) within 28 days of discharge (child/adolescent)	per cent	14	nm	nm	nm
New performance measure for 2022-23 to reflect recommendations of the Royal Commission into Victoria's Mental Health System to better measure government investment in mental health.					
Acute mental health inpatients readmitted (unplanned) within 28 days of discharge (adult)	per cent	14	nm	nm	nm
New performance measure for 2022-23 to reflect recommendations of the Royal Commission into Victoria's Mental Health System to better measure government investment in mental health.					
Acute mental health inpatients readmitted (unplanned) within 28 days of discharge (aged)	per cent	7	nm	nm	nm
New performance measure for 2022-23 to reflect recommendations of the Royal Commission into Victoria's Mental Health System to better measure government investment in mental health.					
Mental health-related emergency department presentations with a length of stay of less than 4 hours	per cent	81	nm	nm	nm
New performance measure for 2022-23 to reflect recommendations of the Royal Commission into Victoria's Mental Health System to better measure government investment in mental health.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Separations from an acute inpatient unit where the consumer received post-discharge follow-up within 7 days	per cent	88	nm	nm	nm
New performance measure for 2022-23 to reflect recommendations of the Royal Commission into Victoria's Mental Health System to better measure government investment in mental health.					
Seclusions per 1 000 occupied bed days (child and youth)	per cent	5	nm	nm	nm
New performance measure for 2022-23 to reflect recommendations of the Royal Commission into Victoria's Mental Health System to better measure government investment in mental health.					
Seclusions per 1 000 occupied bed days (adults and forensic)	per cent	8	nm	nm	nm
New performance measure for 2022-23 to reflect recommendations of the Royal Commission into Victoria's Mental Health System to better measure government investment in mental health.					
Seclusions per 1 000 occupied bed days (aged)	per cent	5	nm	nm	nm
New performance measure for 2022-23 to reflect recommendations of the Royal Commission into Victoria's Mental Health System to better measure government investment in mental health.					
Timeliness					
Emergency patients admitted to a mental health bed within eight hours	per cent	80	52	80	54.4
The 2021-22 expected outcome is lower than the target due to an increasing number of people presenting directly to emergency departments, general demand for mental health services, as well as COVID-19 impacts including staff furloughing. The creation of over 170 new mental health beds, as recommended by the Royal Commission into Victoria's Mental Health System, is responding to this pressure					
Cost					
Total output cost	$ million	2 594.7	2 178.6	2 177.0	1 937.6
The higher 2022-23 target reflects funding provided for government policy commitments.					

Source: Department of Health

Mental Health Community Support Services (2022-23: $155.2 million)

A range of rehabilitation and support services provided to youth and adults with a psychiatric disability, and their families and carers, so that those experiencing mental health problems can access timely, high-quality care and support to recover and reintegrate into the community.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Bed days	number	62 744	48 654	62 744	46 542
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic on activities.					
Client Support Units	number	6 406	23 792	44 157	2 703
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the transition of funding committed to individualised client support packages to the NDIS. *The lower 2022-23 target reflects the cessation of the Mental Health Community Support Services Individual Client Support Packages as part of the transition to the NDIS.*					
Clients receiving community mental health support services	number	391	1 800	1 800	3 180
The lower 2022-23 target reflects the cessation of the Mental Health Community Support Services Individual Client Support Packages as part of the transition to the NDIS.					
Quality					
Proportion of major agencies accredited	per cent	100	100	100	100
Cost					
Total output cost	$ million	155.2	173.7	166.3	121.8
The lower 2022-23 target reflects the transfer of services and funding to the NDIS.					

Source: Department of Health

Community Health Care (2022-23: $401.2 million)

This output includes delivery of a range of community care and support services, including counselling, allied health and nursing, that enable people to continue to live independently in the community.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Rate of admissions for ambulatory care sensitive chronic conditions for Aboriginal Victorians	rate per 1 000	14.4	14.4	14.4	14.4
Number of referrals made using secure electronic referral systems	number	75 000	75 000	75 000	75 000
The 2019-20 actual updates the preliminary result in the Department's 2019-20 Annual Report.					
Primary Care Partnerships with reviewed and updated Strategic Plans	per cent	100	100	100	100
The 2019-20 actual updates the preliminary result in the Department's 2019-20 Annual Report.					
Service delivery hours in community health care	number (thousand)	1 064	1 060	1 060	1 080
The 2022-23 target is higher than the 2021-22 target due to the transfer of service delivery hours from the Small Rural Services–Primary Health output to the Community Health Care Output..					
Quality					
Agencies with an Integrated Health Promotion plan that meets the stipulated planning requirements	per cent	95	98	95	95
Cost					
Total output cost	$ million	401.2	507.7	381.0	329.4
The higher 2021-22 expected outcome and 2022-23 target reflect funding provided for government policy commitments.					

Source: Department of Health

Dental Services (2022-23: $327.7 million)

This output includes delivery of a range of dental health services to support health and wellbeing in the community.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Persons treated	number	332 150	376 150	376 150	323 637
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the COVID-19 pandemic causing service disruptions and impacting performance. *The lower 2022-23 target reflects the additional one-off funding provided in 2021-22.*					
Priority and emergency clients treated	number	249 100	249 100	249 100	263 243
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the COVID-19 pandemic.					
Children participating in the Smiles 4 Miles oral health promotion program	number	49 000	49 000	49 000	34 000
Schools visited by Smile Squad	number	200	nm	nm	nm
This is a new performance measure for 2022-23 to reflect the Government's priorities around dental care.					
Students examined by Smile Squad	number	10 000	nm	nm	nm
This is a new performance measure for 2022-23 to reflect the Government's priorities around dental care.					
Students receiving treatment by Smile Squad	number	1 500	nm	nm	nm
This is a new performance measure for 2022-23 to reflect the Government's priorities around dental care.					
Timeliness					
Waiting time for dentures	months	22	22	22	17.8
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Percentage of Dental Emergency Triage Category 1 clients treated within 24 hours	per cent	90	92	90	94
Waiting time for general dental care	months	23	23	23	19.4
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Cost					
Total output cost	$ million	327.7	294.1	351.9	296.7
The 2021-22 expected outcome is lower than the 2021-22 target owing to the rephase of funding for the Free dental care for government school students initiative which was delayed due to the COVID-19 pandemic. *The lower 2022-23 target reflects updated costings for the delivery of the Free dental care for government school students initiative.*					

Source: Department of Health

Maternal and Child Health and Early Parenting Services (2022-23: $155.0 million)

This output involves the provision of community-based maternal and child health services available to all families with children.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Hours of additional support delivered through the Enhanced Maternal and Child Health program	number	248 000	248 000	248 000	139 797
Total number of Maternal and Child Health Service clients (aged 0 to 1 year)	number	80 000	80 000	80 000	79 156
Timeliness					
Children aged 0 to 1 month enrolled at maternal and child health services from birth notifications	per cent	99	99	99	99
Cost					
Total output cost	$ million	155.0	148.6	150.6	132.7
The higher 2022-23 target reflects funding provided for government policy commitments.					

Source: Department of Health

Health Protection (2022-23: $446.2 million)

Protects the health of Victorians through a range of prevention programs including regulation, surveillance and the provision of statutory services.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Inspections of cooling towers	number	1 300	334	1 300	1 232
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Inspections of radiation safety management licences	number	480	45	480	136
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Percentage of Aboriginal children fully immunised at 60 months	per cent	97	93	97	97.8
Number of available HIV rapid test trial appointments used	number	2 875	1 728	2 875	1 504
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic .					
Women screened for breast cancer by BreastScreen Victoria	number	267 000	266 316	267 000	236 224
Percentage of newborns having a newborn bloodspot screening test	per cent	98	nm	nm	nm
This is a new performance measure, replacing the measure 'Number of persons participating in newborn bloodspot or maternal serum screening'. The change in measurement to percentage participation in the program rather than an absolute number provides a more accurate representation of performance which takes into consideration population growth.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Persons screened for prevention and early detection of health conditions – pulmonary tuberculosis screening	number	2 000	498	2 000	1 351
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic .					
Smoking cessation of Aboriginal mothers	per cent	25.2	25.2	25.2	24.1
Quality					
Calls to food safety hotlines that are answered	per cent	97	100	97	99.8
Percentage of adolescents (aged 15) fully immunised for HPV	per cent	80	nm	nm	nm
The new measure has been created to provide increased clarity over service delivery.					
Immunisation coverage – At five years of age	per cent	95	96	95	95.8
This measure has been renamed from 'Immunisation coverage–at school entry' to more clearly specify the measurement period.					
Immunisation coverage – At two years of age	per cent	95	93	95	93.2
Public health emergency response calls dealt with within designated plans and procedure timelines	per cent	100	100	100	100
Timeliness					
Percentage of food recalls acted upon within 24 hours of notification	per cent	97	97	97	93.2
Infectious disease outbreaks responded to within 24 hours	per cent	100	100	100	100
Participation rate of women in target age range screened for breast cancer	per cent	54	54	54	48.6
Cost					
Total output cost	$ million	446.2	1 592.6	555.0	1 370.7
The 2021-22 expected outcome is higher than the 2021-22 target due to additional government policy commitments in response to COVID-19.					
The lower 2022-23 target reflects one-off funding provided in 2021-22 as part of government's response to COVID-19.					

Source: Department of Health

Health Advancement (2022-23: $103.1 million)

Improves the general health and wellbeing of Victorians through the provision of community information and the fostering of healthy behaviours.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Persons completing the Life! – Diabetes and Cardiovascular Disease Prevention program	number	5 616	3 384	5 616	3 456
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Number of training courses for health professionals on sexual and reproductive health	number	50	50	50	51
Number of education or monitoring visits of tobacco or e-cigarette retailers	number	1 500	2 080	1 500	nm
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Number of sales to minors test purchases undertaken	number	3 000	775	3 000	nm
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Number of education or monitoring visits of smoke-free areas	number	3 500	3 500	3 500	nm
Quality					
Local Government Authorities with Municipal Public Health and Wellbeing Plans	per cent	100	100	100	100
Cost					
Total output cost	$ million	103.1	87.0	81.5	89.1
The higher 2021-22 expected outcome and 2022-23 target reflect funding provided for government policy commitments.					

Source: Department of Health

Emergency Management (2022-23: $12.9 million)

Training in emergency management preparedness, planning, response, relief, and recovery.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of people trained in emergency management	number	2 000	2 780	2 000	2 590
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
Cost					
Total output cost	$ million	12.9	17.1	15.0	24.6
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to additional government policy commitments.					
The lower 2022-23 target reflects program funding transfers to other departments.					

Source: Department of Health

Small Rural Services – Acute Health (2022-23: $429.5 million)

Admitted and non-admitted services delivered by small rural services, including elective and non-elective surgical and medical care, urgent care services, and maternity services.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
NWAU Eligible Separations	number (thousand)	30	nm	nm	nm
This is a new performance measure, replacing the measure 'Separations'. The new measure will only measure activity eligible for funding under the national funding model.					
Small rural weighted activity unit	number (thousand)	315 000	322 000	350 000	308 000
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic. The lower 2022-23 target reflects the transfer of service delivery hours from the 'Small Rural Services–Acute Health' output to the 'Admitted Services' output.					
Small Rural Urgent Care Presentations	number (thousand)	93.0	nm	nm	nm
New performance measure for 2022-23 to enhance the measurement of demand for urgent care centres in small rural services.					
Quality					
Percentage of health services accredited	per cent	100	100	100	100
Cost					
Total output cost	$ million	429.5	440.8	431.5	446.5
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to funding provided for government policy commitments related to the COVID-19 response. The lower 2022-23 target is due to aligning service delivery with capital project delivery.					

Source: Department of Health

Small Rural Services – Aged Care (2022-23: $250.3 million)

This output includes delivery of in home, community-based and residential care services for older people, delivered in small rural towns.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Small rural available bed days	number	701 143	706 906	701 143	701 143
Quality					
Residential care services accredited	per cent	100	100	100	100
Cost					
Total output cost	$ million	250.3	245.6	243.9	260.0
The higher 2022-23 target is due to additional own source revenue generated by the Department of Health and invested in this output.					

Source: Department of Health

Small Rural Services – Home and Community Care (2022-23: $11.5 million)

This output includes delivery of community-based nursing, allied health and support services for younger people who have difficulty with the activities of daily living delivered by small rural services to support them to be more independent and to participate in the community.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Home and Community Care for Younger People – hours of service delivery	hours	51 000	46 480	55 000	45 922
The 2021-22 expected outcome is lower than the 2021-22 target due to the transfer of service delivery hours from the 'Small Rural Services–Home and Community Care Services' output to the 'Home and Community Care Services' output.					
Cost					
Total output cost	$ million	11.5	5.3	5.3	5.0
The higher 2022-23 target reflects funding provided for government policy commitments.					

Source: Department of Health

Small Rural Services – Primary Health (2022-23: $24.7 million)

This output includes delivery of in home, community-based and primary health services delivered by small rural services and designed to promote health and wellbeing and prevent the onset of more serious illness.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Service delivery hours in community health care	number	87 400	91 500	91 500	106 115
The lower 2022-23 target reflects the transfer of service delivery hours from the 'Small Rural Services–Primary Health' output to the 'Community Health Care' output.					
Cost					
Total output cost	$ million	24.7	24.4	24.5	21.5
The higher 2022-23 target reflects funding provided for government policy commitments.					

Source: Department of Health

DEPARTMENT OF JOBS, PRECINCTS AND REGIONS

Ministerial portfolios

The Department of Jobs, Precincts and Regions supports the ministerial portfolios of Agriculture; Business Precincts; Community Sport; Creative Industries; Employment; Industry Support and Recovery; Local Government; Trade; Innovation, Medical Research and the Digital Economy; Racing; Regional Development (and Cross Border Coordination); Resources; Small Business; Suburban Development; and Tourism, Sport and Major Events.

Departmental mission statement

The Department of Jobs, Precincts and Regions is focused on growing our State's economy and ensuring it benefits all Victorians – by creating more jobs for more people, building thriving places and regions, and supporting inclusive communities.

- More jobs for more people: the Department is helping to grow the economy by working with businesses to create and maintain jobs so more people have meaningful work that is safe and secure. It supports workers, develops and grows our industries, and assists industries in transition. It is creating jobs by leveraging and securing our natural assets and regional strengths, along with fostering our visitor economy, creativity and innovation. It is also connecting Victoria to the world by attracting investment and talent, and helping Victorian businesses successfully trade into global markets.
- Thriving places and regions: the Department is building vibrant, prosperous precincts and regions that drive economic growth and opportunities. It is supporting businesses to establish and grow, and its geographic focus on innovation and sector activity is helping attract investment. It is also cementing Victoria's position as Australia's leading cultural, sport, tourism and events destination.
- Inclusive communities: the Department is working to create opportunities for all Victorians in communities that are well connected, culturally diverse and economically resilient. It is doing this by taking a collaborative approach – working across government and with communities to understand how to share the benefits of economic prosperity, address entrenched disadvantage and support a stronger and fairer society.

Departmental objectives

Create and maintain jobs

This objective seeks to secure a growing, sustainable and equitable jobs market for all Victorians by working with businesses to increase job opportunities, support people into meaningful employment, and attract the investment and talent needed to foster job growth.

The Jobs output contributes to this objective by supporting existing workers and businesses by connecting Victorians experiencing disadvantage to job opportunities, supporting Aboriginal economic inclusion, working with the community to create and support social enterprises; as well as attracting new investment and talent into Victoria to grow the economy and share the benefits of economic prosperity.

Foster a competitive business environment

This objective seeks to grow Victorian industries and businesses by working with priority industry sectors, supporting growth and innovation opportunities for industry, supporting startups and small businesses, and assisting industries in transition.

The Industry, Innovation, Medical Research and Small Business output contributes to this objective by providing access to information and connections and building the capability of Victorian businesses and industry to develop and effectively use new practices and technologies, advocating for a fair and competitive business environment, and supporting small businesses.

Be a globally connected economy

This objective seeks to connect Victoria to the world by helping Victorian businesses successfully trade into global markets and grow Victoria's proportion of international student enrolments in Australia.

The Trade and Global Engagement output contributes to this objective by developing the skills and knowledge of current and potential exporters, connecting organisations to global business opportunities, establishing and deepening strategic commercial international partnerships, and increasing the proportion of international students.

Build prosperous and liveable regions and precincts

This objective seeks to ensure that Victoria's precincts, suburbs and regions are developed to create places where all Victorians have an opportunity to participate in growing communities that are well-connected, prosperous, vibrant and diverse.

The Business Precincts output delivers activities to build vibrant and prosperous precincts that drive economic growth and opportunities. The Department works collaboratively with government, industry and community stakeholders to identify opportunities for the development and delivery of initiatives to strengthen our economy, create jobs and improve liveability for all Victorians.

The Local Government and Suburban Development output delivers activities in partnership with the local government sector to support effective and efficient local governance, leadership, infrastructure and service provision. The Department also works collaboratively to develop Melbourne's suburbs through the Suburban Revitalisation Program and the six Metropolitan Partnerships and improve suburban liveability. Through this output, the Department administers programs to support local governments to increase accountability and provides support to the Victorian Local Government Grants Commission.

The Regional Development output contributes to this objective by working with industry and communities to identify opportunities to support job growth and new investment in regional Victoria, strengthening community capability, and engaging with industry and communities to deliver regional priorities.

Grow vibrant, active and creative communities

This objective seeks to increase the economic, social and cultural value of the creative, sport and recreation industries to Victoria, grow the number and yield of visitors, position Victoria as a major events destination, and ensure the best cultural and sporting experiences are accessible to everyone.

The Creative Industries Access, Development and Innovation output contributes to this objective through developing more opportunities for the creation and presentation of new work, building industry capability and growth, stimulating innovation and wider impacts, engaging more Victorians and building international engagement.

The Creative Industries Portfolio Agencies output contributes to this objective through supporting creative industries agencies to promote access and participation, to increase visitor numbers and to manage the State's cultural collections.

The Cultural Infrastructure and Facilities output contributes to this objective through undertaking maintenance activities and developing infrastructure projects to ensure state-owned cultural venues are available to the public.

The Sport, Recreation and Racing output contributes to this objective by providing strategic leadership and investment in the sport, recreation and racing industries through innovation, sector and industry development and funding support. It supports community participation and inclusion in the sport, recreation and racing sectors by strengthening the capacity of sport and recreation organisations to deliver participation opportunities, improving community sport and recreation facilities across the State and guiding the development and management of state-level sporting facilities and events, to encourage participation by all Victorians. This output also supports the development of the Victorian racing industry through strategic investment in world-class racing and training infrastructure, the promotion of animal welfare and integrity initiatives and encourages participation and investment in the breeding industry to cement Victoria's position as Australia's premier racing state.

The Tourism and Major Events output contributes to this objective through increasing the number of visitors to Victoria, boosting expenditure from these visitors, and continuing to strengthen Victoria's major events program.

Promote productive and sustainably used natural resources

This objective supports a more productive, globally competitive, sustainable and jobs-rich agriculture, food and fibre, and resources sectors. The Department delivers the objective in collaboration with partners, local communities and industry to deliver outcomes that provide benefits to all Victorians.

The Agriculture output contributes to increasing the productivity, competitiveness and sustainability of food and fibre industries and creates the conditions to grow the natural resources economy. This includes protecting and enhancing market access and management of biosecurity risks, increasing the use of new technologies, improving farm practices and supply chain efficiency, building the resilience of the sector to manage risks and emergencies, and ensuring forestry and game resources are sustainably allocated and used for both recreational and commercial purposes.

The Resources output contributes to this objective by aiming to achieve a growing and sustainable earth resources sector through effective policy, programs and regulation.

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2021-22 budget	*2021-22 revised*	*2022-23 budget*	*Variation [(a)] %*
Create and maintain jobs				
Jobs	310.0	492.1	389.3	25.6
Foster a competitive business environment				
Industry, Innovation, Medical Research and Small Business	251.2	7431.1	473.2	88.4
Be a globally connected economy				
Trade and Global Engagement	39.2	92.7	46.4	18.3
Build prosperous and liveable regions and precincts				
Business Precincts	16.6	40.6	66.5	299.3
Local Government and Suburban Development	145.4	213.1	140.2	(3.6)
Regional Development	256.0	263.3	176.2	(31.2)
Grow vibrant, active and creative communities				
Creative Industries Access, Development and Innovation	54.8	100.5	55.3	1.0
Creative Industries Portfolio Agencies	393.7	503.6	427.3	8.5
Cultural Infrastructure and Facilities	65.3	66.0	72.0	10.4
Sport, Recreation and Racing	497.4	748.5	407.2	(18.1)
Tourism and Major Events	197.9	483.5	298.4	50.8
Promote productive and sustainably used natural resources				
Agriculture	464.7	551.9	504.1	8.5
Resources	66.2	61.6	69.4	4.8
Total [(b)]	**2 758.3**	**11 048.5**	**3 125.4**	**13.3**

Source: Department of Jobs, Precincts and Regions

Notes:
(a) Variation between 2020-21 budget and 2022-23 budget.
(b) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.10 outlines the Department's income from transactions and Table 2.11 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.10: Income from transactions **($ million)**

	2020-21 actual	*2021-22 budget*	*2021-22 revised*	*2022-23 budget*
Output appropriations	6 929.0	2 534.1	10 619.4	2 864.3
Interest	7.4	10.9	10.7	11.3
Sale of goods and services	57.4	126.4	127.6	123.9
Grants	202.9	12.5	173.6	88.3
Fair value of assets and services received free of charge or for nominal consideration	3.0	0.5	0.5	1.8
Other income	30.1	27.8	29.1	29.6
Total income from transactions [(a)]	**7 229.8**	**2 712.2**	**10 961.0**	**3 119.2**

Source: Department of Jobs, Precincts and Regions

Note:
(a) Table may not add due to rounding.

Table 2.11: Parliamentary authority for resources **($ million)**

	2021-22 budget	*2021-22 revised*	*2022-23 budget*
Annual appropriations	**2 696.7**	**7 682.8**	**3 060.0**
Provision of outputs	2 433.5	7 344.2	2 752.5
Additions to the net asset base	186.5	257.8	212.9
Payments made on behalf of the State	76.7	80.8	94.6
Receipts credited to appropriations	**100.6**	**3 292.2**	**111.8**
Unapplied previous years appropriation	**..**	**19.7**	**..**
Provision of outputs	..	19.7	..
Additions to the net asset base	..	..	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**2 797.3**	**10 994.7**	**3 171.8**
Special appropriations	**..**	**1.5**	**..**
Trust funds	**679.2**	**531.6**	**785.6**
Commonwealth Local Government Grants Trust [(a)]	636.3	325.2	663.8
Other [(b)]	42.9	206.4	121.8
Total parliamentary authority [(c)]	**3 476.6**	**11 527.8**	**3 957.4**

Source: Department of Jobs, Precincts and Regions

Notes:
(a) The purpose of this trust primarily relates to the issuing of grants pursuant to the Commonwealth allocation to the state for on-passing to local government.
(b) Includes inter-departmental transfers.
(c) Table may not add due to rounding.

Departmental performance statement

Objective 1: Create and maintain jobs

This objective seeks to secure a growing, sustainable and equitable jobs market for all Victorians by working with businesses to increase job opportunities, support people into meaningful and secure employment, and attract the investment and talent needed to foster job growth.

The departmental objective indicator is:

- people employed in Victoria.

Outputs

Jobs (2022-23: $389.3 million)

This output includes initiatives to support existing workers and businesses by connecting Victorians experiencing disadvantage to job opportunities, supporting Aboriginal economic inclusion, working with the community to create and support social enterprises; as well as attracting new investment and talent into Victoria to grow the economy and share the benefits of economic prosperity.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Disadvantaged jobseekers who achieve sustainable employment (minimum number of 26 weeks) with the support of Jobs Victoria Services	number	8 250	3 500	4 000	8 314
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of state health restrictions, and fewer jobseekers were able to commence job placements in the first quarter of 2021-22. *The higher 2022-23 target is due to a large number of jobseekers being supported to gain employment in 2021-22, enabling a greater number of jobseekers expected to achieve sustainable employment in 2022-23.*					
Disadvantaged jobseekers who gain employment with the support of Jobs Victoria Services	number	6 630	12 600	12 500	2 117
The lower 2022-23 target is due to more Jobs Victoria services being directed to support jobseekers to achieve sustainable employment in 2022-23.					
Firms assisted from industry growth programs	number	100	100	100	39
Government Youth Employment Scheme traineeships commenced	number	280	280	280	244
Industry stakeholders engaged with the Local Jobs First Policy	number	800	750	600	1 456
The 2021-22 expected outcome is higher than the 2021-22 target due to the timing of projects being released to the market, as well as an increased volume of projects as a result of the Building Works stimulus package. *The higher 2022-23 target is due to an anticipated increase in engagement with Victorian Government tenders through increased activity associated with Big Build infrastructure projects.*					
Capital expenditure from industry growth programs	$ million	500	nm	nm	nm
New performance measure for 2022-23 to capture the impact of the Victorian Industry Investment Fund and other new industry growth programs.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Jobs created from industry growth programs	number	1 500	2 500	1 250	2 282
The 2021-22 expected outcome is higher than the 2021-22 target due to accelerated assistance provided to companies, in line with the government's response to COVID-19 and economic recovery stimulus. *The higher 2022-23 target is due to new funding in the 2022-23 State Budget for the Victorian Industry Investment and Growth initiative.*					
Jobs Victoria Services (Advocates, Mentors, Careers Counsellors) delivered to Victorian jobseekers	number	75 000	75 500	70 000	31 544
The 2021-22 expected outcome is higher than the 2021-22 target as some new services scaled up to full capacity sooner than expected, and there has been strong demand from jobseekers. *The higher 2022-23 target is due to Jobs Services Victoria operating at full capacity for the entire year.*					
Migrant talent nominated for the Skilled, Investor and Business Migration Program	number	4 000	4 000	2 000	nm
The 2021-22 expected outcome is higher than the 2021-22 target. The migration environment remains volatile and the program nominated an appropriate target at the time. Border closures and other impacts of the COVID-19 pandemic continue to generate uncertainty in migration flows, whilst Victorian industries are experiencing skills shortages and increasing their demand for migrants. It is anticipated that the program will therefore exceed its current target. This is anticipated to impact 2021-22 only. *The higher 2022-23 target is due to increased certainty in migration flows, following the opening of Australia's borders, and an increase in the number of available places on the program.*					
Number of eligible workers approved for the Sick Pay Guarantee	number	130 000	nm	nm	nm
New performance measure for 2022-23 to reflect the introduction of the Sick Pay Guarantee.					
Proportion of disadvantaged jobseekers who achieve sustainable employment (minimum number of 26 weeks) with the support of Jobs Victoria Services	per cent	50	50	50	50
Proportion of Jobs Victoria Fund allocated to women	per cent	60	60	60	nm
Retrenched workers supported with employment assistance	number	2 000	1 920	2 000	598
Subsidised jobs for jobseekers through the Jobs Victoria Fund	number	2 000	4 000	4 000	2 387
The lower 2022-23 target is due to the phasing of subsidised jobs, with 2 000 subsidies to be delivered in 2022-23 and services being directed to oversee job placements and manage grants.					
Quality					
Client satisfaction with investor, business and skilled migration services provided	per cent	85	85	85	88
Jobseeker satisfaction with Jobs Victoria Services	per cent	70	70	70	nm
Timeliness					
Average processing time for investor, business and skilled migration visa nomination applications	days	20	20	20	16.2
Percentage of successful Sick Pay Guarantee claims approved by DJPR within 5 business days	per cent	90	nm	nm	nm
New performance measure for 2022-23 to reflect the introduction of the Sick Pay Guarantee.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Cost					
Total output cost	$ million	389.3	492.1	310.0	2 862.5

The 2021-22 expected outcome is higher than the 2021-22 target mainly due to additional funding for Test Isolation Payments and Pandemic Leave Disaster Payments.

The higher 2022-23 target primarily reflects additional funding in the 2022-23 Budget *for the Victorian Sick Pay Guarantee initiative.*

Source: Department of Jobs, Precincts and Regions

Objective 2: Foster a competitive business environment

This objective seeks to grow Victorian industries and businesses by working with priority industry sectors, supporting growth and innovation opportunities for industry, supporting startups and small businesses, and assisting industries in transition.

The departmental objective indicators are:

- change in Victoria's real gross state product
- engagement with businesses.

Outputs

Industry, Innovation, Medical Research and Small Business

(2022-23: $473.2 million)

This output provides access to information and connections and builds the capability of Victorian businesses and industry to develop and effectively use new practices and technologies to increase productivity and competitiveness, advocating for a fair and competitive business environment, and supporting small businesses.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Industry, Innovation and Small Business					
This sub-output supports Victorian businesses, from global enterprises to small, medium and startup businesses, to grow, create more job opportunities, lead innovation, promote digital connectivity and develop strategic industries.					
This is achieved by facilitating new investments, investing in digital connectivity, developing and attracting world-class talent, enhancing industry capability to build on the State's reputation for innovation and encouraging a competitive and fair business environment and a strong, diversified economy.					
Quantity					
Companies or new entrants supported through the LaunchVic initiative	number	140	130	127	127
The higher 2022-23 target reflects continued investment and strong productivity achieved via the LaunchVic initiative.					
Individuals supported under digital skills initiatives	number	2 000	2 000	2 000	573
Industry roundtables and engagement forums	number	60	69	25	520
The 2021-22 expected outcome is higher than the 2021-22 target, reflecting the increased number of industry forums and engagements expected in relation to COVID-19.					
The higher 2022-23 target reflects an increased number of industry forums and engagements expected in the post-pandemic recovery phase.					
Locations to receive broadband infrastructure upgrades as part of the Connecting Victoria program.	number	55	65	65	nm
This performance measure renames the 2021-22 performance measure 'Locations to receive broadband infrastructure upgrades'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity					
The lower 2022-23 target reflects the residual number of locations to be contracted through this program (120 locations in total).					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
New mobile base stations facilitated	number	20	18	20	27
The 2021-22 expected outcome is lower than the 2021-22 target based on delays to a small number of projects in the rollout schedule, which are managed by the mobile carriers. Delays are attributable to third-party dependencies and COVID-19.					
Number of equity investments held in female founders under the Alice Anderson Fund initaitive	number	40	nm	nm	nm
New performance measure for 2022-23 to capture the impact of the Alice Anderson Fund, a 2019-20 Budget *initiative delivered via LaunchVic.*					
Participation in Small Business Victoria events and access to business programs	number	20 000	20 000	20 000	27 014
Private sector capital leveraged under the Victorian Startup Capital Fund initiative	$ million	40	nm	nm	nm
New performance measure for 2022-23 to capture the impact of the Victoria Startup Capital Fund, a 2019-20 Budget *initiative delivered via LaunchVic.*					
Strategic priority businesses engaged on investment and growth	number	1 500	nm	nm	nm
This performance measure is proposed to consolidate the 2021-22 performance measures 'Engagements with businesses' and ' Businesses whose growth and productivity issues are resolved by the Department' into a new measure for 2022-23. The new measure better reflects targeted engagement with a portfolio of strategic priority businesses on investment and growth plans and opportunities.					
Visits to Business Victoria digital channels	number	4 000 000	8 500 000	4 000 000	11 939 871
The 2021-22 expected outcome is higher than the 2021-22 target due to strong performance in the first half of the year. Traffic is expected to be lower in the second half due to reduced number of active grants and programs, but the target is still expected to be exceeded.					
Quality					
Client satisfaction of small business information, referral, coaching service and business programs	per cent	90	93	90	95.3
Client satisfaction with the Victorian Government Business Offices	per cent	80	80	80	76.4
Client satisfaction with Victorian Small Business Commission mediation service	per cent	85	85	85	81.2
Proportion of business disputes presented to the Victorian Small Business Commission successfully mediated	per cent	75	75	75	77
Proportion of business disputes resolved by the Victorian Small Business Commission prior to mediation	per cent	30	35	30	38.1
The 2021-22 expected outcome is higher than the 2021-22 target, reflecting the high number of commercial tenancy relief scheme disputes received, which due to the requirements of the scheme provide greater scope for agreements at a preliminary stage.					
Cost					
Total output cost	$ million	374.5	7 310.9	187.6	991.5
The 2021-22 expected outcome is higher than the 2021-22 target due to additional support for Victorian businesses and industries in response to the COVID-19 pandemic. *The higher 2022-23 target primarily reflects the funding profile of a range of initiatives within the output.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Medical Research					
This sub-output supports maintaining Victoria's position as a leader in health and medical research, while protecting and growing jobs in the sector by funding visionary research through providing critical infrastructure to flagship projects and research institutes and strengthening commercialisation.					
Quantity					
Operational infrastructure supports grants under management	number	12	12	12	12
Projects supported through building and scaling up messenger Ribonucleic Acid Vaccine (mRNA) manufacturing capability in Victoria	number	7	10	5	nm
The 2021-22 expected outcome is higher than the 2021-22 target due to opening a competitive grant program. *The higher 2022-23 target reflects the timelines for assessment and awarding of grants and the maturation of an investment pipeline.*					
Victorian families participating in the Generation Victoria study	number	56 000	30 000	56 000	nm
The 2021-22 expected outcome is lower than the 2021-22 target due to COVID-19 related restrictions in the first half of the financial year impacting GenV's ability to recruit state-wide as originally planned. GenV are now adopting technologies that address the challenges of COVID-19 (e-recruitment system) that will assist them in the second half of the year.					
Cost					
Total output cost	$ million	98.7	120.2	63.6	109.2
The 2021-22 expected outcome is higher than the 2021-22 target due to additional funding for medical research initiatives. *The higher 2022-23 target primarily reflects additional funding in the* 2022-23 Budget *for medical research initiatives.*					

Source: Department of Jobs, Precincts and Regions

Objective 3: Be a globally connected economy

This objective seeks to connect Victoria to the world by helping Victorian businesses successfully trade into global markets, and growing Victoria's proportion of international student enrolments in Australia.

The departmental objective indicators are:

- export sales generated from government programs
- Victoria's share of international student enrolment.

Outputs

Trade and Global Engagement (2022-23: $46.4 million)

This output promotes business growth opportunities by connecting organisations to global business opportunities in priority markets and supporting the establishment and deepening of strategic commercial partnerships. It also positions Victoria as a destination of choice for international students.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Actual export sales generated as a result of participation in government programs	$ million	550	550	550	569
Clients engaged in export and trade programs	number	2 000	2 000	2 000	3 171
Number of Victorian companies assisted by Wine Industry initiatives	number	60	60	60	60
Significant interactions with Victorian agri-food companies and exporters, international customers and trading partners through formal meetings or involvement in trade programs that facilitate export and investment outcomes for Victoria	number	250	250	250	258
This performance measure renames the 2021-22 performance measure 'Significant interactions with Victorian agri-food companies and exporters, international customers and trading partners that facilitate export and investment outcomes for Victoria' The new measure reports on the same activity as the previous measure, however has been amended for increased clarity.					
Victoria's proportion of all international student enrolments in Australia	per cent	31	31.7	30	32.2
The 2021-22 expected outcome is higher than the 2021-22 target as Victoria has maintained its national market share, despite the impacts of COVID-19 on the international education sector. *The higher 2022-23 target reflects actual results over preceding years and continued investment in support of international education sector recovery.*					
Visits to the Global Victoria website	number	100 000	150 000	100 000	208 039
The 2021-22 expected outcome is higher than the 2021-22 target due to continued interest levels in government support and events for exporters as well as the ongoing delivery of online and hybrid events by Global Victoria.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quality					
Client satisfaction with export assistance offered	per cent	90	90	90	90
International student satisfaction with Study Melbourne student programs	per cent	80	85	75	nm
The 2021-22 expected outcome is higher than the 2021-22 target to reflect better-than-anticipated half-year satisfaction survey results received in the first reporting cycle for this new performance measure. Some Study Melbourne programs were postponed to later in the year due to COVID-19, therefore not all surveys have been completed yet and this may have affected the result.					
The higher 2022-23 target reflects the recovery of Victoria's international education sector and improved international student sentiment.					
Cost					
Total output cost	$ million	46.4	92.7	39.2	99.4
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to funding received for the International Education Resilience Fund.					
The higher 2022-23 target reflects funding in the 2022-23 Budget *for continued trade and global engagement activities, including through the Victoria's trade recovery and global engagement initiative.*					

Source: Department of Jobs, Precincts and Regions

Objective 4: Build prosperous and liveable regions and precincts

This objective seeks to ensure that Victoria's precincts, suburbs and regions are developed to create places where all Victorians have an opportunity to participate in communities that are well-connected, prosperous, vibrant and diverse.

The departmental objective indicators are:

- precincts developed and delivered
- community satisfaction in public places
- community satisfaction with the performance of councils as measured through the Local Government Community Satisfaction Survey.

Outputs

Business Precincts (2022-23: $66.5 million)

This output delivers activities to build vibrant and prosperous precincts that drive economic growth and opportunities. The Department works collaboratively with government, industry and community stakeholders to identify opportunities for the development and delivery of initiatives to strengthen our economy, create jobs and improve liveability for all Victorians.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Precincts in the design or delivery phase	number	4	4	4	4
Quality					
Key stakeholders satisfied with the services provided in relation to precincts	per cent	80	80	80	83
Timeliness					
Delivery of financial obligations for departmental Public Private Partnership projects in accordance with contractual timelines	per cent	85	85	85	100
Cost					
Total output cost	$ million	66.5	40.6	16.6	23.6

The 2021-22 expected outcome is higher than the 2021-22 target due to a funding realignment from capital funding to operating funding, in accordance with accounting standards.

The higher 2022-23 target reflects a funding realignment from capital funding to operating funding, in accordance with accounting standards.

Source: Department of Jobs, Precincts and Regions

Local Government and Suburban Development (2022-23: $140.2 million)

This output delivers activities in partnership with the local government sector to support effective and efficient local governance, leadership, infrastructure and service provision. The Department also works collaboratively to develop Melbourne's suburbs through the Suburban Revitalisation Program and the six Metropolitan Partnerships and improve suburban liveability. Through this output, the Department administers programs to support local governments to increase accountability and provide support to the Victorian Local Government Grants Commission.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Attendance at public library community programs	number (000)	2 263	1 800	2 263	nm
The 2021-22 expected outcome is lower than the 2021-22 target as attendance at public library programs was restricted by COVID-19 related lockdowns and directions.					
Average number of monthly pageviews on www.knowyourcouncil.vic.gov.au	number (000)	160	160	160	140
Community Leadership Program training places offered to women	number	40	40	40	nm
Community meetings held with Metropolitan Partnerships	number	18	18	18	30
Councils with approved roadside weeds and pests control plan	number	56	56	56	56
Grants to support local communities and not-for-profit organisations	number	470	nm	nm	nm
New performance measure for 2022-23 based on state budget outcomes supporting local communities and not-for-profit organsations via Living Local Fund – local community grants program.					
Meetings held annually with Victorian councils regarding the Victorian Local Government Grants Commission financial assistance grants allocation model	number	19	19	19	19
Meetings held with Local Government Mayoral Advisory Panel	number	4	4	4	4
Metropolitan Partnership Development Fund projects completed	number	7	7	7	nm
Number of visitors to Metropolitan Public Libraries	number (million)	18.8	15	18.8	nm
The 2021-22 expected outcome is lower than the 2021-22 target as visitation to metropolitan public libraries was restricted by COVID-19 related lockdowns and directions.					
Number of visitors to Regional Public Libraries	number (million)	12.0	10	12.0	nm
The 2021-22 expected outcome is lower than the 2021-22 target as visitation to regional public libraries was restricted by COVID-19 related lockdowns and directions.					
Projects to promote local living and shopping precincts in suburbs	number	50	nm	nm	nm
New performance measure for 2022-23 based on state budget outcomes aimed at the support and promotion of local living and shopping to revitalise suburban activity centres meeting needs of local people.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Projects to support community led recovery and revitalisation in disadvantaged suburbs	number	45	nm	nm	nm
This measure is proposed to replace the 2021-22 performance measure 'Projects in the planning or delivery phase to support and facilitate the revitalisation of Broadmeadows and Frankston'. The new measure is implemented to measure performance of the Suburban Revitalisation Boards Program, promoting recovery and revitalisation in disadvantaged suburbs.					
Quality					
Council satisfaction with the communication, support and advice received from Local Government Victoria in relation to the Local Government Performance Reporting Framework	per cent	80	80	80	70
Participants satisfied with their experience of Metropolitan Partnership community meetings	per cent	80	80	80	88
Submissions that fully meet the objectives within the Growing Suburbs Fund program guidelines	per cent	80	80	80	80
Timeliness					
Average number of days for Municipal Emergency Resource Program grant payments to be made following completion of agreed milestones in the funding agreement	days	21	21	21	21
Average number of days for Public Library Services grant payments to be made following completion of agreed milestones in the funding agreement	days	21	21	21	21
Projects completed in accordance with approved milestones within the Growing Suburbs Fund funding agreements	per cent	80	80	80	80
Roadside Weeds and Pests program grant payments made within 21 days of completion of agreed milestones in the funding agreement	per cent	100	100	100	100
Victoria Local Government Grants Commission allocations finalised to support the completion of council budgets within statutory timeframes	per cent	100	100	100	100
Cost					
Total output cost	$ million	140.2	213.1	145.4	189.8
The 2021-22 expected outcome is higher than the 2021-22 target mainly due to additional funding for COVID-19 programs, including the COVIDSafe Outdoor Activation Program. *The lower 2022-23 target primarily reflects the funding profile of initiatives within the output.*					

Source: Department of Jobs, Precincts and Regions

Regional Development (2022-23: $176.2 million)

This output guides engagement with industry and communities to identify opportunities to support job growth and new investment in regional Victoria, including support and services to grow regional jobs and capability in regional communities.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Actual export sales generated for regional businesses as a result of participation in government programs	$ million	45	82	110	97
The 2021-22 expected outcome is lower than the 2021-22 target due to the impacts of COVID-19 and the difficult trading environment with other countries (including supply chain impacts). *The lower 2022-23 target reflects new funding for the Regional Jobs and Infrastructure Fund (RJIF) and reduced need for COVID-19 stimulus funding.*					
Economic development and service delivery projects supported	number	90	177	175	677
The lower 2022-23 target reflects new funding for the RJIF and reduced need for COVID-19 stimulus funding.					
Jobs in regional Victoria resulting from government investment facilitation services and assistance	number	1 000	1 770	1 770	1 468
The lower 2022-23 target reflects new funding for the RJIF and reduced need for COVID-19 stimulus funding.					
New investment in regional Victoria resulting from government facilitation services and assistance	$ million	500	900	1 400	906.7
The 2021-22 expected outcome is lower than the 2021-22 target due to constraints on private sector initiatives in the current economic climate. *The lower 2022-23 target reflects new funding for the RJIF and reduced need for COVID-19 stimulus funding.*					
Quality					
Participant satisfaction with implementation of Regional Development Victoria programs	per cent	90	90	90	98
Cost					
Total output cost	$ million	176.2	263.3	256.0	540.7
The lower 2022-23 target primarily reflects the funding profile of a range of initiatives within the output, including as a result of a reduction in the need for COVID-19 stimulus measures.					

Source: Department of Jobs, Precincts and Regions

Objective 5: Grow vibrant, active and creative communities

This objective seeks to increase the economic, social and cultural value of the creative, sport and recreation industries to Victoria, grow the number and yield of visitors, position Victoria as a major events destination, and ensure the best cultural and sporting experiences are accessible to everyone.

The departmental objective indicators are:

- attendances at Creative Industries agencies and funded Major Performing Arts organisations
- employment in the Creative Industries sector
- employment in the Visitor Economy sector
- tourists attracted to Victoria
- increase rates of community engagement, including through participation in sport and recreation
- wagering turnover on Victorian racing as a proportion of the national market.

Outputs

Creative Industries Access, Development and Innovation (2022-23: $55.3 million)

This output supports the creative industries to deliver economic, social and cultural benefit through talent and leadership; the creative and business ecology; innovation and social impact; participation and place making; and international engagement.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Attendances at major performing arts organisations	number (000)	1 000	172	1 000	287
The 2021-22 expected outcome is lower than the 2021-22 target as live attendances at performances have been significantly impacted by varied operating conditions during COVID-19, including multiple lockdowns and capacity restrictions on venues.					
Creative Learning Partnerships	number	14	19	14	14
The 2021-22 expected outcome is higher than the 2021-22 target as a result of confirmation of the partnership funding from the Department of Education and Training enabling five more projects to be supported.					
Design organisations supported	number	22	22	22	21
International market development and exchange initiatives	number	12	11	12	12
The 2021-22 expected outcome is lower than the 2021-22 target as there will be no International Engagement funding round.					
Organisations recurrently funded	number	154	154	154	140
Project companies and artists funded	number	469	1 100	450	903
The 2021-22 expected outcome is higher than the 2021-22 target due to additional COVID-19 grants administered during reporting period. *The higher 2022-23 target is due to new funding in the* 2022-23 Budget *for the Creative Spaces and Places program.*					

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Project companies and artists funded which are regionally based	per cent	23	23	23	21.2
Regionally based organisations recurrently funded	number	56	56	56	53
Quality					
Creative Victoria grant recipients who met or exceeded agreed milestones	per cent	85	87	85	81
Public information rated 'informative' or 'very informative' by grant applicants	per cent	90	90	90	89.8
Timeliness					
Performance and grant agreements acquitted within timeframes specified in the funding agreement	per cent	83	86	83	86
Cost					
Total output cost	$ million	55.3	100.5	54.8	85.6
The 2021-22 expected outcome is higher than the 2021-22 target due to additional funding received for a number of initiatives including the Live Music Restart package.					
The higher 2022-23 target primarily reflects the funding profile of initiatives within the output.					

Source: Department of Jobs, Precincts and Regions

Creative Industries Portfolio Agencies (2022-23: $427.3 million)

This output promotes, presents and preserves our heritage and the creative industries through Victoria's creative industries agencies: Arts Centre Melbourne, Australian Centre for the Moving Image (ACMI), Docklands Studios Melbourne, Vic Screen, Geelong Arts Centre, Melbourne Recital Centre, Museums Victoria, National Gallery of Victoria (NGV), and the State Library Victoria.

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quantity					
Additional employment from production supported by Vic Screen	number	10 400	10 400	11 358	9 558
This performance measure renames the 2021-22 performance measure 'Additional employment from production supported by Film Victoria'. The new measure reports on the same activity as the previous measure however has been amended to reflect the organisation's name change.					
The 2021-22 expected outcome is lower than the 2021-22 target due to the productions secured delivering greater FTE and expenditure outcomes over extended time frames.					
The lower 2022-23 target also reflects revised production schedules.					
Agency website visitation	number (000)	21 200	18 793	21 200	18 747
The 2021-22 expected outcome is lower than the 2021-22 target due to impact of closures and program cancellations resulting from COVID-19 health restrictions throughout the year resulting in reduced traffic for information on programs to some agency websites.					
Attendances at Arts Centre Melbourne	number (000)	2 200	946	2 200	450
The 2021-22 expected outcome is lower than the 2021-22 target due to the impacts of COVID-19 and ACM Closure in the first half of the year.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Attendances at Australian Centre for the Moving Image	number (000)	1 051	470	800	263
The 2021-22 expected outcome is lower than the 2021-22 target because ACMI was closed for the majority of first quarter of 2021-22. ACMI reopened in October 2021 and is expected to continue to see an adverse impact in visitation numbers as a result of COVID-19. *The higher 2022-23 target is due to expected increased attendances to touring exhibitions in 2022-23. Higher proportions of attendees at touring programs are projected in the second half of 2022-23.*					
Attendances at Geelong Arts Centre	number (000)	100	30	100	18
The 2021-22 expected outcome is lower than the 2021-22 target due to COVID-19 lockdowns and restrictions continuing in 2021-22.					
Attendances at Melbourne Recital Centre	number (000)	230	50	230	34
The 2021-22 expected outcome is lower than the 2021-22 target as a result of restrictions necessary to manage COVID-19, including closure of the building for the majority of the first quarter, and continuing visitor hesitancy.					
Attendances at Museums Victoria	number (000)	2 000	903	2 000	698
The 2021-22 expected outcome is lower than the 2021-22 target as Museums Victoria venues closed for 68 (out of 92) days in the first quarter due to COVID-19 and resulting restrictions. Continued restrictions/hesitancy is impacting visitation.					
Attendances at National Gallery of Victoria	number (000)	2 235	830	2 235	773
The 2021-22 expected outcome is lower than the 2021-22 target as COVID-19 restrictions and impacts on visitor behaviour have significantly affected attendance.					
Attendances at State Library Victoria	number (000)	2 250	840	2 250	410
The 2021-22 expected outcome is lower than the 2021-22 target based on current settings which reflect eased restrictions but lower visitation due to reduced numbers of international students, CBD residents and workers and visitor hesitancy.					
Direct Full-Time Equivalent (FTE) roles from production supported by Vic Screen	number	2 335	2 838	2 335	nm
This performance measure renames the 2021-22 performance measure 'Direct Full-Time Equivalent (FTE) roles from production supported by Film Victoria'. The new measure reports on the same activity as the previous measure however has been amended to reflect the organisation's name change. *The 2021-22 expected outcome is higher than the 2021-22 target due to COVID-19 impacting the timing of production activity.*					
Members and friends of agencies	number	57 000	53 292	57 000	53 247
The 2021-22 expected outcome is lower than the 2021-22 target due to the impacts of reduced engagement resulting from agency closures in accordance with COVID-19 rules.					
Students participating in agency education programs	number	550 000	197 607	550 000	435 501
The 2021-22 expected outcome is lower than the 2021-22 target as venues did not open from July to November. Many schools were also mainly closed during this time and so excursions did not take place due to COVID-19.					
Value of film, television and digital media production supported by Vic Screen	$ million	350	384	350	391
This performance measure renames the 2021-22 performance measure 'Value of film, television and digital media production supported by Film Victoria'. The new measure reports on the same activity as the previous measure however has been amended to reflect the organisation's name change. *The 2021-22 expected outcome is higher than the 2021-22 target as interstate and international travel restrictions, combined with restrictions on production activity, forced many productions to postpone until the 2022 calendar year. Several large budget projects have also been secured to commence in the third and fourth quarters through the new Victorian Screen Incentive.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Volunteer hours	number	98 900	21 990	98 900	14 928
The 2021-22 expected outcome is lower than the 2021-22 target as onsite closures have severely impacted access for volunteers.					
Quality					
Agency collections storage meeting industry standard	per cent	86	85	86	83
Visitors satisfied with visit: Arts Centre Melbourne	per cent	90	90	90	93
Visitors satisfied with visit: Australian Centre for the Moving Image	per cent	95	95	95	95
Visitors satisfied with visit: Geelong Arts Centre	per cent	98	98	98	98
Visitors satisfied with visit: Melbourne Recital Centre	per cent	95	95	95	97
Visitors satisfied with visit: Museums Victoria	per cent	96	95	96	90
Visitors satisfied with visit: National Gallery of Victoria	per cent	95	95	95	95
Visitors satisfied with visit: State Library Victoria	per cent	90	90	90	96
Cost					
Total output cost	$ million	427.3	503.6	393.7	400.3
The 2021-22 expected outcome is higher than the 2021-22 target mainly due to additional recovery funding for Creative Industries Portfolio agencies.					
The higher 2022-23 target primarily reflects additional funding in the 2022-23 Budget*, including the Creative Industries Portfolio Agencies Recovery initiative.*					

Source: Department of Jobs, Precincts and Regions

Cultural Infrastructure and Facilities (2022-23: $72.0 million)

This output supports Victorian cultural venues and State-owned facilities through strategic assessment and provision of advice on portfolio infrastructure proposals and projects. The output includes consolidation of portfolio asset management plans and management of funding programs for maintenance and minor capital works.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
All facility safety audits conducted	number	16	16	16	16
Infrastructure development projects underway	number	13	14	10	8
The 2021-22 expected outcome is higher than the 2021-22 target due to the inclusion of additional COVID-ready infrastructure projects. *The higher 2022-23 target is due to the addition of projects under the Creative Infrastructure Program.*					
Quality					
State-owned tenanted cultural facilities maintained to agreed service standards	per cent	90	90	90	100
Success measures of projects achieved	per cent	90	90	90	90
Timeliness					
Cultural Facilities Maintenance Fund projects delivered within agreed timeframes	per cent	90	90	90	87
Cost					
Total output cost	$ million	72.0	66.0	65.3	66.6
The higher 2022-23 target primarily reflects additional funding in the 2022-23 Budget *for Creative Infrastructure projects.*					

Source: Department of Jobs, Precincts and Regions

Sport, Recreation and Racing (2022-23: $407.2 million)

This output provides strategic leadership and investment in the sport, recreation and racing industries through innovation, sector and industry development and funding support. It supports community participation and inclusion in the sport, recreation and racing sectors by strengthening the capacity of sport and recreation organisations to deliver participation opportunities, improving community sport and recreation facilities across the state and guiding the development and management of State-level sporting facilities and events, to encourage participation by all Victorians.

This output also supports the development of the Victorian racing industry through strategic investment in world-class racing and training infrastructure, the promotion of animal welfare and integrity initiatives and encourages participation and investment in the breeding industry to cement Victoria's position as Australia's premier racing state.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Combat sports licences, registrations and permits issued	number	550	550	550	323
Community Facility Grants: number approved	number	170	170	140	239
The 2021-22 expected outcome is higher than the 2021-22 target due to the delivery of additional rounds of community infrastructure programs. *The higher 2022-23 target is due to additional funding received for the 'Meeting Victoria's demand for local sport and active recreation infrastructure' initiative from the* 2022-23 Budget.					
Funded State Sport and Recreation Associations that have a minimum of 40 per cent women on their boards	number	90	90	90	nm
Local Sports Infrastructure grant recipients which are regionally based	per cent	45	45	45	nm
Organisations submitting nominations for the Community Sport and Recreation Awards	number	70	70	70	55
Projects in progress that relate to the planning and development of state level facilities	number	14	27	20	26
The 2021-22 expected outcome is higher than the 2021-22 target due to additional planning studies and infrastructure investments in 2021-22. *The lower 2022-23 target is due to a number of projects expected to be completed in 2021-22.*					
Racing industry development initiatives	number	9	9	9	9
Racing matters processed (including licences, permits and grant applications)	number	300	300	300	129
Significant Sporting Events Program – Events Facilitated	number	75	79	75	23
The 2021-22 expected outcome is higher than the 2021-22 target due to increased demand for sporting events following the restart in the sporting events sector.					
Sport and recreation organisations undertaking programs or activities to enhance participation	number	112	109	112	112
Sporting club grants to recipients which are based in low socio-economic areas as identified by the SEIFA index	per cent	45	45	45	50
Sporting club grants to recipients which are regionally based	per cent	35	35	35	42

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Sporting club grants: number approved	number	750	935	750	4 125
The 2021-22 expected outcome is higher than the 2021-22 target due to additional streams of grants provided this year related to COVID-19 support.					
Sports with athletes on Victorian Institute of Sport (VIS) scholarships	number	45	45	45	44
Victorian categorised athletes supported by the VIS	per cent	60	45	45	nm
The higher 2022-23 target reflects the increase in categorised athletes supported due to additional funding received for the 'A Sustainable Victorian Institute of Sport' initiative from the 2021-22 Budget.					
Victorian Institute of Sport scholarship holders on national teams/squads	per cent	60	60	60	67
Quality					
Contract management of outdoor recreation camps meets agreed key performance indicators	per cent	90	90	90	87
Timeliness					
Community Cricket Program milestones delivered within agreed timeframes	per cent	90	95	90	97
The 2021-22 expected outcome is higher than the 2021-22 target due to a strong focus on monitoring the delivery of milestones over the reporting period.					
Cost					
Total output cost	$ million	407.2	748.5	497.4	682.6
The 2021-22 expected outcome is higher than the 2021-22 target mainly due to additional funding for a range of Sport and Recreation grant programs, including COVID-19 supports. *The lower 2022-23 target primarily reflects the funding profile of initiatives within the output.*					

Source: Department of Jobs, Precincts and Regions

Tourism and Major Events (2022-23: $298.4 million)

This output maximises employment and the long-term economic benefits of tourism and major events to Victoria by developing and marketing the State as a competitive destination.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Always Live events held	number	50	3	50	nm
The 2021-22 expected outcome is lower than the 2021-22 target as the initiative was postponed due to COVID-19 related restrictions on events, travel and mass gatherings.					
Major sporting and cultural events held	number	27	16	21	8
The 2021-22 expected outcome is lower than the 2021-22 target due to COVID-19 related restrictions on events, travel and mass gatherings. *The higher 2022-23 target reflects additional funding for government funded major events in 2022-23.*					
Tourism infrastructure projects facilitated	number	38	30	30	32
The higher 2022-23 target is due to additional funding received for the 'Regional tourism infrastructure projects' initiative from the 2022-23 State Budget.					
Visit Victoria's total engaged digital audience	number (million)	6.7	5.55	6.2	5.5
The 2021-22 expected outcome is lower than the 2021-22 target due to the impacts of COVID-19 restrictions, which has reduced demand in planning travel via Visit Victoria's digital channels. *The higher 2022-23 target reflects the expected further easing of travel restrictions and increase in consumer travel demand, resulting in an incremental increase in overall audiences across all digital channels, including social media profiles, and website users.*					
Visitor expenditure: domestic	$ billion	23.2	15	23.2	9.7
The 2021-22 expected outcome is lower than the 2021-22 target due to the ongoing impacts of COVID-19 which have limited movement to and within the State.					
Visitor expenditure: international	$ billion	9	0.5	9	0.1
The 2021-22 expected outcome is lower than the 2021-22 target due to the ongoing impacts of COVID-19. International border closures and ongoing concerns about COVID-19 have significantly reduced the movement of international visitors into Victoria.					
Visitor expenditure: regional Victoria (domestic)	$ billion	11.1	9.6	11.1	7
The 2021-22 expected outcome is lower than the 2021-22 target due to the ongoing impacts of COVID-19. State border closures and travel restrictions have limited visitation to and within the State.					
Visitor expenditure: regional Victoria (international)	$ million	600	45	600	na
The 2021-22 expected outcome is lower than the 2021-22 target due to the ongoing impacts of COVID-19. International border closures and ongoing concerns about COVID-19 have significantly reduced the movement of international visitors into Victoria. *The 2020-21 actual is not available as due to international border closures and the cessation of survey interviewing for the International Visitor Survey, international visitor data being currently limited to state-wide results.*					
Visitor expenditure: regional Victoria (intrastate overnight)	$ billion	5.7	6.2	5.7	4.5
The 2021-22 expected outcome is higher than the 2021-22 target due to the substitution in intrastate overnight travel over other forms of travel.					
Visitors (domestic overnight)	number (million)	29.5	19.1	29.5	13.4
The 2021-22 expected outcome is lower than the 2021-22 target due to the ongoing impacts of COVID-19. State border closures and travel restrictions have limited visitation to and within the state in the year.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Visitors (international)	number (million)	3.2	0.2	3.2	0.01
The 2021-22 expected outcome is lower than the 2021-22 target due to the ongoing impacts of COVID-19. International border closures and ongoing concerns about COVID-19 have significantly reduced the movement of international visitors into Victoria.					
Visitors: regional Victoria (intrastate overnight)	number (million)	16.4	13.1	16.4	10.3
The 2021-22 expected outcome is lower than the 2021-22 target due to the ongoing impacts of COVID-19 which have limited movement in the State.					
Quality					
Value of media coverage generated: domestic	$ million	24	30	23	37.9
The 2021-22 expected outcome is higher than the 2021-22 target for domestic Advertising Value Equivalent due to significant activity for families, activations and broadcast. *The higher 2022-23 target reflects forecast continued easing of COVID-19 restrictions and increase in demand for travel, increasing the number of regions that can be targeted for families, activations and broadcast.*					
Value of media coverage generated: international	$ million	48	23.5	47	17.9
The 2021-22 expected outcome is lower than the 2021-22 target due to border closures limiting families and broadcast opportunities, while also reducing the scope and pausing some of Visit Victoria's global public relations agencies until borders reopen. *The higher 2022-23 target reflects forecast continued easing of COVID-19 restrictions and increase in demand for travel, increasing the number of countries that can be targeted for families, activations and broadcast.*					
Timeliness					
Completion of post-event reports and economic impact assessments of each event (where required) within agreed timeframes	per cent	100	100	100	100
Cost					
Total output cost	$ million	298.4	483.5	197.9	388.7
The 2021-22 expected outcome is higher than the 2021-22 target mainly due to additional COVID-19 support for the Tourism and Events sectors in 2021-22. *The higher 2022-23 target primarily reflects additional funding in 2022-23 for the Regional Tourism Investment Fund.*					

Source: Department of Jobs, Precincts and Regions

Objective 6: Be a globally connected economy

This objective seeks supports more productive, globally competitive, sustainable and jobs-rich agriculture, food and fibre, and resources sectors.

The Department delivers the objective in collaboration with partners, local communities and industry to deliver outcomes that provide benefits to all Victorians.

The departmental objective indicators are:

- value of Victorian agriculture production
- value of Victorian food and fibre exports
- metres drilled for minerals exploration in Victoria
- level of production of minerals and extractives.

Outputs

Agriculture (2022-23: $504.1 million)

This output delivers services to the agriculture, food and fibre sectors to enhance productivity, connect the sector with international markets, create jobs, support growth and maintain effective biosecurity.

This output delivers effective, and efficient regulation, compliance, emergency management, biosecurity research and development, and diagnostic services to protect and enhance market access by addressing trade barriers and managing the risks of pests, diseases and chemical use. The Department undertakes research and development to develop new technologies and practices and provides services to enhance their adoption to increase farm productivity and supply chain efficiencies. It provides policy advice and support to industries and businesses to innovate, manage economic and climatic volatility, natural disasters and biosecurity emergencies, and meet consumer and community expectations for food quality, food safety and animal welfare and environmental standards.

The output also creates the conditions to grow the natural resources economy by ensuring resources are sustainably allocated and used for both recreational and commercial purposes.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Agriculture Industry Development and Regulation					
This sub-output supports a more productive, competitive, sustainable and jobs-rich food and fibre sector by delivering policy advice, regulation and support to meet consumer and community expectations for agriculture industry development, pets and animal welfare, regulatory policies and frameworks.					
Quantity					
Farms and related small businesses facing significant adjustment pressures supported to make better-informed decisions by the Rural Financial Counselling Service	number	1 700	1 500	1 700	1 511
The 2021-22 expected outcome is lower than the 2021-22 target due to favourable seasonal conditions and commodity prices, which means there has been less demand for the service. The full year result will be contingent on the demand of the service.					
Inspections or audits of scientific establishments undertaken to provide assurance of compliance with relevant industry standards for animal welfare	number	25	25	25	18
Number of small scale local and craft producers attending workshops / mentoring programs	number	50	50	50	52
Strategies developed to maintain and / or grow export opportunities, pathways and capability and overcome identified trade barriers	Number	3	3	3	na
The 2020-21 actual is not available as the measure was discontinued at that time and was later reinstated through the 2021-22 Budget*, consistent with PAEC recommendations.*					
Visits of the Responsible Pet Ownership program to Victorian kindergartens and primary schools	number	3 100	400	3 100	243
The 2021-22 expected outcome is lower than the 2021-22 target as school visits could not occur under COVID-19 workplace restrictions.					
Young farmer scholarships awarded	number	12	13	12	13
The 2021-22 expected outcome is higher than the 2021-22 target as 13 scholarships were able to be awarded this financial year within the allocated annual budget. The allocated annual budget allows for 12, $10 000 scholarships to be awarded each year. Where applications are received for less than the maximum scholarship allowable, this provides the opportunity to provide additional scholarships. Following the merit of applications and the total financial request of short-listed applicants, the department is able to award an additional scholarship in 2021-22.					
Quality					
Grant recipients who met or exceeded agreed milestones	per cent	75	75	75	75
Timeliness					
Performance and grant agreements acquitted within timeframes specified in the funding agreement	per cent	90	90	90	90
Cost					
Total output cost	$ million	166.8	196.8	163.1	204.0
The 2021-22 expected outcome is higher than the 2021-22 target mainly due to funding for the Seasonal Agriculture Workforce program.					
The higher 2022-23 target primarily reflects the funding profile of initiatives within the output.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Agriculture Research					
This sub-output supports more productive, competitive, sustainable and jobs-rich food and fibre sectors by delivering research and innovation to develop innovative new technologies and farming systems that increase food and fibre productivity and product quality.					
Quantity					
Applications for intellectual property protection	number	16	16	16	17
Commercial technology licence agreements finalised	number	16	16	16	16
Genetic improvement of dairy cows achieved through breeding contributing to increased milk production and dairy productivity	per cent	1	1	1	1
Key bioscience platform technologies established	number	1	1	1	1
Postgraduate-level/PhD students in training	number	65	65	65	68
Value of co-investment from external (non-state) funding sources attracted to the Department's research projects that support productive agriculture	$ million	41	41	41	42.9
Quality					
Satisfaction rating of industry investors in agriculture productivity research and development	number	7	7	7	9
Scientific and technical publications subjected to independent peer review in international and national journals that promote productive agriculture	number	260	260	260	264
Timeliness					
Provision of technical advice, diagnostic identification tests on pests and diseases including suspected exotics within agreed timeframes	per cent	85	85	85	89
Research project milestones and reports completed on time	per cent	90	90	90	85.6
Cost					
Total output cost	$ million	118.7	122.7	123.2	123.4
The lower 2022-23 target primarily reflects the funding profile of initiatives within the output.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Biosecurity and Agriculture Services					
This sub-output delivers biosecurity, agriculture and emergency management services and regulatory programs which support the food and fibre sector to achieve sustainable growth while managing risks and minimising adverse impacts to the economy, environment and public health and safety.					
Quantity					
Animal pest, disease and residue control programs maintained to ensure Victorian agricultural produce complies with food safety and biosecurity standards required to access markets	number	5	5	5	4
Client interactions with land health services	number	1 700	1 700	1 700	na
The 2020-21 actual is not available as the measure was discontinued at that time and was later reinstated through the 2021-22 Budget*, consistent with PAEC recommendations.*					
Clients engaged with agriculture productivity services	number	3 910	3 910	3 910	na
The 2020-21 actual is not available as the measure was discontinued at that time and was later reinstated through the 2021-22 Budget*, consistent with PAEC recommendations.*					
Improved agricultural services, programs and products developed	number	10	10	10	10
Known state prohibited weed sites monitored and treated in line with the relevant weed action plan	per cent	95	95	95	95
New or amended Interstate Certificate Assurance (ICA) or other market access accreditations developed to restore or enable trade	number	2	12	2	5
The 2021-22 expected outcome is higher than the 2021-22 target due to external factors that are not directly influenced by the department. Changes to import requirements of other jurisdictions and pest-status changes, influenced at the national level, have been driving ICA amendments.					
Plant pest, disease and residue control programs maintained to ensure Victorian agricultural produce complies with food safety and biosecurity standards required to access markets	number	6	6	6	6
Properties inspected for invasive plant and animal priority species	number	2 700	2 160	2 700	2 581
The 2021-22 expected outcome is lower than the 2021-22 target due to the impacts of COVIDSafe settings.					
Quality					
Client satisfaction rating of agricultural services	number	8	8	8	8.6
National biosecurity, agriculture/veterinary chemical use and animal welfare programs implemented in accordance with agreed plans	per cent	96	100	96	100
Preparedness activities implemented, in line with agreed plans, to ensure response readiness for emergency animal and plant pest, disease and natural disaster incidents	per cent	90	90	90	86

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Timeliness					
Animal health certificates issued within specified timeframes to support international market access	per cent	95	95	95	na
The 2020-21 actual is not available as the measure was discontinued at that time and was later reinstated through the 2021-22 Budget*, consistent with PAEC recommendations.*					
Initial action taken to respond to reported emergency animal and plant pest, disease and natural disaster incidents complies with national agreements and obligations	per cent	100	100	100	100
Plant health certificates issued within specified timeframes at the Melbourne Wholesale Fruit and Vegetable Market to support domestic market access	per cent	95	98	95	na
The 2020-21 actual is not available as the measure was discontinued at that time and was later reinstated through the 2021-22 Budget*, consistent with PAEC recommendations.*					
Cost					
Total output cost	$ million	118.5	110.1	113.3	138.1
The higher 2022-23 target primarily reflects the funding profile of initiatives within the output.					
Sustainably manage forest and game resources					
This sub-output creates the conditions to ensure the natural resources economy including forestry and game resources are sustainably allocated and used for both recreational and commercial purposes.					
Quality					
Key statutory obligations relevant to the Game Management Authority complied with (tabling annual report, audits, business plan and board appointments)	per cent	100	100	100	100
Key statutory obligations relevant to VicForests complied with (tabling annual reports, audits, corporate plan and board appointments)	per cent	100	100	100	75
Timeliness					
Facilitate the delivery of game projects in line with key project milestones	per cent	100	100	100	100
Facilitate the delivery of the Victorian Forestry Plan in line with key project milestones	per cent	100	100	100	100
Cost					
Total output cost	$ million	100.1	122.4	65.1	83.2
The 2021-22 expected outcome is higher than the 2021-22 target mainly due to the funding profile for the Plantations Program. The higher 2022-23 target primarily reflects the funding profile in 2022-23 for the Plantations Program.					

Source: Department of Jobs, Precincts and Regions

Resources (2022-23: $69.4 million)

This output develops and delivers policy, programs and regulation to enable investment and generate jobs through the sustainable development of the State's earth resources, including extractives, minerals and petroleum.

The Department acquires and provides access to high-quality geoscience data and knowledge to inform government decision making and attract new investment and jobs to the State. It develops and implements legislative and regulatory reforms in the earth resources sector to improve outcomes for all stakeholders.

Supporting investment in resources and low emission technologies, the Department fosters innovation, productivity, jobs and trade in the State's earth resources sector. Through strategic resource and related land use planning, new opportunities are able to be identified for Victoria's earth resources, along with supporting major infrastructure development in the State.

The Department also regulates the earth resources sector through transparent, consistent and timely regulatory processes that provide industry with confidence to invest and have regard to the needs of communities and minimise impacts to the environment.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2022-22 target*	*2020-21 actual*
Quantity					
Community and stakeholder engagement information forums	number	55	59	55	55
The 2021-22 expected outcome is higher than the 2021-22 target, reflecting the impact of additional information sessions associated with the North Central Victorian Goldfields ground release during November 2021.					
Quality					
Exploration and mining licences which are active	per cent	82.5	82.5	82.5	82.6
Timeliness					
Delivery of key CarbonNet milestones, in line with funding agreements and agreed project deliverables	per cent	100	90	100	81.8
The 2021-22 expected outcome is lower than the 2021-22 target, due to delays in finalising contracts supporting the regulatory work program.					
Extractive Industries Work Authority work plans processed within regulatory timeframes	per cent	95	75	95	97
The 2021-22 expected outcome is lower than the 2021-22 target as the regulator implements Better Approvals for Regulators improvements and builds staff capability and capacity.					
Facilitate the delivery of resources projects in line with grant agreements and project milestones	per cent	100	80	100	82.3
The 2021-22 expected outcome is lower than the 2021-22 target due to delays experienced during the first half of 2021-22 due mainly to the Yallourn coal mine flood emergency and time variations to TARGET exploration milestones.					
Industry geoscience data packages released for minerals and petroleum sectors consistent with agreed timelines	number	10	14	10	10
The 2021-22 expected outcome is higher than the 2021-22 target as the Geological Survey of Victoria released additional reports relating to geothermal, salinity and extractives based LiDAR surveys.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2022-22 target*	*2020-21 actual*
Mineral licence applications and work plans processed within regulatory timeframes	per cent	95	80	95	71.3
The 2021-22 expected outcome is lower than the 2021-22 target as the resolution of legacy caseload (backlog) licensing applications impacted performance against statuatory timeframes. Improvements to the licensing process are being implemented.					
Regulatory audits completed within agreed timelines	per cent	98	90	98	98.6
The 2021-22 expected outcome is lower than the 2021-22 target due to delays experienced during the first half of the year reflecting COVID restrictions to access worksites and the impact of the Yallourn coal mine flood emergency.					
Cost					
Total output cost	$ million	69.4	61.6	66.2	73.8
The 2021-22 expected outcome is lower than the 2021-22 target mainly due to timing of payments for the CarbonNet Program. *The higher 2022-23 target primarily reflects additional funding in the* 2022-23 Budget *for reform including any changes to the* Mineral Resources (Sustainable Development) Act 1990 *and Regulating Safeguards for Gas Resources.*					

Source: Department of Jobs, Precincts and Regions

DEPARTMENT OF JUSTICE AND COMMUNITY SAFETY

Ministerial portfolios

The Department supports the ministerial portfolios of the Attorney General, Police, Emergency Services, Crime Prevention, Corrections, Youth Justice, Victim Support, Workplace Safety and Consumer Affairs, Gaming and Liquor Regulation.

Departmental mission statement

The Department of Justice and Community Safety provides policy and organisational management focus for the vision of a justice and community safety system that works together to build a safer, fairer and stronger Victoria by:

- integrating services and tailoring them for local communities
- prioritising Victorians in need
- focusing on victims and survivors
- strengthening stakeholder partnerships.

The Department contributes to the Government's commitment to a stronger, fairer, better Victoria by providing safer and more resilient communities, ensuring a trusted justice and community safety system with easy access to justice and safety systems and services and ensuring a fair and accessible justice system for Aboriginal people.

Departmental objectives

Objective 1: Ensuring community safety through policing, law enforcement and crime prevention activities

This objective aims to provide a safe and secure environment for the Victorian community. This objective delivers on activities relating to the provision of effective policing, law enforcement and infringement processing services that aim to prevent, detect, investigate, and prosecute crime, and promote safer road user behaviour. It focuses on activities which enable Victorians to undertake their lawful pursuits confidently, safely and without fear of crime.

Objective 2: Reduce the impact of, and consequences from, natural disasters and other emergencies on people, infrastructure, the economy and the environment

This objective aims to deliver a coordinated, all communities, all emergencies approach to emergency management, focusing on risk mitigation and active partnership with the Victorian community.

Emergency management encompasses prevention, preparation and planning for, responding to and recovering from natural disasters (such as bushfires, floods and severe storms), the consequences of terrorism, hazardous material incidents (such as chemical spills and gas leaks), and individual and personal emergencies (such as land and sea rescues, car accidents and residential and commercial fires).

Objective 3: Effective management of prisoners and offenders and provision of opportunities for rehabilitation and reparation

This objective relates to the management of the State's adult correctional system. The overarching purpose of the correctional system is to promote community safety through community-based and custodial supervision of prisoners and offenders through effective management and services to provide opportunities for rehabilitation and reparation.

Objective 4: Effective supervision of children and young people through the provision of youth justice services promoting rehabilitation

This objective aims to promote opportunities for rehabilitation of children and young people in the youth justice system and contribute to the reduction of crime in the community by providing a range of services including diversion services, advice to courts, offence related programs, community based and custodial supervision.

Objective 5: A fair and accessible justice system that supports confidence in the Victorian community

This objective relates to the provision of and access to justice services that support legal processes and law reform. Services that support legal processes include legal assistance and education services, prosecution services and the delivery of independent, expert forensic medical services to the justice system.

Other services that contribute to this objective include legal policy advice to government, law reform, dispute resolution and initiatives focusing on crime prevention and supporting Kooris in the criminal justice system.

Objective 6: Victorians are protected with equal opportunities, secure identities, information freedoms and privacy rights

This objective aims to support the Victorian community through the provision of services relating to rights and equal opportunity, advocacy and guardianship for Victorians with a disability or mental illness and support for victims of crime. This objective supports identity protection of Victorians through life event registration, protection of children through adoption services and risk assessments for those working with or caring for children. The objective also contributes to public sector integrity, information freedoms and privacy protection of Victorians.

Objective 7: A fair marketplace for Victorian consumers and businesses with responsible and sustainable liquor and gambling sectors

This objective relates to harm minimisation through the regulation of the gambling and liquor industries. This objective promotes the empowerment of consumers and businesses to know their rights and responsibilities to promote a well functioning market economy through regulation and support to consumers and businesses. There is a specific focus on the needs of vulnerable and disadvantaged consumers.

Changes to the output structure

The Department has made changes to its output structure for 2022-23 as shown in the table below:

2021-22 outputs	*Reason*	*2022-23 outputs*
Justice Policy, Services and Law Reform	This output has been disaggregated into two outputs (Justice Policy, Services and Law Reform and Forensic Justice Services) in 2022-23 to enhance transparency.	• Justice Policy, Services and Law Reform • Forensic Justice Services

Source: Department of Justice and Community Safety

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2021-22 budget	*2021-22 revised*	*2022-23 budget*	*Variation [(a)] %*
Ensuring community safety through policing, law enforcement and crime prevention activities				
Policing and Community Safety	3 702.8	3 756.7	3 949.0	6.6
Community Crime Prevention	20.9	25.7	28.2	34.9
Fines and Road Safety Enforcement	256.1	265.1	264.5	3.3
Reduce the impact of, and consequences from, natural disasters and other emergencies on people, infrastructure, the economy and the environment				
Emergency Management Capability	1715.0	2 527.3	1 651.2	(3.7)
Effective management of prisoners and offenders and provision of opportunities for rehabilitation and reparation				
Community Based Offender Supervision	290.9	290.1	290.9	0.0
Prisoner Supervision and Support	1 384.4	1 474.1	1 534.9	10.9
Effective supervision of children and young people through the provision of youth justice services promoting rehabilitation				
Youth Justice Community Based Services	76.7	80.3	80.4	4.9
Youth Justice Custodial Services	191.3	186.6	259.4	35.6
A fair and accessible justice system that supports confidence in the Victorian community				
Public Prosecutions and Legal Assistance	355.2	361.7	381.1	7.3
Forensic Justice Services	55.6	56.1	64.8	16.5
Justice Policy, Services and Law Reform	157.3	309.1	169.3	7.6
Victorians are protected with equal opportunities, secure identities, information freedoms and privacy rights				
Advocacy, Human Rights and Victim Support	136.2	141.2	141.9	4.2
Protection of Children, Personal Identity and Screening Services	45.7	49.3	59.7	30.6
Public Sector Information Management, Privacy and Integrity	18.9	19.0	20.2	6.9
A fair marketplace for Victorian consumers and businesses with responsible and sustainable liquor and gambling sectors				
Regulation of the Victorian Consumer Marketplace	137.2	141.8	133.6	(2.6)
Gambling and Liquor Regulation	79.9	86.7	80.8	1.1
Total	**8 624.1**	**9 770.8**	**9 109.9**	**5.6**

Source: Department of Justice and Community Safety

Note:
(a) Variation between 2021-22 budget and 2022-23 budget.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.12 outlines the Department's income from transactions and Table 2.13 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.12: Income from transactions **($ million)**

	2020-21 actual	*2021-22 budget*	*2021-22 revised*	*2022-23 budget*
Output appropriations	10 400.1	8 379.7	9 449.5	8 911.1
Special appropriations	54.7	5.1	49.9	43.1
Interest	22.4	27.1	21.8	21.8
Sale of goods and services	22.2	19.0	14.5	12.0
Grants	98.0	91.6	104.3	73.6
Fair value of assets and services received free of charge or for nominal consideration	3.3	..	..	..
Other income	45.2	38.9	47.1	49.9
Total income from transactions [(a)]	**10 645.9**	**8 561.4**	**9 687.2**	**9 111.4**

Source: Department of Justice and Community Safety

Note:
(a) Table may not add due to rounding.

Table 2.13: Parliamentary authority for resources **($ million)**

	2021-22 budget	*2021-22 revised*	*2022-23 budget*
Annual appropriations	**9 490.2**	**10 247.3**	**9 541.5**
Provision of outputs	8 108.7	9 278.9	8 613.5
Additions to the net asset base	1 328.5	904.9	875.0
Payments made on behalf of the State	53.0	63.6	53.0
Receipts credited to appropriations	**271.6**	**275.3**	**282.4**
Unapplied previous years appropriation	**..**	**120.2**	**15.8**
Provision of outputs	..	29.4	15.8
Additions to the net asset base	..	90.8	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**9 761.8**	**10 642.8**	**9 839.7**
Special appropriations	**120.9**	**193.5**	**154.8**
Trust funds	**180.5**	**190.2**	**161.0**
Residential Tenancy Fund [(a)]	30.5	31.7	32.7
Victorian Property Fund [(b)]	21.6	15.7	15.7
Victorian Responsible Gambling Trust [(c)]	38.4	38.4	38.8
Other [(d)]	90.1	104.5	73.8
Total parliamentary authority [(e)]	**10 063.2**	**11 026.6**	**10 155.5**

Source: Department of Justice and Community Safety

Notes:

(a) The purpose of this trust primarily relates to holding Victorian residential tenancy bonds, including those on rented premises, long-terms caravans, rooming houses and sites under site agreements.

(b) The purpose of this trust primarily relates to holding funds from license fees and fines paid by estate agents and can be used for various property-related purposes.

(c) The purpose of this trust primarily relates to programs to reduce the prevalence of problem gambling and to foster responsible gambling.

(d) Includes inter-departmental transfers.

(e) Table may not add due to rounding.

Departmental performance statement

Objective 1: Ensuring community safety through policing, law enforcement and crime prevention activities

This objective aims to provide a safe and secure environment for the Victorian community. This objective delivers on activities relating to the provision of effective policing, law enforcement and infringement processing services that aim to prevent, detect, investigate, and prosecute crime, and promote safer road user behaviour. It focuses on activities which enable Victorians to undertake their lawful pursuits confidently, safely and without fear of crime.

The departmental objective indicators are:

- community safety during the day and at night
- community safety on public transport
- crime statistics
- number of road fatalities[(a)]
- number of hospitalisations from road injuries.

Note:

(a) Revised objective indicators in 2022-23, replacing former objective indicators 'road fatalities and injuries' and 'an effective fines system' to more accurately reflect underlying data and demonstrate progress towards increasing safety on Victorian roads.

Outputs

Policing and Community Safety (2022-23: $3 949.0 million)

Victoria Police strives to reduce violence and crime through law enforcement, judicial support, community assistance, guidance and leadership. The output reflects the Government's focus on reducing the overall incidence and fear of crime and enhancing the safety of individuals and families.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of Family Violence incidents attended	number	91 200	nm	nm	nm
New performance measure for 2022-23 to reflect the Government's significant investment into family violence incident identification and response by Victoria Police.					
Number of impounded/surrendered vehicles related to high risk driving behaviours or other traffic offences	number	9 500	nm	nm	nm
New performance measure for 2022-23 to reflect the number of vehicles impounded due to high-risk driving/ behaviour and other traffic offences. This aligns with the Road Safety Strategy.					
Community calls for assistance to which a Victoria Police response is dispatched	number	900 000	892 544	900 000	922 318
Contravention of family violence intervention order (FVIO) offences per 100 000 population	number	720	742	720	827

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Crimes against property – excluding family violence related crime (rate per 100 000 population)	number	4 200	3 398	4 200	3 591
The 2021-22 expected outcome is lower than the 2021-22 target. This is likely to have been caused by the restricted mobility of the community due to COVID-19.					
Crimes against property – family violence related crime (rate per 100 000 population)	number	160	166	160	180
Crimes against the person – excluding family violence related crime (rate per 100 000 population)	number	660	654	660	685
Crimes against the person – family violence related crime (rate per 100 000 population)	number	580	564	580	597
Number of youth referrals	number	2 050	3 219	2 050	2 443
The expected outcome for 2021-22 is higher than the 2021-22 target due to changes to IT systems which has simplified the process of creating Youth referrals.					
Police record checks conducted to contribute to community safety	number	703 333	703 000	703 333	684 518
Number of alcohol screening tests conducted	number	3 000 000	1 230 000	3 000 000	1 147 866
The 2021-22 expected outcome is lower than the 2021-22 target due to testing ability being impacted by significant police resource commitment support the health response to the pandemic including to COVID-19 public health restriction compliance, hotel quarantine and border closures. Additionally, volume testing by the Alcohol and Drug Testing Vehicle (which brought a greater risk of exposure to COVID-19) was temporarily suspended to ensure the community, and Victoria Police employees, were not unnecessarily placed in situations of risk to their health and safety.					
Number of prohibited drug screening tests conducted	number	150 000	150 000	150 000	150 397
This performance measure renames the 2021-22 performance measure 'Number of prohibited drug screening tests conducted by booze and drug buses and highway patrol units' to more accurately reflect data captured and the total number of prohibited drug screening tests conducted in line with government investment.					
Total reported road fatalities in vehicle collisions	number	≤200	248	≤200	204
The 2021-22 expected outcome is higher than the 2021-22 target with road fatalities occurring on country roads accounting for 58.8 per cent of all road fatalities. The 5-year average for country fatalities is 56.2 per cent. In Victoria, drivers (52.9 per cent) accounted for most of the fatalities followed by motorcyclists (18.6 per cent) and pedestrians (13.2 per cent).					
Total persons reported injured in vehicle collisions	number	15 000	15 601	15 000	15 260
Quality					
Perceptions of safety – walking locally at night	per cent	55	55	55	56.9
Proportion of community satisfied with policing services (general satisfaction)	per cent	80	78	80	79.5
Proportion of Family Incident Report affected family members receiving referrals	per cent	87	86	87	87
Proportion of successful prosecution outcomes	per cent	92	92	92	93
Proportion of the community who have confidence in police (an integrity indicator)	per cent	82	77	82	79.9
The 2021-22 expected outcome is lower than the 2021-22 target and this is likely due to COVID-19 related activities to support the health response to the pandemic including enforcing public health directions.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Proportion of drivers tested by road safety cameras who comply with posted speed limits	per cent	99.5	99.5	99.5	99.8
Timeliness					
Proportion of crimes against the person resolved within 30 days	per cent	45	42	45	42.4
The 2021-22 expected outcome is lower than the 2021-22 target and this is likely due to COVID-19 impacting the clearance rates for crimes against the person.					
Proportion of property crime resolved within 30 days	per cent	25	23	25	24.8
The 2021-22 expected outcome is lower than the 2021-22 target and this is likely due to COVID-19 impacting the clearance rates for property crime.					
Cost					
Total output cost	$ million	3 949.0	3 756.7	3 702.8	3 981.1
The higher 2022-23 target mainly reflects the impact of the 2019 Sworn Enterprise Bargaining Agreement and new funding announced in the 2022-23 Budget *including Equipping frontline police officers with conducted energy devices and Justice system costs associated with additional judicial resources and the extension of court programs.*					

Source: Department of Justice and Community Safety

Community Crime Prevention (2022-23: $28.2 million)

This output reports on activities relating to Crime Prevention through the Community Crime Prevention Program, which supports communities in preventing crime and addressing local crime issues. This output also reports on Countering Violent Extremism, which helps keep communities safe from violent extremism through the identification of individuals at risk of radicalisation.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Proportion of crime prevention grant applications prepared using crime prevention resources	per cent	75	nm	nm	nm
New performance measure for 2022-23 to reflect the importance of investing in evidence-based crime prevention initiatives.					
Number community members engaged in Crime Prevention capacity building activities, to increase community capability to deliver crime prevention initiatives	number	500	500	500	nm
Quality					
Number of crime prevention projects supported to improve the quality of partnerships to deliver effective projects	number	10	nm	nm	nm
New performance measure for 2022-23 to reflect a whole of government and community approach to implementing the Government's Crime Prevention Strategy.					
Timeliness					
Outcomes of Crime Prevention funded projects published within 12 months of project completion	per cent	100	100	100	nm

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Cost					
Total output cost	$ million	28.2	25.7	20.9	52.2
The 2021-22 expected outcome is higher than the 2021-22 target mainly due to funding released post the 2021-22 Budget *for the Crime Prevention initiatives.* *The higher 2022-23 target mainly reflects continuation of funding for initiatives announced/funded through the 2021-22 and* 2022-23 Budget *including Crime Prevention Strategy implementation and Early intervention to counter violent extremism.*					

Source: Department of Justice and Community Safety

Fines and Road Safety Enforcement (2022-23: $264.5 million)

This output reports on enforcement action by the Sheriff's Office of Victoria and the management of fines, warrants and infringement notices under this output serves as an administrative method for dealing with minor criminal offences.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Infringement notices processed	number (million)	2.7–2.9	1.9	2.7–2.9	1.8
The 2021-22 expected outcome is lower than the 2021-22 target due to COVID-19 impacts on State Government law enforcement and toll-road fine issuance, resulting in reduced numbers of tolling and officer-issued infringements.					
Warrants actioned	number	450 000	350 000	450 000	128 085
The 2021-22 expected outcome is lower than the 2021-22 target due to the limited ability of the Sheriff's Office of Victoria to execute warrants in the field due to COVID-19.					
Quality					
Proportion of images that are capable of supporting the issue of an infringement notice	per cent	95	96.5	95	95.4
Timeliness					
Clearance of infringements within 180 days	per cent	75	70	75	66.6
The 2021-22 expected outcome is lower than the 2021-22 target due to the impacts of COVID-19. These include increased demand for payment by instalment and extension of time to pay, affecting the timeliness of clearance. The composition of fine types within the reporting period has also affected the clearance rate, with a higher proportion of fine types that have a lower clearance rate making up total fines.					
Cost					
Total output cost	$ million	264.5	265.1	256.1	246.2

Source: Department of Justice and Community Safety

Objective 2: Reduce the impact of, and consequences from, natural disasters and other emergencies on people, infrastructure, the economy and the environment

This objective aims to deliver a coordinated, all communities, all emergencies approach to emergency management, focusing on risk mitigation and active partnership with the Victorian community.

Emergency management encompasses prevention, preparation and planning for, responding to and recovering from natural disasters (such as bushfires, floods and severe storms), the consequences of terrorism, hazardous material incidents (such as chemical spills and gas leaks), and individual and personal emergencies (such as land and sea rescues, car accidents and residential and commercial fires).

The departmental objective indicators are:

- value of domestic fire insurance claims
- rate of deaths from fire events.

Outputs

Emergency Management Capability (2022-23: $1 651.2 million)

This output provides for the management of emergencies by developing and adopting emergency prevention and mitigation strategies, providing fire suppression and road crash rescue services and supporting local government and communities in disaster mitigation and recovery. Key components of this output reduce the level of risk to the community of emergencies occurring and the adverse effects of emergency events, such as death and injury rates.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Permanent operational staff	number	3 886	3 790	3 722	3 667
The higher 2022-23 target reflects the reclassification of some staff from support to operational.					
Permanent support staff	number	1 606	1 655	1 618	1 535
The lower 2022-23 target reflects the reclassification of some staff from support to operational.					
Volunteers – Operational	number	38 500–39 500	32 949	40 000–41 000	33 066
The 2021-22 expected outcome is lower than the 2021-22 target due to this being an aspirational target. The lower 2022-23 target reflects the projected optimum number of operational volunteers.					
Volunteers – Support	number	23 000–24 000	25 381	24 000–25 000	25 602
The lower 2022-23 target reflects the projected optimum number of support volunteers.					
Quality					
Level 3 Incident Controller trained staff and volunteers	number	70	64	70	63
The 2021-22 expected outcome is lower than the 2021-22 target due to unanticipated retirement, resignation or reaccreditation decisions and the length of time necessary to train more Level 3 Incident Controllers. The measure is indicative only of accredited personnel funded through the Emergency Management Capability Output. Additional capability exists within the DELWP portfolio.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Road accident rescue accredited brigades/units	number	133	133	131	132
The higher 2022-23 target reflects additional sector capacity.					
Structural fire confined to room of origin (FRV and CFA)	per cent	80	78	80	83.9
Timeliness					
Emergency response times meeting benchmarks – emergency medical response (FRV)	per cent	90	95	90	92.2
This performance measure renames the 2021-22 performance measure 'Emergency response times meeting benchmarks – emergency medical response'. The new measure reports on the same activity as the previous measure, however has been renamed for increased clarity.					
Emergency response times meeting benchmarks – road accident rescue response (CFA)	per cent	90	90	90	94.3
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Emergency response times meeting benchmarks – Road accident rescue'. The new performance measure is the same as the previous measure except is disaggregated by agency for increased transparency.					
Emergency response times meeting benchmarks – road accident rescue response (FRV)	per cent	90	81	90	85.1
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Emergency response times meeting benchmarks – Road accident rescue'. The new performance measure is the same as the previous measure except is disaggregated by agency for increased transparency. *The 2021-22 expected outcome is lower than the 2021-22 target due to the small sample size, as small changes in the number of appliances not meeting target can have a significant impact on the results.*					
Emergency response times meeting benchmarks – road accident rescue response (VICSES)	per cent	90	90	90	92.6
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Emergency response times meeting benchmarks – Road accident rescue'. The new performance measure is the same as the previous measure except is disaggregated by agency for increased transparency.					
Emergency response times meeting benchmarks – structural fires (CFA)	per cent	90	90	90	81.8
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Emergency response times meeting benchmarks – structural fires'. The new performance measure is the same as the previous measure except is disaggregated by agency for increased transparency.					
Emergency response times meeting benchmarks – structural fires (FRV)	per cent	90	86	90	88.6
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Emergency response times meeting benchmarks – structural fires'. The new performance measure is the same as the previous measure except is disaggregated by agency for increased transparency.					
Community Recovery and Resilience Grants provided aligned to milestone payments (BRV)	per cent	90	nm	nm	nm
New performance measure for 2022-23 to reflect Government priorities regarding Bushfire Recovery Victoria funding.					
Cost					
Total output cost	$ million	1 651.2	2 527.3	1 715.0	2 295.6
The 2021-22 expected outcome is higher than the 2021-22 target mainly due to funding for initiatives announced in the 2022-23 Budget *including COVID-19 Quarantine Victoria and Emergency Services Telecommunications Authority (ESTA). In addition, funding supplementation for the High Risk Industries: Engagement and Enforcement Operation initiative and funding released to ESTA post* 2021-22 Budget *also contributed to the increase.*					

Source: Department of Justice and Community Safety

Objective 3: Effective management of prisoners and offenders and provision of opportunities for rehabilitation and reparation

This objective relates to the management of the State's adult correctional system. The overarching purpose of the correctional system is to promote community safety through community-based and custodial supervision of prisoners and offenders through effective management and services to provide opportunities for rehabilitation and reparation.

The departmental objective indicators are:

- escapes from correctional facilities
- percentage of community corrections orders completed
- rate of prisoner return to prison within two years
- rate of offender return to corrective services within two years.

Outputs

Community Based Offender Supervision (2022-23: $290.9 million)

This output relates to the effective supervision of offenders in the community, including ensuring compliance with orders of the court and Adult Parole Board, engagement in programs to reduce reoffending and reparation to the community.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Average daily offenders with reparation orders	number	2 900	964	2 900	847
The 2021-22 expected outcome is lower than the 2021-22 target due to reforms to the fines system.					
Average daily offenders with supervised court orders	number	11 750	7 334	11 750	6, 935
The 2021-22 expected outcome is lower than the 2021-22 target due to a decrease in the number of community correction orders imposed by courts. It is expected to increase throughout 2022-23 as the courts increase their operations with a mixture of in-person attendance and WebEx.					
Average daily prisoners on parole	number	1 000	859	1 000	902
The 2021-22 expected outcome is lower than the 2021-22 target due to fewer prisoners being granted parole, following reforms to the parole system, and an increase in the proportion of shorter parole orders.					
Community work hours performed	number	700 000	233 300	700 000	327 276
The 2021-22 expected outcome is lower than the 2021-22 target due to fewer community correction orders with a community work condition being ordered by the courts, fewer fine orders being issued.					
Quality					
Rate of return to corrective services within two years of discharge from a community corrections order	per cent	14	10.5	16	13.1
The 2021-22 expected outcome is lower than the 2021-22 target due to a review of the application of national counting rules, meaning the offender return rates have changed significantly from those published in previous reports. The target was set prior to this correction taking place. *The lower 2022-23 target reflects historical performance.*					
Successful completion of parole orders	per cent	75	81.5	75	80.0
The 2021-22 expected outcome is higher than the 2021-22 target due to the ongoing impact of improvements to the operation of Victoria's parole system.					

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Successful completion of reparation orders	per cent	68	44.9	68	54.8
The 2021-22 expected outcome is lower than the 2021-22 target due to a combination of factors including a high proportion of offenders with concurrent supervised orders, a reduction in fine order completions and a reduction in fine order completions which historically have a better success rate.					
Successful completion of supervised court orders	per cent	65	48	65	55.8
The 2021-22 expected outcome is lower than the 2021-22 target due to a combination of factors including a more complex offender profile affecting successful completions. Offenders on combined orders are more complex to manage than offenders who are sentenced to a supervised court order alone, having transitional support needs associated with having spent time in custody immediately prior to commencing their order.					
Percentage of community work hours ordered that are completed	per cent	70	57.5	70	64.5
The 2021-22 expected outcome is lower than the 2021-22 target due to a combination of factors including fewer offenders undertaking fine orders (which have high completion rates), a more complex offender profile impacting hours completed.					
Successful completion of violence related programs for family violence offenders in community corrections	per cent	70	65.7	70	42.5
The 2021-22 expected outcome is lower than the 2021-22 target due to disruptions in program delivery due to COVID-19 restrictions that made face-to-face client engagement challenging.					
Timeliness					
Offenders with a treatment or rehabilitation program condition who have been appropriately referred to a program	per cent	95	95.7	95	95.7
Cost					
Total output cost	$ million	290.9	290.1	290.9	281.2

Source: Department of Justice and Community Safety

Prisoner Supervision and Support (2022-23: $1 534.9 million)

This output relates to the safe, secure and humane containment of prisoners as well as the delivery of programs and effective case management to engage prisoners in positive behavioural change.

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quantity					
Average daily male prison utilisation rate of total male prison capacity	per cent	85–90	77.1	85–90	80.5
The 2021-22 expected outcome is lower than the 2021-22 target due to a decrease in the number of male prisoners, arising from the impact of COVID-19, while the capacity of the men's prisons has remained stable.					
Average daily female prison utilisation rate of total female prison capacity	per cent	85–90	61.9	85–90	64.1
The 2021-22 expected outcome is lower than the 2021-22 target due to a decrease in the number of female prisoners, arising from the impact of COVID-19, while the capacity of the women's prisons has remained stable.					
Annual daily average number of male prisoners	number	7 100–7 518	6 415	7 100–7 518	6 728
The 2021-22 expected outcome is lower than the 2021-22 target due to a slower than forecast growth in male prisoner numbers. This is largely due to the impact of COVID-19-related disruptions and associated decreases in system-wide demand.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Annual daily average number of female prisoners	number	544–576	396	544–576	410
The 2021-22 expected outcome is lower than the 2021-22 target due to a slower than forecast growth in female prisoner numbers. This is largely due to the impact of COVID-19-related disruptions and associated decreases in system-wide demand.					
Total annual number of random drug tests undertaken	number	6 011–6 365	5 355	10 492–11 110	9 486
The 2021-22 expected outcome is lower than the 2021-22 target due to a decrease in prisoner numbers which is attributed to the impact of changes to criminal justice system activity during COVID-19 restrictions. *The lower 2022-23 target reflects the expected impact of reduced prisoner numbers.*					
Quality					
Proportion of benchmark measures in prison services agreement achieved	per cent	90	71.8	90	79.2
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19.					
Proportion of eligible prisoners in employment	per cent	89	92.4	89	94.3
Rate of prisoner participation in education	per cent	36	34.9	36	33.3
Rate of return to prison within two years	per cent	39	37.7	41	43.6
The 2021-22 expected outcome is lower than the 2021-22 target due to a review of the application of national counting rules, meaning the prisoner return rates have changed significantly from those published in previous reports. The target was set prior to this correction taking place. *The lower 2022-23 target reflects the review into the application of national counting rules.*					
Percentage of positive random drug tests	per cent	5	4	5	2.8
The 2021-22 expected outcome is lower than the 2021-22 target due to the restriction of prisoner movements and cessation of prisoner visits as part of COVID-19 restrictions, which limits the availability of contraband.					
Percentage of education modules successfully completed	per cent	80	51.3	80	84.3
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions, with minimal onsite education. This limited the ability of prisoners to access education programs across the prison system.					
Average daily out of cell hours–secure prisons	number	10.5	9.3	10.5	9.6
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions, which has led to restricted movements for prisoners.					
Average daily out of cell hours–open prisons	number	14	13.5	14	14.2
Timeliness					
Assessment of prisoners 'at risk' undertaken within two hours	per cent	100	99.8	100	99.8
Proportion of prisoner risk assessments completed within set timeframes	per cent	95	99.1	95	98.7
Cost					
Total output cost	$ million	1 534.9	1474.1	1 384.4	1 483.0
The 2021-22 expected outcome is higher than the 2021-22 target mainly due to funding for the Responding to COVID-19 in Corrections and Youth Justice initiative which was announced in the 2022-23 Budget. *The higher 2022-23 target mainly reflects funding for initiatives announced in the* 2022-23 Budget *including Reducing future justice demand and Western Plains Correctional Centre, and the increase in depreciation expenses reflecting Government's continued investments in additional beds across the corrections system.*					

Source: Department of Justice and Community Safety

Objective 4: Effective supervision of children and young people through the provision of youth justice services promoting rehabilitation

This objective aims to promote opportunities for rehabilitation of children and young people in the youth justice system and contribute to the reduction of crime in the community by providing a range of services including diversion services, advice to courts, offence related programs, community based and custodial supervision.

The departmental objective indicators are:

- percentage of community-based orders successfully completed
- young people in youth justice participating in community reintegration activities.

Outputs

Youth Justice Community Based Services (2022-23: $80.4 million)

This output provides community statutory supervision and support to young people subject to community-based dispositions in order to divert young people from the youth justice system and minimise the likelihood of further offending.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of Children's Court Youth Diversions (CCYD)	number	1 100	nm	nm	nm
New performance measure for 2022-23 to reflect the focus on diverting children from the Youth Justice system.					
Average daily number of young people under community-based supervision	number	750	690	800	708
The 2021-22 expected outcome is lower than the 2021-22 target due to a reduction in young people under community-based supervision. This reduction represents a redirection of young people from the Youth Justice System. *The lower 2022-23 target reflects a focus on diversion, balanced against projections for the youth justice system post the COVID-19 pandemic.*					
Proportion of young people in youth justice under community-based supervision	per cent	85	85	85	81.5
Quality					
Proportion of successfully completed Children's Court Youth Diversions (CCYD)	per cent	90	nm	nm	nm
New performance measure for 2022-23 to reflect the focus on diverting children from the Youth Justice system.					
Community-based orders completed successfully	per cent	90	90	88	93.5
The higher 2022-23 target reflects the continued higher performance against this measure.					
Timeliness					
Young people on supervised orders who have a case plan completed within six weeks of the commencement of the order	per cent	95	95	95	92.1
Cost					
Total output cost	$ million	80.4	80.3	76.7	69.2

Source: Department of Justice and Community Safety

Youth Justice Custodial Services (2022-23: $259.4 million)

This output provides supervision and rehabilitation, through the provision of case management, health and education services and the establishment of structured community supports, to assist young people to address offending behaviour, develop non offending lifestyles and support reintegration of young people into the community on their exit from custody.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Average daily number of young people aged 10-13 under supervision	number	<5	nm	nm	nm
New performance measure for 2022-23 to reflect the focus on reducing the number of young people aged under 14 in custody.					
Annual daily average number of young people in custody–male (under 15 years) and female	number	15–25	15	15–25	16.7
Annual daily average number of young people in custody–males (15 years plus)	number	170–210	125	210–250	143.7
The 2021-22 expected outcome is lower than the 2021-22 target due to a decline in the number of young people in custody. This reduction represents a redirection of young people from the Youth Justice Custodial System. The lower 2022-23 target reflects the continued focus on this.					
Average daily custodial centre utilisation rate of total centre capacity–males (15 years plus)	per cent	80–85	50	90–95	64.7
The 2021-22 expected outcome is lower than the 2021-22 target due to a decline in the number of young people in custody. This reduction represents a redirection of young people from the Youth Justice Custodial System. The lower 2022-23 target reflects the continued focus on this.					
Average daily custodial centre utilisation rate of total centre capacity–males (under 15 years) and female	per cent	60–80	60	60–80	55.7
Average daily number of Aboriginal children and young people (10-17 years) in custody	number	8–13	10	14–18	10.5
The 2021-22 expected outcome is lower than the 2021-22 target due to the priority to divert more Aboriginal children from Youth Justice custody. The lower 2022-23 target reflects the continued focus on diversion this. as well as the implementation of Wirrara Kulpa.					
Quality					
Young people in youth justice participating in community re-integration activities	per cent	80	30	80	34.7
The 2021-22 expected outcome is lower than the 2021-22 target as temporary leave from custody to undertake re-integration activities was suspended for large parts of the financial year for safety reasons to reduce the transmission of COVID-19.					
Timeliness					
Young people on custodial orders who have a case plan completed within six weeks of the commencement of the order	per cent	95	95	95	97.2
Cost					
Total output cost	$ million	259.4	186.6	191.3	188.5
The higher 2022-23 target reflects funding for initiatives announced in the 2022-23 Budget *mainly for the Improving custodial services for youth justice and Diverting children from youth justice initiatives, including funding for opening the Cherry Creek Youth Justice facility.*					

Source: Department of Justice and Community Safety

Objective 5: A fair and accessible justice system that supports confidence in the Victorian community

This objective relates to the provision of and access to justice services that support legal processes and law reform. Services that support legal processes include legal assistance and education services, prosecution services and the delivery of independent, expert forensic medical services to the justice system.

Other services that contribute to this objective include legal policy advice to government, law reform, dispute resolution and initiatives focusing on crime prevention and supporting Kooris in the criminal justice system.

The departmental objective indicators are:

- prosecutions completed and returning guilty outcomes (OPP) (percentage of total case finalisations)
- legal advice and assistance provided (VLA)
- law reform publications completed (VLRC)
- medico-legal death investigations (VIFM)
- number of Sentencing Advisory Council publications (SAC)
- dispute resolution services provided in the Dispute Settlement Centre of Victoria (DSCV).

Outputs

Public Prosecutions and Legal Assistance (2022-23: $381.1 million)

This output delivers activities relating to Victoria's public prosecutions service and Victoria Legal Aid (VLA).

The Office of Public Prosecutions (OPP) provides an independent, effective and efficient prosecutions service on behalf of the Director of Public Prosecutions (DPP). In addition to the prosecution of serious crimes, the OPP also provides professional support to prosecution witnesses and victims of crime involved in its cases.

VLA is an independent statutory authority that provides a range of legal services for both Victorian and Commonwealth law matters. These services include legal representation, legal advice, advocacy and education services.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Judicial Officer sitting days requiring prosecutors (OPP)	number	11 500–13 500	13 000	11 000–13 000	12 353
The higher 2022-23 target reflects growth in the number of matters entering the criminal justice system, new court case management practices and anticipated extra demand for prosecution services as the courts and wider criminal system rebounds from the impacts of COVID-19.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Number of briefs prepared and hearings attended (OPP)	number	74 500–78 500	90 000	74 500–78 500	83 674
The 2021-22 expected outcome is higher than the 2021-22 target due to more summary and administrative, and case management hearing types.					
Number of victim and witness consultations (OPP)	number	46 000–48 000	50 000	34 000–36 000	43 800
The 2021-22 outcome is expected to be higher than the 2021-22 target due to higher than anticipated demand for services. The higher 2022-23 target reflects anticipated sustained demand for OPP Victim and Witness engagement services.					
Community legal education and information services (VLA)–excluding family violence related services	number	102 000	102 000	101 000–103 000	81 602
The 2022-23 target has been updated from a range to single figure target.					
Community legal education and information services (VLA)–family violence related services	number	27 000	27 000	26 000–28 000	20 753
The 2022-23 target has been updated from a range to single figure target.					
Duty lawyer services (VLA)–excluding family violence related services	number	70 853	70 000	69 000–71 000	28 070
The 2022-23 target has been updated from a range to single figure target.					
Grants of legal assistance provided (VLA)–excluding family violence related services	number	32 900	32 900	32 900	29 466
Legal advice and minor assistance for clients (VLA)–excluding family violence related services	number	41 347	41 000	40 000–42 000	28 211
The 2022-23 target has been updated from a range to single figure target.					
Family violence legal services (VLA)	number	46 000	46 000	46 000	39 894
Number of unique clients who accessed one or more of VLA's legal services	number	105 000	105 000	105 000	74 670
Quality					
Guilty outcomes (guilty pleas and trial convictions) as a percentage of case completions (OPP)	per cent	89	90	89	95.3
Client satisfaction with services provided by Victoria Legal Aid	per cent	80	80	80	na
The 2020-21 actual was 'na' as VLA was unable to access a statistically significant sample of clients due to the combined adverse impacts of the COVID-19 pandemic, court adjournments, and reductions in face-to-face services.					
Timeliness					
Proportion of trials listed which did not proceed to adjournment on application of the Crown (OPP)	per cent	99	99	99	99.9
Average wait time to Legal Help (VLA)	minutes	<15	15	<15	17.1
This performance measure renames the 2021-22 performance measure 'Average call wait time to the Legal Help phone line (VLA)'. The new measure reports on the same activity as the previous measure but has been amended to more accurately reflect that the service is delivered through several channels including by phone and webchat.					
Cost					
Total output cost	$ million	381.1	361.7	355.2	342.3
The higher 2022-23 target mainly reflects funding for initiatives announced in the 2022-23 Budget *including Commonwealth funding contribution for Legal Assistance, and a number of initiatives including Justice system costs associated with additional judicial resources and the extension of court programs, Helping Courts respond to the impacts of the pandemic, Delivery of prosecution services and Supporting community legal centres. This is partly offset by lapsing funding including the Addressing COVID-19 related delay in the Justice Sector initiative which was announced in* 2020-21 Budget.					

Source: Department of Justice and Community Safety

Forensic Justice Services (2022-23: $64.8 million)

This output delivers forensic medical services and medico legal advice provided through the Victorian Institute of Forensic Medicine (VIFM).

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Clinical forensic medical services by the Victorian Institute of Forensic Medicine (VIFM)	number	2 600–3 000	2 200	2 600–3 000	2 443
The 2021-22 expected outcome is lower than the 2021-22 target due to revised reporting methodologies.					
Medico legal death investigations (VIFM)	number	6 450–6 950	6 950	6 450–6 950	6 707
Provision of expert forensic medical and scientific evidence in court (VIFM)	number	200–250	230	150–250	221
The narrowed 2022-23 target range reflects demonstrated performance within the top of the range.					
Peer reviewed research articles published	number	85	nm	nm	nm
New performance measure for 2022-23 to reflect VIFM's academic and scholarly contribution to forensic medicine and demonstrated research excellence.					
Enquiries resolved by the Coronial Admissions and Enquiries Office of non-reportable deaths	number	5 900	nm	nm	nm
New performance measure for 2022-23 to reflect VIFM's support to medical profession to reduce demand on Coroners Court.					
Quality					
Audited medico legal death investigation reports with no significant diagnostic errors (VIFM)	per cent	98	99	95	97.3
The higher 2022-23 target reflects demonstrated high performance.					
Timeliness					
Medical and scientific investigations on the body of the deceased completed within two days (VIFM)	per cent	75–85	75	75–85	67.4
Medico-legal death investigation reports issued within agreed period (VIFM)	per cent	65–75	73	60–70	68.5
The higher 2022-23 target reflects demonstrated high performance.					
Cost					
Total output cost	$ million	64.8	56.1	55.6	55.2
Forensic Justice Services is a new output in 2022-23, disaggregated from Justice Policy, Services and Law Reform for increased transparency. The 2020-21 actual and 2021-22 target have been restated to reflect this disaggregation. *The higher 2022-23 target mainly reflects incremental funding for the Supporting the State's forensic capability initiative which was announced in the* 2021-22 Budget*, higher estimated costs for the Victorian Institute of Forensic Medicine trust fund, and funding announced in the* 2022-23 Budget *for the Supporting victims of sexual violence and harm initiative.*					

Source: Department of Justice and Community Safety

Justice Policy, Services and Law Reform (2022-23: $169.3 million)

This output delivers a broad range of services including the provision of law reform and sentencing advisory information. It also includes practical legal solutions and strategic advice through the Victorian Government Solicitor's Office (VGSO) and dispute resolution and mediation services to members of the community through the Dispute Settlement Centre of Victoria (DSCV).

This output also reports on the activities of the Land Justice Unit (LJU) and the Koori Justice Unit (KJU). The LJU seeks to increase the economic, social and cultural development of traditional owner communities by negotiating comprehensive settlements of native title claims. The KJU focuses on Victoria's commitment to the Aboriginal Justice Agreement and other initiatives focused on crime prevention and reducing re offending of Kooris in the criminal justice system.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Community education sessions (in-person or online) conducted by Victorian Law Reform Commission (VLRC)	number	25	10	25	2
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Community education and consultation sessions conducted by Victorian Law Reform Commission (VLRC)'. The new performance measure is the same as the previous measure except is disaggregated by activity for increased transparency. The 2020-21 actual and 2021-22 target have been restated to reflect this disaggregation. *The 2021-22 expected outcome is lower than the 2021-22 target due to the continuing impact of COVID-19 restrictions on in-person school and community education sessions.*					
Consultation sessions conducted by Victorian Law Reform Commission (VLRC)	number	75	50	75	162
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Community education and consultation sessions conducted by Victorian Law Reform Commission (VLRC)'. The new performance measure is the same as the previous measure except is disaggregated by activity for increased transparency. *The 2021-22 expected outcome is lower than the 2021-22 target due to most consultations for references running throughout 2021-22 being undertaken in 2020-21.*					
Views of school curriculum related material on VLRC website	number	1 000	nm	nm	nm
New performance measure for 2022-23 to reflect school education material made available on the VLRC website and the transition to online website use.					
Written submissions made to the VLRC including online surveys	number	150	nm	nm	nm
New performance measure for 2022-23 to reflect community and stakeholder engagement in law reform projects and that the receipt of written submissions is a significant part of VLRC work.					
Law reform publications completed by VLRC	number	3	4	3	3
This performance measure renames the 2021-22 performance measure 'Law reform projects conducted by VLRC'. The new measure reports on the same activity as the previous measure, however has been amended for increased clarity. *The 2021-22 expected outcome is higher than the 2021-22 target due to an additional topic requested for an Attorney-General reference being published as a separate publication rather than being incorporated in the larger report.*					
Number of Sentencing Advisory Council (SAC) publications	number	6	5	6	6
The 2021-22 expected outcome is lower than the 2021-22 target due to staff attrition.					
Grant and program funding administered by the KJU provided to Aboriginal Community Controlled Organisations (ACCOs)	per cent	98	99	95	98.9
The higher 2022-23 target reflects historical performance.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Number of Recognition and Settlement Agreements that commence (LJU)	number	3	0	3	nm
The 2021-22 expected outcome is lower than the 2021-22 target due to strategic issues including protracted Federal Court proceedings in relation to some matters and interdepartmental policy challenges.					
Dispute resolution services provided in the Dispute Settlement Centre of Victoria (DSCV)	number	25 000	8 845	25 000	12 524
The 2021-22 expected outcome is lower than the 2021-22 target as a result of the DSCV temporarily closing its general service and resources being diverted to assisting renters and rental providers to resolve disputes at the Victorian Civil and Administrative Tribunal.					
Quality					
Teachers and students who are satisfied with education programs delivered by VLRC and the school curriculum related material provided on the VLRC website	per cent	85	85	85	na
This performance measure renames the 2021-22 performance measure 'Teachers and students who are satisfied with education programs delivered by VLRC'. It has been amended to more accurately reflect the expanded range of educational resources provided by the VLRC on its website and the difficulty of undertaking face to face presentations over the last two years.					
Client satisfaction with quality of legal advice provided (VGSO)	per cent	85	85	85	85
Overall client satisfaction rate (DSCV)	per cent	85	na	85	na
The 2021-22 expected outcome is 'na' for this measure as client satisfaction surveys were not sent this year due to the DSCV temporarily closing its general service to assist the Residential Tenancies list at the Victorian Civil and Administrative Tribunal.					
Settlement rate of mediation (DSCV)	per cent	70	72	65	73.1
The 2021-22 expected outcome is higher than the 2021-22 target as a result of an increased uptake in Dispute Resolution and Mediation service since June 2021, attributed to improved telephone technology and telephone mediations, resulting in more matters proceeding to mediation and parties' willingness to resolve their matters. *The higher 2022-23 target reflects historical performance.*					
Timeliness					
Client satisfaction with timeliness of legal advice provided (VGSO)	per cent	85	85	85	85
Proportion of Native Title negotiations progressed in accordance with the Department's annual work plan and timeframes monitored by the Federal Court (LJU)	per cent	100	100	100	100
Intake and mediation services conducted within agreed timeframes by the DSCV	per cent	95	98	85	97.0
The 2021-22 expected outcome is higher than the 2021-22 target as a result of implementing technology advances, which have improved the delivery of standard services. The higher 2022-23 target reflects the improved delivery of standard services.					
Cost					
Total output cost	$ million	169.3	309.1	157.3	193.3
Forensic Justice Services has been disaggregated from this output in 2022-23 for increased transparency. The 2020-21 actual and 2021-22 target for Justice Policy, Services and Law Reform have been restated to reflect this disaggregation. *The 2021-22 expected outcome is higher than the 2021-22 target mainly due to the recognition of Stolen Generations Reparations Package, increased legal services from the Victorian Government Solicitors Office, and new funding announced in the* 2022-23 Budget *as part of the Whole of Government's Aboriginal affairs. In addition, the release of funding post the* 2021-22 Budget *for the Decriminalising of public drunkenness initiative also contributed to the increase.* *The higher 2022-23 target mainly reflects funding for initiatives announced in the* 2022-23 Budget *including Improving capacity for Traditional Owner Corporations to negotiate Recognition and Settlement Agreements with the State as part of the Whole of Government's Aboriginal affairs. In addition, there are also expected higher costs from increased legal services from the Victorian Government Solicitors Office. This is partly offset by lapsing funding for the Enabling economic recovery and development through Traditional Owners' Corporations which was announced in the* 2020-21 Budget.					

Source: Department of Justice and Community Safety

Objective 6: Victorians are protected with equal opportunities, secure identities, information freedoms and privacy rights

This objective aims to support the Victorian community through the provision of services relating to rights and equal opportunity, advocacy and guardianship for Victorians with a disability or mental illness and support for victims of crime. This objective supports identity protection of Victorians through life event registration, protection of children through adoption services and risk assessments for those working with or caring for children. The objective also contributes to public sector integrity, information freedoms and privacy protection of Victorians.

The departmental objective indicators are:

- complaint files received and handled by the Victorian Equal Opportunity and Human Rights Commission (VEOHRC)
- people assisted through Public Advocate advice and education activities (OPA)
- services provided to victims of crime against the person (VSA)
- births, deaths and marriages registration transaction accuracy rate
- Working with Children and NDIS Checks processed (exclusions issued within three days of receiving a decision)[(a)]
- education and training activities delivered by the Office of the Victorian Information Commissioner (OVIC).

Note:
(a) Revised objective indicators in 2022-23 to better align with terminology used in legislation.

Outputs

Advocacy, Human Rights and Victim Support (2022-23: $141.9 million)

This output focuses on the delivery of services aimed at protecting vulnerable people, supporting victims and safeguarding human rights through the work of the Office of the Public Advocate (OPA), the Victim Support Agency (VSA) and the Victorian Equal Opportunity and Human Rights Commission (VEOHRC). OPA protects the rights, interests and dignity of people with disability and mental illness. VSA provides support to victims of crime with practical assistance, counselling and support through the justice system. VEOHRC provides education and capacity building to protect and promote human rights in Victoria.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Conciliation and facilitation activities delivered by VEOHRC	number	900–1 050	1 020	900–1 050	1 303
This performance measure renames the 2021-22 performance measure 'Complaint files received and handled by VEOHRC'. It has been renamed to more accurately measure substantive work performed by VEOHRC, and to measure facilitation activities which will commence with the operation of the Change or Suppression (Conversion Practices) Prohibition Act 2021. *The higher 2022-23 target reflects additional conciliation and facilitation activities which will commence with the operation of the* Change or Suppression (Conversion Practices) Prohibition Act 2021.					
Education and information sessions delivered by VEOHRC	number	615	700	600	778
This performance measure renames the 2021-22 performance measure 'Education and consultancy sessions delivered by VEOHRC'. The new measure reports on the same activity as the previous measure, but has been renamed for increased clarity. The 2021-22 expected outcome is higher than the 2021-22 target due to a higher-than-expected completion rate of the Commission's eLearning modules. The Commission is monitoring whether this is due to more digital learning under COVID-19 restrictions or an ongoing preference trend. The higher 2022-23 target reflects additional education and information sessions which will commence with the operation of the Change or Suppression (Conversion Practices) Prohibition Act 2021.					
Information and advice provided by VEOHRC	number	8 000–8 500	8 250	8 000–8 500	8 578
Information and advice provided by OPA	number	11 334–13 306	11 619	11 334–11 306	11 619
Community education sessions (OPA)	number	150–190	150	150–190	70
Public Advocate auspiced volunteer interventions for people with disability (OPA)	number	7 900–8 200	7 900	7 900–8 200	7 118
New guardianship and investigation orders of VCAT actioned by OPA	number	1 340–1 480	1 560	1 340–1 480	1 389
The 2021-22 expected outcome is higher than the 2021-22 target as the COVID-19 pandemic temporarily slowed guardianship numbers, however, the easing of restrictions coincided with a record high number of guardianship matters.					
Advocacy matters opened by OPA	number	348–389	250	348–389	352
The 2021-22 expected outcome is lower than the 2021-22 target due to a range of factors, including staff vacancies and the high demand for statutory functions (including guardianship), which have adversely impacted the amount of advocacy undertaken.					
Decisions made by the Public Advocate under the *Medical Treatment Planning and Decisions Act 2016 (OPA)*	number	464–533	410	464–533	490
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 on the health system, including closure of elective surgeries.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Victims receiving a service from the Victims of Crime Helpline, Victims Register, Youth Justice Group Conferencing and Victims Support (VSA)	number	26 000	26 000	23 500	25 988
The 2021-22 expected outcome is higher than the 2021-22 target due to an increase in referrals from Victoria Police to the Victims of Crime Helpline for male victims of family violence during the COVID-19 pandemic. *The higher 2022-23 target reflects historical performance.*					
Victims receiving a service from the Victims Assistance Program (VSA)	number	12 000	10 400	12 000	10 358
The 2021-22 expected outcome is lower than the 2021-22 target due to a reduction in referrals from Victoria Police to the Victims Assistance Program (VAP) during the COVID-19 pandemic. This resulted in less referrals being made to the VAP for 'new' clients.					
Quality					
Customer satisfaction rating – Education and information sessions delivered by VEOHRC	per cent	90	89	85	89
This performance measure renames the 2021-22 performance measure 'customer satisfaction rating – education and consultancy sessions delivered by VEOHRC'. The new measure reports on the same activity as the previous measure, but has been renamed for increased clarity. *The higher 2022-23 target reflects historical performance.*					
Customer satisfaction rating – Conciliation and facilitation delivered by VEOHRC	per cent	95	95	85	95
This performance measure renames the 2021-22 performance measure 'customer satisfaction rating - conciliation delivered by VEOHRC'. The new measure reports on the same activity as the previous measure, however has been amended to include new facilitation activity which will commence with the operation of the Change or Suppression (Conversion Practices) Prohibition Act 2021. *The 2021-22 expected outcome is higher than the 2021-22 target due to initiatives implemented to streamline the service and triage complaints to meet the needs of a diverse range of clients. This high satisfaction rating continues to be achieved despite a delay in commencing dispute resolution due to the increase in complaints being received.* *The higher 2022-23 target reflects the improved delivery of standard services.*					
Settlement rate of conciliation and facilitation (VEOHRC)	per cent	65	67	65	66
This performance measure edits the 2021-22 performance measure 'Settlement rate of conciliation (VEOHRC)'. The new measure reports on the same activity as the previous measure, however has been amended to include new facilitation activity which will commence with the operation of the Change or Suppression (Conversion Practices) Prohibition Act 2021.					
Client satisfaction with victim services	per cent	80	82	80	nm
Timeliness					
VEOHRC complaints and reports of change or suppression practices finalised within six months	per cent	85	60	85	82
This performance measure edits the 2021-22 performance measure 'VEOHRC complaints finalised within six months'. The new measure reports on the same activity as the previous measure, however has been amended to include reports made pursuant to the Change or Suppression (Conversion Practices) Prohibition Act 2021. *The 2021-22 expected outcome is lower than the 2021-22 target due to a sustained increase in complaint numbers, largely relating to the COVID-19 pandemic. This has created a significant backlog of complaints, which VEOHRC is addressing through additional resourcing and prioritising early resolution of complaints where possible.*					
Average number of days a guardianship or investigation order of VCAT is held on a wait list prior to being allocated to a delegated officer by the Public Advocate (OPA)	number	15–19	21.4	15–19	17
The 2021-22 expected outcome is higher than the 2021-22 target due to increasing demand for guardianship services, capping of guardians caseload in response to WorkSafe provisional improvement notice and staff attrition and turnover.					
Cost					
Total output cost	$ million	141.9	141.2	136.2	647.6

Source: Department of Justice and Community Safety

Protection of Children, Personal Identity and Screening Services

(2022-23: $59.7 million)

This output supports the protection of children through adoption services and in protecting children from sexual and physical harm by providing screening of persons who work with or care for, children and screening of persons engaged in risk assessed roles for the purposes of the National Disability Insurance Scheme. This output protects personal identity through the registration of significant life events by the Victorian Registry of Births, Deaths and Marriages (BDM).

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of Working with Children and NDIS checks processed	number (thousand)	380–420	380	380–420	319
Number of Adoption Records released	number	350	350	350	366
Quality					
Births, Deaths and Marriages registration transaction accuracy rate (BDM)	per cent	99	99	99	99.9
Customer satisfaction rating – BDM service centre	per cent	85	na	85	na
The 2021-22 expected outcome is 'na' due to the closure of the customer service centre since late March 2020 due to COVID-19. As a result of the closure, survey data could not be collected.					
Clearances for Working with Children and NDIS checks issued within three days of receiving a clear notification	per cent	98	99.9	98	99.9
Exclusions for Working with Children and NDIS checks issued within three days of receiving the delegate's decision	per cent	100	98	100	98
Timeliness					
Average number of days to process compliant applications for birth, death and marriage certificates	number	<10	10	<10	12.4
Cost					
Total output cost	$ million	59.7	49.3	45.7	52.6
The higher 2021-22 expected outcome and 2022-23 target mainly reflects funding for initiatives announced in the 2022-23 Budget *for a Digital and Efficient Births, Deaths and Marriages Registry and Responding to historical forced adoptions in Victoria. In addition, there is incremental funding announced in the* 2022-23 Budget *for Working with Children Check and National Disability Insurance Scheme worker screening which also contributes to the increase.*					

Source: Department of Justice and Community Safety

Public Sector Information Management, Privacy and Integrity

(2022-23: $20.2 million)

This performance measure is proposed to be discontinued as it reflects a minimum level of service related to grants management. New performance measures that better reflect service delivery for community crime prevention have been introduced in 2022-23.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Education and training activities delivered by Office of the Victorian Information Commissioner	number	120	120	120	137
Regulatory actions conducted: Examinations, reviews, audits or investigations	number	8	5	5	5
Reviews and complaints closed by Office of the Victorian Information Commissioner	number	950	1 200	950	1 315
The 2021-22 expected outcome is higher than the 2021-22 target due to larger than anticipated numbers of received FOI and Privacy complaints which are being effectively handled during the COVID -19 pandemic.					
Quality					
Local Government Inspectorate (LGI) Governance recommendations adopted and implemented by councils	per cent	100	89	100	89
The 2021-22 expected outcome is lower than the 2021-22 target due to a timing issue. Recommendations made later in a financial year may not have been adopted and implemented within that financial year due to the time frames councils have to implement (3 months).					
Client satisfaction with education and training provided	per cent	90	94	90	97.5
FOI review decisions overturned or set aside on appeal to VCAT	per cent	<25	7.5	<25	7.5
FOI reviews withdrawn by agreement following informal resolution	per cent	25	25	25	21.2
This performance measure renames the 2021-22 measure 'FOI reviews withdrawn by agreement following internal resolution' to reflect more accurate terminology.					
Timeliness					
FOI reviews completed within timelines agreed with applicant	per cent	60	60	60	56.1
Complaints received by the Local government Inspectorate assessed and actioned within five working days	per cent	95	87	95	87
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of working from home arrangements and staff vacancies.					
Councillor serious misconduct matters referred to Conduct Panel within 30 days of allegations being substantiated	per cent	100	na	100	na
The 2021-22 expected outcome is 'na' due to no matters being referred to Conduct Panel.					
Cost					
Total output cost	$ million	20.2	19.0	18.9	15.3
The higher 2022-23 target mainly reflects funding for initiatives announced in the 2022-23 Budget *for the Supporting the Office of the Victorian Information Commissioner and Royal Commission into the Management of Police Informants.*					

Source: Department of Justice and Community Safety

Objective 7: A fair marketplace for Victorian consumers and businesses with responsible and sustainable liquor and gambling sectors

This objective relates to harm minimisation through the regulation of the gambling and liquor industries. This objective promotes the empowerment of consumers and businesses to know their rights and responsibilities to promote a well-functioning market economy through regulation and support to consumers and businesses. There is a specific focus on the needs of vulnerable and disadvantaged consumers.

The departmental objective indicators are[(a)]:

- increased access by consumers, renters, rental providers, businesses and community organisations to digital information[(b)]
- increased awareness of factors that limit gambling harm[(c)].

Notes:

(a) The 2021-22 objective indicator 'percentage of licenced venues with a rating that is greater than three stars' has been discontinued in 2022-23 and will be replaced with an outcome focused objective indicator in 2023-24.

(b) This objective indicator has been revised for 2022-23 to reflect terminology changes in line with legislative amendments and broadened the reach of information dissemination.

(c) New objective indicator for 2022-23, replacing the previous indicator 'Responsive Gamblers Help Services' to more effectively report on the Department's work in limiting gambling harm.

Outputs

Regulation of the Victorian Consumer Marketplace (2022-23: $133.6 million)

This output upholds a fair and competitive Victorian marketplace. As Victoria's consumer regulator, Consumer Affairs Victoria (CAV) works to ensure that the market works effectively by detecting and addressing non-compliance with the law. The output provides for informing consumers and businesses about their rights and responsibilities under the law, engaging with business to ensure compliance, registration and occupational licensing for individuals and organisations and regulation of the residential tenancies market. Domestic Building Dispute Resolution Victoria is an independent government agency that provides free services to help resolve domestic (residential) building disputes.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of court and administrative actions	number	900	80	900	533
The 2021-22 expected outcome is lower than the 2021-22 target due to COVID-19 restrictions impacting Consumer Affairs Victoria's ability to undertake site visits, which in turn impacted the number of court and administrative actions.					
Information and advice provided to consumers, renters, rental providers and businesses – through other services including written correspondence, face to face and dispute assistance	number	157 343	135 017	115 700	144 533
This performance measure renames the 2021-22 performance measure 'Information and advice provided to consumers, tenants and businesses–through other services including written correspondence, face to face and dispute assistance'. The new measure reports on the same activity as the previous measure, but has been amended to reflect terminology changes in legislation and a broadened reach of information dissemination.					
The expected outcome for 2021-22 is higher than the 2021-22 target due to increased demand for dispute services that require responses to written correspondence.					
The higher 2022-23 target reflects anticipated higher demand for these services continuing.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Information and advice provided to consumers, renters, rental providers and businesses – through telephone service	number	293 265	265 510	302 900	205 508
This performance measure renames the 2021-22 performance measure 'Information and advice provided to consumers, tenants and businesses–through telephone service'. The new measure reports on the same activity as the previous measure, but has been amended to reflect terminology changes in legislation and a broadened reach of information dissemination. *The expected outcome for 2021-22 is lower than the 2021-22 target due to service model changes to promote online advice where appropriate whilst ensuring telephone support for those who need it.* *The lower 2022-23 target reflects those service model changes.* *The 2020-21 actual differs from the figure of 214,819 reported in the DJCS 2020-21 Annual Report due to calculation error identified post publication. The correct 2020-21 actual is 205,508.*					
Transactions undertaken – Residential Tenancies Bond Authority (RTBA) transactions	number	501 000	495 000	490 000	498 336
The higher 2022-23 target reflects the expectation that rental market activity will return to regular rates of growth throughout the year.					
Transactions undertaken – registration and licensing transactions	number	108 735	108 100	95 500	95 096
The 2021-22 expected outcome is higher than the 2021-22 target due to the commencement of the new Professional Engineers registration scheme on 1 July 2021. *The higher 2022-23 target reflects the inclusion of the new Professional Engineers registration scheme and the expected transaction volumes received in regard to new applications, renewals, notifications and annual statements.*					
Victims of family violence assisted with financial counselling	number	3 750	3 750	3 750	3 178
Dispute resolution services provided by Domestic Building Dispute Resolution Victoria	number	6 000	5 500	6 000	5 175
The 2021-22 expected outcome is lower than the 2021-22 target due to the continued impact of COVID-19 and the limited ability of the building industry to continue unimpeded throughout the period.					
Quality					
Rate of compliance with key consumer laws	per cent	95	95	95	90.2
Proportion of high-priority breaches resulting in regulatory response	per cent	100	100	100	100
Timeliness					
Regulatory functions delivered within agreed timeframes	per cent	95	97	95	96.7
Cost					
Total output cost	$ million	133.6	141.8	137.2	147.7

Source: Department of Justice and Community Safety

Gambling and Liquor Regulation (2022-23: $80.8 million)

This output provides for monitoring and regulation of gambling and liquor activities in Victoria, including the operations of the Victorian Gambling and Casino Control Commission (VGCCC) and the Victorian Responsible Gambling Foundation (VRGF). It also provides leadership and strategic policy advice to the Minister for Consumer Affairs, Gaming and Liquor Regulation on the regulation of the gambling and liquor industries, problem gambling and harm minimisation in relation to liquor and gambling.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Liquor applications and licensee monitoring activities	number	38 480	37 520	38 480	38 717
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Liquor and gambling applications and licensee monitoring activities (VCGLR)' to separate application and licence type for increased transparency and to reflect revised regulatory arrangements. *The previously published aggregated 2020-21 actual of 51 012 and 2021-22 target of 50 000 have been restated to reflect these revised arrangements.*					
Gambling applications and licensee monitoring activities	number	11 520	11 550	11 520	12 295
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Liquor and gambling applications and licensee monitoring activities (VCGLR)' to separate application and licence type for increased transparency and to reflect revised regulatory arrangements. *The previously published aggregated 2020-21 actual of 51 012 and 2021-22 target of 50 000 have been restated to reflect these revised arrangements.*					
Liquor information and advice	number	102 400	106 000	102 400	118 351
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Liquor and gambling information and advice (VCGLR)' to separate information and advice type for increased transparency and to reflect revised regulatory arrangements. *The previously published aggregated 2020-21 actual of 147 938 and 2021-22 target of 128 000 have been restated to reflect these revised arrangements.*					
Gambling information and advice	number	25 600	27 000	25 600	29 587
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Liquor and gambling information and advice (VCGLR)' to separate information and advice type for increased transparency and to reflect revised regulatory arrangements. *The previously published aggregated 2020-21 actual of 147 938 and 2021-22 target of 128 000 have been restated to reflect these revised arrangements.* *The 2021-22 expected outcome is higher than the 2021-22 target due to increased enquiries from industry, attributed to the dynamic environment with respect to COVID-19 restrictions, industry support programs, and legislative reform.*					
Liquor inspections completed – metropolitan	number	5 400	3 503	5 400	6 417
This performance measure renames the 2021-22 performance measure 'Liquor inspections completed by the VCGLR – metropolitan' to reflect revised regulatory arrangements. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions.*					
Liquor inspections completed – regional	number	1 500	609	1 500	833
This performance measure renames the 2021-22 performance measure 'Liquor inspections completed by the VCGLR – regional' to reflect revised regulatory arrangements. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions.*					
Gambling inspections completed – metropolitan	number	1 350	672	1 350	1 009
This performance measure renames the 2021-22 performance measure 'Gambling inspections completed by the VCGLR – metropolitan' to reflect revised regulatory arrangements. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions.*					
Gambling inspections – regional	number	250	107	250	123
This performance measure renames the 2021-22 performance measure 'Gambling inspections completed by the VCGLR – regional' to reflect revised regulatory arrangements. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Mainstream Gambler's Help client service hours provided by therapeutic and financial counselling activities (VRGF)	number	75 400	75 400	75 400	70 245
Increased access to digital information by the community and stakeholders who have an interest in gambling harm (VRGF)	number	654 885	623 000	623 000	682 600
The higher 2022-23 target reflects changes in demand for information about gambling during COVID-19 restrictions and further optimisation of digital activity via search, display and social media channels.					
Operations with co-regulators to identify licensees supplying alcohol to minors or persons who are intoxicated – Metropolitan	number	15	5	15	0
This performance measure renames the 2021-22 performance measure 'Operations with co-regulators to identify licensees supplying alcohol to minors or persons who are intoxicated – Metropolitan' (VCGLR)' to reflect revised regulatory arrangements. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions.*					
Operations with co-regulators to identify licensees supplying alcohol to minors or persons who are intoxicated – Regional	number	5	3	5	2
This performance measure renames the 2021-22 performance measure 'Operations with co-regulators to identify licensees supplying alcohol to minors or persons who are intoxicated – Regional' (VCGLR)' to reflect revised regulatory arrangements. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions.*					
Audits of casino operations undertaken	number	1 260	791	1 260	634
This performance measure renames the 2021-22 performance measure 'Audits of casino operations undertaken by the VCGLR' to reflect revised regulatory arrangements. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions.*					
Quality					
Liquor licensing client satisfaction	per cent	85	85	85	84
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Liquor and gambling licensing client satisfaction (VCGLR)'. The new performance measure is the same as the previous measure except is disaggregated by licence type for increased transparency and to reflect revised regulatory arrangements.					
Gambling licensing client satisfaction	per cent	85	85	85	84
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Liquor and gambling licensing client satisfaction (VCGLR)'. The new performance measure is the same as the previous measure except is disaggregated by licence type for increased transparency and to reflect revised regulatory arrangements.					
Liquor inspections conducted at high risk times	per cent	12	8.15	11.5	6.38
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Liquor and gambling inspections conducted at high risk times (VCGLR)' to reflect revised regulatory arrangements. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions.* *The 2022-23 target reflects these revised arrangements.*					
Gambling inspections conducted at high risk times	per cent	12	0.45	0.5	0.53
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Liquor and gambling inspections conducted at high risk times (VCGLR)' to reflect revised regulatory arrangements. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions.* *The 2022-23 target reflects these revised arrangements.*					
Proportion of high harm liquor breaches resulting in regulatory action	per cent	95	95	95	nm
This performance measure renames the 2021-22 performance measure 'Proportion of high harm breaches resulting in regulatory action (VCGLR)' to reflect revised regulatory arrangements.					
Proportion of high harm gambling breaches resulting in regulatory action	per cent	95	nm	nm	nm
New performance measure for 2022-23 to reflect priorities of the new gambling regulator.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Timeliness					
Calls to VGCCC client services answered within 60 seconds	per cent	80	80	80	54.7
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Calls to VCGLR client services answered within 60 seconds' to reflect revised regulatory arrangements.					
Calls to liquor regulator client services answered within 60 seconds	per cent	80	80	80	54.7
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Calls to VCGLR client services answered within 60 seconds' to reflect revised regulatory arrangements.					
Gamblers Help Service clients who receive a service within five days of referral (VRGF)	per cent	96	96	96	98.4
Liquor approvals, licence, permit applications and variations completed within set time	per cent	85	85	85	95.3
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Liquor and gambling approvals, licence, permit applications and variations completed within set time (VCGLR)'. The new performance measure is the same as the previous measure except is disaggregated by type for increased transparency and to reflect revised regulatory arrangements.					
Gambling approvals, licence, permit applications and variations completed within set time	per cent	85	85	85	81.3
This performance measure is disaggregated in 2022-23 from the previous performance measure 'Liquor and gambling approvals, licence, permit applications and variations completed within set time (VCGLR)'. The new performance measure is the same as the previous measure except is disaggregated by type for increased transparency and to reflect revised regulatory arrangements.					
Cost					
Total output cost	$ million	80.8	86.7	79.9	88.0
The higher 2022-23 target mainly reflects funding for initiatives announced in the 2022-23 Budget *for the Supporting the Office of the Victorian Information Commissioner and Royal Commission into the Management of Police Informants.*					

Source: Department of Justice and Community Safety

DEPARTMENT OF PREMIER AND CABINET

Ministerial portfolios

The Department supports the ministerial portfolios of the Premier, Aboriginal Affairs, Government Services, and Industrial Relations.

Departmental mission statement

The Department of Premier and Cabinet's mission is to support the people of Victoria by:

- helping government achieve its strategic objectives
- providing leadership to the public sector to improve its effectiveness
- promoting collaboration across government to drive performance and improve outcomes.

Departmental objectives

Strong policy outcomes

- Pursue policy and service delivery excellence and reform.
- Lead the public sector response to significant state issues, industrial relations, policy challenges and projects.
- Support the effective delivery of government services through digital platforms.

First Peoples in Victoria are strong and self-determining

- Improve outcomes and services for First Peoples through prioritising actions to enable self-determination, including advancing treaty, protecting and promoting cultural rights and responding to and engaging with the Yoo-rrook Justice Commission.
- Address trauma and support healing; address racism established through colonisation.
- Provide culturally safe systems and services and transfer power and resources to communities.

Professional public administration

- Foster and promote a high-performing public service.
- Ensure effective whole of government performance and outcomes and support the effective administration of government.
- Protect the values of good governance, integrity and accountability to foster and maintain public trust in government.

Changes to the output structure

The Department has made changes to its output structure for 2022-23, in addition to the machinery of government changes reflected in Table 2.1, as shown in the table below.

2021-22 outputs	*Reason*	*2022-23 outputs*
Government-wide leadership, reform and implementation	Disaggregation of output groups to more accurately reflect service delivery, improve accountability and better align with standard output practice across government.	• Social policy advice and intergovernmental relations • Economic policy advice and support • Executive Government advice and services • Digital strategy and transformation
Strategic advice and government support	Disaggregation of output groups to more accurately reflect service delivery, improve accountability and better align with standard output practice across government.	• Social policy advice and intergovernmental relations • Economic policy advice and support • Executive Government advice and services • Digital strategy and transformation
Digital government and communications	Renamed to more accurately reflect service delivery.	Digital strategy and transformation
Aboriginal policy, strengthening Aboriginal cultural heritage and communities	Disaggregation of output groups to more accurately reflect service delivery, improve accountability and better align with standard output practice across government.	• Self-determination policy and reform advice and programs • Traditional owner engagement and cultural heritage management programs
Advice and support to the Governor	Aggregation of output groups to more accurately reflect service delivery, improve accountability and better align with standard output practice across government.	Executive Government advice and services
Public administration advice and support	Renamed to more accurately reflect service delivery.	Public sector administration advice and support

Source: Department of Premier and Cabinet

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2021-22 budget	*2021-22 revised*	*2022-23 budget*	*Variation [(a)] %*
Government-wide leadership, reform and implementation	80.2	na	na	na
Strategic advice and government support	123.2	na	na	na
Advice and support to the Governor	12.7	na	na	na
Strong policy outcomes				
Economic policy and support	na	37.6	34.4	na
Social policy advice and intergovernmental relations	na	23.1	19.7	na
Digital strategy and transformation	91.2	154.2	115.7	26.9
Office of the Victorian Government Architect	1.2	1.3	0.7	(41.7)
Industrial relations	27.3	25.7	35.7	30.8
First Peoples in Victoria are strong and self-determining				
Aboriginal policy, strengthening Aboriginal cultural heritage and communities	99.8	na	na	na
Self-determination policy and reform advice and programs	na	93.5	75.1	na
Traditional owner engagement and cultural heritage management programs	na	21.3	36.6	na
Professional public administration				
Executive government advice and services	na	151.8	126.8	na
Public sector administration advice and support	15.6	26.6	23.5	50.6
Chief Parliamentary Counsel services	7.9	9.3	9.7	22.8
Management of Victoria's public records	11.6	12.8	12.8	10.3
State electoral roll and electoral events	42.6	51.4	117.3	175.4
Total [(b)(c)]	**513.2**	**608.4**	**608.1**	**18.5**

Source: Department of Premier and Cabinet

Notes:

(a) Variation between 2021-22 budget and 2022-23 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant outputs.

(b) Some outputs listed with output costs in the '2021-22 budget' figures no longer apply as they were subsequently restructured into new outputs after the release of the 2021-22 Budget*. The associated output costs were reapportioned across DPC's restructured outputs in the '2021-22 revised' and '2022-23 budget' figures.*

(c) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.14 outlines the Department's income from transactions and Table 2.15 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.14: Income from transactions **($ million)**

	2020-21 actual	*2021-22 budget*	*2021-22 revised*	*2022-23 budget*
Output appropriations	531.9	470.0	556.4	490.2
Special appropriations	75.5	43.1	51.9	117.9
Interest	0.8	1.5	0.8	0.8
Sale of goods and services	177.6	186.8	209.3	217.8
Grants	27.7	3.2	4.1	4.2
Other income	119.1	1.4	1.0	1.0
Total income from transactions [(a)]	**932.5**	**706.0**	**823.5**	**831.8**

Source: Department of Premier and Cabinet

Note:
(a) Table may not add due to rounding.

Table 2.15: Parliamentary authority for resources **($ million)**

	2021-22 budget	*2021-22 revised*	*2022-23 budget*
Annual appropriations	**469.3**	**682.0**	**502.7**
Provision of outputs	456.5	655.7	489.4
Additions to the net asset base	12.8	26.3	13.3
Payments made on behalf of the State	..	..	..
Receipts credited to appropriations	**0.8**	**0.8**	**0.8**
Unapplied previous years appropriation	**12.8**	**8.6**	**..**
Provision of outputs	12.8	8.6	..
Additions to the net asset base	..	..	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**482.8**	**691.4**	**503.4**
Special appropriations	**61.5**	**71.3**	**141.8**
Trust funds	**10.0**	**20.3**	**11.4**
Departmental Suspense Account [(a)]	5.9	5.9	5.9
Treasury Trust Fund [(b)]	2.6	..	..
Other [(c)]	1.5	14.3	5.4
Total parliamentary authority [(d)]	**554.3**	**783.0**	**656.6**

Source: Department of Premier and Cabinet

Notes:
(a) This account is a departmental working account.
(b) The purpose of this trust primarily relates to facilitating the exchange of unclaimed monies and other funds held in trust.
(c) Includes interdepartmental transfers.
(d) Table may not add due to rounding.

Departmental performance statement

Objective 1: Strong policy outcomes

This objective pursues policy and service excellence and reform. It leads the public sector response to significant state issues, workplace relations, policy challenges and projects. It supports the delivery of policy and projects that enables increased productivity and improved social outcomes in Victoria.

The departmental objective indicators are:

- growth in economic investment and jobs[(a)]
- the development and effective use of technology supports productivity and competitiveness
- advice contributes to the achievement of government policies and priorities relating to economic and social outcomes, emergency management, significant architectural projects, industrial relations and use of digital platforms for government service delivery[(a)].

Note:
(a) New objective indicator for 2022-23 to provide better insight into the DPC objective of 'Strong policy outcomes'.

Outputs

Economic policy advice and support (2022-23: $34.4 million)

This output contributes to the delivery of strategic, timely and comprehensive analysis and advice on economic policy to support government decision making.

This output also contributes to strengthening Victoria's economic performance through the activities of Breakthrough Victoria and the Victorian Jobs and Investment Fund.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actuals*
Quantity					
Companies and consortia supported by the Breakthrough Victoria Fund	number	10	5	5	nm
The higher 2022-23 target reflects that Breakthrough Victoria Pty Ltd is now fully established, with a permanent CEO and executive team. It replaces a lower target in 2020-21, which reflected its first year of operation. *This performance measure is transferred directly from the 2021-22 output 'Government-wide leadership, reform and implementation'.*					
New investment resulting from government facilitation services and assistance under the Victorian Jobs and Investment Fund	$ million	150	400	120	380
The 2021-22 expected outcome is higher than the 2021-22 target due to a small number of high capital expenditure projects. *The higher 2022-23 target reflects the expected outcome of the fund based on its performance over the past two years.* *This performance measure is a whole of government target with relevant activities across departments (Department of Premier and Cabinet, Department of Jobs, Precincts and Regions, Invest Victoria) contributing to the performance measure.* *This performance measure is transferred directly from the 2021-22 output 'Government-wide leadership, reform and implementation'.*					

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actuals
Jobs resulting from government facilitation services and assistance under the Victorian Jobs and Investment Fund	number	2 000	2 000	2 000	2 569
This performance measure is a whole of government target with relevant activities across departments (Department of Premier and Cabinet, Department of Jobs, Precincts and Regions, Invest Victoria) contributing to the performance measure. This performance measure is transferred directly from the 2021-22 output 'Government-wide leadership, reform and implementation'.					
Quality					
Key stakeholder satisfaction with advice and support relating to economic policy	per cent	85	nm	nm	nm
New performance measure for 2022-23 to reflect key stakeholder satisfaction with the quality of economic policy advice and support.					
Timeliness					
Provision of economic policy briefings within agreed timeframes	per cent	85	nm	nm	nm
New performance measure for 2022-23 to reflect the completion of economic policy briefings within agreed timeframes.					
Cost					
Total output cost	$ million	34.4	37.6	na	na
New performance measure following changes to the output structure to better reflect the activities undertaken by the department. As a result, information on the 2020-21 actual is not available. *The 2021-22 expected outcome has been restated to reflect the revised departmental output structure and apportionment of enabling costs across all outputs. The 2021-22 target is not applicable as the output was not published in the* 2021-22 Budget *and was created after the publication was released.* *The lower 2022-23 target reflects the funding profile for initiatives following the disaggregation of the 2021-22 'Government-wide leadership, reform and implementation' and 'Strategic advice and government support' outputs.*					

Source: Department of Premier and Cabinet

Social policy advice and intergovernmental relations (2022-23: $19.7 million)

This output contributes to the delivery of strategic, timely and comprehensive analysis and advice on social policy to support government decision making.

This output also contributes to the strategic coordination of emergency management strategies and planning across the Victorian public sector.

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quantity					
Whole of Government emergency management forums, meetings and exercises facilitated	number	20	230	20	218
The 2021-22 expected outcome is higher than the 2021-22 target due to the activities of the Coordinating Ministers Committee of Cabinet which was not accounted for in the target. *This performance measure is transferred directly from the 2021-22 output 'Government-wide leadership, reform and implementation'.*					
Quality					
Key stakeholder satisfaction with advice and support relating to social policy	number	85	nm	nm	nm
New performance measure for 2022-23 to reflect key stakeholder satisfaction with the quality of social policy advice and support.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Timeliness					
Provision of social policy briefings within agreed timeframes.	per cent	85	nm	nm	nm
This new performance measure replaces the 2021-22 performance measure 'Policy services timeliness rating' reflecting the completion of social policy briefings within agreed timeframes.					
Cost					
Total output cost	$ million	19.7	23.1	na	na
New performance measure following changes to the output structure to better reflect the activities undertaken by the department. As a result, information on the 2020-21 actual is not available.					
The 2021-22 expected outcome has been restated to reflect the revised departmental output structure and apportionment of enabling costs across all outputs. The 2021-22 target is not applicable as the output was not published in the 2021-22 Budget *and was created after the publication was released.*					
The lower 2022-23 target reflects the funding profile for initiatives following the disaggregation of the 2021-22 'Government-wide leadership, reform and implementation' and 'Strategic advice and government support' outputs.					

Source: Department of Premier and Cabinet

Digital strategy and transformation (2022-23: $115.7 million)

This output contributes to continued innovation in digital technology to improve whole of government service delivery and business processes.

This output also contributes to the digital delivery of information and services to Victorian citizens and businesses.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Average number of monthly visits to www.vic.gov.au	number	375 000	509 587	356 000	1 043 658
The 2021-22 expected outcome is higher than the 2021-22 target due to the growth in users seeking coronavirus support and information.					
The higher 2022-23 target reflects increased traffic to the website due to the community's increased need for COVID-19 information.					
Existing Victorian Government department or entity websites transitioned, or new websites built, on the Single Digital Presence Platform	number	30	49	49	23
The lower 2022-23 target reflects the number of known website transitions that have been forecast for the two-year program.					
Average number of monthly visits to Data.Vic	number	22 000	65 000	22 000	nm
The 2021-22 expected outcome is higher than the 2021-22 target due to the growth in users seeking coronavirus open data.					
Number of VPS active users in the Data Directory	number	250	250	250	nm
Government entities reporting cyber maturity	number	75	148	75	na
The 2021-22 expected outcome is higher than the 2021-22 target due the voluntary uptake of training by public sector organisations.					
Government board members trained on Cyber Security	number	60	60	60	58

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Digital Victoria: Milestones delivered in accordance with agreed budget and timeline	per cent	75	100	75	80
New Victorian Government entities using the Standard User Experience Framework	number	40	80	25	74a
The 2021-22 expected outcome is higher than the 2021-22 target due to promotional and training activities that lead to increased demand and engagement. *The higher 2022-23 target reflects the increasing demand across the Victorian public service to better understand human centred design methods, which is reflected in new users to the Framework.* *This performance measure renames the 2021-22 performance measure 'Victorian Government entities using the Standard User Experience Framework'. The new measure reports on the same activity and has been amended for increased clarity.*					
Number of data sharing arrangements enabled by Victorian Centre for Data Insights (VCDI)	number	15	30	15	26
The 2021-22 expected outcome is higher than the 2021-22 target due to the demand for data for the COVID-19 response, including interjurisdictional data agreements. *This performance measure is transferred directly from the 2021-22 output 'Government wide leadership, reform and implementation'.*					
Average monthly analysis reports generated to guide government decision making	number	65	120	65	102
The 2021-22 expected outcome is higher than the 2021-22 target due to the growth in demand across the government responding to COVID-19. *This performance measure is transferred directly from the 2021-22 output 'Digital government and communications'.*					
Establishment or renewal of ICT whole of government State Purchase Contracts	number	6	6	6	6
This performance measure is transferred directly from the 2021-22 output 'Strategic advice and government support'.					
Number of new services Service Victoria delivers	number	20	nm	nm	nm
New performance measure for 2022-23 to better reflect the service being delivered.					
Volume of activities delivered by Service Victoria	number	25 000 000	nm	nm	nm
New performance measure for 2022-23 to better reflect the service being delivered.					
Average cost per activity delivered by Service Victoria	$	4	nm	nm	nm
New performance measure for 2022-23 to better reflect the service being delivered.					
Quality					
Overall satisfaction of customers completing a transaction on the Service Victoria digital customer platform	per cent	95	95	95	96
VCDI satisfaction rating	per cent	70	85	70	86
The 2021-22 expected outcome is higher than the 2021-22 target due to the higher than anticipated engagement with VCDI during 2021-22. *This performance measure is transferred directly from the 2021-22 output 'Government wide leadership, reform and implementation'.*					
Timeliness					
VCDI: Proportion of data published on agreed cadence	per cent	80	95	80	nm
The 2021-22 expected outcome is higher than the 2021-22 target due to the demand for timely COVID-19 related data for decision making and communications. *This performance measure is transferred directly from the 2021-22 output 'Government wide leadership, reform and implementation'.*					

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Cost					
Total output cost	$ million	115.7	154.2	91.2	81.3
The 2021-22 expected outcome has been restated to reflect the revised departmental output structure and apportionment of enabling costs across all outputs.					
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to funding provided for government policy commitments related to the COVID-19 response and funding released from contingency for Digital Victoria.					
The higher 2022-23 target primarily reflects funding provided for government policy commitments.					

Source: Department of Premier and Cabinet

Office of the Victorian Government Architect (2022-23: $0.7 million)

This output provides strategic leadership and advice to government and key stakeholders on architecture and the built environment.

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quantity					
Strategic advice provided to government on significant projects in the built environment	number	85	80	80	110
The higher 2022-23 target reflects expected outcomes based on average performance over the past five years.					
Quality					
Stakeholder satisfaction with the quality of strategic advice provided on significant projects in the built environment	per cent	80	80	80	100
This performance measure renames the 2021-22 performance measure 'Strategic advice on significant public and private sector projects from project inception and procurement to design and delivery' so it is more easily understood.					
Timeliness					
Formal advice issued within 10 business days	per cent	95	nm	nm	nm
This performance measure renames the 2021-22 performance measure 'Average number of business days to issue formal advice' and edits the unit of measure from days to per cent. The new measure reports on the same activity and has been amended for increased clarity.					
Cost					
Total output cost	$ million	0.7	1.3	1.2	1.2
The lower 2022-23 target reflects savings applied as part of the department's acquittal of whole of government efficiencies.					

Source: Department of Premier and Cabinet

Industrial Relations (2022-23: $35.7 million)

This output contributes to promoting fair jobs and a positive industrial relations environment through sound industrial relations policy and advice to government. This includes oversight of enterprise bargaining across the Victorian public sector and support for Victoria's participation in the national workplace relations system.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Employers informed on OH&S obligations under both State and Commonwealth legislation and regulations	number	>3 500	3 500	>3 500	9 375
Workers informed on OH&S obligations under both State and Commonwealth legislation and regulations	number	>40 000	40 000	>40 000	41 200
Child employment investigations completed	number	200	170	170	171
The higher 2022-23 target reflects the number of investigations that are currently in progress and known upcoming investigations.					
Quality					
Public sector agreements renewed and approved within current enterprise bargaining framework	per cent	100	100	100	100
Victoria represented in major industrial relations cases and inquiries	per cent	100	100	100	100
Timeliness					
Review and assessment of submitted public sector enterprise bargaining costings and proposed agreements completed and submitted for approval within four weeks	per cent	90	90	90	97.7
Long Service leave investigations completed within 90 days of lodgement	per cent	25	80	15	80
The 2021-22 expected outcome is higher than the 2021-22 target due to internal business improvements which have delivered timelier outcomes of regulatory operations.					
The higher 2022-23 target reflects the expected outcome based on performance over the past two years.					
Cost					
Total output cost	$ million	35.7	25.7	27.3	20.2
The 2021-22 expected outcome, 2021-22 target and 2020-21 actual have been restated to reflect the revised departmental output structure and apportionment of enabling costs across all outputs.					
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the rephase of funding from 2021-22 to 2022-23 for Wage Inspectorate Victoria and the 'Better supports for on-demand or gig workers in Victoria' initiatives.					
The higher 2022-23 target primarily reflects funding announced in the 2022-23 Budget.					

Source: Department of Premier and Cabinet

Objective 2: First Peoples in Victoria are strong and self-determining

This objective focuses on improving outcomes and services for First Peoples through prioritising actions to enable self-determination, including advancing treaty, protecting and promoting cultural rights and engaging with and responding to the Yoo-rrook Justice Commission. It addresses trauma and supports healing; addresses racism established through colonisation; and provides culturally safe systems and services. It also transfers power and resources to communities.

The departmental objective indicator is:

- First Peoples in Victoria have increased control over decisions that impact their lives.

Outputs

Self-determination policy and reform advice and programs

(2022-23: $75.1 million)

This output supports the Victorian Government's commitment to self-determination for First Peoples and to improving long-term social and economic outcomes. This includes progress towards Treaty; engaging with the Yoo-rrook Justice Commission; and work to reform government to enable self-determination, as well as undertaking outcomes-focused reporting across the portfolio.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of Assembly and/or State-Assembly meetings held	number	40	55	40	65
The 2021-22 expected outcome is higher than the 2021-22 target due to greater than anticipated treaty negotiation meetings.					
This performance measure is transferred directly from the 2021-22 output 'Aboriginal policy, strengthening Aboriginal cultural heritage and communities'.					
Quality					
Government stakeholder satisfaction with coordination of Victorian Government's response to the Yoo-rrook Justice Commission	per cent	80	nm	nm	nm
New performance measure for 2022-23 to reflect the establishment of the Yoo-rrook Justice Commission.					
Completion of an Aboriginal-led evaluation and review of government performance under the Victorian Aboriginal Affairs Framework 2018-2023 and the National Agreement on Closing the Gap	number	1	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Funding payments for Aboriginal community initiatives made in accordance with milestones' to better reflect the engagement between government and Aboriginal communities to progress self-determination. DPC's ability to manage grant payments for several initiatives is reflected through other performance measures, for example 'Funding recipients report that the achievement of program objectives is supported by DPC's role in the funding relationship'.					

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Timeliness					
Delivery of a public report on outcomes for Aboriginal Victorians to be tabled in parliament by 30 June each financial year	number	1	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Delivery of a public report on outcomes for Aboriginal Victorians to be tabled in parliament' to achieve a balanced set of quantity, quality, timeliness, and cost measures across the new output 'Self-determination policy, reform advice and programs'.					
The performance measure edits the classification from quantity to timeliness.					
This performance measure was transferred directly from the 2021-22 output 'Aboriginal policy, strengthening Aboriginal cultural heritage and communities'.					
Cost					
Total output cost	$ million	75.1	93.5	na	na
New performance measure following changes to the output structure to better reflect the activities undertaken by the department. As a result, information on the 2020-21 actual is not available.					
The 2021-22 expected outcome has been restated to reflect the revised departmental output structure and apportionment of enabling costs across all outputs. The 2021-22 target is not applicable as the output was not published in the 2021-22 Budget *and was created after the publication was released.*					
The lower 2022-23 target primarily reflects the lapsing stimulus funding.					

Source: Department of Premier and Cabinet

Traditional owner engagement and cultural heritage management programs (2022-23: $36.6 million)

This output supports the government's commitment to protecting Aboriginal cultural rights, including supporting Traditional Owners and First Peoples organisations to deliver self-determined initiatives for their communities. This includes the protection and management of Aboriginal cultural heritage; and strengthening Aboriginal community organisations.

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quantity					
Capacity building activities provided for Traditional Owners to support the management and protection of Aboriginal cultural and intangible heritage	number	16	16	16	10
This performance measure is transferred directly from the 2021-22 output 'Aboriginal policy, strengthening Aboriginal cultural heritage and communities'.					
Average weekly hours of case management provided to members of the Stolen Generations	number	80	82	80	125
This performance measure is transferred directly from the 2021-22 output 'Aboriginal policy, strengthening Aboriginal cultural heritage and communities'.					
Number of family history investigations conducted by the Victorian Koorie Family History Service on behalf of members of the Stolen Generations	number	240	367	240	353
The 2021-22 expected outcome is higher than the 2021-22 target due to increased demand for family history investigations ahead of the establishment of the Stolen Generations Reparations Scheme.					
This performance measure is transferred directly from the 2021-22 output 'Aboriginal policy, strengthening Aboriginal cultural heritage and communities'.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Removal of first mortgages on titles of property owned by Aboriginal Community-Controlled Organisations	number	4	4	4	6
This performance measure is transferred directly from the 2021-22 output 'Aboriginal policy, strengthening Aboriginal cultural heritage and communities'.					
Quality					
The service provision of the Office of the Victorian Aboriginal Heritage Council enables the Victorian Aboriginal Heritage Council to undertake its statutory responsibilities	per cent	80	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Victorian Aboriginal Heritage Council meetings conducted within legislative timeframes' to enable more meaningful comparison of performance over time. *This performance measure is transferred directly from the 2021-22 output 'Aboriginal policy, strengthening Aboriginal cultural heritage and communities'.*					
Funding recipients report that the achievement of program objectives is supported by DPC's role in the funding relationship	per cent	80	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Funding payments for Aboriginal cultural heritage protection initiatives, sector support and nation building made in accordance with milestones' to enable more meaningful comparison of performance over time. *This performance measure is transferred directly from the 2021-22 output 'Aboriginal policy, strengthening Aboriginal cultural heritage and communities'.*					
Timeliness					
Average days to process applications to register an Aboriginal Cultural Heritage Place (CHMP-related) on the Victorian Aboriginal Cultural Heritage Register	days	60	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Assessments completed by Aboriginal Victoria within legislative timeframe–cultural heritage management plans, cultural heritage permits, preliminary Aboriginal heritage tests' to enable more meaningful comparison of performance over time. *This performance measure is transferred directly from the 2021-22 output 'Aboriginal policy, strengthening Aboriginal cultural heritage and communities'.*					
Cost					
Total output cost	$ million	36.6	21.3	na	na
New performance measure following changes to the output structure to better reflect the activities undertaken by the department. As a result, information on the 2020-21 actual is not available. *The 2021-22 expected outcome has been restated to reflect the revised departmental output structure and apportionment of enabling costs across all outputs. The 2021-22 target is not applicable as the output was not published in the 2021-22 Budget and was created after the publication was released.* *The higher 2022-23 target primarily reflects funding announced in the* 2022-23 Budget.					

Source: Department of Premier and Cabinet

Objective 3: Professional public administration

This objective fosters and promotes a high-performing public service. It ensures effective whole of government performance and outcomes. It protects the integrity and values of good governance to foster and maintain public trust in government.

The departmental objective indicators are:

- support for Cabinet, committee members and Executive Council are valued and inform decision making[(a)]
- agency compliance with government advertising and communication guidelines[(a)]
- Victoria's electoral system is supported by an accurate and secure electoral roll, electoral services and conduct of fair and impartial elections[(a)]
- provision of high-quality advice to support evidence-based decisions that drive the progress of Victoria socially and economically as assessed by feedback from key stakeholders[(b)]
- provision of high-quality legislative drafting and publication services[(a)]
- advice contributes to the achievement of government policies and priorities relating to records management, Victoria's electoral system, executive and parliamentary remuneration and public sector governance[(a)].

Notes:

(a) New objective indicator for 2022-23 to provide better insight into the DPC objective of 'Professional public administration'.

(b) New objective indicator for 2022-23 replacing the previous objective indicator 'a values-driven, high-integrity public service characterised by employees who collaborate across government and in partnership with the community and other sectors, and who use evidence to support decisions that drive progress of Victoria socially and economically' to provide better insight into the DPC objective of 'Professional public administration'.

Outputs

Executive Government advice and services (2022-23: $126.8 million)

This output contributes to the provision of strategic, timely and comprehensive support to Cabinet and Cabinet Sub-Committees.

This output also contributes to the provision of support to the Governor and maintenance of Government House and its collections as a heritage asset of national importance.

This output also contributes to the delivery of analysis and advice to support evidence-based decision making across the public sector.

This output also contributes to the provision of whole of government community engagement and communications activity.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Whole of government forums, meetings and advisory groups chaired	number	85	74	85	77
The 2021-22 expected outcome is lower than the 2021-22 target due to fewer meetings being chaired. *This performance measure is transferred directly from the 2021-22 output 'Government-wide leadership, reform and implementation'.*					
Number of briefs supporting Cabinet and Cabinet committee decision making	number	1 200	1 600	1 200	1 806
The 2021-22 expected outcome is higher than the 2021-22 target due an increase in meetings to address the COVID-19 pandemic response. *This performance measure is transferred directly from the 2021-22 output 'Strategic advice and government support'.*					
Office of the Governor: Increase in the annual number of guests and visitors to Government House	per cent	5	5	5	(70)
This performance measure renames 'Increase in the annual number of guests and visitors to Government House'. *This performance measure is transferred directly from the 2021-22 output 'Advice and support to the Governor'.*					
Number of projects and advisory support provided to departments facilitated by the Behavioural Insights Unit	number	60	100	60	10
The 2021-22 expected outcome is higher than the 2021-22 target due to a higher than anticipated volume of COVID-19 requests. *This performance measure is transferred directly from the 2021-22 output 'Government-wide leadership, reform and implementation'.*					
Quality					
Office of the Governor: Government House accessibility and useability meets standards in asset management strategy	per cent	79	80	79	79
This performance measure renames the 2021-22 performance measure 'Maintenance of Government House in accordance with the asset management strategy'. The new measure reports on the same activity as the previous measure however it has been amended for increased clarity. *This performance measure is transferred directly from the 2021-22 output 'Advice and support to the Governor'.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Office of the Governor: Government House gardens and grounds meet standards in asset management strategy	per cent	85	85	85	85
This performance measure renames the 2021-22 performance measure 'Standard, physical appearance of gardens and grounds in accordance with contract key performance indicators'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.					
This performance measure is transferred directly from the 2021-22 output 'Advice and support to the Governor'.					
Satisfaction with services provided by the Behavioural Insights Unit to government agencies	per cent	70	80	70	nm
The 2021-22 expected outcome is higher than the 2021-22 target due to the higher than anticipated engagement with the Behavioural Insights Unit during 2021-22.					
This performance measure is transferred directly from the 2021-22 output 'Government-wide leadership, reform and implementation'.					
Relevant communication activity compliant with government advertising and communication guidelines	per cent	100	100	100	100
This performance measure is transferred directly from the 2021-22 output 'Government-wide leadership, reform and implementation'.					
Timeliness					
Office of the Governor: Support the Governor's community engagement activities by arranging all internal and external events in a timely manner	per cent	100	100	100	100
This performance measure renames the 2021-22 performance measure 'Support the Governor's community engagement activities by arranging all internal and external events in a timely manner'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.					
This performance measure is transferred directly from the 2021-22 output 'Advice and support to the Governor'.					
Timely delivery of State events and functions	per cent	100	100	100	100
This performance measure is transferred directly from the 2021-22 output 'Strategic advice and government support'.					
Cost					
Total output cost	$ million	126.8	151.8	na	na
New performance measure following changes to the output structure to better reflect the activities undertaken by the department. As a result, information on the 2020-21 actual is not available.					
The 2021-22 expected outcome has been restated to reflect the revised departmental output structure and apportionment of enabling costs across all outputs. The 2021-22 target is not applicable as the output was not published in the 2021-22 Budget *and was created after the publication was released.*					

Source: Department of Premier and Cabinet

Public sector administration advice and support (2022-23: $23.5 million)

This output provides advice and support on issues relevant to public sector administration, Members of Parliament and executive officer remuneration, governance, service delivery and workforce matters, as well as to public sector professionalism and integrity. It includes related research, determinations, data collection, reporting and dissemination of information.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
VPSC: Percentage of new to VPS executives participating in the induction program	per cent	78	93	78	92
The 2021-22 expected outcome is higher than the 2021-22 target due to fewer than anticipated program withdrawals. *This performance measure renames the 2021-22 performance measure 'Percentage of new-to-VPS executives participating in the VPSC induction program'. The new measure reports on the same activity as the previous measure but has been amended for increased clarity.*					
VPSC: Percentage of VPS jobs advertised through the Jobs and Skills Exchange	per cent	90	85	90	88.2
This performance measure renames the 2021-22 performance measure 'Percentage of VPS jobs advertised through the Jobs and Skills Exchange'. The new measure reports on the same activity as the previous measure but has been amended for increased clarity. *The 2021-22 expected outcome is lower than the 2021-22 target due to positions being readvertised through other platforms when a candidate could not be found through the Jobs and Skills Exchange.*					
VPSC: Number of engagement and promotional activities undertaken by the Jobs and Skills Exchange	number	20	69	20	12
This performance measure renames the 2021-22 performance measure 'Number of engagement and promotion activities undertaken by the Jobs and Skills Exchange'. The new measure reports on the same activity as the previous measure but has been amended for increased clarity. *The 2021-22 expected outcome is higher than the 2021-22 target due to the successful internal promotion of the platform and targeted advertising.*					
Quality					
Key stakeholder satisfaction with advice and support relating to public administration and whole of government governance	per cent	90	nm	nm	nm
New performance measure for 2022-23 to measure key stakeholder satisfaction with the quality of advice and support DPC provides on whole of government governance policy.					
Stakeholder satisfaction with the Remuneration Tribunal's process regarding determinations, reviews, and advice	per cent	80	80	80	75
VPSC: Percentage of agencies that indicated that VPSC advice assisted in improving their integrity capability	per cent	90	90	90	90
This performance measure renames the 2021-22 performance measure 'Percentage of agencies who interacted with VPSC and who indicated VPSC advice and support assisted them to improve integrity capability'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.					
VPSC: Overall satisfaction with engagement, consultation, and responsiveness from the GRADS team	per cent	85	85	85	87
This performance measure renames the 2021-22 performance measure 'Overall satisfaction with engagement, consultation and responsiveness from the VPSC GRADS team'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.					

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
VPSC: Satisfaction with responses to user queries on the Jobs and Skills Exchange platform	per cent	80	89	80	91
This performance measure renames the 2021-22 performance measure 'Satisfaction with response to user queries on the Jobs and Skills Exchange platform'. The new measure reports on the same activity as the previous measure but has been amended for increased clarity.					
The 2021-22 expected outcome is higher than the 2021-22 target due to internal improvements in procedures and technical improvements to the platform.					
Timeliness					
Tribunal's legislated work program delivered within established timeframes	per cent	85	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Advice from the Remuneration Tribunal provided within 15 working days of receipt of submission'.					
VPSC: Percent of process completion of Victorian public sector annual workforce data by the end of February each year	per cent	95	100	95	94
This performance measure renames the 2021-22 performance measure 'Percentage of collection, validation and reporting of Victorian public sector annual workforce data completed by the end of February each year'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.					
Cost					
Total output cost	$ million	23.5	26.6	15.6	14.7
The 2021-22 expected outcome has been restated to reflect the revised departmental output structure and apportionment of enabling costs across all outputs.					
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to funding provided for government policy commitments relating to service delivery efficiency and effectiveness.					
The higher 2022-23 target primarily reflects funding announced in the 2022-23 Budget *for the 'Supporting public sector diversity, capability, and integrity' initiative.*					

Source: Department of Premier and Cabinet

Chief Parliamentary Counsel services (2022-23: $9.7 million)

This output provides Bills for introduction in parliament, including providing quality and timely legislative drafting services; hard copy and electronic publication of Acts and Statutory Rules; and maintaining a database of Victorian legislation and legislative information at www.legislation.vic.gov.au.

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quantity					
Formal advice provided on legislation	number	500	465	465	544
The higher 2022-23 target reflects consistently meeting previous years' performance targets.					
Acts and Statutory Rules published electronically and in hard copy without error	per cent	96	96	96	99
Statutory Rules made and Bills prepared and introduced into Parliament	number	220	220	220	214
Number of sets of House Amendments drafted for Members of Parliament	number	75	60	60	75
The higher 2022-23 target reflects consistently meeting previous years' performance targets.					

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quality					
Bills and Statutory Rules drafted or settled which meet required standard	per cent	97	97	97	99
Timeliness					
Bills and statutory rules drafted or settled within required timeframe	per cent	97	97	97	97
Electronically published versions of Principal Acts and Statutory Rules published within three business days of coming into operation and new Acts and Statutory Rules published within 24 hours of making	per cent	96	96	96	100
Cost					
Total output cost	$ million	9.7	9.3	7.9	7.3

The 2021-22 expected outcome has been restated to reflect the revised departmental output structure and apportionment of enabling costs across all outputs.

The 2021-22 expected outcome is higher than the 2021-22 target primarily due to an increase in base funding to support continued delivery of core functions.

The higher 2022-23 target primarily reflects the increase in base funding in 2022-23 to support continued delivery of core functions.

Source: Department of Premier and Cabinet

Management of Victoria's public records (2022-23: $12.8 million)

This output provides direction to government on the management of public records and ensures the historical memory of the Victorian Government endures, is secure and accessible.

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quantity					
Physical and digital records utilised by public and government users	number	5 400 000	5 400 000	5 400 000	6 093 283

This performance measure renames the 2021-22 performance measure 'Collection Usage: Utilisation of physical and digital records held by Public Record Office Victoria'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.

Quality					
Satisfaction with quality of services provided to the government agencies and to the public	per cent	90	90	90	90
Timeliness					
Provision of services within published timeframes	per cent	95	87	95	88

The 2021-22 expected outcome is lower than the 2021-22 target due to access restrictions relating to COVID-19 protocols.

Cost					
Total output cost	$ million	12.8	12.8	11.6	18.0

The 2021-22 expected outcome has been restated to reflect the revised departmental output structure and apportionment of enabling costs across all outputs.

The 2021-22 expected outcome is higher than the 2021-22 target primarily due to additional asset maintenance costs.

Source: Department of Premier and Cabinet

State electoral roll and electoral events (2022-23: $117.3 million)

This output provides a high-quality electoral system that supports democracy in Victoria through the administration of an accurate and secure electoral roll, electoral services to ensure fair and equitable representation, the conduct of fair and impartial elections and encouraging greater participation in civic life through education and awareness activities and improving ease of access.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Election events conducted by the Victorian Electoral Commission, including State elections and by-elections, local government elections, by-elections and countbacks, and statutory elections or polls	number	28	25	28	10
The 2021-22 expected outcome is lower than the 2021-22 target due to fewer than anticipated election activities taking place.					
Quality					
Election events invalidated by a court of disputed returns as a result of a proven claim against the Victorian Electoral Commission's conduct of that event	number	0	0	0	0
Timeliness					
Meets timeframes for application of elector-initiated enrolment, direct enrolment and close of roll enrolment activity in the maintenance and accuracy of the register of electors	per cent	95	95	90	99.9
This performance measure renames the 2021-22 performance measure 'Electoral enrolment transactions applied to the Victorian Register of Electors within set timeframes'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.					
The 2021-22 expected outcome is higher than the 2021-22 target due to the anticipated transactions that will occur around the next federal election.					
The higher 2022-23 target reflects the expected outcome based on performance over the past two years.					
Cost					
Total output cost	$ million	117.4	51.4	42.6	77.6
The 2021-22 expected outcome has been restated to reflect the revised departmental output structure and apportionment of enabling costs across all outputs.					
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to the rephase of funding from 2022-23 to 2021-22 to support preparations for the 2022 State Election due to the potential impacts and uncertainties associated with COVID-19.					
The higher 2022-23 target reflects additional funding to support the 2022 State Election.					

Source: Department of Premier and Cabinet

DEPARTMENT OF TRANSPORT

Ministerial portfolios

The Department supports the ministerial portfolios of Transport Infrastructure, Public Transport, Roads and Road Safety, Ports and Freight and Fishing and Boating.

Departmental mission statement

The Department of Transport's mission is to meet the aspirations of Victorians for an integrated transport system that contributes to an inclusive, prosperous and environmentally responsible state. The Department plans, builds and operates the transport system in a way that meets the needs of the people and freight that travel on it, now and in the future, and works with transport agencies and operators to achieve this. It brings together management of ports, boating and fisheries for commercial and recreational uses.

Departmental objectives

Reliable and people-focused transport services

The Department enhances liveability by providing Victorians with a transport system that connects people and places, taking them where they want to go, when they want to go.

The Bus Services, Tram Services and Train Services outputs contribute to the objective by delivering safe, inclusive, reliable and cost-effective public transport services across Victoria and infrastructure investments. This includes services delivered through contractual arrangements with private operators.

The Road Operations output contributes to this objective by delivering initiatives that provide more predictable and reliable journeys, improve safety and meet the service quality expected from transport users.

The objective indicators are:

- user satisfaction with the transport system
- reliable travel.

Safe and well-regulated transport services

The Department focuses on helping Victorians arrive safely, whether they are travelling by road, rail or water.

The Regulation of Commercial Passenger Vehicle Services output contributes to this objective by delivering a commercial passenger vehicle industry that is customer-focused, safe, accessible and competitive through the regulation of commercial passenger vehicles, booking service providers and drivers.

The Transport Safety and Security output contributes to this objective by delivering initiatives and regulatory activities that will improve safety and security on Victoria's transport network.

The objective indicator is:

- safety of the transport system.

Deliver investments that achieve social and economic benefits

The Department delivers infrastructure investments to transform the way that Victorians travel.

The Transport Infrastructure output contributes to this objective by delivering strategic transport infrastructure activities that are value for money and focused on user outcomes to improve the transport system.

The Ports and Freight output contributes to this objective by delivering a range of capital initiatives and programs to increase the capacity, efficiency and safety of the ports, freight and logistics network.

The Road Asset Management output contributes to the objective by delivering programs and initiatives to maintain Victoria's freeways and arterial roads.

The objective indicator is:

- improved transport infrastructure and planning.

Sustainably managed fish and boating resources

The Department supports the development of sustainable fishing and aquaculture activities in Victoria and promotion of responsible boating, fishing and fishing-related activities so that boating and fishing are more accessible to more people.

This includes commercial and recreational licensing and quota management, education, enforcement, fishery monitoring and assessment, administration of recreational fishing grants and on-ground delivery of fishing-related election commitments, and working with a number of partners, local communities and industry to deliver positive outcomes that provide benefits to Victorians.

The Sustainably Managed Fish and Boating Resources output contributes to this objective by delivering improved recreational boating and fishing services and facilities.

The objective indicators are:

- sustainability of assessed fish stocks
- improved recreational fishing and boating services and facilities.

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2021-22 budget	*2021-22 revised*	*2022-23 budget*	*Variation [(a)] %*
Reliable and people-focused transport services				
Bus Services	1 356.9	1 368.8	1 402.6	3.4
Road Operations	1 827.6	1 840.5	1 808.1	(1.1)
Train Services	2 016.9	2 328.3	2 162.8	7.2
Tram Services	369.8	472.1	337.3	(8.8)
Safe and well-regulated transport services				
Regulation of Commercial Passenger Vehicle Services	117.6	122.7	112.4	(4.4)
Transport Safety and Security	40.0	30.5	44.8	11.9
Deliver investments that achieve social and economic benefit				
Ports and Freight	97.4	89.8	86.8	(10.9)
Road Asset Management[(b)]	616.9	605.0	592.7	(3.9)
Transport Infrastructure	378.1	383.8	302.2	(20.1)
Sustainably managed fish and boating resources				
Sustainably Managed Fish and Boating Resources	72.8	73.4	87.9	20.7
Total [(c)]	**6 894.0**	**7 314.8**	**6 937.7**	**0.6**

Source: Department of Transport

Notes:
(a) Variation between 2021-22 and 2022-23 budget.
(b) In 2022-23 expected road maintenance output and asset expenditure is $780.0 million.
(c) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.16 outlines the Department's income from transactions and Table 2.17 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.16: Income from transactions **($ million)**

	2020-21 actual	2021-22 budget	2021-22 revised	2022-23 budget
Output appropriations	8 533.6	4 999.1	5 622.4	5 011.9
Special appropriations	471.6	621.4	599.9	617.4
Interest	0.9	3.5	3.5	3.5
Sale of goods and services	120.8	388.4	129.5	383.8
Grants	418.4	462.4	310.7	453.7
Fair value of assets and services received free of charge or for nominal consideration	409.0	708.4	433.1	379.6
Other income	172.9	248.1	248.1	250.1
Total income from transactions [(a)]	**10 127.2**	**7 431.2**	**7 347.2**	**7 099.9**

Source: Department of Transport

Note:
(a) Table may not add due to rounding.

Table 2.17: Parliamentary authority for resources **($ million)**

	2021-22 budget	2021-22 revised	2022-23 budget
Annual appropriations	**11 600.3**	**13 741.5**	**12 688.2**
Provision of outputs	4 593.0	5 041.8	4 557.4
Additions to the net asset base	7 007.3	8 699.7	8 130.8
Payments made on behalf of the State	..	..	..
Receipts credited to appropriations	**1 553.8**	**1 309.6**	**2 169.5**
Unapplied previous years appropriation	**..**	**430.6**	**..**
Provision of outputs	..	219.7	..
Additions to the net asset base	..	211.0	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**13 154.1**	**15 481.7**	**14 857.7**
Special appropriations	**902.1**	**1 197.3**	**672.5**
Trust funds	**885.8**	**473.2**	**874.4**
Public Transport Fund [(a)]	414.5	155.6	409.8
Recreational Fishing Licence Trust [(b)]	8.5	8.5	8.6
Road Safety Fund [(c)]	202.0	92.2	196.8
State Development Special Projects Trust [(d)]	54.5	4.8	5.5
Other [(e)]	206.3	212.1	253.6
Total parliamentary authority [(f)]	**14 942.1**	**17 152.2**	**16 404.6**

Source: Department of Transport

Notes:
(a) The purpose of this trust primarily relates to public transport functions of the Head, Transport for Victoria (Head, TfV), as per section 39A of the Transport Integration Act 2010*.*
(b) The purpose of this trust primarily relates to recreational fishing projects funded from income received from the sale of recreational fishing licences.
(c) The purpose of this trust primarily relates to the income received and payments made for the road system and road functions of the Head, TfV and the Secretary of the department. The majority of the funds from the Transport Accident Commission will be receipted here.
(d) The purpose of this trust primarily relates to funding for initiatives that enhance economic development.
(e) Includes interdepartmental transfers.
(f) Table may not add due to rounding.

Departmental performance statement

Objective 1: Reliable and people-focused transport services

This objective group enhances liveability by providing Victorians with a transport system that connects people and places, taking them where they want to go, when they want to go.

The departmental objective indicators are:

- user satisfaction with the transport system
- reliable travel.

Outputs

Bus Services (2022-23: $1 402.6 million)

This output delivers reliable and cost-effective statewide bus services and infrastructure investments, including services delivered through contractual arrangements with private operators.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Bus Services – Metropolitan					
This sub-output reports on bus services delivered in metropolitan Melbourne.					
Quantity					
Passengers carried: metropolitan bus services	number (million)	121.8	69.1	121.8	58.6
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of COVID-19 on demand for public transport.					
Payments made for: metropolitan bus services	$ million	847.5	797.2	779.7	732.5
The higher 2022-23 target is due to investment in service improvements and indexation.					
Scheduled services delivered: metropolitan bus	per cent	99.9	99.7	99.9	99.9
Total kilometres scheduled: metropolitan bus	km (million)	129.3	128.9	125.8	125.7
The higher 2022-23 target reflects updated timetables in line with network service changes.					
Quality					
Customer experience index: metropolitan bus services	score	77.5	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Customer satisfaction index: metropolitan bus services' to reflect the new Customer Experience Survey.					
Metropolitan fare compliance rate: bus services	per cent	91	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Metropolitan fare compliance rate across all public transport modes'. The new performance measure reports on the same activity as the previous measure, but has been disaggregated by public transport mode to provide greater transparency and accountability.					
Timeliness					
Service punctuality for: metropolitan bus services	per cent	86	93	86	93.2
The 2021-22 expected outcome is higher than the 2021-22 target due to reduced road traffic and patronage.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Cost					
Total output cost	$ million	896.5	875.5	867.4	790.9
The higher 2022-23 target is primarily due to indexation on contract payments.					
Bus Services – Regional					
This sub-output reports on bus services delivered in regional Victoria.					
Quantity					
Passengers carried: regional bus services	number (million)	14.3	9.6	14.3	8.4
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of COVID-19 on demand for public transport.					
Payments made for: regional bus services	$ million	158	152	152	150.1
The higher 2022-23 target is due to investments in service improvements.					
Scheduled services delivered: regional bus	per cent	99	99	99	100
Total kilometres scheduled: regional bus	km (million)	27.3	27.3	27.3	27.25
Quality					
Customer experience index: regional coach services	score	78	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Customer satisfaction index: regional coach services' to reflect the new Customer Experience Survey.					
Timeliness					
Service punctuality for: regional bus services	per cent	92	95	92	95.2
Cost					
Total output cost	$ million	158.8	157.6	155.8	154.7
The higher 2022-23 target is primarily due to indexation on contract payments.					
Bus Services – Statewide					
This sub-output reports on upgrades and school bus services delivered statewide.					
Quantity					
Myki: Fare payment device speed–number of touch on/offs per minute (Bus/Tram)	number	28	nm	nm	nm
The performance measure replaces the 2021-22 performance measure 'Myki: Fare payment device speed–number of touch on/offs per minute' to reflect performance of myki devices by public transport mode.					
Number of bus routes upgraded	number	48	37	40	18
The 2021-22 expected outcome is lower than the 2021-22 target due to rescheduling of three upgrades to accommodate network changes and infrastructure delivery timeframes. *The higher 2022-23 target reflects the projects scheduled for completion in 2022-23 and new funding in the* 2022-23 Budget *for Delivering Victoria's Bus Plan.*					
Scheduled services delivered: school bus	per cent	99.0	99.5	99.0	98.5
Total kilometres scheduled: school bus	km (million)	31.2	31.1	31.2	30.8
Cost					
Total output cost	$ million	347.3	335.6	333.7	293.0
The higher 2022-23 target is primarily due to indexation on contract payments.					

Source: Department of Transport

Road Operations (2022-23: $1 808.1 million)

This output operates the road network by managing access and use, and delivering initiatives that provide more predictable and reliable journeys, improve safety and meet the service quality expected from transport users.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Road Network Performance					
This sub-output reports on the operation of the road network in Victoria and initiatives to improve network performance.					
Quantity					
Active transport: cycling projects completed	number	9	7	8	3
The 2021-22 expected outcome is lower than the 2021-22 target date due to delays with detailed project design. The higher 2022-23 target reflects the projects scheduled for completion in 2022-23 and new funding in the 2022-23 Budget *for the Active Transport initiative.*					
Active transport: pedestrian projects completed	number	1	2	3	7
The 2021-22 expected outcome is lower than the 2021-22 target due to delays with project design and obtaining consent for works. The lower 2022-23 target reflects the projects scheduled for completion in 2022-23.					
Bridge strengthening and replacement projects completed: metropolitan	number	1	3	3	1
The lower 2022-23 target reflects the projects scheduled for completion in 2022-23.					
Bridge strengthening and replacement projects completed: regional	number	7	7	9	4
The 2021-22 expected outcome is lower than the 2021-22 target date due to land agreement considerations. The lower 2022-23 target reflects the projects scheduled for completion in 2022-23.					
Congestion management and minor road improvements completed: metropolitan	number	7	14	9	11
The 2021-22 expected outcome is higher than the 2021-22 target due to the identification and delivery of additional works. The lower 2022-23 target reflects the projects scheduled for completion in 2022-23.					
Congestion management and minor road improvements completed: regional	number	9	25	16	20
The 2021-22 expected outcome is higher than the 2021-22 target due to the identification and delivery of additional works. The lower 2022-23 target reflects the projects scheduled for completion in 2022-23.					
Road vehicle and driver regulation: driver licences renewed	number (thousand)	950	905	905	797
The higher 2022-23 target reflects cyclical trends in driver licence renewal.					
Road vehicle and driver regulation: new driver licences issued	number (thousand)	192	190	190	192
The higher 2022-23 target is based on the observed uptake in new driver licenses.					
Road vehicle and driver regulation: new vehicle registrations issued	number (thousand)	580	540	580	521
The 2021-22 expected outcome is lower than the 2021-22 target due to a decline in new car sales, due to supply shortages and the ongoing impact of COVID-19.					
Road vehicle and driver regulation: vehicle and driver information requests, including toll operator and council requests, processed	number (thousand)	4 030	2 700	4 030	2 430
The 2021-22 expected outcome is lower than the 2021-22 target due to reduced road traffic as result of COVID-19 restrictions, leading to a reduction in the number of requests.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Road vehicle and driver regulation: vehicle registration transfers	number (thousand)	910	790	910	815
The 2021-22 expected outcome is lower than the 2021-22 target due to a decline in car sales, due to supply shortages and the ongoing impact of the COVID-19 restrictions.					
Road vehicle and driver regulation: vehicle registrations renewed	number (thousand)	11 500	10 070	10 070	9 460
The higher 2022-23 target reflects the continuing increase in take up of short-term registrations.					
Quality					
Road projects completed within agreed scope and standards: metropolitan	per cent	100	100	100	100
Road projects completed within agreed scope and standards: regional	per cent	100	100	100	100
Road vehicle and driver regulation: currency of vehicle registration and driver licensing records	per cent	99	99	99	99
Road vehicle and driver regulation: user satisfaction with vehicle registration and driver licensing	per cent	85	85	85	94
Timeliness					
Average incident response time within agreed timeframes: metropolitan	per cent	80	85	80	90.8
The 2021-22 expected outcome is higher than the 2021-22 target due to additional response vehicles and staff, and lower road traffic volumes as a result of COVID-19 restrictions.					
Programmed works completed within agreed timeframes: metropolitan	per cent	80	80	80	79
Programmed works completed within agreed timeframes: regional	per cent	80	80	80	100
Road vehicle and driver regulation: average speed of calls answered in registration and licensing call centres	seconds	240	850	240	601
The 2021-22 expected outcome is higher than the 2021-22 target due to the impact of COVID-19 on staff availability and the complexity of inquiries.					
Road vehicle and driver regulation: customers served within 10 minutes in registration and licensing customer service centres	per cent	80	70	80	71
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of the COVID-19 response.					
Cost					
Total output cost	$ million	1 718.8	1 753.8	1 690.7	1 766.8
The higher 2022-23 target is in alignment with the 2021-22 target.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Road Safety					
This sub-output reports on the safety of the road network in Victoria and initiatives to improve road safety.					
Quantity					
High risk driver reviews	number (thousand)	151	145	152	nm
The lower 2022-23 target reflects the forecasted number of driving offenders for the financial year.					
Kilometres of road treated with tactile line marking	km	tbc	534	466	811
The 2021-22 expected outcome is higher than the 2021-22 target due to the identification and delivery of additional works, including projects that were completed ahead of schedule. *The 2022-23 target is 'tbc' as works are planned but subject to Commonwealth confirmation through the Road Safety Program.*					
Kilometres of safety barrier installed	km	195	173.5	167	312
The higher 2022-23 target reflects the projects scheduled for completion in 2022-23, and does not include works that are planned but subject to Commonwealth confirmation through the Road Safety Program.					
Road safety initiatives completed	number	34	73	50	52
The 2021-22 expected outcome is higher than the 2021-22 target due to the identification and delivery of additional works. *The lower 2022-23 target reflects the projects scheduled for completion in 2022-23, and does not include works that are subject to Commonwealth confirmation through the Road Safety Program.*					
Road vehicle safety certificates issued	number (thousand)	827	875	875	nm
The lower 2022-23 target reflects a return to pre-pandemic transaction volumes following clearnace of transactions that had accumulated as a result of the impact of COVID-19 restrictions.					
Vehicle safety inspections	number	1 350	1 320	1 350	nm
Quality					
Number of schools reached by the Road Smart program – metro	number	249	183	268	nm
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions on schools. *The lower 2022-23 target reflects reflects the number of schools eligible for the 2022 school year..*					
Number of schools reached by the Road Smart program – regional	number	208	177	208	nm
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 restrictions on schools.					
Road safety projects completed within agreed scope and standards	per cent	100	100	100	100
Timeliness					
Road safety programmed works completed within agreed timeframes	per cent	80	80	80	87
Cost					
Total output cost	$ million	89.3	86.6	136.9	98.2
The 2021-22 expected outcome is lower than the 2021-22 target due to changes to the work program for the Safer Road Infrastructure Program, partially offset by acceleration of work for the Federal Safety Program.					

Source: Department of Transport

Train Services (2022-23: $2 162.8 million)

This output delivers reliable and cost-effective train services and infrastructure investments across the Victorian rail network, including services delivered through contractual arrangements with private operators.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Train Services – Metropolitan					
This sub-output reports on train services and maintenance works in metropolitan Melbourne.					
Quantity					
Passengers carried: metropolitan train services	number (million)	249.7	105.3	249.7	81.7
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of COVID-19 on demand for public transport.					
Payments made for: metropolitan train services	$ million	1 107.9	1 021.5	1 021.5	1 018.0
The higher 2022-23 target is due to an investment in new services and infrastructure as part of the Big Build.					
Scheduled services delivered: metropolitan train	per cent	98.5	98.0	99.0	98.8
The lower 2022-23 target is due to alignment in public reporting targets within the public transport service contracts.					
Total kilometres scheduled: metropolitan train	km (million)	24.9	24.9	24.9	24.9
Quality					
Availability of rolling stock: metropolitan trains	per cent	94	94	94	94.9
Customer experience index: metropolitan train services	score	77.5	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Customer satisfaction index: metropolitan train services' to reflect the new Customer Experience Survey.					
Metropolitan fare compliance rate: train services	per cent	96	nm	nm	nm
This performance measure is proposed to replace the 2021-22 performance measure 'Metropolitan fare compliance rate across all public transport modes'. The new performance measure reports on the same activity as the previous measure, but has been disaggregated by public transport mode to provide greater transparency and accountability.					
Timeliness					
Major periodic maintenance works completed against plan: metropolitan train network	per cent	100	100	100	99
Service punctuality for: metropolitan train services	per cent	92.0	93.4	92.5	95.2
The lower 2022-23 target is due to alignment in public reporting targets within the public transport service contracts.					
Cost					
Total output cost	$ million	1 092.4	1 229.0	997.0	2 534.7
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to the impact of COVID-19 on public transport. *The higher 2022-23 target is due to additional investment in new services and infrastructure as part of the Big Build.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Train Services – Regional					
This sub-output reports on train services and maintenance works in regional Victoria.					
Quantity					
Passengers carried: regional train and coach services	number (million)	24.4	11.5	24.4	9
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of COVID-19 on demand for public transport.					
Payments made for: regional train and coach services	$ million	716.7	727.8	727.8	669.9
The lower 2022-23 target reflects the contract payment due to profiling of maintenance works.					
Scheduled services delivered: regional train	per cent	98.5	92.5	98.5	96.1
The 2021-22 expected outcome is lower than the 2021-22 target due to COVID-19 impacts on the V/Line workforce and severe weathe events.					
Total kilometres scheduled: regional train and coach	km (million)	27.5	27.5	27.5	27.4
Quality					
Availability of rolling stock: VLocity fleet	per cent	92.5	80.0	92.5	87
The 2021-22 expected outcome is lower than the 2021-22 target due to ongoing maintenance and repair work, and increasing animal strikes.					
Customer experience index: regional train services	score	80	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Customer satisfaction index: regional train services' to reflect the new Customer Experience Survey.					
Regional fare compliance rate: V/Line train services	per cent	95.5	nm	nm	nm
New performance measure for 2022-23 to reflect the regional fare compliance rate for V/Line train services.					
Scheduled services not delayed by infrastructure faults: regional train network	per cent	97	99	97	99.4
Timeliness					
Major periodic maintenance works completed against plan: regional train network	per cent	100	100	100	88
Service punctuality for: regional train services	per cent	92.0	92.7	92.0	93.5
Cost					
Total output cost	$ million	811.0	835.3	763.6	1392.6
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to the impact of COVID-19 on public transport. The higher 2022-23 target is primarily due to additional funding to maintain regional rail network, improve V/Line capability, and deliver more services					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Train Services – Statewide					
This sub-output reports on train services and network improvements delivered statewide.					
Quantity					
Myki: Fare payment device speed – number of touch on/offs per minute (Train)	number	37	nm	nm	nm
The performance measure replaces the 2021-22 performance measure 'Myki: Fare payment device speed–number of touch on/offs per minute' to reflect performance of myki devices by public transport mode.					
Public railway crossings upgraded	number	82	29	53	15
The 2021-22 expected outcome is lower than the 2021-22 target due to delays in the commissioning of level crossings as a result of COVID-19 impacts on availability of signalling resources. *The higher 2022-23 target reflects the projects scheduled for completion in 2022-23.*					
Public transport network improvement: minor projects completed – train	number	12	12	17	5
The 2021-22 expected outcome is lower than the 2021-22 target due to delays caused by the impacts of COVID-19. *The lower 2022-23 target reflects the projects scheduled for completion in 2022-23.*					
Quality					
Myki device availability	per cent	99.5	99.9	99.5	99.9
Public transport network improvement: performance against master project schedule	per cent	90	90	90	90
Timeliness					
Calls to the public transport call centre answered within 30 seconds	per cent	80	80	80	80
Cost					
Total output cost	$ million	259.3	263.9	256.3	277.4
The higher 2022-23 target is in alignment with the 2021-22 target.					

Source: Department of Transport

Tram Services (2022-23: $337.3 million)

This output delivers reliable and cost-effective tram services and infrastructure investments, including public transport services delivered through contractual arrangements with private operators.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of tram routes upgraded	number	0	1	1	2
The lower 2022-23 target reflects that there are no tram route upgrades scheduled for completion in 2022-23, following the completion of the E-class tram rollout program.					
Passengers carried: tram services	number (million)	208.1	84.6	208.1	60.2
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of COVID-19 on demand for public transport					
Payments made for: tram services	$ million	403.8	380.9	380.9	419.3
The higher 2022-23 target is due to an increase in operational costs associated with assets added to the network.					
Public transport accessibility: level access tram stops upgraded	number	2	2	4	2
The 2021-22 expected outcome is lower than the 2021-22 target due to design and community consultation taking longer than expected. *The lower 2022-23 target reflects the projects scheduled for completion in 2022-23.*					
Scheduled services delivered: tram	per cent	98.5	98.4	99.2	98.5
The lower 2022-23 target is due to alignment with the public reporting targets within the public transport service contracts.					
Total kilometres scheduled: tram	km (million)	24.6	24.6	24.6	24.6
Quality					
Availability of rolling stock: trams	per cent	94	90	94	88
Customer experience index: tram services	score	78	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Customer satisfaction index: tram services' to reflect the new Customer Experience Survey.					
Metropolitan fare compliance rate: tram services	per cent	97	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Metropolitan fare compliance rate across all public transport modes'. The new performance measure reports on the same activity as the previous measure, but has been disaggregated by public transport mode to provide greater transparency and accountability.					
Timeliness					
Major periodic maintenance works completed against plan: tram network	per cent	100	90	100	88.1
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 on supply chain issues..					
Service punctuality for: tram services	per cent	82.0	88.8	82.9	92.2
The 2021-22 expected outcome is higher than the 2021-22 target due to reduced road traffic and patronage. *The lower 2022-23 target reflects an alignment with the public reporting targets within the public transport service contracts.*					
Cost					
Total output cost	$ million	337.3	472.1	369.8	1 017.2
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to the impact of COVID-19 on public transport. *The lower 2022-23 target is due to alignment reflects the agreed profile of the franchise contract.*					

Source: Department of Transport

Objective 2: Safe and well-regulated transport services

This objective focuses on helping Victorians arrive safely, whether they are travelling by road, rail or water.

The departmental objective indicator is:

- safety of the transport system.

Outputs

Regulation of Commercial Passenger Vehicle Services (2022-23: $112.4 million)

This output delivers a commercial passenger vehicle industry that is customer-focused, safe, accessible and competitive in metropolitan and regional Victoria through regulating commercial passenger vehicles, booking service providers, and drivers.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Completed driver accreditation applications processed	number	43 000	32 000	43 000	35 852
The 2021-22 expected outcome is lower than the 2021-22 target due to reduced customer demand.					
Multi-Purpose Taxi Program: number of trips subsidised	number (thousand)	6 178	4 196	6 178	3 770
The 2021-22 expected outcome is lower than the 2021-22 target due to reduced trip volumes due to COVID-19 restrictions.					
Multi-Purpose Taxi Program: number of wheelchair and scooter lifting fees paid	number (thousand)	1 437	1 070	1 437	908
The 2021-22 expected outcome is lower than the 2021-22 target due to reduced trip volumes due to COVID-19 restrictions.					
Quality					
Average wait time for conventional commercial passenger vehicles booked to arrive during daytime periods of demand	minutes	4.8	7.2	4.8	5.8
The 2021-22 expected outcome is higher than the 2021-22 target due to reduced numbers of commercial passenger vehicles on the road as a result of COVID-19.					
Average wait time for wheelchair accessible commercial passenger vehicles booked to arrive during daytime periods of demand	minutes	10.1	9.6	10.1	6.4
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 on road traffic volumes, which allowed for higher performance.					
Calls to the Commercial Passenger Vehicles Victoria call centre resolved at the first point of contact	per cent	80	85	80	87.5
The 2021-22 expected outcome is higher than the 2021-22 target due to improved staff capability to answer queries without the need to transfer calls.					
Commercial passenger vehicle industry participants conform to key safety requirements	per cent	75	75	75	53
Commercial passenger vehicles met safety standards	per cent	85	87	85	87.6

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Overall satisfaction with level of commercial passenger vehicle regulatory service provided by Commercial Passenger Vehicles Victoria.	per cent	80	80	80	78
Timeliness					
Commercial passenger vehicle service complaints and intelligence reports investigated and closed within 45 days	per cent	92	92	92	89.6
Multi-Purpose Taxi Program: applications assessed and completed within 14 days	per cent	97	97	97	97.5
Road vehicle and driver regulation: new and renewed driving instructor authority applications processed within 14 days	per cent	90	90	90	62.9
Valid driver accreditation applications determined within 20 business days in accordance with statutory requirements	per cent	85.0	87.5	85.0	96.3
Cost					
Total output cost	$ million	112.4	122.7	117.6	106.4
The lower 2022-23 target reflects new administrative arrangements for contributions to the NDIS.					

Source: Department of Transport

Transport Safety and Security (2022-23: $44.8 million)

This output delivers initiatives and regulatory activities that will improve safety and security on Victoria's transport network.

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quantity					
Accredited State maritime training providers audited in accordance with risk-based annual audit plan	number	21	21	21	20
Risk-based vessel inspections undertaken to determine compliance with State marine safety law	number	500	500	500	536
Safety audits of bus safety duty holders conducted in accordance with risk-based plan	per cent	100	100	100	nm
Sector Resilience Plans endorsed by State Crisis and Resilience Council	number	1	1	1	1
Security and emergency management exercises coordinated or contributed to by the Department	number	11	5	9	3
The 2021-22 expected outcome is lower than the 2021-22 target due to exemptions granted to two organisations and postponements from another two organisations. *The higher 2022-23 target reflects the once-off change in schedule of two exercises following exemptions granted under section 74Q(7) of the* Emergency Management Act 2013.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Transport and marine safety investigations: proportion of notified accidents with passenger fatalities and/or multiple serious passenger injuries investigated	per cent	100	100	100	100
Quality					
Compliance inspections of commercial maritime duty holders other than vessel owners and operators audited in accordance with legislative requirements and timelines	per cent	100	100	100	100
Prosecution success rate for transport safety offences	per cent	80	80	80	100
Risk assessment of managed and unmanaged Victorian waterways with high levels of boating activity and competing use	number	30	10	30	7
The 2021-22 expected outcome is lower than the 2021-22 target due to COVID-19 restrictions, which prevented waterway audits from being undertaken.					
Timeliness					
Applications for bus operator accreditation processed on time in accordance with the *Bus Safety Act 2009* requirements	per cent	100	100	100	100
This performance measure renames the 2021-22 performance measure 'Applications for bus operator registration and safety accreditation processed on time in accordance with Bus Safety Act 2009 *(Vic) requirements' due to the removal of the registration option from 1 March 2022 in accordance with amendments to the* Bus Safety Act 2009*.*					
Initiate marine pollution response action within 60 minutes of incident notification	per cent	100	100	100	100
Transport and marine safety investigations: accidents/incidents assessed within two days of notification to determine need for detailed investigation	per cent	100	100	100	100
Transport and marine safety investigations: investigations completed within 12 months	per cent	50	40	50	67
The 2021-22 expected outcome is lower than the 2021-22 target due to the increased complexity of investigations.					
Cost					
Total output cost	$ million	44.8	30.5	40.0	31.0
The 2021-22 expected outcome is lower than the 2021-22 target due to the timing of delivery of Emergency Management Sector Reform. *The higher 2022-23 target is due to the timing of delivery of Emergency Management Sector Reform.*					

Source: Department of Transport

Objective 3: Deliver investments that achieve social and economic benefits

The objective delivers infrastructure investments to transform the way that Victorians travel.

The departmental objective indicator is:

- improved transport infrastructure and planning.

Outputs

Ports and Freight (2022-23: $86.8 million)

This output delivers a range of capital initiatives and programs to increase the capacity, efficiency and safety of the ports, freight and logistics network.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Accessible local ports	number	14	14	14	14
Containers transported by rail under the Mode Shift Incentive Scheme program	number	42 508	42 508	42 508	37 235
Number of months per year average channel depth at Lakes Entrance meets standards	number	12	12	12	12
Progress with delivery of a Port Rail Shuttle – percentage of project funding expended	per cent	85	60	85	45
This performance measure renames the 2021-22 performance measure 'Progress with delivery of a Metropolitan Intermodal System – percentage of project funding expended' to reflect the updated program name. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19.*					
Road-based freight accessibility and reliability improvement projects completed	number	1	2	2	2
The lower 2022-23 target reflects the scheduling of projects for completion in 2022-23.					
Quality					
Road network permitted for use by high productivity freight vehicles	per cent	34	34	30	27
The 2021-22 expected outcome is higher than the 2021-22 target due to funding secured through the Regulatory Reform Incentive Fund to assess an additional 700 kilometres of network. *The higher 2022-23 target reflects the 2021-22 expected outcome.*					
Road-based freight accessibility and reliability projects completed within specified scope and standards	per cent	100	100	100	100
Timeliness					
Pre-approved Heavy Vehicle consents completed within 3 business days	per cent	20	nm	nm	nm
New performance measure for 2022-23 to capture the impact of heavy vehicle permit reforms.					
Road-based freight accessibility and reliability projects completed within agreed timeframes	per cent	80	80	80	100

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Cost					
Total output cost	$ million	86.8	89.8	97.4	89.8
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to a rephase of funding for the Better Piers and Waterside Facilities initiative.					
The lower 2022-23 target is mainly due to the approved funding allocation for multiple initiatives being lower in 2022-23 than 2021-22.					

Source: Department of Transport

Road Asset Management (2022-23: $592.7 million)

This output delivers programs and initiatives to maintain Victoria's freeways and arterial roads.

Performance measures	Unit of measure	2022-23 target	2021-22 expected outcome	2021-22 target	2020-21 actual
Quantity					
Bridges maintained: metropolitan	number	985	985	984	985
The higher 2022-23 target is due to one bridge bordering both zones changing in management from regional to metropolitan.					
Bridges maintained: regional	number	2 227	2 224	2 232	2 229
The lower 2022-23 target reflects six bridges being decommissioned, one bridge changing in management from regional to metropolitan, and one bridge declared as a local bridge and therefore no longer maintained by the Department.					
Road area treated: roads in inner metropolitan Melbourne	m^2 (000)	490	540	350	nm
The 2021-22 expected outcome is higher than the 2021-22 target due to work being rephased from 2020-21 into 2021-22. The higher 2022-23 target reflects new funding for road maintenance provided in the 2022-23 Budget.					
Road area treated: roads in outer suburban Melbourne	m^2 (000)	560	740	690	nm
The 2021-22 expected outcome is higher than the 2021-22 target due to work being rephased from 2020-21 into 2021-22. The lower 2022-23 target reflects reaching the 2021-22 target and additional funding for regional road maintenance in 2022-23.					
Road area treated: roads in regional Victoria	m^2 (000)	12 140	11 476	11 800	nm
The higher 2022-23 target reflects new funding for road maintenance in the 2022-23 budget.					
Road network maintained: inner metropolitan	m^2 (000)	24 017	24 017	24 006	nm
The higher 2022-23 target reflects the expansion of the inner metropolitan road network.					
Road network maintained: outer suburban	m^2 (000)	31 760	31 760	31 632	nm
The higher 2022-23 target reflects the expansion of the outer suburban road network.					
Road network maintained: regional	m^2 (000)	173 533	173 533	173 410	173 410
The higher 2022-23 target reflects the expansion of the regional road network.					
Quality					
Bridges that are acceptable for legal load vehicles: metropolitan	per cent	99.7	99.7	99.7	99.7
Bridges that are acceptable for legal load vehicles: regional	per cent	99.6	99.6	99.6	99.6
Road length meeting cracking standard: metropolitan	per cent	88.5	90.3	92.8	95.3
The lower 2022-23 target reflects a more accurate assessment of road condition.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Road length meeting cracking standard: regional	per cent	98.6	98.5	95.1	97.5
The higher 2022-23 target reflects new funding for road maintenance.					
Road length meeting roughness standard: metropolitan	per cent	93.0	93.2	92.2	93.1
The higher 2022-23 target reflects new funding for road maintenance.					
Road length meeting roughness standard: regional	per cent	96.0	96.0	93.0	93.6
The higher 2022-23 target reflects new funding for road maintenance.					
Road length meeting rutting standard: metropolitan	per cent	96.5	97.5	93.6	95.6
The higher 2022-23 target reflects new funding for road maintenance.					
Road length meeting rutting standard: regional	per cent	98.2	98.4	97.8	98.4
The higher 2022-23 target reflects new funding for road maintenance.					
Traffic signal operational availability	per cent	100	99.94	100	99.95
Traffic signal performance – communications ('DA Alarm'): vehicle detector connectivity to signals	per cent	97	99.6	97	99.6
Traffic signal performance – communications ('Stop Talk'): connectivity between different traffic signals	per cent	99.6	99.59	99.6	99.7
Timeliness					
Annual road maintenance program completed within agreed timeframes: metropolitan	per cent	100	100	100	91
Annual road maintenance program completed within agreed timeframes: regional	per cent	100	100	100	100
Cost					
Total output cost	$ million	592.7	605.0549.0	616.9	822.5
The lower 2022-23 target reflects prioritisation of additional investment into road restoration and renewal activity which is treated as asset funding and reported in Budget Paper 4. .					

Source: Department of Transport

Transport Infrastructure (2022-23: $302.2 million)

This output delivers strategic transport infrastructure and planning initiatives to improve the transport system and transform the way that Victorians travel, to create more productive and liveable cities and regions.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Major rail improvement projects completed: regional	number	5	3	5	nm
The 2021-22 expected outcome is lower than the 2021-22 target due to a combination of COVID-19 impacts, on site restrictions and impacts to design development, construction and commissioning activities as a result of signalling and design resource availability.					
Major road improvement projects completed: metropolitan	number	3	2	2	1
The higher 2022-23 target reflects the projects scheduled for completion in 2022-23.					
Major road improvement projects completed: regional	number	1	3	3	0
The lower 2022-23 target reflects the projects scheduled for completion in 2022-23.					
Planning projects for other major transport infrastructure	number	4	4	6	5
The 2021-22 expected outcome is lower than the 2021-22 target due to the deferral of two projects to 2023-24. The lower 2022-23 target reflects the projects scheduled for completion in 2022-23.					
Precincts in the design or delivery phase	number	3	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Integrated transport planning to support urban renewal projects' to reflect works undertaken for transport precincts following a machinery of government change in 2021-22.					
Quality					
Level Crossing Removal Project – milestones delivered in accordance with agreed budget and timelines	per cent	100	100	100	100
Metro Tunnel Project – milestones delivered in accordance with agreed budget and timelines	per cent	100	100	100	100
North East Link Project – milestones delivered in accordance with agreed budget and timelines	per cent	100	100	100	100
Suburban Rail Loop Initial and Early Works – milestones delivered in accordance with agreed budget and timelines	per cent	100	nm	nm	nm
New performance measure for 2022-23 to reflect works undertaken for the Suburban Rail Loop.					
West Gate Tunnel Project – milestones delivered in accordance with agreed budget and timelines	per cent	100	100	100	100
Cost					
Total output cost	$ million	302.2	383.8	378.1	905.4
The lower 2022-23 target is primarily due to infrastructure projects progressing from development phase (supported by operating expenditure) to project delivery phase (supported by capital expenditure) and cashflow rephasing to outer years.					

Source: Department of Transport

Objective 4: Sustainably managed fish and boating resources

This objective supports the development of sustainable fishing and aquaculture activities in Victoria and the delivery of improved recreational fishing and boating services and facilities so that boating and fishing are more accessible to more people and deliver outcomes that provide benefits to Victorians.

The departmental objective indicators are:

- sustainability of assessed fish stocks
- improved recreational fishing and boating services and facilities.

Outputs

Sustainably Managed Fish and Boating Resources (2022-23: $87.9 million)

This output delivers improved recreational boating and fishing services and facilities.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Community and stakeholder engagement information forums – Fisheries	number	10	10	10	10
Complete stock assessment for key quota managed fish stocks	number	3	3	3	3
This performance measure renames the 2021-22 performance measure 'Complete total allowable commercial catch setting processes for key species'.					
Complete quota setting processes for key quota managed fish stocks	number	3	3	3	3
This performance measure renames the 2021-22 performance measure 'Complete stock assessment for key quota managed fish species' to improve clarity.					
Develop, implement and review overarching fisheries compliance strategy	number	1	1	1	1
Enhance levels of community participation in achieving fisheries compliance through calls to the 13FISH reporting line	number	1 950	1 750	1 750	2 150
The higher 2022-23 target reflects the increase in call volume over the past five years. Call volume is influenced by factors such as compliance operations, patron patterns and public education regarding the need for fisheries rules and regulations.					
Key fisheries managed in accordance with Fishery Management Plans	number	6	6	6	6
This performance measure renames the 2021-22 performance measure 'Key fisheries managed in accordance with best practice management plans' to improve clarity.					
Minimum uniformed fisheries officers maintaining operational coverage during priority fishing periods	number	20	20	17	21
This performance measure renames the 2021-22 performance measure 'Minimum number of uniformed fisheries officers maintaining operational coverage for priority fishing activity periods, as defined by the Compliance Strategic Assessment' to improve clarity. *The 2021-22 expected outcome is higher than the 2021-22 target due to employment of additional officers enabling increased coverage over priority fishing periods.* *The higher 2022-23 target reflects the 2021-22 expected outcome.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Native and salmonid fish stocked	number (thousand)	10 000	10 000	10 000	8 377
Recreational boating and fishing infrastructure improvements delivered	number	3	2	2	6
The higher 2022-23 target reflects the projects scheduled for completion in 2022-23.					
Quality					
Key statutory obligations relevant to the Victorian Fisheries Authority complied with (tabling annual report, audits, business plan and board appointments)	per cent	100	100	100	100
Percentage of investigations into serious or organised fisheries offending that result in a prosecution, disruption or intelligence referral outcome	per cent	90	nm	nm	nm
This performance measure replaces the 2021-22 performance measure 'Undertake activities to detect, disrupt and dismantle serious or organised fisheries criminal entities (individuals or groups)' to better reflect the VFA's investigative work undertaken into serious or organised fisheries crime.					
Timeliness					
Proportion of fisheries cost recovery levies reviewed and set prior to the commencement of the licensing year	per cent	100	100	100	100
This performance measure renames the 2021-22 performance measure 'Proportion of fisheries cost recovery levies reviewed and set prior to the commencement of the licensing year (1 April)' to improve clarity.					
Research project milestones and reports completed on time	per cent	90	90	90	90
This performance measure renames the 2021-22 performance measure 'Research project milestones and reports completed on time (Fisheries)' to improve clarity.					
Cost					
Total output cost	$ million	87.9	73.4	72.8	64.7
The higher 2022-23 target is due to timing of delivery of Better Boating initiatives.					

Source: Department of Transport

DEPARTMENT OF TREASURY AND FINANCE

Ministerial portfolios

The Department supports the ministerial portfolios of the Treasurer, Minister for Economic Development, Assistant Treasurer, and Minister for Regulatory Reform.

Departmental mission statement

The Department of Treasury and Finance's mission is to provide economic, commercial, financial and resource management advice to help the Victorian Government deliver its policies.

Departmental objectives

Optimise Victoria's fiscal resources

The Department of Treasury and Finance has a central role in providing high-quality advice to Government on sustainable financial, resource and performance management policy and other key policy priorities; overseeing related frameworks; as well as leading the production of the State budget papers and reports of both financial and non-financial performance in the Victorian public sector.

The Budget and Financial Advice output contributes to this objective by providing strategic, timely and comprehensive analysis and information to Government to support decision-making and reporting.

The Revenue Management and Administrative Services to Government output contributes to this objective by providing revenue management and administration services across the various state-based taxes for the benefit of all Victorians.

Strengthen Victoria's economic performance

The Department of Treasury and Finance provides Government with advice on key economic matters and policies to increase economic productivity, competitiveness and equity across the Victorian economy.

The Economic and Policy Advice output contributes to this objective by providing strategic, timely and comprehensive analysis and information to Government to support decision-making and reporting.

The Economic Regulatory Services output contributes to this objective by providing economic regulation of utilities and other specified markets in Victoria to protect the long-term interests of Victorian consumers with regard to price, quality and reliability of essential services.

The Invest Victoria output contributes to this objective by facilitating private sector investment in Victoria to strengthen innovation, productivity, job creation, and diversification of Victoria's economy.

Improve how Government manages its balance sheet, commercial activities and public sector infrastructure

The Department of Treasury and Finance develops and applies prudent financial and commercial principles and practices to influence and help deliver government policies focused on overseeing the State's balance sheet, major infrastructure and government business enterprises (in the public non-financial corporations (PNFC) sector and public financial corporations (PFC) sector).

The Commercial and Infrastructure Advice output contributes to this objective by providing strategic, timely and comprehensive analysis and information to Government to support decision-making and reporting.

Deliver strategic and efficient whole of government common services

The Department of Treasury and Finance assists government agencies by delivering integrated and client-centred common services that achieve value for the Victorian public sector.

The Services to Government output contributes to this objective by delivering whole of government services, policies and initiatives in areas including procurement, fleet and accommodation.

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives and outputs, together with key performance indicators, are presented in subsequent tables.

($ million)

	2021-22 budget	*2021-22 revised*	*2022-23 budget*	*Variation [(a)] %*
Optimise Victoria's fiscal resources				
Budget and Financial Advice	36.8	37.7	36.1	(1.9)
Revenue Management and Administrative Services to Government	153.1	155.3	154.7	1.0
Strengthen Victoria's economic performance				
Economic and Policy Advice	96.8	104.6	81.3	(16.0)
Economic Regulatory Services	31.7	33.0	35.7	12.6
Invest Victoria	147.7	88.1	150.0	1.6
Improve how Government manages its balance sheet, commercial activities and public sector infrastructure				
Commercial and Infrastructure Advice	83.6	92.8	53.6	(35.9)
Infrastructure Victoria	9.9	10.0	10.0	1.0
Deliver strategic and efficient whole of government common services				
Services to Government	48.9	48.1	53.1	8.6
Total [(b)]	**608.5**	**569.6**	**574.5**	**(5.6)**

Source: Department of Treasury and Finance

Notes:

(a) Variation between the 2021-22 budget and the 2022-23 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant output cost.

(b) Table may not add due to rounding.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.18 outlines the Department's income from transactions and Table 2.19 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.18: Income from transactions **($ million)**

	2020-21 actual	*2021-22 budget*	*2021-22 revised*	*2022-23 budget*
Output appropriations	506.2	587.8	558.6	564.5
Interest	0.2	..	..	..
Sale of goods and services	39.8	15.2	15.2	15.2
Grants	29.4	18.1	8.1	9.6
Other income	41.0	37.3	37.3	37.3
Total income from transactions [(a)]	**616.6**	**658.3**	**619.1**	**626.5**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Table 2.19: Parliamentary authority for resources **($ million)**

	2021-22 budget	*2021-22 revised*	*2022-23 budget*
Annual appropriations	**20 752.2**	**10 309.9**	**18 410.0**
Provision of outputs	579.3	503.8	555.9
Additions to the net asset base	147.1	27.9	172.4
Payments made on behalf of the State	20 025.8	9 778.1	17 681.7
Receipts credited to appropriations	**8.5**	**8.5**	**8.5**
Unapplied previous years appropriation	**..**	**15.8**	**..**
Provision of outputs	..	14.4	..
Additions to the net asset base	..	..	..
Payments made on behalf of the State	..	1.4	..
Gross annual appropriation	**20 760.8**	**10 334.2**	**18 418.6**
Special appropriations	**2 738.5**	**3 120.0**	**2 874.6**
Trust funds	**4 721.2**	**4 949.2**	**5 178.8**
Commonwealth Treasury Trust Fund [(a)]	4 201.5	4 304.4	4 507.5
Victorian Transport Fund [(b)]	22.7	22.7	7.8
Other [(c)]	497.0	622.1	663.5
Total parliamentary authority [(d)]	**28 220.5**	**18 403.4**	**26 471.9**

Source: Department of Treasury and Finance

Notes:
(a) The purpose of this trust primarily relates to the receipt of Commonwealth Government grants to be on-passed to relevant departments.
(b) The purpose of this trust primarily relates to the use of the funds received from the lease over the operations of the Port of Melbourne towards the removal of level crossings and other transport initiatives.
(c) Includes inter-departmental transfers.
(d) Table may not add due to rounding.

Departmental performance statement

Objective 1: Optimise Victoria's fiscal resources

Under this objective, the Department provides analysis and advice to Government on the management of Victoria's fiscal resources to support decision-making and reporting for the benefit of all Victorians.

The Department leads the development of financial policy advice to Government and the Victorian public sector through detailed analysis of key policy priorities including resource allocation, financial risk and government service performance, financial reporting frameworks, and the State's budget position to inform and support the publication of key whole of state financial reports.

The departmental objective indicators that support the Government to achieve its fiscal objectives are:

- general government net debt as a percentage of gross state product (GSP) to stabilise in the medium term
- fully fund the unfunded superannuation liability by 2035
- a net operating cash surplus consistent with maintaining general government net debt at a sustainable level after the economy has recovered from the COVID-19 pandemic[(a)]
- general government interest expense as a percentage of revenue to stabilise in the medium term
- agency compliance with the Standing Directions under the *Financial Management Act 1994*
- advice contributes to the achievement of Government policies and priorities relating to optimising Victoria's fiscal resources.

Note:

(a) This objective indicator has been updated from 'a net operating cash surplus consistent with maintaining general government net debt at a sustainable level after the economy has recovered after the coronavirus (COVID-19) pandemic' to 'a net operating cash surplus consistent with maintaining general government net debt at a sustainable level after the economy has recovered from the COVID-19 pandemic'.

Outputs

Budget and Financial Advice (2022-23: $36.1 million)

This output contributes to the provision of strategic, timely and comprehensive analysis and advice to Ministers, Cabinet and Cabinet Sub-Committees on:

- Victorian public sector resource allocation
- departmental financial, output and asset delivery performance to support government in making decisions on the allocation of the State's fiscal resources
- departmental and agency funding reviews.

This output maintains the integrity of systems and information for financial planning, management, monitoring and reporting of the State of Victoria via:

- a best practice financial reporting framework, and whole of state management information systems, supporting financial reporting across the Victorian public sector
- publication of the State budget and financial reports, including quarterly, mid-year, annual and estimated financial reports
- publication of non-financial performance in the Victorian public sector.

This output develops and maintains cohesive financial and resource management frameworks that drive sound financial and resource management practices in the Victorian public sector by:

- enhancing key frameworks to drive performance
- monitoring Victorian Public Sector (VPS) agencies' compliance
- advising government and key stakeholders on financial and resource management and compliance issues
- ensuring that financial and resource management frameworks are established and complied with
- promoting continuous improvement in VPS resource allocation and management through regular reviews and updates to ensure the frameworks represent good practice
- promoting awareness of financial management accountabilities and roles.

This output contributes to the Department's objective to optimise Victoria's fiscal resources.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of funding reviews contributed to by DTF	number	3	5	3	8
The 2021-22 expected outcome is higher than the 2021-22 target due to the number of funding reviews commissioned for 2021-22.					
Quality					
Variance of the revised estimate of general government budget expenditure	per cent	≤5.0	≤5.0	≤5.0	1.9
Unqualified audit reports/reviews for the State of Victoria Financial Report and Estimated Financial Statements	number	2	2	2	3
Recommendations on financial management framework matters made by PAEC and VAGO and supported by Government are actioned	per cent	100	100	100	100
VPS stakeholder feedback indicates delivery of advice and information sessions supported the financial reporting framework across the VPS and supported the VPS to understand the financial management framework	per cent	80	80	80	100
Timeliness					
Delivery of advice to Government on portfolio performance within agreed timeframes	per cent	100	100	100	100
Annual Budget published by date agreed by Treasurer	date	May 2023	May 2022	May 2022	May 2021
Budget Update, Pre-Election Budget Update, Financial Report for the State of Victoria, Mid-Year Financial Report, and Quarterly Financial Reports are transmitted by legislated timelines	per cent	100	100	100	100
This performance measure renames the 2021-22 performance measure 'Budget Update, Financial Report for the State of Victoria, Mid-Year Financial Report, and Quarterly Financial Reports are transmitted by legislated timelines' to include the Pre-Election Budget Update as a publication required to be submitted by a legislated timeline in 2022-23.					
Annual financial management compliance report for the previous financial year is submitted to the Assistant Treasurer	date	By 15 Dec 2022	By 15 Dec 2021	By 15 Dec 2021	May 2021
Cost					
Total output cost	$ million	36.1	37.7	36.8	36.9

Source: Department of Treasury and Finance

Revenue Management and Administrative Services to Government (2022-23: $154.7 million)

This output provides revenue management and administrative services across the various state-based taxes in a fair and efficient manner for the benefit of all Victorians. By administering Victoria's taxation legislation and collecting a range of taxes, duties and levies, this output contributes to the Department's objective to optimise Victoria's fiscal resources.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Revenue collected as a percentage of State budget target	per cent	≥99	≥99	≥99	105
Cost to collect $100 of tax revenue raised is less than the average of State and Territory Revenue Offices	achieved/ not achieved	achieved	achieved	achieved	achieved
Compliance revenue assessed meets target	per cent	≥95	≥95	≥95	81
Quality					
Customer satisfaction level	per cent	≥85	≥85	≥85	96
Ratio of outstanding debt to total revenue (monthly average)	per cent	<2	3.2	<2	3.2
The 2021-22 expected outcome is higher than the 2021-22 target due to policies implemented as a result of the COVID-19 pandemic including payment deferrals, extensions, suspension of reminder letters, legal action and use of external debt collectors. The SRO is undertaking targeted debt collection activities and has also initiated a phased transition to business-as-usual debt recovery activities, which will result in a reduction in the ratio of outstanding debt to total revenue.					
Objections received to assessments issued as a result of compliance projects	per cent	<3	<3	<3	2.3
Timeliness					
Revenue banked on day of receipt	per cent	≥99	100	≥99	100
Timely handling of objections (within 90 days)	per cent	≥80	80	≥80	78
Timely handling of private rulings (within 90 days)	per cent	≥80	80	≥80	89
Achievement of scheduled milestones in budget funded projects of Master Data Management Toolsets, Identity and Access Management system and Microservices implementation	per cent	>85	nm	nm	nm
New performance measure for 2022-23 to reflect Government priorities which received new funding in 2021-22.					
Cost					
Total output cost	$ million	154.7	155.3	153.1	145.2

Source: Department of Treasury and Finance

Objective 2: Strengthen Victoria's economic performance

Under this objective, the Department delivers advice on economic policy, forecasts, legislation and frameworks. It also supports Government by administering economic regulation of utilities and other specified markets in Victoria to protect the long-term interests of Victorian consumers with regard to price, quality, efficiency and reliability of essential services.

The Department leads the development of advice to Government on key economic and financial strategies including regulatory reform, Government tax policy and intergovernmental relations to drive improvements in Victoria's productive and efficient resource allocation, competitiveness and equity across the Victorian economy.

Invest Victoria contributes to the Department's objective to strengthen Victoria's economic performance through facilitating private sector investment in Victoria. This is achieved through a focus on investments that strengthen innovation, productivity, job creation and diversification of Victoria's economy.

The departmental objective indicators are:

- economic growth to exceed population growth as expressed by GSP per capita increasing in real terms (annual percentage change)
- total Victorian employment to grow each year (annual percentage change)
- advice contributes to the achievement of Government policies and priorities relating to economic and social outcomes.

Outputs

Economic and Policy Advice (2022-23: $81.3 million)

This output contributes to the Department's objective to strengthen Victoria's economic performance through increased productive and efficient resource allocation, competitiveness and equity by providing evidence, advice and engagement on:

- medium and longer-term strategies to strengthen productivity, participation and the State's overall competitiveness
- State tax and revenue policy
- intergovernmental relations, including the distribution of Commonwealth funding to Australian states and territories (including representation on various inter-jurisdictional committees)
- production of the economic and revenue forecasts that underpin the State budget
- economic cost benefit analysis, demand forecasting and evaluation of best practice regulatory frameworks
- approaches for innovative, effective and efficient delivery of government services, including social services.

This output also provides advice on ways the Government can improve the business environment by the Commissioner for Better Regulation and Red Tape Commissioner:

- reviewing Regulatory Impact Statements, Legislative Impact Assessments, and providing advice for Regulatory Change Measurements
- assisting agencies to improve the quality of regulation in Victoria and undertaking research into matters referred to it by the Government
- operating Victoria's competitive neutrality unit
- working with businesses and not-for-profit organisations to identify and solve red tape issues.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Economic research projects and papers completed that contribute to deeper understanding of economic issues and development of government policy	number	8	8	8	8
Regulation reviews completed	number	6	6	6	nm
High-level engagement with non-Victorian Public Service stakeholder groups that contributes to public policy debate	number	20	30	20	43
The 2021-22 expected outcome is higher than the 2021-22 target due to more intensive stakeholder consultation that has occurred to inform implementation of key programs.					
Home purchases settled through the Victorian Homebuyer Fund	number	600	nm	nm	nm
New performance measure for 2022-23 to provide insight into the Big Housing Build's impact on economic recovery and achievement of housing outcomes.					
Social Housing dwellings committed by the Social Housing Growth Fund Grants Program	number	500	nm	nm	nm
New performance measure for 2022-23 to provide insight into the Big Housing Build's impact on economic recovery and achievement of housing outcomes.					
Quality					
Conduct an annual survey to assess the impact of changes to Victorian regulations on business	number	1	1	1	1
Accuracy of estimating State taxation revenue in the State budget	percentage variance	≤5.0	>5	≤5.0	13
The 2021-22 expected outcome is higher than the 2021-22 target largely owing to higher than forecast land transfer duty collections associated with stronger than expected activity in the Victorian property market. This is likely to continue during the fourth quarter of 2021-22.					
Accuracy of estimating the employment growth rate in the State budget	percentage point variance	≤1.0	≤1.0	≤1.0	2.25
Accuracy of estimating the gross state product rate in the State budget	percentage point variance	≤1.0	≤1.0	≤1.0	3.6

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Better Regulation Victoria's support for preparing Regulatory Impact Statements or Legislative Impact Assessments was valuable overall, as assessed by departments	per cent	90	100	90	100
The 2021-22 expected outcome is higher than the 2021-22 target due to Better Regulation Victoria consistently receiving positive feedback this year when reviewing Regulatory Impact Statements or Legislative Impact Assessments.					
Proportion of people making inquiries to the Red Tape Unit who found it responsive to issues raised	per cent	80	80	80	86
Benefit to business as a ratio of red tape savings delivered by the Business Acceleration Fund	ratio	2:1	nm	nm	nm
New performance measure for 2022-23 to reflect new funding for regulatory reform.					
Timeliness					
Briefings on key Australian Bureau of Statistics economic data on the day of release	per cent	100	100	100	100
Better Regulation Victoria's advice on Regulatory Impact Statements or Legislative Impact Assessments was timely, as assessed by departments	per cent	90	100	90	96
The 2021-22 expected outcome is higher than the 2021-22 target due to Better Regulation Victoria consistently receiving positive feedback this year when reviewing Regulatory Impact Statements or Legislative Impact Assessments.					
Regulation reviews completed by scheduled date	per cent	100	100	100	nm
Cost					
Total output cost	$ million	81.3	104.6	96.8	52.8
The 2021-22 expected outcome is higher than the 2021-22 target due to funding allocated for the Victorian Homebuyer Fund after the published budget. *The lower 2022-23 target reflects higher funding allocated for the Regulatory Reform Packages in 2021-22 in response to COVID-19 support initiatives.*					

Source: Department of Treasury and Finance

Economic Regulatory Services (2022-23: $35.7 million)

This output provides economic regulation of utilities and other specified markets in Victoria to protect the long-term interests of Victorian consumers with regard to price, quality, reliability and efficiency of essential services. By providing these services, this output contributes to the Departmental objective to strengthen Victoria's economic performance.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Performance reports for regulated industries	number	12	16	12	23
This performance measure renames the 2021-22 performance measure 'Performance reports for regulated businesses or industries' to better reflect the intent of the measure. *The 2021-22 expected outcome is higher than the 2021-22 target due to monthly COVID-19 reporting by the energy division.*					
Performance reviews and compliance audits of regulated businesses	number	150	101	142	145
The 2021-22 expected outcome is lower than the 2021-22 target due to an extension to the timeframe for energy retailers to submit information on their certificate obligations. *The higher 2022-23 target reflects new funding for the expansion of the Victorian Energy Upgrades Program.*					
Price determinations of regulated businesses	number	20	18	20	19
This performance measure replaces the 2021-22 performance measure 'Price approvals of regulated businesses' to better reflect the intent of the measure. *The 2021-22 expected outcome is lower than the 2021-22 target due to no applications being received for council rate variations.*					
Registration, project-based activity, product and accreditation decisions/approvals in relation to the Victorian Energy Upgrades program	number	6 000	7 672	5 250	5295
The 2021-22 expected outcome is higher than the 2021-22 target because updated processes have resulted in more approval decisions. *The higher 2022-23 target reflects new funding for the expansion of the Victorian Energy Upgrades Program.*					
Reviews, investigations or advisory projects	number	2	3	2	5
The 2021-22 expected outcome is higher than the 2021-22 target due the inclusion of the five yearly Port of Melbourne pricing review.					
Compliance and enforcement activities–energy	number	150	874	150	272
The 2021-22 expected outcome is higher than the 2021-22 target due to increased capability of the Commission to deliver compliance and enforcement actions, an increase in compliance activities and several large enforcement matters that were concluded.					
Setting of regulated price and tariffs in the energy sector	number	15	31	15	17
This performance measure renames the 2021-22 performance measure 'Setting of regulated price and tariffs'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity. *The 2021-22 expected outcome is higher than the 2021-22 target due to additional Victorian Default Offer prices being set in the financial year.*					
Quality					
Stakeholder satisfaction survey result	per cent	≥ 65	nm	nm	nm
New performance measure for 2022-23 to reflect performance against industry standard.					
Timeliness					
Delivery of major milestones within agreed timelines	per cent	100	100	100	100

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Cost					
Total output cost	$ million	35.7	33.0	31.7	32.3
The higher 2022-23 target primarily reflects new funding announced in the 2022-23 Budget including *Supporting better customer protections in essential services.*					

Source: Department of Treasury and Finance

Invest Victoria (2022-23: $150.0 million)

This output contributes to the Department's objective to strengthen Victoria's economic performance through facilitating private sector investment in Victoria. This is achieved through a focus on investments that strengthen innovation, productivity, job creation and export growth in Victoria's economy.

This output also provides support and advice to Government on Victoria's long-term economic development, including in relation to:

- ensuring Victoria is a leading destination for business, innovation and talent globally
- continuous enhancement on Victoria's approach to investment attraction
- enhancing Victoria's business investment environment.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Jobs generated from international investment secured through Government facilitation services and assistance	number	1 250	1 750	1 250	5 740
The 2021-22 expected outcome is higher than the 2021-22 target due to several key projects that deliver over half of the measure.					
Innovation expenditure generated from international investment secured through Government facilitation services and assistance	$ million	135	150	60	496
The 2021-22 expected outcome is higher than the 2021-22 target due to one key project accounting for 70 per cent of the innovation measure. *The higher 2022-23 target reflects new funding for investment attraction activities.*					
Quality					
Wages generated from international investment secured through Government facilitation services and assistance	$ million	110	200	110	297
This performance measure is reclassified from a 'Quantity' to a 'Quality' measure to better reflect the intent of the measure. *The 2021-22 expected outcome is higher than the 2021-22 target due to two projects delivering almost 70 per cent of the wages measure.*					
Cost					
Total output cost	$ million	150.0	88.1	147.7	53.8
The 2021-22 expected outcome is lower than the 2021-22 target mainly due to the delays in a range of grants programs resulting from the COVID-19 pandemic and related economic conditions.					

Source: Department of Treasury and Finance

Objective 3: Improve how Government manages its balance sheet, commercial activities and public sector infrastructure

Under this objective, the Department delivers Government policies focused on overseeing the State's balance sheet, major infrastructure and Government Business Enterprises by the delivery and application of prudent financial and commercial principles and practices.

The Department leads the development of strategic commercial and financial advice to Government to support key decisions regarding the State's financial assets and liabilities and infrastructure investment to drive improvement in public sector commercial and asset management and the delivery of infrastructure for the State of Victoria.

The departmental objective indicators are:

- High-Value High-Risk (HVHR) projects have had risks identified and managed through tailored project assurance, policy advice and governance to increase the likelihood that projects are completed within agreed timeframes, budget and scope
- Government Business Enterprises performing against agreed financial and non-financial indicators
- advice contributes to the achievement of Government policies and priorities relating to Victoria's balance sheet, commercial activities and public sector infrastructure
- quality infrastructure drives economic growth activity in Victoria.

Outputs

Commercial and Infrastructure Advice (2022-23: $53.6 million)

This output contributes to the Department's objective to improve how Government manages its balance sheet, commercial activities and public sector infrastructure by:

- providing advice to Government and guidance to departments on infrastructure investment and other major commercial projects
- providing governance oversight of Government Business Enterprises and managing the Crown land sales program, acquisition and sale of freehold land, DTF-owned property assets, and the Greener Government Buildings Program
- providing advice and reports on the State's financial assets and liabilities and associated financial risks, including the State's investments, debts, unfunded superannuation, insurance claims liabilities and overseeing the registration and regulation of rental housing agencies
- providing commercial, financial and risk management advice to Government and guidance to departments regarding infrastructure projects including Partnerships Victoria projects, administration of the Market-led Proposals Guidelines and managing major commercial activities on behalf of Government
- Office of Projects Victoria (OPV) providing project advice on technical, scope, cost and scheduling matters at key milestones in a project's lifecycle to complement the economic, financial, contractual and risk advice provided by the Department
- management of Public Account operations
- overseeing potential commercialisation opportunities
- producing budget and financial reporting data for Government Business Enterprise sectors.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Gateway reviews undertaken	number	70	70	70	62
Develop and implement policy guidance and infrastructure investment frameworks to govern and build capability to deliver infrastructure	number	58	58	58	58.5
Develop and implement training to build capability to deliver infrastructure	number	56	56	56	64.5
Undertake project reviews to support the Government's program in the delivery of public infrastructure projects	number	12	12	12	10
Number of cost redesign reviews undertaken	number	3	9	9	nm
The lower 2022-23 target reflects the number of projects now proposed to be reviewed.					
Revenue from sale of surplus Government land including Crown land	$ million	150	150	150	97
Provision of PNFC/PFC financial estimates and actuals, along with commentary and analysis, for the State budget papers and financial reports	number	6	6	6	6
Number of HVHR project assurance plans in place	number	6	6	6	14
Percentage of registered housing agencies assessed annually against performance standards	per cent	90	90	90	97
This performance measure renames the 2021-22 performance measure 'Percentage of registered housing agencies assessed annually as meeting performance standards' to better reflect the intent of the measure. This performance measure measures the percentage of compliance assessments completed by the Housing Registrar annually. Further compliance and performance information is contained in the Housing Registrar's Sector Performance Report. *This performance measure is reclassified from 'Quality' to 'Quantity' measure to better reflect the intent of the measure.*					
Quality					
Conduct surveys on the stakeholder experiences of OPV initiatives to determine the effectiveness of project system initiatives, technical advice and trainings provided to internal government clients	grading	satisfactory	satisfactory	satisfactory	satisfactory
Credit agencies agree that the presentation and information provided support annual assessment	per cent	80	80	80	96
Senior responsible owner agrees Gateway review was beneficial and would impact positively on project outcomes	per cent	90	90	90	100
Timeliness					
Advice provided to Government on board appointments at least three months prior to upcoming board vacancies	per cent	100	100	100	100

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Analysis and review of corporate plans within two months of receipt	per cent	95	100	95	100
The 2021-22 expected outcome is higher than the 2021-22 target, as all corporate plans received were analysed and reviewed within two months of receipt.					
Dividend collection in accordance with budget decisions	per cent	100	100	100	100
Develop and implement reporting to ensure the effective monitoring of the delivery of HVHR public infrastructure commitments	per cent	100	100	100	100
Cost					
Total output cost	$ million	53.6	92.8	83.6	92.3
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to funding approved since the 2021-22 Budget such as COVID-19 Event Insurance and funding provided for site remediation works at the Energy Brix site. *The lower 2022-23 target reflects funding transferred from prior years into 2021-22 for providing advice on infrastructure investments and overseeing a range of commercial and transactional activities on behalf of the Government.*					

Source: Department of Treasury and Finance

Infrastructure Victoria (2022-23: $10.0 million)

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of publications or discussion papers released	number	6	10	6	6
The 2021-22 expected outcome is higher than the 2021-22 target due to the release of the Infrastructure Victoria 30-year infrastructure strategy in August 2021, increasing the overall number of expected publications for this financial year.					
Quality					
Stakeholder satisfaction with consultation process	per cent	75	75	75	81
Timeliness					
Delivery of research, advisory or infrastructure strategies within agreed timelines	per cent	100	100	100	100
Cost					
Total output cost	$ million	10.0	10.0	9.9	9.5

Source: Department of Treasury and Finance

Objective 4: Deliver strategic and efficient whole of government common services

Under this objective, the Department delivers whole of government common services through working with business partners.

The Department leads the delivery of integrated and client-centred whole of government services, policies and initiatives to achieve value for the Victorian public sector. Areas include procurement, office accommodation management, carpool and government library services.

The departmental objective indicators are:

- benefits delivered as a percentage of expenditure under DTF managed state purchasing contracts, including reduced and avoided costs
- low vacancy rates for government office accommodation maintained
- high-quality whole of government common services provided to government agencies, as assessed by feedback from key clients.

Outputs

Services to Government (2022-23: $53.1 million)

The output contributes to the Department's objective of delivering strategic and efficient whole of government common services to the Victorian public sector by:

- developing and maintaining a framework of whole of government policies, strategies, standards and guidelines which promote the efficient and effective use of common services including procurement, office accommodation management, carpool and government library services
- managing a program of whole of government procurement contracts to ensure optimum benefit to government
- supporting the operations of the Victorian Government Purchasing Board
- providing strategic and fit-for-purpose shared services advisory to clients to deliver value to the Victorian Government
- providing whole of government office accommodation and accommodation management
- providing carpool and government library services.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Total accommodation cost	$ per square metre per year	397	419	397	389
The 2021-22 expected outcome is higher than the 2021-22 target due to a large proportion of onboarded properties being located in the CBD/fringe with a higher $/sqm rental profile. Further, the Managed Portfolio has reduced with the vacated number of smaller regional sites and the offboarding of a significant site, which was the Jacksons Hill Sunbury site to DELWP. This reduction in the regional area, which generally carry lower $/sqm profile, has an adverse effect on the overall $/sqm.					
Workspace ratio	square metre per FTE	12.0	13.0	12.0	13.7
The 2021-22 expected outcome is higher than the 2021-22 target mainly due to the new space management system's (Serraview) maturation and validation meaning that more space was included which was excluded previously. While DTF is progressively implementing strategies and initiatives to increase utilisation to support progress towards achieving the target, lockdowns and pandemic considerations have delayed some of these strategies. It is expected that following full implementation of return to the office and the ongoing transition towards hybrid and flexible working that future workspace ratio results will progressively fall to 12sqm per FTE.					
Percentage of agencies reporting full compliance with VGPB Supply Policies	per cent	100	nm	nm	nm
New performance measure for 2022-23 to reflect Government priorities regarding VGPB expansion agencies.					
Number of Zero Emission Vehicles acquired via VicFleet	number	325	nm	nm	nm
New performance measure for 2022-23 to reflect Government priorities regarding commitment to low emission vehicles.					
Number of State procurement high value engagements supported	number	70	nm	nm	nm
New performance measure for 2022-23 to reflect approved budget funding.					
Quality					
Client agencies' satisfaction with the service provided by the Shared Service Provider	per cent	70	70	70	70
Cost					
Total output cost	$ million	53.1	48.1	48.9	92.8
The higher 2022-23 target primarily reflects higher funding allocated in 2022-23 for the Zero Emission Vehicle Support Package.					

Source: Department of Treasury and Finance

PARLIAMENT
(INCLUDING THE VICTORIAN AUDITOR-GENERAL'S OFFICE, PARLIAMENTARY BUDGET OFFICE, AND THE INTEGRITY AGENCIES)

The Parliament of Victoria is an independent body that, through its elected representatives, is accountable to the Victorian community for the provision and conduct of representative government in the interests of Victorians.

The Parliament of Victoria's vision is to deliver apolitical, professional and innovative services which will support Victoria's elected representatives and the Parliament as an institution to ensure the proper, effective and independent functioning of the Parliament.

Victorian Auditor-General's Office

Victoria's *Constitution Act 1975* provides that the Auditor-General is an independent officer of Parliament. For budgetary purposes, the Victorian Auditor-General's Office is included as an output classification within Parliament.

The main purpose of the Victorian Auditor-General's Office is to provide assurance to Parliament on the accountability and performance of the Victorian public sector.

Parliamentary Budget Office

The Parliamentary Budget Office informs policy choices by providing trusted fiscal, economic, and financial advice.

Independent Broad-based Anti-corruption Commission

The Independent Broad-based Anti-corruption Commission (IBAC) is Victoria's independent anti-corruption agency responsible for identifying and preventing public sector corruption and police misconduct. Our jurisdiction covers state and local government, police, parliament and the judiciary.

The Commissioner is appointed by the Governor in Council and holds office for a term of 5 years. For budgetary purposes, the Independent Broad-based Anti-corruption Commission is included as an output classification within Parliament. The Independent Broad-based Anti-corruption Commission reports direct to Parliament.

Under the General Order, the Attorney-General is responsible for overseeing IBAC's legislation.

Victorian Inspectorate

The Inspector is appointed by the Governor in Council and holds office for a term of five years. As an Independent Officer of the Parliament, the Inspector reports directly to Parliament and does not report to any Minister. For budgetary purposes, the Victorian Inspectorate (VI) is included as an output classification within Parliament. The VI was established in 2013 by the *Victorian Inspectorate Act 2011*, to provide oversight of other integrity, accountability or investigatory bodies and their officers.

Victorian Ombudsman

The Victorian Ombudsman provides a service essential to promoting public confidence in the integrity of government. In view of the unique nature of its work, investigating government-related decisions and promoting accountability, the Victorian Ombudsman seeks to be above, and be seen to be above, the politics of the day, funded to do the job expected by Parliament.

The Ombudsman acts to ensure fairness for Victorians in their dealings with the public sector and to improve public administration. The Ombudsman is open, transparent and evidence-based, focussing on practical and meaningful outcomes to address injustice. The Ombudsman is sensitive to the circumstances of individuals and communities with specific needs.

Departmental objectives

Parliament

The Departments of the Parliament of Victoria aim to:

- support Members to fulfil their roles
- protect the independence and integrity of Parliament
- inform and engage with the community
- engage with Victoria's First People
- ensure the organisational resilience and efficiency of Parliament.

Victorian Auditor-General's Office

The Victorian Auditor-General's Office vision is for 'Better lives for Victorians through our insights and influence' and aims to:

- increase our relevance – be more relevant by delivering credible and authoritative reports and advice about things that matter and will make a difference
- grow our influence – be valued for our independence and more influential because of the unique perspectives provided
- invest in our people – enable high performance by our people through a supportive culture, professional development and collaboration
- lead by example – model exemplary performance in everything the Victorian Auditor-General's Office does.

Parliamentary Budget Office

The Parliamentary Budget Office:

- provides members of parliament with ongoing, authoritative, independent, and credible policy costing and advisory services
- provides policy costing and advisory services that are delivered in a timely, relevant, and readily understandable manner
- informs policy development and public debate in the parliament and the community.

Independent Broad-based Anti-corruption Commission objectives

The Independent Broad-based Anti-corruption Commission aims to prevent and expose public sector corruption and police misconduct in Victoria.

The Commission does this by:

- receiving and assessing complaints and notifications, including assessing all complaints to see if they qualify as public interest disclosures
- referring matters to other appropriate agencies (such as public sector bodies and integrity agencies) for action
- investigating allegations of serious or systemic corruption and police misconduct
- undertaking strategic research and other initiatives to inform the public sector, police and the community of the detrimental impacts of corruption and how it can be prevented.

Victorian Inspectorate

The Victorian Inspectorate's vision is that Victoria's integrity system is robust and trusted.

Aspirations

Public confidence and trust in Victoria's integrity system

- The right checks and balances are in place.
- Participants understand rights and responsibilities in the integrity system.
- The community knows when to come to the VI to protect their rights.

A robust Victorian integrity system

- Parliament and integrity agencies have confidence in the VI.
- The VI is positively influencing integrity agencies.
- Intrusive and coercive powers are exercised lawfully.
- The public sector is being held to account.

Victorian Ombudsman

The Ombudsman acts to ensure fairness for Victorians in their dealings with the public sector and to improve public administration. The Ombudsman is open, transparent and evidence-based, focusing on practical and meaningful outcomes to address injustice. The Ombudsman is sensitive to the circumstances of individuals and communities with specific needs.

Ensure Fairness

- Independent and impartial complaint resolution.
- Encourage fair and reasonable decision making within the public sector.

Enhance integrity and accountability

- Independently investigates serious matters.
- Reports on misconduct and poor administration.

Support Innovation and Improvement

- Assist agencies to learn from complaints and investigations.
- Investigate systemic issues and identify solutions.

Protect Humans Rights

- Investigate whether an action or decision is incompatible with human rights.
- Make it easier for vulnerable people to complain.

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2021-22 budget	*2021-22 revised*	*2022-23 budget*	*Variation[(a)] %*
Legislative Council	23.5	20.8	21.5	(8.6)
Legislative Assembly	45.1	40.2	41.5	(8.0)
Parliamentary Services	133.7	126.3	137.3	2.7
Parliamentary Investigatory Committees	6.0	6.1	5.8	(3.3)
Parliamentary Budget Office	3.3	3.7	3.9	16.7
Victorian Inspectorate	7.3	7.5	7.9	8.2
Victorian Auditor-General's Office	46.8	47.8	47.6	1.7
Independent Broad-based Anti-corruption Commission	54.0	64.5	61.9	14.6
Victorian Ombudsman	20.2	20.6	21.2	5.0
Total	**339.9**	**337.5**	**348.6**	**2.5**

Source: Parliament of Victoria, Victorian Auditor-General's Office, Parliamentary Budget Office, Victorian Inspectorate, Victorian Ombudsman and Independent Broad-based Anti-corruption Commission

Note:

(a) Variation between 2021-22 budget and 2022-23 budget. Explanations for variations greater than five per cent are included in footnotes to the relevant outputs.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.20 outlines the Department's income from transactions and Table 2.21 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.20: Income from transactions **($ million)**

	2020-21 actual	*2021-22 budget*	*2021-22 revised*	*2022-23 budget*
Output appropriations	271.1	282.6	286.4	294.1
Special appropriations	46.1	56.1	48.5	50.1
Sale of goods and services	0.2	..	..	..
Total income from transactions [(a)]	**317.5**	**338.8**	**334.9**	**344.2**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Table 2.21: Parliamentary authority for resources **($ million)**

	2021-22 budget	*2021-22 revised*	*2022-23 budget*
Annual appropriations	**264.1**	**264.8**	**268.7**
Provision of outputs	248.2	251.2	256.4
Additions to the net asset base	15.9	13.6	12.3
Payments made on behalf of the State	..	..	..
Receipts credited to appropriations	**27.7**	**30.0**	**30.8**
Unapplied previous years appropriation	**6.7**	**5.3**	**6.9**
Provision of outputs	6.7	5.2	6.9
Additions to the net asset base	0.1	0.1	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**298.6**	**300.1**	**306.4**
Special appropriations	**56.1**	**59.0**	**56.5**
Trust funds	**..**	**..**	**..**
Total parliamentary authority [(a)]	**354.7**	**359.2**	**362.8**

Source: Department of Treasury and Finance

Note:
(a) Table may not add due to rounding.

Departmental performance statement

Outputs

Legislative Council (2022-23: $21.5 million)

This output involves the provision of procedural advice to Members of the Legislative Council including: processing of legislation; preparation of the records of the proceedings and documentation required for the sittings of the Council; provision of assistance to Parliamentary Committees; provision of information relating to the proceedings of the Council; and the enhancement of public awareness of Parliament.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Procedural References – updates published biannually	number	2	2	2	2
Quarterly allowance reports published in accordance with *Victorian Independent Remuneration Tribunal and Improving Parliamentary Standards Act 2019*	number	4	4	4	4
Quality					
Bills and amendments processed accurately through all relevant stages and other business of the House conducted according to law, Standing and Sessional Orders	per cent	98	98	98	95
Member satisfaction with accuracy, clarity and timeliness of advice	per cent	80	80	80	100
Timeliness					
Documents tabled within time guidelines	per cent	90	90	90	90
House documents and other Sitting related information available one day after sitting day	per cent	95	95	95	95
Cost					
Total output cost	$ million	21.5	20.8	23.5	19.4

The lower 2021-22 expected outcome and lower 2022-23 target reflect no contributions required for Members of Parliament defined benefit scheme (Parliamentary Contributory Super Fund) in 2021-22 and 2022-23.

Source: Parliament of Victoria

Legislative Assembly (2022-23: $41.5 million)

This output involves the provision of procedural advice to Members of the Legislative Assembly including: processing of legislation; preparation of the records of the proceedings and documentation required for the sittings of the Assembly; provision of assistance to Parliamentary Committees; provision of information relating to the proceedings of the Assembly; and the enhancement of public awareness of Parliament.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Procedural References – updates published biannually	number	2	2	2	2
Quarterly allowance reports published in accordance with *Victorian Independent Remuneration Tribunal and Improving Parliamentary Standards Act 2019*	number	4	4	4	4
Regional visits to schools to conduct Parliamentary role plays	number	5	5	5	1
The 2020-21 expected outcome is lower than the 2021-22 target as only one regional visit was possible in 2020-21 due to COVID-19 restrictions. Online incursions have been offered to regional schools instead.					
Quality					
Bills and amendments processed accurately through all relevant stages in compliance with constitutional requirements and standing orders	per cent	100	100	100	100
Member satisfaction that advice is responsive, prompt, clear and objective	per cent	80	80	80	99
Teacher satisfaction with school tours of Parliament for school groups and outreach programs	per cent	95	95	95	100
This performance measure renames the 2021-22 performance measure 'Teacher satisfaction with tours of Parliament for school groups'. The new measure expands the scope of the output to capture the metropolitan schools visits and online incursions delivered by the Department and better reflect the range of programs delivered to schools.					
Timeliness					
Documents tabled within time guidelines	per cent	90	90	90	100
House documents available one day after sitting day	per cent	100	100	100	100
Online information relating to bills updated within one day	per cent	95	95	95	100
Cost					
Total output cost	$ million	41.5	40.2	45.1	38.4
The lower 2021-22 expected outcome and the lower 2022-23 target reflect no contributions required for Members of Parliament's defined benefit scheme (Parliamentary Contributory Super Fund) in 2021-22 and 2022-23.					

Source: Parliament of Victoria

Parliamentary Investigatory Committees (2022-23: $5.8 million)

Joint Investigatory Committees are appointed pursuant to the *Parliamentary Committees Act 2003* to inquire into and report on matters referred by either House or the Governor in Council, or which may be self-generated by a committee.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Reports tabled per annum	number	10	20	20	24
The 2022-23 target has been reduced due to the number of committee inquiries completed in 2022-23 will be lower because the Parliament is dissolved in the lead up to the State election in November 2022. After the election it is customary for a delay in re-establishing committees and starting new inquiries.					
Quality					
Committee members satisfied that advice about procedure, research and administration is responsive, clear, objective and prompt	per cent	80	80	80	97
Inquiries conducted and reports produced in compliance with procedural and legislative requirements	per cent	95	95	95	100
Timeliness					
Reports tabled in compliance with procedural and legislative deadlines	per cent	95	95	95	100
Cost					
Total output cost	$ million	5.8	6.1	6.0	5.5
The 2021-22 financial year for the Integrity and Oversight Committee has one-off funding for an audit of IBAC.					

Source: Parliament of Victoria

Parliamentary Services (2022-23: $137.3 million)

Parliamentary Services provides consultancy, advisory and support services in the areas of library, Hansard, education, human resources, finance, security, information technology (IT), maintenance, grounds and facilities along with planning, implementation and management of capital projects, for the Parliament of Victoria.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Percentage of chamber proceedings available to MP's and Electorate Officers through Video on Demand.	per cent	99	99	99	100
Quarterly budget reports published in accordance with *Victorian Independent Remuneration Tribunal and Improving Parliamentary Standards Act 2019*	number	4	4	4	4
Provide MPs with an approved standard electorate office	per cent	95	95	95	98
Quality					
Clients satisfied with quality of information provided by Library staff	per cent	85	85	85	99
MP Offices visited by a member of DPS Staff during the year	per cent	95	95	95	95
Legislative activities at Parliament House undisrupted by service interruptions or security incidents	per cent	98	98	98	100
Scheduled availability of IT systems (network, email, and windows file and print)	per cent	99	99	99	99
Timeliness					
Indexes, records, speeches, video and transcripts available within published timeframes	per cent	85	85	85	94
Payroll processing completed accurately and within agreed timeframes	per cent	99	99	99	99
Monthly budget management reports to MPs and departments within five business days after closing monthly accounts	number	12	12	12	12
Cost					
Total output cost	$ million	137.3	126.3	133.7	136.0

Source: Parliament of Victoria

Parliamentary Budget Office (2022-23: $3.9 million)

The Parliamentary Budget Office provides independent and confidential policy costing and advisory services to all members of parliament.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of requests	number	210	275	210	236
Request completion rate	per cent	80	95	80	88
The PBO has been able to complete MP requests from previous financial years after obtaining a number of responses to long-term outstanding public sector information requests.					
Quality					
Parliamentary stakeholder satisfaction	per cent	80	92	80	93
The PBO continues its strategy to enhance relationships and the value we provide through more systemic client relationship management approaches.					
Timeliness					
Requests responded to by date	per cent	80	90	80	95
The PBO has developed repeatable costing models and alternative data sources in response to public sector information supply performance.					
Cost					
Total output cost	$ million	3.9	3.7	3.3	3.3
The higher 2022-23 target reflects the impact of 2021-22 Budget *funding of $0.9 million provided for 2022 general election services.*					

Source: Parliamentary Budget Office

Victorian Inspectorate (2022-23: $7.9 million)

The Victorian Inspectorate (VI) was established to provide oversight of other integrity, accountability or investigatory bodies and their officers. The VI is committed to providing the Parliament and the people of Victoria with independent assurance that these bodies, which collectively constitute Victoria's 'integrity system', act lawfully and properly in the performance of their functions. Under the *Victorian Inspectorate Act 2011*, the VI receives and investigates complaints, monitors how bodies use their coercive powers and inspects records of bodies that use covert powers including the conduct of controlled operations and the use of surveillance devices and police counter-terrorism powers. In addition, the VI has a key function under the *Public Interest Disclosures Act 2012* to receive disclosures and to assess and investigate some public interest complaints.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Recommendations of the VI accepted by the agencies	per cent	75	75	75	100
Reasons for decisions provided for complaint outcomes	per cent	100	100	100	100
Educational activities delivered and material or tools produced	number	2	nm	nm	nm
New performance measure for 2022-23 relating to delivering education activities and producing materials and tools as a preventative measure to help improve the public sector, community, and the legal profession's understanding of the integrity system. This data will be taken from the VI's case management system.					
Quality					
Improvements to the integrity systems	number	6	6	6	5
Timeliness					
Acknowledge receipt of new complaints within 5 business days	per cent	95	nm	nm	nm
New performance measure for 2022-23 to reflect the increased funding for the Victorian Inspectorate.					
Proportion of standard VI investigations completed within 12 months	per cent	30	nm	nm	nm
New performance measure for 2022-23 to reflect the increased funding for the Victorian Inspectorate. The target for completion of investigations is relatively low as the VI is unable to control the number of investigations it undertakes due to the VI's statutory requirement to investigate all public interest complaints.					
Cost					
Total output cost	$ million	7.9	7.1	7.3	4.9
The 2022-23 budget is higher than the 2021-22 revised budget primarily due to the impact of the Victorian Inspectorate base funding initiative in the 2022-23 Budget.					

Source: Victorian Inspectorate

Victorian Auditor-General's Office

The purpose of the Victorian Auditor-General's Office is to help the Parliament hold government to account and help the public sector to improve its performance. Under the *Audit Act 1994*, the Auditor-General audits financial statements prepared by Victorian public sector agencies and issues audit reports. In addition, the Auditor-General carries out performance audits and assurance reviews to determine whether authorities, operations or activities are operating effectively, economically and efficiently in compliance with all relevant Acts.

Audit opinions on financial and performance statements (2022-23: $28.9 million)

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Average cost of audit opinions issued on performance statements *The higher 2022-23 target reflects indexation.*	$ thousand	5.5	5.2	5.4	5.2
Average cost of audit opinions issued on the financial statements of agencies *The 2021-22 expected outcome is higher than the 2021-22 target mainly due to additional employee and contractor costs as more financial audit resources than planned were needed to meet the legislated work program.* *The higher 2022-23 target reflects indexation.*	$ thousand	50.8	52.8	50.0	50.7
Quality					
External/peer reviews finding no material departures from professional and regulatory standards *The 2021-22 expected outcome is lower than the 2021-22 target because one of the 17 audit files reviewed was found to have some material departures from professional standards. Despite this, VAGO is expected to observe a very low disclosure rate of prior period errors by agencies during 2021-22, which indicates that any identified material departures from standards are not leading to incorrect audit opinions.*	per cent	100	94	100	81.2
Proportion of agencies disclosing prior period material errors in financial statements *The 2021-22 expected outcome is lower than the 2021-22 target due to the continued focus on audit quality in the conduct of our audits.*	per cent	≤5	1.1	≤5	2.0
Timeliness					
Audit opinions issued within statutory deadlines	per cent	98	98	98	97.3
Management letters to agencies issued within established timeframes	per cent	90	90	90	93.8
Cost					
Total output cost *The higher 2022-23 target reflects indexation.*	$ million	28.9	29.8	28.4	28.9

Source: Victorian Auditor-General's Office

Parliamentary reports and services (2022-23: $18.7 million)

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Average cost of parliamentary reports	$ thousand	535.4	628.0	527.0	535.3
The 2021-22 expected outcome is higher than the 2021-22 target due to the increase in time taken to produce performance audits. *The higher 2022-23 target reflects indexation.*					
Quality					
Percentage of performance audit recommendations accepted which are reported as implemented by audited agencies	per cent	80	72	80	70.8
The 2021-22 expected outcome is lower than the 2021-22 target as agencies have continued to be affected by the impacts of COVID-19. This has caused delays in implementing audit recommendations.					
Overall level of external satisfaction with audit reports and services–parliamentarians	per cent	85	85	85	87.5
Timeliness					
Average duration taken to finalise responses to inquiries from Members of Parliaments (MPs)	days	≤20	17	≤20	12
The 2021-22 expected outcome is lower than the 2021-22 due to the continued focus on identifying process efficiencies.					
Average duration taken to produce performance audit parliamentary reports	months	≤9	13.0	≤9	12.2
The 2021-22 expected outcome is higher than the 2021-22 target due to delays in the conduct of audits caused by the impacts of COVID-19, unplanned staff leave and external secondments.					
Average duration taken to produce financial audit parliamentary reports after balance date	months	≤5	4.9	≤5	6.7
Cost					
Total output cost	$ million	18.7	18.0	18.4	16.8
The higher 2022-23 target reflects indexation.					

Source: Victorian Auditor-General's Office

Independent Broad-based Anti-corruption Commission (2022-23: $61.9 million)

The Independent Broad-based Anti-corruption Commission (IBAC) is Victoria's agency responsible for preventing and exposing public sector corruption and police misconduct. Our jurisdiction covers state and local government, police, parliament and the judiciary.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Corruption prevention measures delivered by IBAC	number	115	136	100	115
The 2021-22 expected outcome is higher than the 2021-22 target, due to an increased emphasis on producing prevention resources for the public sector, an increased number of speaking engagements and events, and the publication of several reports based on recent investigations, including several special reports. *The higher 2022-23 target reflects additional funding received to deliver corruption prevention activities.*					
Quality					
Satisfaction rating with corruption prevention initiatives delivered by IBAC	per cent	95	95	95	99

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Timeliness					
Public Interest Disclosure (PID) complaints and notifications assessed within 30 days	per cent	70	65	70	nm
The 2021-22 expected outcome is lower than the 2021-22 target as a result of significant impacts from resourcing constraints. Given the fixed term resources that IBAC has been able to employ pursuant to the Treasurer's Advance, IBAC expects the results will improve in second half of 2021-22.					
Complaints or notifications about public sector corrupt conduct (excluding police personnel conduct and police personnel corrupt conduct) assessed by IBAC within 45 days	per cent	85	65	85	46
The 2021-22 expected outcome is lower than the 2021-22 target as a result of significant impacts from resourcing constraints. Given the fixed term resources that IBAC has been able to employ pursuant to the Treasurer's Advance, IBAC expects the results will improve in second half of 2021-22.					
Complaints or notifications about police personnel conduct and police personnel corrupt conduct assessed by IBAC within 45 days	per cent	85	65	90	49
The 2021-22 expected outcome is lower than the 2021-22 target as a result of significant impacts resourcing constraints. Given the fixed term resources that IBAC has been able to employ pursuant to the Treasurer's Advance, IBAC expects the results will improve in second half of 2021-22.					
Proportion of standard IBAC investigations into public sector corrupt conduct (excluding police personnel conduct and police personnel corrupt conduct) completed within 9 months	per cent	60	60	60	0
Proportion of complex IBAC investigations into public sector corrupt conduct (excluding police personnel conduct and police personnel corrupt conduct) completed within 18 months	per cent	60	60	60	50
Proportion of standard IBAC investigations into police personnel conduct and police personnel corrupt conduct completed within 9 months	per cent	60	60	60	0
Proportion of complex IBAC investigations into police personnel conduct and police personnel corrupt conduct completed within 18 months	per cent	60	60	60	0
Cost					
Total output cost	$ million	61.9	64.5	54.0	46.2
The 2021-22 expected outcome is higher than the target as it includes $3.5 million allocation from the IBAC Trust fund and Treasurer's Advance of $7 million in 2021-22.					
The higher 2022-23 target reflects additional funding for an increase to base operational funding, subject to $7 million in funding being released to the entity upon completion of the IBAC base review.					

Source: Independent Broad-based Anti-corruption Commission

Victorian Ombudsman (2022-23: $21.2 million)

The Ombudsman is a constitutional entrenched and independent officer of Parliament. Under the *Ombudsman Act 1973* (Vic), the Ombudsman resolves and investigates complaints, protected disclosure complaints and 'own motion' matters. The Ombudsman is a timely, efficient, effective, flexible and independent means of resolving complaints about administrative actions of authorities, and has a role to expose and prevent maladministration, improper conduct and corrupt conduct. Core to the Ombudsman's role is to improve the quality of public administration where an authority appears to have acted in a way that is unlawful, unreasonable, oppressive, unjust, improperly discriminatory or wrong.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of jurisdictional cases opened	number	18 000	19 268	14 000	18 058
This measure demonstrates the overall volume and output of complaints received. *This measure replaced the 2019-20 performance measure 'Number of jurisdictional cases finalised'. The measure is designed to enhance transparency and accountability as well as better reflect the work undertaken by the office within a financial year.* *The Public Accounts and Estimates Committee (PAEC) recommended as part of the 2021-22 Budget Estimates report tabled in Parliament on 5 October 2021, to review the discontinued measure 'Number of jurisdictional cases finalised'* *The Victorian Ombudsman has reviewed this request and while it notes the PAEC recommendation, the Victorian Ombudsman will continue to measure and report on 'Number of Jurisdictional cases opened.' The Victorian Ombudsman further notes that the timeliness measure of complaints closed within 30 days further speaks to the complaints finalisation accountability.* *The 2021-22 expected outcome is expected to be higher than the 21-22 target because this output is contingent on approaches to the office by members of the public, which is an external factor beyond the control of the Victorian Ombudsman. This leads to a variance between the target and the outcome.* *The higher 2022-23 target reflects 2020-21 actual performance and the higher 2021-22 expected outcome compared to the 2021-22 target.*					
Jurisdictional cases selected for enquiry/investigation	per cent	20	25	20	30
The performance measure reflects the Victorian Ombudsman's overall functions and activity, clarifying that it conducts both enquiries and investigations. It accurately portrays the Victorian Ombudsman's discretion to select cases for enquiry/investigation, which is done in consideration of the Victorian Ombudsman's strategic objectives and limited resources. *The 2021-22 expected outcome is higher than the 2021-22 target because where possible the Victorian Ombudsman has introduced 'batching' as a method to efficiently deal with enquiries into a number of complaints about a systemic issue.*					
Education and training participants	number	490	460	642	358
The measure is designed to support the educational function of the Victorian Ombudsman. The Victorian Ombudsman delivers training to the Victorian Public Sector agencies as an important preventative mechanism aimed at improving their decision making and ethical awareness. The higher 2022-23 target is subject to COVID restrictions which may adversely affect the overall output. *The Victoria Ombudsman target of 490 Education and training participants for the 2022-23 period is subject to the COVID-19 environment and the participants' preparedness to attend face to face or online training.*					
Quality					
Jurisdictional cases that lead to an agreed improvement (e.g., practice/policy/law reform, remedial/rectification/mitigation action)	per cent	35	65	35	19
The measure reflects the nature of the Victorian Ombudsman's role of facilitating administrative improvement/remedy. The measure includes jurisdictional cases that have been subject to enquiry/investigation in which an agency has agreed to take improvement action. It is intentional that the measure does not reflect the agency's implementation of the agreement, as this is dependent on external factors, such as legislative amendment, time considerations and funding. Instead, the Victorian Ombudsman monitors agencies' implementation of investigation recommendations and publishes the results in a biennial report. *The 2021-22 expected outcome is higher than the 2021-22 target due to Jurisdictional cases selected that lead to an agreed improvement being contingent on case issues having a remedy.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Public sector education program satisfaction rate	per cent	85	90	85	87
This measure supports the measure of 'education and training participants', and it quantifies and reflects the quality of the Victorian Ombudsman's education programs and the extent they are meeting the educational needs and expectations of the public sector participants. *The 2021-22 expected outcome is higher than the 2021-22 target due to continuous improvements in the Victorian Ombudsman's delivery of virtual training to participants during COVID-19 has seen an increase in satisfaction rates.*					
Complaint service satisfaction	per cent	60	55	60	57
This measure reflects complaint service satisfaction from members of the public who contact the Victorian Ombudsman for assistance. Surveys are conducted by an external vendor and results are provided to the Victorian Ombudsman quarterly to analyse and look for opportunities to improve our services. *The 2021-22 expected outcome is lower than the 2021-22 target because the Victorian Ombudsman continues to receive a significant amount of non-Jurisdictional complaints which affects service satisfaction results. Several initiatives are currently underway to support this measure.*					
Timeliness					
Complaints closed within 30 days	per cent	85	90	85	89
This measure supports the Ombudsman's business model to provide service excellence that is tailored to the unique and complex needs of the individuals who contact it, as opposed to providing a 'one size fits all' approach. *The 2021-22 expected outcome is higher than the 2021-22 target because the Victorian Ombudsman has been conducting workforce planning initiatives and system enhancements in prioritising resourcing to its early resolutions team to ensure timely closure of complaints.*					
Investigations closed within 12 months	per cent	80	80	80	93
This performance measure, together with the 'Complaints closed within 30 days' measure, seeks to provide performance insights into how the Victorian Ombudsman meets community expectations in relation to timely service delivery. *The 2021-22 expected outcome is lower than the 2021-22 target because the Victorian Ombudsman has implemented project management principles and system upgrades to support timely completion of its investigations.*					
Cost					
Total cost output	$ million	21.2	20.6	20.2	19.3
A Treasurer's Advance of $0.700 million in 2022-23 will also be approved to support the increasing number of overall jurisdictional complaints and complex complaints. *The 2021-22 expected outcome is higher than the 2021-22 target as the Victorian Ombudsman has commenced implementation of the alternative dispute resolution function and complaints review function.* *The 2022-23 target is higher than the 2021-22 target as the Victorian Ombudsman has experienced an increase in volume for community access and engagement.*					

Source: Victorian Ombudsman

COURT SERVICES VICTORIA

Ministerial portfolios

Victoria's courts and tribunals are part of the ministerial portfolio of the Attorney-General.

Departmental mission statement

Victoria's courts and tribunals' mission is to safeguard and maintain the rule of law through the fair, timely and efficient dispensing of justice.

Victoria's courts and tribunals are supported by Court Services Victoria, which is an independent statutory body established to provide administrative services and facilities to support Victorian courts, the Victorian Civil and Administrative Tribunal, the Judicial College of Victoria and the Judicial Commission of Victoria.

Departmental objectives

The fair, timely and efficient dispensing of justice

Victoria's courts and tribunals aim to:

- provide equal access to justice
- ensure fairness, impartiality and independence in decision making
- follow processes that are transparent, timely and certain
- strive for leadership and best practice in court administration
- strengthen links with the community.

The Courts output contributes to this objective by delivering court and tribunal services, which provide access to the highest standard of justice for the community, and inspire public confidence in the rule of law.

Output summary by departmental objectives

The Department's outputs and funding are provided in the table below. Detailed descriptions of objectives, outputs, together with their key performance indicators are presented in subsequent tables.

($ million)

	2021-22 budget	*2021-22 revised*	*2022-23 budget*	*Variation [(a)] %*
The fair, timely and efficient dispensing of justice				
Courts	755.2	766.9	815.8	8.0
Total	**755.2**	**766.9**	**815.8**	**8.0**

Source: Court Services Victoria

Note:

(a) Variation between 2021-22 budget and 2022-23 budget. Explanations for variations greater than five per cent are included in the footnotes to the relevant output cost.

Amounts available

The following tables detail the amounts available to the Department from Parliamentary authority and income generated through transactions.

Table 2.22 outlines the Department's income from transactions and Table 2.23 summarises the sources of Parliamentary authority available to the Department to fund the provision of outputs, additions to the net asset base, payments made on behalf of the State, and other sources expected to become available to the Department.

Table 2.22: Income from transactions **($ million)**

	2020-21 actual	*2021-22 budget*	*2021-22 revised*	*2022-23 budget*
Output appropriations	512.5	530.6	543.5	576.4
Special appropriations	170.1	200.6	200.6	216.7
Grants	28.0	24.0	22.8	22.7
Other income	0.4	..	..	..
Total income from transactions [(a)]	**710.9**	**755.2**	**766.9**	**815.8**

Source: Court Services Victoria

Note:
(a) Table may not add due to rounding.

Table 2.23: Parliamentary authority for resources **($ million)**

	2021-22 budget	*2021-22 revised*	*2022-23 budget*
Annual appropriations	**667.1**	**982.1**	**641.5**
Provision of outputs	455.8	473.0	500.9
Additions to the net asset base	211.3	509.1	140.5
Payments made on behalf of the State	..	..	..
Receipts credited to appropriations	**74.8**	**65.8**	**75.4**
Unapplied previous years appropriation	**..**	**25.3**	**..**
Provision of outputs	..	4.7	..
Additions to the net asset base	..	20.6	..
Payments made on behalf of the State	..	..	..
Gross annual appropriation	**741.9**	**1 073.2**	**716.9**
Special appropriations	**271.3**	**271.3**	**287.4**
Trust funds	**24.0**	**22.8**	**22.7**
Victorian Civil and Administrative Tribunal Trust [(a)]	23.8	20.6	20.6
Other [(b)]	0.3	2.2	2.1
Total parliamentary authority [(c)]	**1 037.2**	**1 367.2**	**1 027.0**

Source: Court Services Victoria

Notes:
(a) The purpose of this trust primarily relates to funding the Victorian Civil and Administrative Tribunal's Owners Corporation, Domestic Building, and Residential Tenancies lists.
(b) Includes inter-departmental transfers.
(c) Table may not add due to rounding.

Departmental performance statement

Objective 1: The fair, timely and efficient dispensing of justice

This objective delivers the fair, timely and efficient dispensing of justice for Victorians. It aims to provide equal access to justice for all, and ensure fairness, impartiality and independence in decision making. All processes followed by courts and tribunals are transparent, timely and certain for all parties. The delivery of this objective requires courts and tribunals to strive for leadership and best practice in court administration to dispense justice for Victorians, and engage with the community to strengthen their understanding of court procedure and confidence in the rule of law.

The departmental objective indicators are:

- clearance of criminal caseload (finalisations/lodgements)
- clearance of civil caseload (finalisations/lodgements).

Courts **(2022-23: $815.8 million)**

This output delivers impartial and independent dispensing of justice across six jurisdictions:

- Supreme Court of Victoria
- County Court of Victoria
- Magistrates' Court of Victoria
- Children's Court of Victoria
- Coroners Court of Victoria
- Victorian Civil and Administrative Tribunal.

Other areas that contribute to the achievement of this objective include functions that support the operation of each jurisdiction. These include:

- corporate and service functions delivered by Court Services Victoria
- criminal recording and transcription services delivered by the Victorian Government Reporting Service
- judicial training and education delivered by the Judicial College of Victoria
- investigative and other functions of the Judicial Commission of Victoria.

The performance measures below compare estimates and expected or actual results from the delivery of court services by the six jurisdictions as part of this output. Some performance measures have corresponding measures in other reports, such as the Productivity Commission's Report on Government Services. Despite similarities in names and descriptions of these measures, methodological differences between reports (such as counting rules) may lead to different results being published elsewhere.

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Average cost per case – Civil matters disposed in the Supreme Court	dollars	2 911	2 889	2 745	2 861
The 2021-22 expected outcome is higher than the 2021-22 target due to changes in the Court's operations in response to the COVID-19 public health restrictions, which resulted in a decrease in the number of cases expected to be finalised in 2021-22. *The higher 2022-23 target reflects a decrease in the number of cases expected to be finalised in comparison to the 2021-22 target, which did not account for the impact of COVID-19 on finalisations, and an increase in the Court's output budget.*					
Average cost per case – Civil matters disposed in the County Court	dollars	9 191	8 562	7 564	7 928
The 2021-22 expected outcome is higher than the 2021-22 target due to an increase in the output budget, and changes in the Court's operations in response to the COVID-19 public health restrictions which resulted in a decrease in the number of cases expected to be finalised in 2021-22. *The higher 2022-23 target reflects an increase in the Court's output budget.*					
Average cost per case – Civil matters disposed in the Magistrates' Court	dollars	1 548	1 508	1 083	1 022
The 2021-22 expected outcome is higher than the 2021-22 target due to changes in the Court's operations in response to the COVID-19 public health restrictions, which resulted in a decrease in the number of cases expected to be finalised in 2020-21. *The higher 2022-23 target reflects a decrease in the number of cases expected to be finalised in comparison to the 2021-22 target which did not account for the impact of COVID-19 on finalisations.*					
Average cost per case – Family Division matters disposed in the Children's Court	dollars	1 403	1 407	1 436	1 268
The lower 2022-23 target reflects an increase in the number of cases expected to be finalised in 2022-23.					
Average cost per case – Civil matters disposed in the Victorian Civil and Administrative Tribunal	dollars	1 556	1 498	1 185	1 386
The 2021-22 expected outcome is higher than the 2021-22 target due to changes in the Tribunal's operations in response to the COVID-19 public health restrictions, which resulted in a decrease in the number of cases expected to be finalised in 2021-22. *The higher 2022-23 target reflects an increase in the Tribunal's output budget and a decrease in the number of cases expected to be finalised in comparison to the 2021-22 target which did not account for the impact of COVID-19 on finalisations.*					
Average cost per case – Coronial matters disposed in the Coroners Court	dollars	3 944	4 053	4 267	4 095
The 2021-22 expected outcome is lower than the 2021-22 target due to an increase in the number of cases expected to be finalised in 2021-22. *The lower 2022-23 target reflects an increase in the number of cases expected to be finalised.*					
Average cost per case – Criminal matters disposed in the Supreme Court	dollars	47 476	46 280	47 757	42 115
The lower 2022-23 target reflects an increase in the number of cases expected to be finalised in 2021-22.					
Average cost per case – Criminal matters disposed in the County Court	dollars	25 127	40 936	17 936	27 684
The 2021-22 expected outcome is higher than the 2021-22 target due to an increase in the output budget, and changes in the Court's operations in response to the COVID-19 public health restrictions which resulted in a decrease in the number of cases expected to be finalised in 2021-22. *The higher 2022-23 target reflects an increase in the output budget and a decrease in the number of cases expected to be finalised in comparison to the 2021-22 target which did not account for the impact of COVID-19 on finalisations.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Average cost per case – Criminal matters disposed in the Magistrates' Court	dollars	1 728	1 714	1 342	1 747
The 2021-22 expected outcome is higher than the 2021-22 target due to changes in the Court's operations in response to the COVID-19 public health restrictions, which resulted in a decrease in the number of cases expected to be finalised in 2021-22. *The higher 2022-23 target reflects an increase in the output budget and a decrease in the number of cases expected to be finalised in comparison to the 2021-22 target which did not account for the impact of COVID-19 on finalisations.*					
Average cost per case – Criminal matters disposed in the Children's Court	dollars	1 055	1 245	1 130	1 626
The 2021-22 expected outcome is higher than the 2021-22 target due to a decrease in the number of cases expected to be finalised due to the impact of the COVID-19 pandemic on operations. *The lower 2022-23 target reflects an expected increase in finalisations to pre-COVID levels.*					
Case clearance rate – Civil matters disposed in the Supreme Court	per cent	100	100	100	98.3
The case clearance rate is calculated as (number of cases disposed/number of cases initiated).					
Case clearance rate – Civil matters disposed in the County Court	per cent	100	92	100	94.6
The case clearance rate is calculated as (number of cases disposed/number of cases initiated). *The 2021-22 expected outcome is lower than the 2021-22 target due to a decrease in finalisations, partly attributed to fewer Judicial Officers sitting in the Common Law Division as they were diverted to the Criminal Law Division to assist with the case backlog.*					
Case clearance rate – Civil matters disposed in the Magistrates' Court	per cent	104	100	100	87.4
The case clearance rate is calculated as (number of cases disposed/number of cases initiated). *The higher 2022-23 target reflects the anticipated benefits from 2022-23 budget decisions, most notably the proposed backlog reduction program.*					
Case clearance rate – Family Division matters disposed in the Children's Court	per cent	100	102	100	103
The case clearance rate is calculated as (number of cases disposed/number of cases initiated).					
Case clearance rate – Civil matters disposed in the Victorian Civil and Administrative Tribunal	per cent	100	83	100	81.8
The case clearance rate is calculated as (number of cases disposed/number of cases initiated). *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of the COVID-19 public health restrictions on VCAT operations. This included the temporary need to close VCAT offices in October 2021 due to COVID-19 exposure, increased participation from parties in online hearings (resulting in longer hearing times) and reduced availability of VCAT members to hear matters during the year.*					
Case clearance rate – Coronial matters disposed in the Coroners Court	per cent	100	100	100	93.4
The case clearance rate is calculated as (number of cases disposed/number of cases initiated).					
Case clearance rate – Criminal matters disposed in the Supreme Court	per cent	100	100	100	92.9
The case clearance rate is calculated as (number of cases disposed/number of cases initiated).					
Case clearance rate – Criminal matters disposed in the County Court	per cent	90	87	100	83.4
The case clearance rate is calculated as (number of cases disposed/number of cases initiated). *The 2021-22 expected outcome is lower than the 2021-22 target due to an increase in criminal matter initiations, when compared to 2020-21. This has been further amplified by the negative impact of the COVID-19 public health restrictions on criminal finalisations in the first half of 2021-22.* *The lower 2022-23 target reflects the court backlog caused by an increase in criminal matters initiations and the suspension of jury trials in response to the COVID-19 public health restrictions.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Case clearance rate – Criminal matters disposed in the Magistrates' Court	per cent	104	100	100	80
The case clearance rate is calculated as (number of cases disposed/number of cases initiated). *The higher 2022-23 target reflects the anticipated benefits from 2022-23 Budget decisions, most notably the Helping Courts respond to the impacts of the pandemic initiative.*					
Case clearance rate – Criminal matters disposed in the Children's Court	per cent	100	108	100	107.2
The case clearance rate is calculated as (number of cases disposed/number of cases initiated). *The 2021-22 expected outcome is higher than the 2021-22 target due to fewer initiations, targeted practice directions and active case management.*					
Case clearance rate – Family violence intervention orders disposed in the Magistrates' and Children's Courts	per cent	104	100	100	84
The case clearance rate is calculated as (number of cases disposed/number of cases initiated). *The higher 2022-23 target reflects the anticipated benefits from* 2022-23 Budget *decisions, most notably the Helping Courts respond to the impacts of the pandemic initiative.*					
Quality					
Court file integrity in the Supreme Court – availability, accuracy and completeness	per cent	90	90	90	93
Court file integrity in the County Court – availability, accuracy and completeness	per cent	90	97	90	94.5
The 2021-22 expected outcome is higher than the 2021-22 target due to the increased use of electronic filing.					
Court file integrity in the Magistrates' Court – availability, accuracy and completeness	per cent	90	90	90	89.5
Court file integrity in the Children's Court – availability, accuracy and completeness	per cent	90	90	90	90.4
Court file integrity in the Coroners Court – availability, accuracy and completeness	per cent	90	na	90	na
The Coroners Court has adopted an electronic file management system and will update standard operating procedures to recommence audits in 2022-23 to enable court file integrity to be measured.					
Court file integrity in the Victorian Civil and Administrative Tribunal – availability, accuracy and completeness	per cent	90	85	90	79
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of the COVID-19 public health restrictions on VCAT operations, including remote hearings and work-from-home practices.					
Timeliness					
On-time case processing – Civil matters resolved or otherwise finalised within established timeframes in the Supreme Court	per cent	90	90	90	86.8
On-time case processing – Civil matters resolved or otherwise finalised within established timeframes in the County Court	per cent	90	88	90	88.7
On-time case processing – Civil matters resolved or otherwise finalised within established timeframes in the Magistrates' Court	per cent	80	66	80	66
The 2021-22 expected outcome is lower than the 2021-22 target due to the COVID-19 public health restrictions, resulting in the court's initial focus on complying with restrictions and finalising urgent matters. Subsequent easing of restrictions and changes to the Magistrates' Court's operating model in late 2020-21 saw an increase in cases finalised with a greater focus on the older cases in the backlog, which has continued on into 2021-22. The prioritisation of older cases has negatively impacted the timeliness measure for 2021-22.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
On-time case processing – Family Division matters resolved or otherwise finalised within established timeframes in the Children's Court	per cent	90	90	90	80
On-time case processing – Civil matters resolved or otherwise finalised within established timeframes in the Victorian Civil and Administrative Tribunal	per cent	90	91.5	90	87.8
On-time case processing – Coronial matters resolved or otherwise finalised within established timeframes in the Coroners Court	per cent	80	80	80	79.6
On-time case processing – Criminal matters resolved or otherwise finalised within established timeframes in the Supreme Court	per cent	85	85	85	81.2
On-time case processing – Criminal matters resolved or otherwise finalised within established timeframes in the County Court	per cent	80	78	90	75.8
The 2021-22 expected outcome is less than the 2021-22 target due the impact of the COVID-19 public health restrictions on court operations, resulting in jury trial delays and/or the need to operate at a significantly reduced capacity. *The lower 2022-23 target reflects the significant backlog caused by an increase in criminal matters initiations and the suspension of jury trials in response to public health restrictions.*					
On-time case processing – Criminal matters resolved or otherwise finalised within established timeframes in the Magistrates' Court	per cent	85	42	85	44.2
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 public health restrictions, resulting in the court's initial focus on complying with restrictions and finalising urgent matters. Subsequent easing of restrictions and changes to the Magistrates' Court's operating model in late 2020-21 saw an increase in cases finalised with a greater focus on the older cases in the backlog, which has continued on into 2021-22. The prioritisation of older cases has negatively impacted the timeliness measure for 2021-22.					
On-time case processing – Criminal matters resolved or otherwise finalised within established timeframes in the Children's Court	per cent	90	90	90	72.7
On-time case processing – Family violence intervention orders resolved or otherwise finalised within established timeframes in the Magistrates' and Children's Courts	per cent	90	68	90	68.8
The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of COVID-19 public health restrictions, resulting in the court's initial focus on complying with restrictions and finalising urgent matters. Subsequent easing of restrictions and changes to the Magistrates' Court's operating model in late 2020-21 saw an increase in cases finalised with a greater focus on the older cases in the backlog, which has continued on into 2021-22. The prioritisation of older cases has negatively impacted the timeliness measure for 2021-22.					
Cost					
Total output cost	$ million	815.8	766.9	755.2	656.1

Source: Court Services Victoria

APPENDIX A – OUTPUT PERFORMANCE MEASURES FOR REVIEW BY THE PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

DEPARTMENT OF EDUCATION AND TRAINING

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quantity					
Number of Digital Assessment Library items developed	number	1 590	2 034	1 590	1 887
This performance measure is proposed to be discontinued noting this component of the Digital Assessment Library program has been completed. *This performance measure relates to the calendar year.* *The 2021-22 expected outcome is higher than the 2021-22 target due to a greater than expected amount of content becoming available within the library for construction of tests.*					
Units of service provided by Data and Evidence Coaches	number	1 140	1 078	1 140	934
This performance measure is proposed to be discontinued given the scale of the investment and time limited nature of the program – within the context of a broader review of all measures in response to VAGO recommendations. *This performance measure relates to the calendar year. This performance measure refers to government schools only. The 2021-22 expected outcome is lower than the 2021-22 target with COVID-19 affecting onsite service delivery to schools.*					

DEPARTMENT OF ENVIRONMENT, LAND, WATER AND PLANNING

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Environment and Biodiversity					
Quality					
Portfolio entity annual reports including financial statements produced in line with the *Financial Management Act 1994* and free from material errors	per cent	100	100	100	100
This performance measure is proposed to be discontinued because it represents core governance and compliance work rather than an output of service delivery to the community. It is a legislative requirement for portfolio entities to comply with the Financial Management Act 1994*, as referenced in the recent Auditor General's report on Measuring and Reporting on Service Delivery.*					
Statutory Activities and Environment Protection					
Quantity					
Events and activities that engage business and community in environment protection	number	60-65	200	60-65	nm
This performance measure is proposed to be discontinued as it has been replaced by the 2022-23 performance measure 'Community and duty holder trust in EPA'. The replacement better measures the quality of EPA's performance in meeting its regulatory responsibilities as assessed by community and duty holders (businesses issued a license, permit or registration by EPA).					
The 2021-22 expected outcome is above the 2021-22 target reflecting ongoing high levels of engagement with industry, government and community stakeholders about transition to the amended Environment Protection Act 2017*.*					
Quality					
EPA prosecutions are selected using a risk-based approach, focused on environmental outcomes and are successful	number	90	82	90	86
This performance measure is proposed to be discontinued because it reflects progress towards achieving an objective rather than measuring a departmental output. This activity is now reflected through the new departmental objective indicator 'Environment Protection Authority prosecutions result in a finding of guilt or a clarification of the law' under the department's 'Healthy, resilient and biodiverse environment' objective.					
The 2021-22 expected outcome is below the 2021-22 target due to three unsuccessful prosecutions relative to a lower than usual number of total prosecutions owing to COVID-19 impacts on the court system.					
Waste and Recycling					
Quantity					
Proportion of waste diverted away from landfill	per cent	70	70	70	70
This performance measure is proposed to be discontinued because it reflects progress towards achieving the objective rather than measuring a departmental output. This activity is now reflected through the new departmental objective indicator 'Increase in diversion of municipal and industrial waste from landfill' under the department's 'Healthy, resilient and biodiverse environment' objective.					
Energy					
Quality					
Victoria is represented at each Energy Ministers' meeting	per cent	100	100	100	100
This performance measure is proposed to be discontinued as it is not a meaningful measure of output performance.					
Land Use Victoria					
Quantity					
Property transfers, discharge of mortgages and registration of new mortgages	number (thousand)	850	850	850	891
This performance measure is proposed to be discontinued as it has been replaced by the new 2022-23 performance measure 'Land dealings accurately registered'. The new measure better reflects activity within the Department's control.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Management of Public Land and Forests					
Quantity					
Beaches renourished in Port Phillip Bay	number	na	3	3	4
This performance measure is proposed to be discontinued as the program will be completed in 2021-22.					
Suburban dog parks and pocket parks under development	number	60	44	43	43
This performance measure is proposed to be discontinued and replaced with new measures 'Off-leash dog parks completed' and 'Suburban pocket parks completed' to provide clarity on the number of parks being established in each category and demonstrate the department's progress in delivering the Suburban Parks Program and the Building Works Package.					
Planning, Building and Heritage					
Quantity					
Building inspections undertaken by the Victoria Building Authority to identify use of noncompliant cladding materials	number	na	151	480	nm
This performance measure is proposed to be discontinued as the program will be completed in 2021-22. *The 2021-22 expected outcome is lower than the 2021-22 target due to COVIDSafe settings limiting on-site inspections.*					
Planning projects initiated in regional cities and towns to unlock and deliver zoned land supply	number	na	3	3	nm
This performance measure is proposed to be discontinued as it has been replaced by the new 2022-23 performance measure 'Regional Victoria plans where preparation is complete'. The new measure reflects the work undertaken by the Victorian Planning Authority in fulfilling its legislated obligations in delivering precinct structure plans, which is a subsequent milestone of the same process previously measured.					
Planning projects initiated to deliver zoned land supply for new 20-minute neighbourhoods in Greenfields Melbourne	number	na	3	3	nm
This performance measure is proposed to be discontinued as it has been replaced by the new 2022-23 performance measure 'Metropolitan Greenfield plans where preparation is complete'. The new measure reflects the work undertaken by the Victorian Planning Authority in fulfilling its legislated obligations in delivering precinct structure plans, which is a subsequent milestone of the same process previously measured.					
Building audits undertaken by the Victoria Building Authority to identify use of noncompliant cladding materials	number	na	86	350	*276*
This performance measure is proposed to be discontinued as the program will be completed in 2021-22. *The 2021-22 expected outcome is lower than the 2021-22 target due to COVIDSafe settings limiting on-site inspections..*					
Projects approved through the Streamlining for Growth program that benefit councils	number	na	30	30	43
This performance measure is proposed to be discontinued as it has been replaced by the new 2022-23 performance measure 'Council grant applications that meet relevant objectives of the Streamlining for Growth guidelines'. The new measure is a more meaningful indicator of performance, as it provides information on councils' ability to develop submissions that meet the objectives of the Streamlining for Growth program which in turn reflects the quality of support and guidance provided by the department to councils during the application process.					
In-scope government buildings that have commenced cladding rectification works	number	0	36	7	nm
This performance measure is proposed to be discontinued as the program will be completed in 2021-22. The 2021-22 expected outcome is higher than the 2021-22 target due to additional buildings added to the program including hospitals which were previously inaccessible, and commencement of projects delayed from 2020-21.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quality					
Planning Scheme Amendments that are correct upon submission for approval	per cent	na	70	80	73
This performance measure is proposed to be discontinued as the Smart Planning program has been completed. *The 2021-22 expected outcome is lower than the 2021-22 target due to the impact of council planners working remotely, combined with high staff turnover at some councils resulting in gaps in institutional knowledge which reduced the overall quality and accuracy of amendment content.*					
Proportion of planning applications that proceed through the VicSmart process within 10 days	per cent	16	16	16	16
This performance measure is proposed to be discontinued as it is no longer relevant. This measure was introduced in 2016-17 to reflect funding provided in the 2016-17 Budget *for the Smart Planning program. This initiative funded the expansion of eligible permit types that could be assessed by local councils through the VicSmart 10 day process. The Smart Planning program concluded on 30 June 2021. The 16 per cent target has consistently been achieved and will not increase as the eligible classes of permits as a proportion of all permit applications that can be assessed through this pathway has been reached.*					

Source: Department of Environment, Land, Water and Planning

DEPARTMENT OF FAMILIES, FAIRNESS AND HOUSING

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Child Protection and Family Services					
Quantity					
Number of Child FIRST assessments and interventions	number	760	9 722	6 815	16 364
This performance measure is proposed to be discontinued as this activity is now delivered within The Orange Door and captured within the output measure 'Total assessments undertaken for children in the Support and Safety Hubs/ The Orange Door'.					
The lower 2022-23 target reflects the transfer of services to The Orange Door.					
Victorian Contribution to National Disability Insurance Scheme					
Quantity					
National Disability Insurance Scheme participants jointly funded with the Commonwealth	number	111 236	109 592	109 592	108 786
This performance measure is proposed to be discontinued due to changed NDIS funding arrangements. Funding will continue to be reported in Budget Paper No. 5, along with the performance measure target for 2022-23 and expected outcome for 2021-22.					
This performance measure renames the 2021-22 performance measures 'National Disability Insurance Scheme participants'. The new measure reports on the same activity as the previous measure, however has been amended for increased clarity.					
The higher 2022-23 target reflects the number of NDIS participants Victoria is expected to fund jointly with the Commonwealth under the bilateral Agreement.					
Office for Disability					
Timeliness					
Annual reporting against the State disability plan within agreed timeframes	per cent	na	100	100	0
This performance measure is proposed to be discontinued as it has been replaced by the new performance measure 'Departments report progress to Office for Disability on state disability plan responsibilities within agreed time frames'.					
Support to veterans in Victoria					
Quantity					
Number of ex-service organisation training and/or information sessions delivered	number	4	4	4	3
This performance measure is proposed to be discontinued given the program is now complete. Four years of capacity building training has been delivered to the sector.					
LGBTIQ+ equality policy and programs					
Quantity					
Number of organisations engaged through the establishment of a Trans and Gender Diverse Peer Support Program	number	10	60	10	60
This performance measure is proposed to be discontinued and replaced by the new performance measure, 'Number of people engaged through a Trans and Gender Diverse Peer Support Program'.					
The 2021-22 expected outcome is higher than the 2021-22 target due to higher than anticipated engagement with organisations following a restructure of the Trans and Gender Diverse Peer Support Program.					
Timeliness					
Payments for events made in accordance with department milestones	per cent	100	100	100	100
This performance measure is proposed to be discontinued as it has been replaced by the 2022-23 performance measure, 'Percentage of payments for events made within agreed timeframes.'					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Multicultural affairs policy and programs					
Quantity					
Attendance at Cultural Diversity Week flagship event, Victoria's Multicultural Festival	number	55 000	na	55 000	na
This performance measure is proposed to be discontinued as it has been replaced by the 2022-23 performance measure 'Number of people engaged through Cultural Diversity Week events and engagement'.					
The 2021-22 expected outcome is lower than the 2021-22 target because of the Multicultural Festival in 2022 not being hosted due to COVID-19. It has been replaced with targeted engagement with communities to promote social cohesion.					

Source: Department of Families, Fairness and Housing

DEPARTMENT OF HEALTH

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected*	*2021-22 target*	*2020-21 actual*
Health Workforce Training and Development					
Quantity					
Health workers trained in information sharing and family violence risk assessment and risk management	number (thousand)	12 000	24 000	12 000	nm
This measure is proposed to be discontinued as funding will not continue after 30 June 2022.					
Mental Health Clinical Care					
Quality					
Seclusions per 1 000 occupied bed days	number	8	9	8	9.2
This measure is proposed to be discontinued to be replaced by cohort-specific measures of seclusion rates.					
The 2021-22 expected outcome is higher than the 2021-22 target primarily due to a lack of capacity caused by an increase in the number of individuals presenting to emergency departments and population growth across the North West and South East.					
Health Protection					
Quality					
Number of persons participating in newborn bloodspot or maternal serum screening	number	80 000	79 706	80 000	79 367
This measure is proposed to be discontinued to be replaced by the measure 'Percentage of newborns having a newborn bloodspot screening test'.					
Immunisation coverage – adolescent (Year 7) students fully immunised for DTPa (diphtheria, tetanus and pertussis)	per cent	90	not measured	90	100
The 2021-22 expected outcome was not measured as measurement of returned consent cards to local council immunisation services has not occurred in the past two years.					
This measure is proposed to be discontinued to be replaced by the measure 'Percentage of adolescents (aged 15) fully immunised for HPV'. The new measure reports on the same activity as the previous measure however has been amended for increased clarity.					
Separations	number (thousand)	35.8	33	35.8	31
The 2021-22 expected outcome is lower than the 2021-22 target primarily due to the impact of the COVID-19 pandemic.					
This measure is proposed to be discontinued to be replaced by the measure 'NWAU eligible separations', in line with Victoria adopting National Weighted Activity Units as a standard for health funding.					

Source: Department of Health

DEPARTMENT OF JOBS, PRECINCTS AND REGIONS

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Industry, Innovation, Medical Research and Small Business					
Quantity					
Businesses whose growth and productivity issues are resolved by the Department	number	1 200	1 200	1 200	2 263
This performance measure is proposed to be discontinued and replaced by a new performance measure 'Strategic priority businesses engaged on investment and growth'. The new measure is more specific and better reflects the department's current strategic business engagement model and activities for investment attraction and industry growth.					
Engagements with businesses	number	14 000	14 000	14 000	15 481
This performance measure is proposed to be discontinued as it has been replaced by the 2022-23 performance measure 'Strategic priority businesses engaged on investment and growth'. The new measure is more specific and better reflects the department's current strategic business engagement model and activities for investment attraction and industry growth.					
Local Government and Suburban Development					
Quantity					
Projects in the planning or delivery phase to support and facilitate the revitalisation of Broadmeadows and Frankston	number	6	24	6	20
This performance measure is proposed to be discontinued and replaced with the new measure 'Projects to support community led recovery and revitalisation in disadvantaged suburbs' due to lapsing funding in the Suburban Revitalisation and Growth initiative, and to reflect the Suburban Revitalisation Boards Program promoting recovery and revitalisation in disadvantaged suburbs.					
Tourism, Sport and Major Events					
Quantity					
Business program grants delivered	number	12	12	12	9
This performance measure is proposed to be discontinued due to lapsing funding for the 'Visitor Economy: Industry Strengthening' initiative.					

Source: Department of Jobs, Precincts and Regions

DEPARTMENT OF JUSTICE AND COMMUNITY SAFETY

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Policing and Community Safety					
Quality					
Proportion of drivers tested who return a clear result for prohibited drugs	per cent	93	93	93	93.1
This performance measure is proposed to be discontinued as it measures an outcome rather than the delivery of initiatives designed to increase clear results.					
Community Crime Prevention					
Quality					
Community Crime Prevention grant payments properly acquitted	per cent	100	100	100	100
This performance measure is proposed to be discontinued as it reflects a minimum level of service related to grants management. It has been replaced with new performance measures in 2022-23 that better reflect service delivery for community crime prevention.					
Percentage of funded initiatives that support local communities to deliver innovative crime and community safety solutions in local areas; promote the development and delivery of collaborative, partnership approaches to crime prevention; or build community capability through knowledge sharing and strengthened relationships.	per cent	100	100	100	nm
This performance measure is proposed to be discontinued as it reflects a minimum standard of performance rather than a desired quality of service. It has been replaced with new performance measures in 2022-23 that better reflect service delivery for community crime prevention.					
Emergency Management Capability					
Quality					
Emergency response times meeting benchmarks – Road accident rescue response	per cent	90	na	90	91.2
This performance measure is proposed to be discontinued and *replaced by the related disaggregated measures 'Emergency response times meeting benchmarks – road accident rescue response (CFA)', 'Emergency response times meeting benchmarks – road accident rescue response (FRV)', and 'Emergency response times meeting benchmarks – road accident rescue response (VICSES)' for increased transparency of emergency management agencies.*					
Emergency response times meeting benchmarks – structural fires'	per cent	90	na	90	86.7
This performance measure is proposed to be discontinued and *replaced by the related disaggregated measures 'Emergency response times meeting benchmarks – structural fires (CFA)', and 'Emergency response times meeting benchmarks – structural fires (FRV)' for increased transparency of emergency management agencies.*					
Justice Policy, Services and Law Reform					
Quantity					
Community education and consultation sessions conducted by Victorian Law Reform Commission (VLRC)'	number	75	60	75	164
This performance measure is proposed to be discontinued and replaced by the related disaggregated measures 'Community education and consultation sessions conducted by Victorian Law Reform Commission (VLRC)', and 'Community education and consultation sessions conducted by Victorian Law Reform Commission (VLRC)' for increased transparency.					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Advocacy, Human Rights and Victim Support					
Timeliness					
Confiscated assets sold or destroyed within 90 days	per cent	85	40	85	33
This performance measure is proposed to be discontinued as it not a true representation of the effectiveness of the Asset Confiscation Scheme (ACS). *The 2021-22 expected outcome is lower than the 2021-22 target due to COVID-19 lockdown restrictions preventing Victoria Police from disposing of personal property through public auctions. Now that the auctions have resumed, the majority of assets being sold will take longer than the 90-day timeframe while the backlog is cleared*					
Gambling and Liquor Regulation					
Quantity					
Liquor and gambling applications and licensee monitoring activities (VCGLR)	number	50 000	na	50 000	51 012
This performance measure is proposed to be discontinued and replaced by the related disaggregated measures 'Liquor applications and licensee monitoring activities', and 'Gambling applications and licensee monitoring activities' to reflect the separation of agencies.					
Liquor and gambling information and advice (VCGLR)	number	128 000	na	128 000	147 938
This performance measure is proposed to be discontinued and replaced by the related disaggregated measures 'Liquor information and advice' and 'Gambling information and advice' to reflect the separation of agencies.					
Quality					
Liquor and gambling licensing client satisfaction (VCGLR)	per cent	85	na	85	84
This performance measure is proposed to be discontinued and replaced by the related disaggregated measures 'Liquor licensing client satisfaction', and 'Gambling licensing client satisfaction' to reflect the separation of agencies.					
Liquor and gambling inspections conducted at high risk times (VCGLR)	per cent	12	na	12	7.2
This performance measure is proposed to be discontinued and replaced by the related disaggregated measures 'Proportion of high harm liquor breaches resulting in regulatory action', and 'Proportion of high harm gambling breaches resulting in regulatory action' to reflect the separation of agencies.					
Timeliness					
Calls to VCGLR client services answered within 60 seconds	per cent	80	na	80	54.7
This performance measure is proposed to be discontinued and replaced by the related disaggregated measures 'Calls to VGCCC client services answered within 60 seconds', and 'Calls to liquor regulator client services answered within 60 seconds' to reflect the separation of agencies.					
Liquor and gambling approvals, licence, permit applications and variations completed within set time (VCGLR)	per cent	85	na	85	85.8
This performance measure is proposed to be discontinued and replaced by the related disaggregated measures 'Liquor approvals, licence, permit applications and variations completed within set time', and 'Gambling approvals, licence, permit applications and variations completed within set time' to reflect the separation of agencies.					

Source: Department of Justice and Community Safety

DEPARTMENT OF PREMIER AND CABINET

Performance measures	*Unit of measure*	*2022–23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Digital Government and Communications					
Quantity					
Average number of monthly visits to www.together.gov.au	number	40 000	40 000	40 000	nm
This performance measure is proposed to be discontinued as funding for the program ceases after 30 June 2022.					
Aboriginal policy, strengthening Aboriginal cultural heritage and Communities					
Quantity					
Participation of Aboriginal people in Local Aboriginal Networks	number	0	2 800	2 800	2 737
This performance measure is proposed to be discontinued as initiative funding for the program has ceased.					
Delivery of a public report on outcomes for Aboriginal Victorians to be tabled in parliament	number	1	1	1	1
This performance measure is proposed to be discontinued and replaced with 'Delivery of a public report on outcomes for Aboriginal Victorians to be tabled in parliament by 30 June each financial year' to enable a balanced set of quantity, quality, timeliness and cost measures across the new Self-determination policy, reform advice and programs output.					
Victorian Aboriginal Heritage Council meetings conducted within legislative timeframes	number	6	8	6	9
The 2021-22 expected outcome is higher than the 2021-22 target due to a higher than anticipated number of meetings being held in response to the increase in number and complexity of Registered Aboriginal Party applications. *This performance measure is proposed to be discontinued and replaced with 'The service provision of the Office of the Victorian Aboriginal Heritage Council enables the Victorian Aboriginal Heritage Council to undertake its statutory responsibilities' to enable more meaningful comparison of performance over time.*					
Quality					
Funding payments for Aboriginal community initiatives made in accordance with milestones	per cent	100	100	100	nm
This performance measure is proposed to be discontinued and replaced with 'Completion of an Aboriginal-led evaluation and review of government performance under the Victorian Aboriginal Affairs Framework 2018-2023 and the National Agreement on Closing the Gap' to better reflect the engagement between government and Aboriginal communities to progress self-determination. DPC's ability to manage grant payments for several initiatives are reflected through other performance measures, for example, 'Funding recipients report that the achievement of program objectives is supported by DPC's role in the funding relationship'.					
Funding payments for Aboriginal cultural heritage protection initiatives, sector support and nation building made in accordance with milestones	per cent	100	100	100	100
This performance measure is proposed to be discontinued and replaced with 'Funding recipients report that the achievement of program objectives is supported by DPC's role in the funding relationship' to enable more meaningful comparison of performance over time.					
Timeliness					
Koorie Heritage Trust initiative grants acquitted within the timeframe specified in the funding agreements	per cent	100	100	100	100
This performance measure is proposed to be discontinued as DPC's performance in relation to funding agreements is measured by the 'Funding recipient satisfaction with DPC's role in delivering and managing its funding relationship' performance measure, and performance related to Koorie Heritage Trust initiatives is measured by the 'Average weekly hours of case management provided to members of the Stolen Generations' and 'Number of family history investigations conducted by the Victorian Koorie Family History service' performance measures.					

Performance measures	*Unit of measure*	*2022–23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Assessments completed by Aboriginal Victoria within legislative timeframe – cultural heritage management plans, cultural heritage permits, preliminary Aboriginal heritage tests	per cent	100	99	100	100
This performance measure is proposed to be discontinued and replaced with 'Average days to process applications to register an Aboriginal Cultural Heritage Place (CHMP-related) on the Victorian Aboriginal Cultural Heritage Register' to enable more meaningful comparison of performance over time.					
Strategic Advice and Government Support					
Quality					
Policy services satisfaction rating	per cent	90	90	90	84
This performance measure is proposed to be discontinued and replaced by 'Key stakeholder satisfaction with advice and support relating to economic policy' under the new Economic policy advice and support output and by 'Key stakeholder satisfaction with advice and support relating to social policy' under the new Social policy and intergovernmental relations outputs.					
Timeliness					
Policy services timeliness rating	per cent	95	95	95	97
This performance measure is proposed to be discontinued and replaced by 'Provision of DPC products within agreed timeframes' under the new Economic policy advice and support output and by 'Provision of social policy briefings within agreed timeframes' under the new Social policy and intergovernmental relations outputs.					
Public administration advice and support					
Timeliness					
Advice from the Remuneration Tribunal provided within 15 working days of receipt of submission	per cent	90	90	90	76.1
This performance measure is proposed to be discontinued and replaced with 'Tribunal's legislated work program delivered within established timeframes' to ensure reporting captures the scope of activities undertaken by the Tribunal.					
Office of the Victorian Government Architect					
Timeliness					
Average number of business days to issue formal advice	days	10	10	10	8
This performance measure is proposed to be discontinued and replaced with 'Formal advice issued within 10 business days' to enable more meaningful comparison of performance over time.					

Source: Department of Premier and Cabinet

DEPARTMENT OF TRANSPORT

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Bus Services – Metropolitan					
Quality					
Customer satisfaction index: metropolitan bus services	score	77	80	77	78
This performance measure is proposed to be discontinued as it has been replaced by the 2022-23 performance measure 'Customer experience index: metropolitan bus services' to reflect the new Customer Experience Survey.					
Bus Services – Regional					
Quality					
Customer satisfaction index: regional coach services	score	84	81.9	84	83.3
This performance measure is proposed to be discontinued as it has been replaced by the 2022-23 performance measure 'Customer experience index: regional coach services' to reflect the new Customer Experience Survey.					
Train Services – Metropolitan					
Quality					
Customer satisfaction index: metropolitan train services	score	75	79.1	75	77.7
This performance measure is proposed to be discontinued as it has been replaced by the 2022-23 performance measure 'Customer experience index: metropolitan train services' to reflect the new Customer Experience Survey. *The 2021-22 expected outcome is higher than the 2021-22 target due to the significant impact of COVID-19 on patronage, which is expected to continue contributing to higher than targeted performance.*					
Metropolitan fare compliance rate across all public transport modes	per cent	96.5	95	96.5	93.8
This performance measure is proposed to be discontinued as it has been replaced by the 2022-23 performance measures 'Metropolitan fare compliance rate: bus services', 'Metropolitan fare compliance rate: train services' and 'Metropolitan fare compliance rate: tram services.'					
Train Services – Regional					
Quality					
Customer satisfaction index: regional train services	score	78	80.5	78	79.5
This performance measure is proposed to be discontinued as it has been replace by the 2022-23 performance measure 'Customer experience index: regional train services' to reflect the new Customer Experience Survey.					
Train Services – Statewide					
Quantity					
Myki: device speed – number of touch on/offs per minute	number	37	37	37	42.3
This performance measure is proposed to be discontinued and replaced by the 2022-23 performance measures 'Myki: Fare payment device speed – number of touch on/offs per minute (Bus/Tram)' and 'Myki: Fare payment device speed – number of touch on/offs per minute (Train)' to reflect performance of myki devices by public transport mode. The new performance measures will provide more transparency and accountability.					
Tram Services					
Quantity					
Progress of tram procurement and supporting infrastructure – cumulative project expenditure	per cent	100	100	97.5	95.4
This performance measure is proposed to be discontinued due to the completion of E-Class Tram Procurement (Rolling Stock) in 2021-22. The scope of the project has changed due to the movement of the supporting infrastructure works to the E-Class Tram Infrastructure Program. *The higher 2022-23 target is due to the completion of E-Class Tram Procurement (Rolling Stock) in 2021-22.*					

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Quality					
Customer satisfaction index: tram services	score	76.5	80	76.5	79.6
This performance measure is proposed to be discontinued as it has been replaced by the 2022-23 performance measure 'Customer experience index: tram services' to reflect the new Customer Experience Survey.					
Transport Infrastructure					
Quantity					
Integrated transport planning to support urban renewal projects	number	3	4	4	4
This performance measure is proposed to be discontinued as it has been replaced by the 2022-23 performance measure 'Precincts in the design or delivery phase' that better reflect works undertaken for transport precincts following a machinery of government change in 2021-22. *The lower 2022-23 target reflects the scheduled Department-led projects.*					
Sustainably Managed Fish and Boating Resources					
Quantity					
Better boating initiatives commenced	number	10	16	16	8
This performance measure is proposed to be discontinued and combined into the existing performance measure 'Recreational boating and fishing infrastructure improvements delivered' to simplify reporting and clarify the intended outputs from delivery. *The lower 2022-23 target reflects the projects scheduled to commence in the financial year.*					
Recreational fishing licences sold online as a proportion of total sales	per cent	90	90	90	92
This performance measure is proposed to be discontinued as over 90 per cent of recreational fishing licenses are now sold online annually.					
Undertake activities to detect, disrupt and dismantle serious or organised fisheries criminal entities (individuals or groups)	number	20	15	20	12
This performance measure is proposed to be discontinued as it has been replaced by the 2022-23 performance measure 'Percentage of investigations into serious or organised fisheries offending that result in a prosecution, disruption or intelligence referral outcome' to better reflect the VFA's investigative work undertaken into serious or organised fisheries crime. *The 2021-22 expected outcome is lower than the 2021-22 target due to a 33 per cent reduction in VFA Investigations staff resulting from vacancies and secondments, and the commencement of a large prosecution case which has consumed existing resources.*					

Source: Department of Transport

DEPARTMENT OF TREASURY AND FINANCE

Performance measures	*Unit of measure*	*2022-23 target*	*2021-22 expected outcome*	*2021-22 target*	*2020-21 actual*
Economic Regulatory Services					
Quantity					
New or revised regulatory instruments issued	number	9	7	9	12
This performance measure is proposed to be discontinued as it is no longer meaningful and subject to fluctuation based on changes to enabling legislation and operational priorities.					
Quality					
Decisions overturned on review or appeals	number	0	0	0	100
This performance measure is proposed to be discontinued due to unavailability of data.					
Revenue Management and Administrative Services to Government					
Quantity					
Business processes maintained to retain ISO 9001 (Quality Management Systems) Certification	per cent	100	100	100	100
This performance measure is proposed to be discontinued as quality management processes is a business-as-usual function performed by the Department.					

Source: Department of Treasury and Finance

APPENDIX B – LOCAL GOVERNMENT FINANCIAL RELATIONS

This appendix provides an overview of the local government sector in Victoria and highlights the *2022-23 Budget* initiatives that impact on councils.

Local government is a distinct and essential tier of government, enshrined in Victoria's Constitution. Victoria has 79 councils providing a wide range of services and infrastructure. Many Victorian Government programs are delivered by or in partnership with local governments.

SUPPORTING SUSTAINABLE AND EFFECTIVE LOCAL GOVERNMENT

Local councils play a critical role in creating liveable, inclusive, and sustainable communities. Councils deliver vital services and infrastructure, support local economies, and provide meaningful local democracy and governance.

The *Local Government Act 2020* came into operation on 24 March 2020. The Act enabled a once in a generation change to the operations of Victoria's 79 councils. It introduced a principles-based approach to the operation of local government, empowering councils to tailor their policies and plans to meet the needs of their local communities. The Act has an emphasis on community engagement, including explicitly recognising the Aboriginal community as an important subset of the municipal community. It introduced a new, robust governance framework and universal standards of conduct. The Act strengthens the strategic planning and reporting requirements for councils and ensures that key strategies, such as the community vision and council plan, are developed through deliberative engagement processes with their communities. The implementation of the Act is now complete, and this process was guided by a project control board with sector representation and based on co-design and collaborative engagement with the sector.

Support to improve the long-term financial and operational sustainability of rural and regional councils continues through the ongoing Rural Councils Transformation Program. This $20 million program incentivises the sharing of council knowledge, costs, and resources at a regional scale to deliver more efficient, effective, and sustainable services for communities. Both rounds of funding under this program in 2018-19 and 2021-22, have highlighted the criticality of aligning council technology and business processes for regional service delivery.

The Government remains committed to ensuring that the impact of council rates on the cost of living is minimised through the Fair Go Rates System. Victorian council rate rises have been capped at 1.75 per cent for 2022-23. Rating reforms will be guided by the Government's response to the local government rating system review final report. The Government's response – to be implemented from 2022 to 2024 – will prioritise support to ratepayers in financial hardship, improve the transparency and consistency of decision making by councils and build greater equity and fairness in the rating system.

An ongoing investment of $4.9 million towards the Municipal Emergency Resourcing Program increased the capacity and capability of councils to prepare for emergencies. Further development is being undertaken with councils to support the recommendations of the Inspector-General for Emergency Management Inquiry into the 2019-20 Victorian fire season and the Royal Commission into National Natural Disaster Arrangements.

Victoria's local government sector faces challenges that impact on its performance. In particular, interface and rural councils face challenges resulting from population movements, local economic circumstances and their capacity to deal with multifaceted issues confronting their communities. The Government's Know Your Council website will continue to report on local government financial and service performance.

The Government's additional investment of $50 million in the Growing Suburbs Fund will assist Melbourne's interface and regional peri-urban councils to build the facilities they need for healthy and liveable communities in fast growing suburbs.

Councils will continue to receive ongoing support through the Government's $2.9 million annual commitment for the roadside weeds and pests program to protect Victoria's agricultural production and environmental assets such as parks and forests.

The Government will continue to support the delivery of public library services and programs across the state through the Living Libraries Infrastructure Program and the Premiers' Reading Challenge Book Fund, with an additional $2.3 million in 2022-23 for the Public Libraries Funding Program.

FUNDING SOURCES TO LOCAL GOVERNMENT IN VICTORIA

Victorian councils spend about $9.8 billion a year[1]. Councils have vital responsibilities that include community services, planning, local roads, waste management, recreation and cultural activities.

Rates revenue of $6.5 billion in 2020-21 ($6.3 billion in 2019-20) made up 54 per cent of total revenue. The second largest revenue stream for the sector was government grants revenue, totalling $2.3 billion in 2020-21 ($1.9 billion in 2019-20).

The Government provides local government with exemptions from land tax, payroll tax and the Mental Health and Wellbeing Levy. It is estimated that these exemptions will benefit Victorian councils by about $725 million in 2022-23 (refer to Tables 5.2 and 5.4 in Budget Paper No. 5 *Statement of Finances*).

[1] Victorian Auditor-General's Results of 2020-21 Audits: Local Government

Table B.1: Grants and transfers to local government ($ thousand)

Department	*2021-22 budget*	*2021-22 revised [(a)]*	*2022-23 budget*
Department of Education and Training [(b)]	109 105	72 174	158 072
Department of Environment Land Water and Planning	5 445	26 175	5 067
Catchment Management Authorities	280	562	558
Environment Protection Authority	25	25	25
Department of Health	1 586	1 586	72
Department of Families, Fairness and Housing	6 217	9 988	7 359
Department of Jobs Precincts and Regions	931 049	733 557	889 347
Department of Justice and Community Safety	13 777	33 832	12 206
Country Fire Authority	321	214	329
Department of Premier and Cabinet	5 104	5 091	5 091
Department of Transport	51 411	110 200	132 254
Department of Treasury and Finance	5 776	5 776	10 051
Total grants	**1 130 097**	**999 180**	**1 220 432**

Source: Department of Treasury and Finance

Notes:

(a) The revised figures reflect variations to the 2021-22 financial year since the publication of the 2021-22 Budget.

(b) Excludes funds provided to local government for service delivery.

Local Government Victoria within the Department of Jobs, Precincts and Regions, provides the majority of funds to local government. For 2022-23 it is estimated that around $171 million of total grants will be Commonwealth financial assistance grants, including road and general purpose grants that are passed on to local government in their entirety. This amount is considerably less than the estimated $850 million provided by the Commonwealth in 2021-22. All administration costs are borne by the Department of Jobs, Precincts and Regions.

As shown in Table B.1, grants and transfers to local government are expected to be $999 million in 2021-22. This is a decrease of $131 million from the original 2021-22 estimate of $1 130 million. The key drivers of the variance in 2021-22 include:

- Department of Education and Training – a decrease in grants and transfers mainly driven by a rephase of grants from 2021-22 into the forward years for Ready for School: Kinder for every three-year-old, Kindergarten refurbishment and minor works, and Building Blocks
- Department of Jobs, Precincts and Regions – a decrease in grants and transfers mainly driven by the rephasing from 2021-22 into 2020-21 of Commonwealth financial assistance to local governments.

This is partially offset by:

- Department of Environment, Land, Water and Planning – an increase in grants and transfers mainly driven by Commonwealth funding to support the delivery of projects identified through the National Flood Mitigation Infrastructure Program and the grant profile of Recycling Victoria
- Department of Families, Fairness and Housing – an increase in grants and transfers mainly driven by funding provided to continue and boost key pandemic-related supports for Victorian communities and adjustments between service contracts and other grant and expense accounts to better reflect the nature of actual spending
- Department of Jobs, Precincts and Regions – an increase in grants and transfers mainly driven by COVIDSafe Outdoor Activation grants, Investing in local sport infrastructure grants, and Melbourne City Revitalisation grants to local councils
- Department of Justice and Community Safety – an increase in grants and transfers mainly driven by funding directed to local government as a result of the June 2021 Flood and Storm event and residual needs from the 2019 Victorian Bushfires
- Department of Transport – an increase in grants and transfers mainly driven by an increase in Commonwealth funding in 2021-22 for Bridge Renewal Programs, the Heavy Vehicle Safety Productivity Program, local councils for road projects and local port works.

The *2022-23 Budget* provides an estimated $1 220 million in grants and transfers to local government. This represents an increase of $221 million from the 2021-22 revised figures. The key drivers (excluding additional funding for *2022-23 Budget* initiatives) relate to:

- Department of Education and Training – an increase in grants and transfers mainly driven by a rephase of grants for Ready for School: Kinder for every three-year-old
- Department of Jobs, Precincts and Regions – an increase in grants and transfers mainly due to the *2022-23 Budget* not yet recognising the Commonwealth rephasing of grant payments from 2022-23 into 2021-22
- Department of Transport – an increase in grants and transfers mainly driven by the realignment of funding for the Accident Blackspot initiative, Commonwealth funding into 2022-23 for the Commuter Car Park Upgrade program and a rephasing of Better Boating Victoria initiatives from 2021-22 into 2022-23.

This is partially offset by:

- Department of Environment, Land, Water and Planning – decrease in grants and transfers mainly due to one-off Commonwealth funding provided in 2021-22 relating to the National Flood Mitigation Infrastructure Program and the grant profile of Recycling Victoria
- Department of Justice and Community Safety – a decrease in grants and transfers mainly due to one-off funding provided in 2021-22 relating to Commonwealth registered natural disaster events.

The value of grants and transfers made to local government by a number of departments is also expected to increase due to the funding of *2022-23 Budget* initiatives listed later in this appendix.

COMMUNITY SUPPORT FUND

The Government funds a range of initiatives through the Community Support Fund (CSF), some of which are delivered by councils. The CSF grants are managed by the Department of Treasury and Finance and payments are made to other government departments, which administer and oversee the CSF funded projects and distribute funds to grant recipients.

In 2021-22, the CSF's revenue from electronic gaming machines (EGMs) in hotels continued to be impacted by the public health restrictions due to the coronavirus (COVID-19) pandemic. However, it is expected that the CSF's total revenue in 2021-22 will be higher than the revenue received in 2020-21.

In 2020-21 and 2021-22, councils and other grant recipients continued to receive funding from the CSF for the development of community infrastructure and the provision of community support initiatives.

Significant CSF funding projects approved in 2021-22 include:

- $8 500 000 to the City of Greater Geelong via the Department of Jobs, Precincts and Regions to support the delivery of the Northern Aquatics and Recreation Centre's Health & Wellbeing Hub (also known as Northern Aquatic and Community Hub)
- $700 000 to the Ballarat City Council via the Department of Jobs, Precincts and Regions for the Alfredton Reserve Netball Courts project. This funding provides facilities to complement the overall development at Alfredton Reserve
- $500 000 to the Cardinia Shire Council via the Department of Jobs, Precincts and Regions for Bunyip Soccer and Cricket Sports Field redevelopment works
- $420 000 to the Golden Plains Shire Council via the Department of Jobs, Precincts and Regions for the Meredith BMX Facility Project. This included upgrading the existing skate facility, building a new BMX track, and upgrading the playground
- $308 000 to the Whitehorse City Council via the Department of Jobs, Precincts and Regions for the Mahoneys Reserve Sports Field Floodlighting Upgrade Project
- $290 000 to the Maroondah City Council via the Department of Jobs, Precincts and Regions for the Town Park Soccer Field Redevelopment Project
- $250 000 to the Stonnington City Council via the Department of Jobs, Precincts and Regions for the Sports Ground Lighting Upgrade Project at Orrong-Romanis Reserve.

DISASTER RESPONSE

Emergency Management Victoria, within the Department of Justice and Community Safety, administers the Commonwealth's Disaster Recovery Funding Arrangements (DRFA) (for events post 1 November 2018), which provides financial assistance to councils affected by disasters such as bushfires, floods and severe storms. The DRFA standard assistance measures are largely used to reimburse eligible costs incurred by councils including counter disaster operations and in the repair and reinstatement of damaged essential public assets.

Additional DRFA special financial assistance measures were also made available for significant events including the 2019-20 Victorian bushfires and June 2021 Storm and Flood event. These special measures were administered by Bushfire Recovery Victoria, within the Department of Justice and Community Safety.

Actual natural disaster financial assistance expenditure fluctuates each year depending on the number and magnitude of natural disasters that have occurred. The standard and special DRFA measures can follow up to three years from the date of the natural disaster.

Assistance may also be provided to councils outside of the DRFA that is directly provided by various Victorian Government agencies.

2022-23 BUDGET INITIATIVES

This section outlines the key *2022-23 Budget* initiatives by department that will be undertaken in partnership with local government. This includes initiatives that broadly impact on local government. Funding details for each of these initiatives are provided in Chapter 1 – *Output, asset investment, savings and revenue initiatives*.

Whole of government

The whole of government *2022-23 Budget* initiative that affects local government includes:

- Victorian Aboriginal and Local Government Strategy 2021-2026.

Department of Education and Training

The Department of Education and Training works with local government to plan, provide or facilitate early childhood services and provides financial support including capital grants for this purpose.

The Department of Education and Training's *2022-23 Budget* initiatives that affect local government include:

- Building inclusive kindergartens
- Improving outcomes for culturally and linguistically diverse (CALD) children.

Department of Environment, Land, Water and Planning

The Department of Environment, Land, Water and Planning works with local government to deliver additional support for community infrastructure, coastal assets and integrated water management strategy and projects.

The Department of Environment, Land, Water and Planning's *2022-23 Budget* initiatives that affect local government include:

- Implementation of the Central and Gippsland Region Sustainable Water Strategy
- Revitalising Central Geelong
- VicCoasts: Building a safe, healthier and more resilient marine and coastal environment for the community.

Department of Families, Fairness and Housing

The Department of Families, Fairness and Housing works together with local government to deliver programs that help Victorians to be safe and secure, participate in the economy, and be connected to culture and community.

The Department of Families, Fairness and Housing's *2022-23 Budget* initiatives that affect local government include:

- Continuing COVID-19 support and recovery for multicultural communities
- Investing in a thriving North Richmond
- Investing to make homelessness rare, brief and non-recurring
- Victorian State Disability Plan
- Victorian Social Recovery Support program.

Department of Health

The Department of Health partners with community providers and local government across a range of areas. This includes working with local governments to deliver public and mental health services.

The Department of Health's *2022-23 Budget* initiatives that affect local government include:

- Promoting good mental health and wellbeing in all communities
- Public health and local place-based delivery.

Department of Jobs, Precincts and Regions

The Department of Jobs, Precincts and Regions works in close partnership with the local government sector to deliver programs across Victoria and to ensure Victorians enjoy responsive and accountable local government services. The Department provides financial and in-kind support to local government through Local Government Victoria including grants for vital community infrastructure, and public libraries. In addition, the Department partners with local government to deliver programs in areas such as creative industries, business precincts, regional development, sport and recreation, and suburban development.

The Department of Jobs, Precincts and Regions' *2022-23 Budget* initiatives that affect local government include:

- Creative spaces and places
- Creative West
- Growing Suburbs Fund
- Meeting Victoria's demand for local sport and active recreation infrastructure
- Our Suburbs: Living Local – supporting our suburbs to recover and thrive
- Public Libraries Funding Program
- Regional Jobs and Infrastructure Fund
- Transforming small business
- Transforming Western Melbourne.

Department of Transport

The Department of Transport works with local government to deliver a range of initiatives, including local transport infrastructure and roads to benefit Victorian communities. This can include providing financial and in-kind support to local government.

The Department of Transport's *2022-23 Budget* initiatives that affect local government include:

- Active transport
- Arden Precinct redevelopment
- Delivering the Road Safety Action Plan
- Local ports critical maintenance works
- Maintaining Victoria's road network
- Metropolitan road upgrades.

Department of Treasury and Finance

The Department of Treasury and Finance works with local government to support projects that modernise and streamline council regulatory processes.

The Department of Treasury and Finance's *2022-23 Budget* initiative that affects local government includes:

- Business Acceleration Fund.

STYLE CONVENTIONS

Figures in the tables and in the text have been rounded. Discrepancies in tables between totals and sums of components reflect rounding. Percentage changes in all tables are based on the underlying unrounded amounts.

The notation used in the tables and charts is as follows:

n.a. or na	not available or not applicable
1 billion	1 000 million
1 basis point	0.01 per cent
..	zero, or rounded to zero
tbc	to be confirmed
ongoing	continuing output, program, project etc.
(x xxx.x)	negative amount
x xxx.0	rounded amount

Please refer to the **Treasury and Finance glossary for budget and financial reports** at dtf.vic.gov.au for additional terms and references.

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Victorian Budget
2022/23

Service Delivery
Budget Paper No. 3

budget.vic.gov.au

VICTORIA State Government | Treasury and Finance

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Victoria's mental health and wellbeing workforce strategy 2021–2024

December 2021

VICTORIA State Government | Department of Health

We acknowledge Victoria's First Peoples and their rich culture.

We respectfully acknowledge all Countries of the Kulin Nation and pay respects to their Spiritual Ancestors, Elders, families, children and young people of past, current and future generations. This acknowledgement also extends to the Traditional Custodians protecting and nurturing its lands, waters and other significant sites.

We recognise their lived experiences of colonisation and the strength and resilience of their living cultures and connection to Country. We embrace the spirit of reconciliation and commit to working towards community-driven and self-determining outcomes that ensure equality of outcomes and an equal voice.

To receive this document in another format, phone 1300 650 172, using the National Relay Service 13 36 77 if required, or email Mental Health Workforce (MentalHealthWorkforce@health.vic.gov.au).

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Except where otherwise indicated, the images in this document show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. This document may contain images of deceased Aboriginal and Torres Strait Islander peoples.

In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

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Available at: https://www.health.vic.gov.au/strategy-and-planning/mental-health-workforce-strategy

Minister's foreword

Nine months ago, I stood up at an historic sitting of the Victorian Parliament alongside the Premier and made a commitment to rebuild Victoria's mental health system from the ground up.

Not just to improve things a little bit, but to reconsider every dimension of the care Victorians receive if they are living with a mental illness or supporting someone who is facing mental health challenges.

But providing better care requires people. People who are skilled and trained to do the jobs that will deliver that care, and who approach their work with compassion, empathy and dedication.

From social workers in community health, to mental health nurses in our acute units, we need a workforce that is built to support Victorians whether they are experiencing mental health challenges for the first time or dealing with chronic illness.

Victoria's mental health and wellbeing workforce strategy 2021–2024 sets out a clear and actionable plan to attract, train and support the workforce we need for our future. If we are to deliver on every recommendation of the Royal Commission, as promised, we must start by strengthening and expanding our mental health workforce.

This strategy identifies the gaps and the challenges we face in getting workers skilled up and into jobs – and provides a pathway towards building a workforce that is capable of delivering the care Victorians need and deserve.

We have already made significant progress on many of the workforce initiatives recommended by the Royal Commission into Victoria's Mental Health System, including a record $228 million investment since the 2020-21 Victorian State Budget. But we acknowledge that we are at the start of a long process to build the foundations for change, and to ensure we stay on track we will review and update the strategy every two years, so it reflects the needs of the mental health and wellbeing workforce as we build the new system from the ground up.

To all members of our mental health and wellbeing workforce, I want to thank you on behalf of the Victorian community for your dedication, perseverance and the important work you do to care for our state each day as we create a better system of care for every single Victorian.

The Hon James Merlino MP
Deputy Premier
Minister for Mental Health

Contents

Minister's foreword **3**

1. Reforms to promote mental health and wellbeing for all Victorians **6**
- A bold vision for reform 6
- Better mental health for Victoria leading to better opportunities for jobs 7
- A different approach to change 7
- The workforce's role in system reforms 7

2. Overview of Victoria's mental health and wellbeing workforce strategy 2021–2024 ..... **8**
- Purpose of the strategy 8
- Stakeholder input 9
- Vision for the mental health and wellbeing workforce 10
- Key priorities 11

3. Spotlight: Lived and living experience workforces **14**

4. Workforce profile **16**

5. Spotlight: Supporting workforce capability to provide integrated care **18**

6. Priority 1: Building workforce supply **19**
- **Action area 1a:** Attracting people to mental health careers 23
- **Action area 1b:** Growing graduate, post-qualifying and transition training pathways 24
- **Action area 1c:** Building emergent and new workforces 26
- **Action area 1d:** Ensuring workforce meets regional needs 27

7. Spotlight: Capability Framework **28**

8. Priority 2: Building workforce skills, knowledge and capabilities **29**
- **Action area 2a:** Ensuring education and training meets the needs of the community 30
- **Action area 2b:** Embedding a system wide capability focus 32
- **Action area 2c:** Improving capability through ongoing training opportunities 34
- **Action area 2d:** Ensuring workforce reflects and responds to diverse communities 35

DOH.0003.0001.2001

9. Spotlight: Aboriginal social and emotional wellbeing workforce **37**

10. Priority 3: Supporting the safety, wellbeing and retention of the mental health and wellbeing workforce **38**

Action area 3a: Establishing workforce wellbeing monitoring and supports 42

11. Spotlight: Rural and regional incentive **45**

12. Priority 4: Building system enablers for excellence in workforce **46**

Action area 4a: Improving system planning and sustainability 47

Action area 4b: Shaping the workforce for the future 48

13. Spotlight: Collaborating with the Commonwealth and other partners **50**

14. Implementation **53**

15. Appendices **58**

Stakeholder engagement 58

Members of the Workforce Technical Advisory Group 59

Glossary 60

DOH.0003.0001.2002

1. Reforms to promote mental health and wellbeing for all Victorians

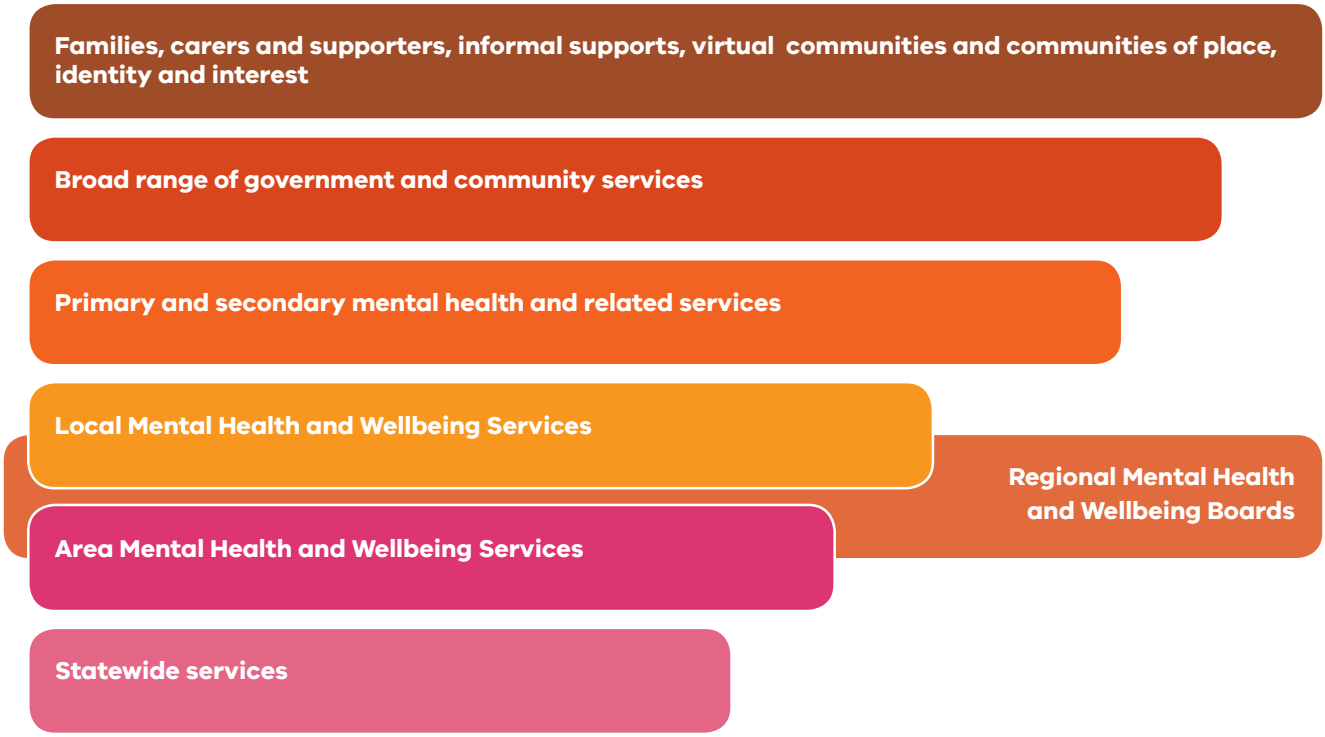
A bold vision for reform

The Royal Commission released its final report in March 2021, setting out its vision for the future mental health and wellbeing system. The 65 recommendations of the final report, along with nine recommendations in the interim report, lay the foundations for a future where more people needing mental health and wellbeing support will receive services in the community. The system will be responsive and integrated, and people will be able to access a mix of treatment, care and support options as set out in Figure 1.

The ten-year reform program is ambitious, and will see:

- community-based services at the core of the new system
- services that are responsive to people's level of need
- promotion of good mental health and wellbeing where people live, work and learn
- support for all Victorians to experience their best mental health and wellbeing
- new system foundations underpinned by lived experience leadership and supported by a strengthened workforce
- a commitment to research and innovation
- evidence-based service planning and contemporary, fit-for-purpose infrastructure.

Figure 1: Victoria's new responsive and integrated system



Royal Commission into Victoria's Mental Health System, Final Report, Volume 1, p. 297

Better mental health for Victoria leading to better opportunities for jobs

The Victorian Government is committed to improving Victoria's mental healthcare system by investing in better support, better environments and better facilities. By doing this now, and into the future, there will be better outcomes for many more Victorians.

In order to make this happen, the government needs to recruit many more people into the mental healthcare workforce, meaning there are better job opportunities across a range of disciplines, roles and levels.

A new approach to change

The Royal Commission made clear statements that the government's approach to reform needs to be different. Many flaws in the current system stem from how the system was designed – favouring expertise inside government or clinical settings or choosing organisational needs over people's experience.

To avoid repeating these mistakes, these reforms will apply a different approach, focused on collaboration and learning. Lived experiences will be central to the work and will be part of planning, design and delivery in the new system. There is a commitment to listen to expertise from diverse sources including the community, clinicians, providers, and other sectors who have been through change processes.

The workforce's role in system reforms

The mental health and wellbeing workforce will have a key role in these changes. Members of the workforce hold the knowledge and experience to guide service design; they are the trainers of new staff and continuous builders of skills; and they are the backbone of the system who will enable a holistic care environment for consumers.

In the Royal Commission's interim report, *Recommendation 7: Workforce readiness* sets out actions to strengthen and expand the workforce, and to build an evidence base to plan, project and respond to future needs and demand. The final report builds on these foundations. Implementation of *Recommendation 57: Workforce strategy, planning and structural reform* will see a workforce that is of the appropriate size, diversity and composition to deliver services to Victorians in the reformed system. *Recommendation 58: Workforce capabilities and professional development* will ensure members of the workforce have the right capabilities across professions, roles and settings, and *Recommendation 59: Workforce safety and wellbeing* will deliver sustainable working environments where staff feel safe, supported and valued.

Victoria's mental health and wellbeing workforce strategy 2021–2024 sets out priority activities to address existing challenges in the workforce pipeline, build attractive and rewarding workplaces, and pursue excellence in practice and outcomes. The Victorian Government has committed to refreshing the strategy every two years so it can reflect the changing needs of the system, the community, and of the mental health and wellbeing workforce.

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2. Overview of *Victoria's mental health and wellbeing workforce strategy 2021–2024*

Purpose of the strategy

Victoria's mental health and wellbeing workforce strategy 2021–2024 sets out a coordinated and strategic approach to deliver the diverse, skilled and multidisciplinary workforce required for Victoria's reformed mental health and wellbeing system. This strategy sets out the Government's vision for the mental health and wellbeing workforce, including the activities that are necessary in the short, medium and longer term to deliver on this vision and implement recommendation 57 of the Royal Commission's final report.

Approach to the strategy

This strategy sets out four key priorities for workforce reform, along with actions to build the mental health and wellbeing workforce that Victoria needs. It reflects immediate and inherited challenges to reform, and focuses on the urgent need to stabilise workforce supply. The strategy will provide a basis for structural reforms that assist in attracting, training and transitioning staff into new roles, services and models of care. These structural reforms will be revisited every two years to ensure the strategy reflects and responds to the evolving mental health and wellbeing system.

Final report recommendation 57: workforce strategy, planning and structural reform

The Royal Commission recommended that the Victorian Government:

1. ensure that the range of expanded mental health and wellbeing services is delivered by a diverse, multidisciplinary mental health and wellbeing workforce of the necessary size and composition across Victoria.
2. by the end of 2023, implement and support structural workforce reforms to:
   a. attract, train and transition staff to deliver the core functions of services across Local, Area and Statewide Mental Health and Wellbeing Services; and
   b. develop new and enhanced workforce roles as described by the Royal Commission in its final report.
3. develop, implement and maintain a Workforce Strategy and Implementation Plan and, by the end of 2021, enable the Department of Health to:
   a. conduct ongoing workforce data collection, analysis and planning;
   b. establish a dedicated workforce planning and strategy function; and
   c. encourage collaborative engagement and partnerships with relevant workforce stakeholders in implementing recommendations.

Stakeholder input

This strategy has been developed through the active support and leadership of the mental health sector. The Department of Health hosted a number of consultation activities, which were attended by more than 350 people and 100 organisations.

Lived experience engagement

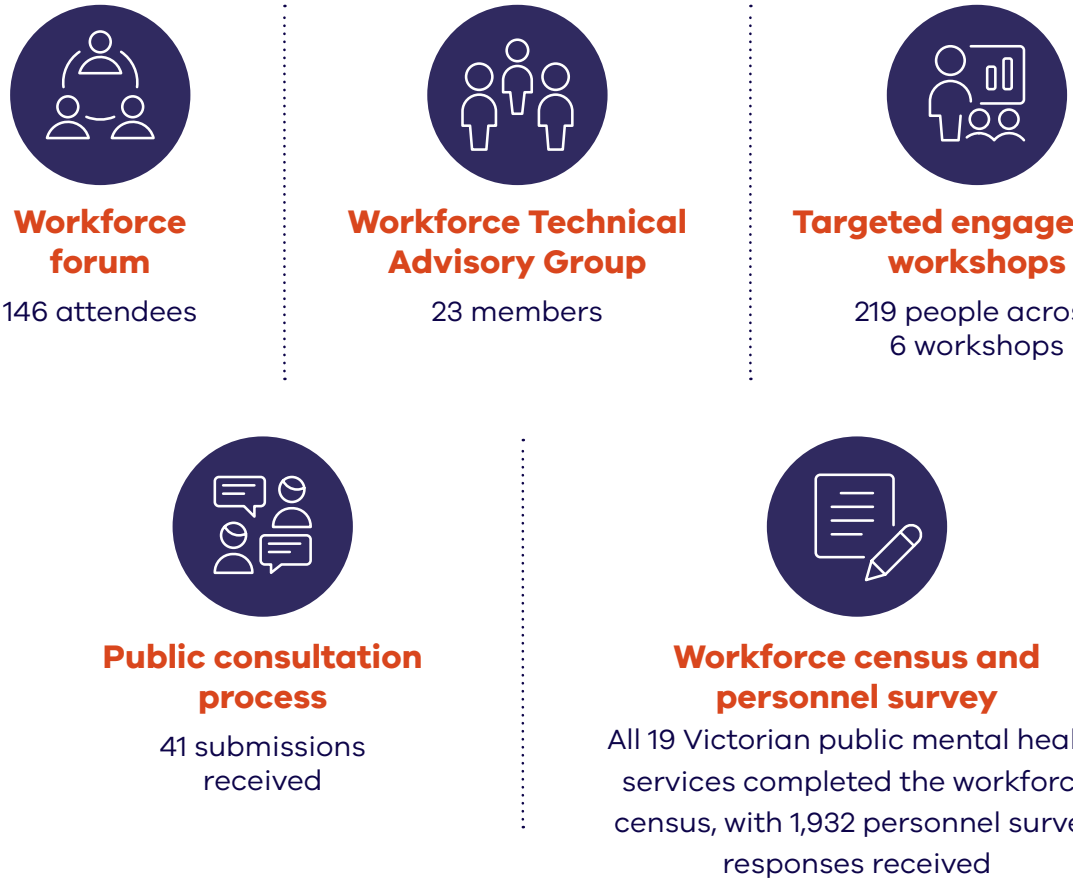
Lived experience is central to the transformation of the mental health and wellbeing system. Engagement on this strategy included people who brought lived experience perspectives, including consumer and carer peak bodies (the Victorian Mental Illness Awareness Council (VMIAC) and Tandem) and their members as well as members of the lived experience workforces.

People with a lived experience will have a central role in implementing the strategy. To further embed lived experience perspectives and support engagement on strategy initiatives, the Department of Health has funded two workforce lead roles at VMIAC and Tandem.

Engagement activities

A summary of engagement activities is set out in Figure 2, with further detail provided in Appendix 1.

Figure 2: Engagement activities to support the development of the workforce strategy



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Vision for the mental health and wellbeing workforce

Five principles will guide the design and delivery of workforce reforms, as set out in Figure 3.

Figure 3: Workforce reform principles

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Key priorities

The Victorian Government is committed to reforming the system and workforce and is already delivering **$269 million to supporting workforce reform**.

This includes **$41 million in new initiatives** for *Victoria's mental health and wellbeing workforce strategy 2021–2024* which will provide **358 full-time equivalent positions** across the mental health system. These new initiatives build on the **$228 million** previously invested through the 2020-21 and 2021-22 Victorian State Budgets, which provided approximately **580 new entry-to-mental health positions** for nurses, lived experience workers and allied health roles.

This **$269 million** investment includes:

Graduate mental health nurses

$70 million

to support up to **120 graduate mental health nurses** and supporting nurse educators each year

Lived experience workforces

$40.7 million

to support and grow the consumer and carer **lived experience workforces,** including support for 30 peer cadets each year

Allied health graduates

$39.4 million

in funding to support **60 allied health graduates** annually, with an additional **41 graduates** and eight educators funded to boost critical supply in 2022

Junior doctors

$37.4 million

to continue training up to **575** of Victoria's junior doctors in **foundational mental health skills**

Mental health and AOD workforces

$30 million

annually for workforce development for the mental health and AOD workforces

Allied health and nurse clinicians

$12.2 million

for a training program for experienced allied health and nurse clinicians to transition into mental health with up to **50 nurses**, **30 allied health** training positions and supporting educator roles funded

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Key priorities (cont.)

Rural and regional workforce

$10.5 million

for the rural and regional workforce incentive program

Students

$8 million

to provide students the opportunity to work and start building careers in mental health alongside their study

Enrolled nurses

$4.6 million

for a new enrolled nurse pipeline, with **40 enrolled nurses** and eight educators trained in mental health in 2022

Capacity building programs

$4.5 million

investment in capacity building programs for the psychiatry training pipeline, including **a new training group**, continued support of **mandatory training placements** and new **Directors of Training**, including for addiction psychiatry and rural and regional services in 2022

Mental health careers

$3.7 million

to attract people to mental health careers

Postgraduate scholarships

$1.3 million

for up to **70 postgraduate scholarships**, including 20 to AOD practitioners in 2022 to undertake postgraduate training such as a Graduate Certificate in Mental Health

Capability training program

$0.6 million

capability training program to implement the Victorian Mental Health and Wellbeing Workforce Capability Framework

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Strategy overview

Priority	Action areas
Priority 1: Building workforce supply	**1a:** Attracting people to mental health careers **1b:** Growing graduate, post-qualifying and transition training pathways **1c:** Building emergent and new workforces **1d:** Ensuring workforce meets regional needs
Priority 2: Building workforce skills, knowledge and capabilities	**2a:** Ensuring education and training meets the needs of the community **2b:** Embedding a system wide capability focus **2c:** Improving capability through ongoing training opportunities **2d:** Ensuring workforce reflects and responds to diverse communities
Priority 3: Supporting the safety, wellbeing and retention of the mental health and wellbeing workforce	**3a:** Establishing workforce wellbeing monitoring and supports
Priority 4: Building system enablers for excellence in workforce	**4a:** Improving system planning and sustainability **4b:** Shaping the workforce for the future

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SPOTLIGHT

3. Lived and living experience workforces

The Royal Commission outlines a vision for a system in which people with lived experience of mental illness or psychological distress and their families and carers shape the design and delivery of services, and where lived experience workforces are a core part of multidisciplinary teams and care models.

There are designated lived and living experience workforce positions across the mental health, Alcohol and Other Drug (AOD) treatment and harm reduction sectors.

To enable lived and living experience workforces to be effective, the roles need to be supported, valued and sustained. The 2021–22 Victorian State Budget invested $40 million over four years to build the required supports, structures and career pathways for the lived and living experience workforces to ensure a solid foundation for growth.

Initiatives to meet the following 10 actions will be designed and implemented with lived experience leadership and using the principles of co–production. Priorities for action are:

1. Strengthen discipline foundations

Commencing in early 2022, discipline frameworks to articulate each discipline's professional and ethical values, practice principles and scope of practice will be developed.

2. Improve understanding of lived and living experience workforces in mental health and AOD services and create conditions that support best practice lived experience work and models of care

Commencing in 2022, services will have access to training and development from lived experience educators to build their capability in this area.

3. Increase lived and living experience leadership roles

In addition to establishing new lived and living experience leadership roles within the Mental Health and Wellbeing Division and in the mental health and AOD sectors, a further $2 million has been invested in new leadership positions and professional development for lived experience workers in mental health services.

New and expanded services will result in lived experience leadership roles increasing across every part of the system. Growth will be measured through a workforce census and personnel surveys that will be conducted every 12–24 months.

4. Promote sustainability of lived experience roles and models of care that include lived and living experience workforces

Work will be undertaken to understand how to effectively embed establishing lived and living experience workforces into models of care and multidisciplinary teams; identify optimal workforce models and composition (role types, numbers and distribution) including models that support interconnections with Aboriginal social and emotional wellbeing workforces.

5. Create access to quality training and development and qualifications for lived and living experience workforces

A $360,000 grant program is in place to support lived experience workforce leadership, project management skills, and capability building in community mental health services. From 2022, an ongoing program of training and development will be commissioned and higher education needs will be identified.

6. Create equitable access to discipline specific supervision for lived and living experience workforces

A program of work is underway to build mental health lived experience workforces' capability and capacity to provide supervision through development and delivery of training, supervision supports and access to discipline-specific supervisors through the Centre for Mental Health Learning supervision database.

7. Support career pathways into lived and living experience work

A $1.3 million 12–month peer cadet program is underway across six community-managed mental health services to support lived

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experience workforces studying a Certificate IV in Mental Health Peer Work to gain valuable work experience and mentoring as they study. This program will be expanded into public specialist mental health services and opportunities identified across all lived and living experience workforces and for priority population groups.

8. Create accountability by establishing and monitoring measures for change

In addition to data published in the *Lived Experience Workforce Positions Report 2019–20*, projects are underway to collect current workforce data; understand the experiences of the lived and living experience workforces; understand organisational attitudes and establish ongoing measures to monitor change.

9. Strengthen networks and support communities of practice

Communities of practice are resourced and in place for AOD treatment and harm reduction peer workers and the Centre for Mental Health Learning supports a number of online communities of practice.

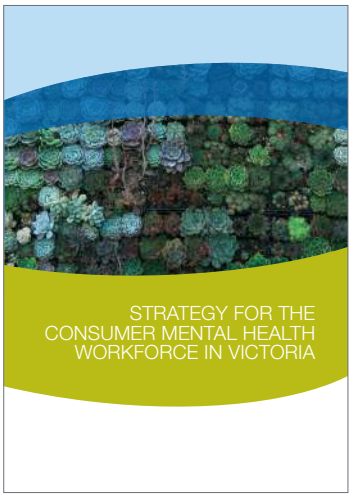
Communities of practice will be established for Consumer and Carer Consultants in 2022. Work will commence to identify ways to strengthen and support existing networks.

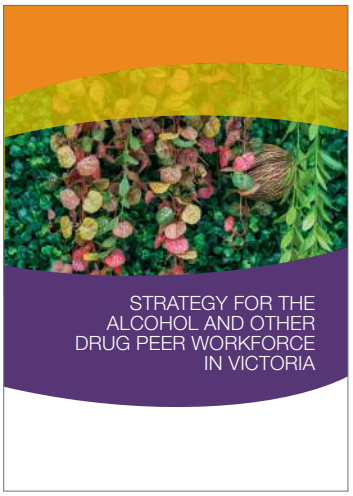
10. Attract people into lived and living experience work and promote careers

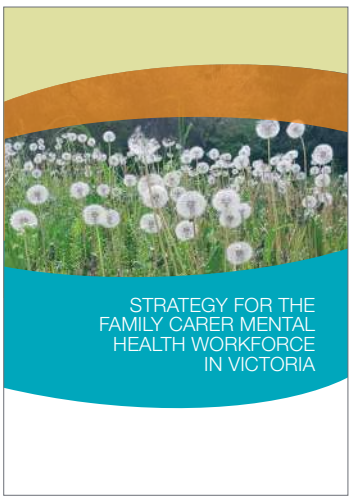
On completion of the discipline frameworks and establishment of key structures and supports, an approach to attraction and promotion of lived and living experience workforces will be developed.

Recognising that each of the lived and living experience workforce disciplines are at different stages of development, strategies for each discipline have been co-produced that outline further actions. These strategies will be monitored on an annual basis in partnership with the Department of Health's Lived Experience Workforce Advisory Group. Further information about lived experience workforce positions and access to the strategies can be found on the department's lived experience workforce initiatives website (www.health.vic.gov.au/workforce-and-training/lived-experience-workforce-initiatives).

A strategy for the harm reduction peer workforce is currently in development.







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4. Workforce profile

The mental health workforce comprises a range of different professionals and disciplines which contribute both to direct treatment, care and support and to the operational and leadership requirements of the system. This includes lived experience workers, nurses, a wide variety of allied health professionals, psychologists, psychiatrists and other medical practitioners, as well as health management and administration and support personnel. To fulfil recommendation 7 of the Royal Commission's interim report, work has been undertaken to create a current profile of the mental health workforce utilising Commonwealth Government datasets of Australia Health Practitioner Regulation Agency (Ahpra) registered professionals, as well as drawing on data from the Victorian Department of Health's August 2021 Workforce Census, which was completed by all 19 public mental health services.

Figure 4: Ahpra-regulated professionals (headcount) by sector

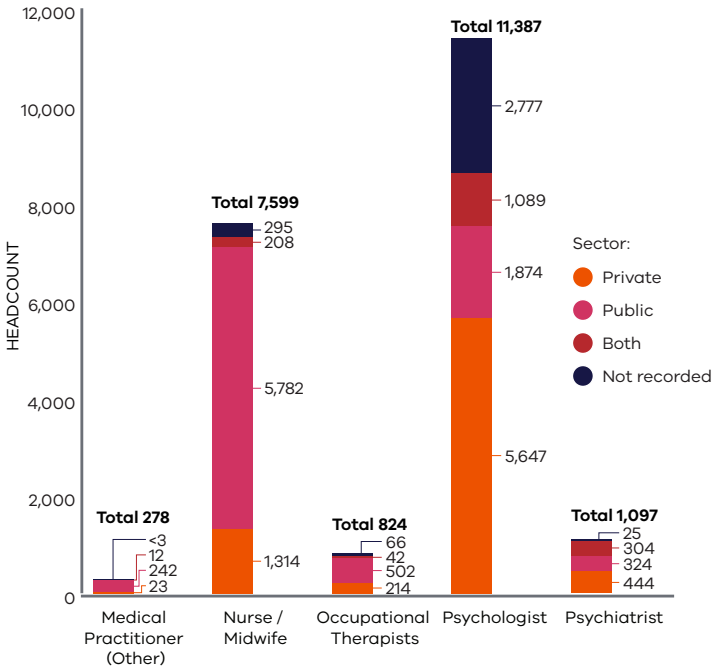
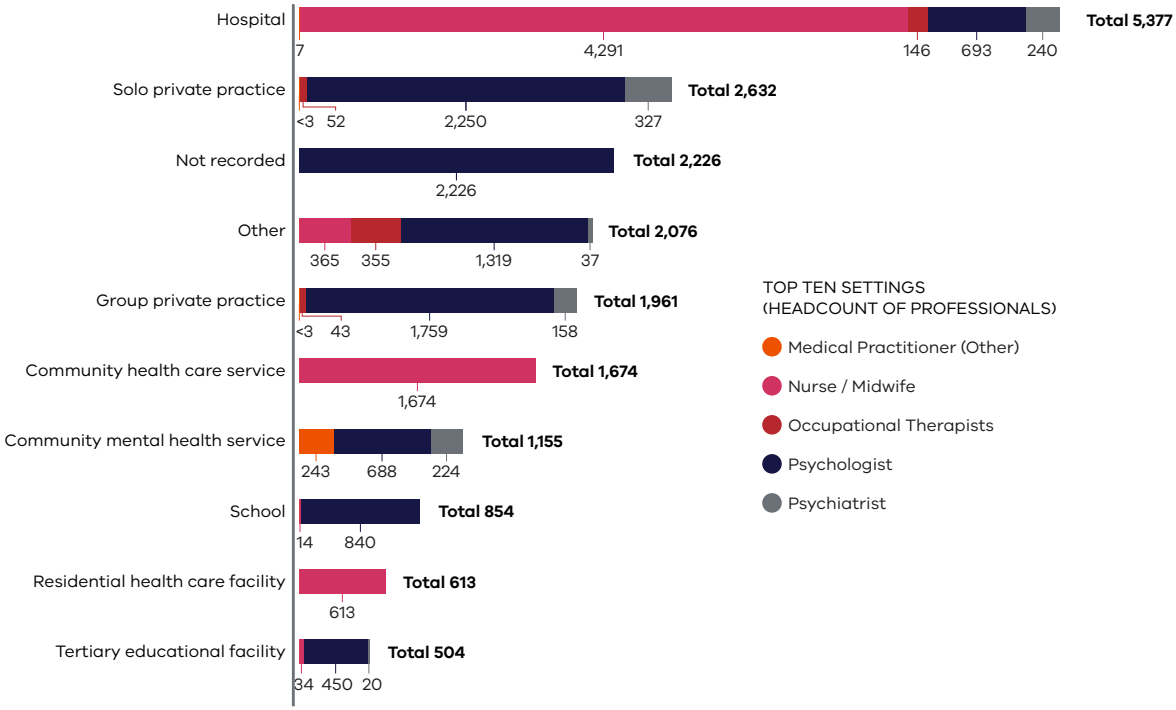


Figure 5: Top ten workplace settings for Ahpra-regulated professionals



Source: Commonwealth Healthcare Workforce Dataset Tool data (2020)
Note: Data is presented in headcount. Medical practitioners include (1) Addiction medicine practitioners, and (2) Other medical practitioners that work in community and residential mental health settings (this relates to any medical practitioner that has 'job setting' filtered for 'community mental health' and 'residential mental health'. This may include general practitioners and physicians).

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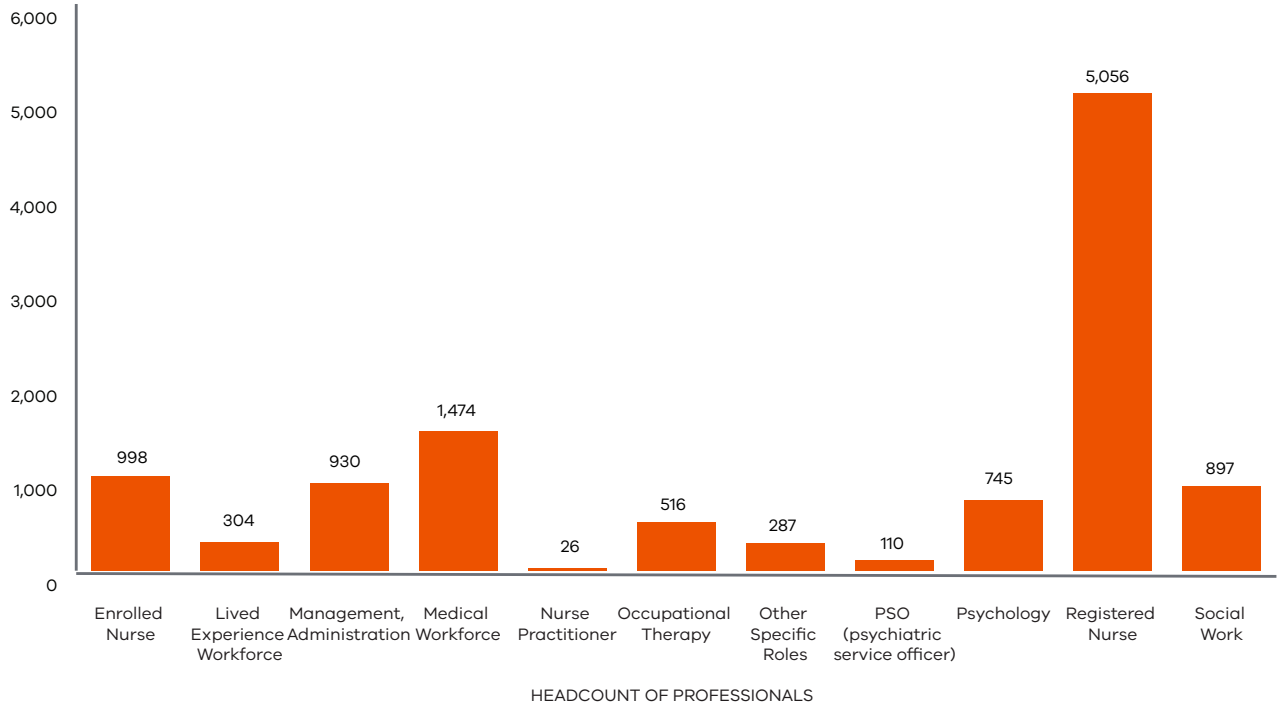
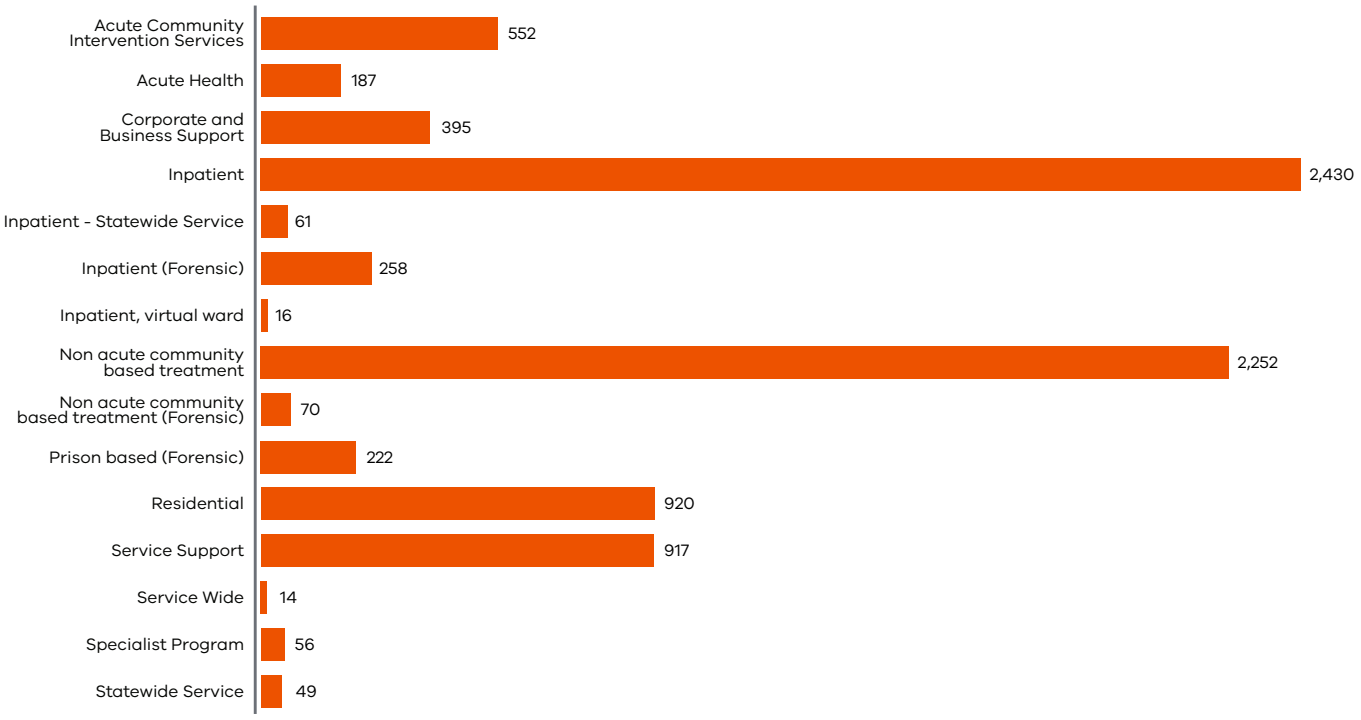
Figure 6: Headcount of public specialist mental health professionals



Source: Service Census Survey dataset (2021).

Figure 7: Public specialist mental health professionals (FTE) by job setting



Source: Service Census Survey dataset (2021)

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SPOTLIGHT

5. Supporting workforce capability to provide integrated care

The Royal Commission highlighted the lack of integration of treatment for co-occurring substance use and addiction and mental health concerns. The separation of mental health and AOD services has resulted in consumers having to navigate two distinct systems that often treat their interrelated needs separately.

Recommendations 35 and 36 of the Royal Commission's final report create the opportunity to improve outcomes for people with co-occurring concerns, by requiring mental health services to provide integrated care – including through the establishment of a statewide service for people living with mental illness and substance use or addiction – and by increasing the number of addiction specialists in Victoria. As well as providing dedicated research, primary and secondary consultation functions, the statewide service will have a role in supporting education and training initiatives for a broad range of mental health and AOD practitioners and clinicians.

Current initiatives to support integrated care capability include the cross-sector Victorian Dual Diagnosis Initiative, which aims to develop the capacity of mental health and AOD workers, agencies and sectors to recognise and respond effectively to people experiencing co-occurring mental health and substance use concerns and related issues.

Victoria's mental health and wellbeing workforce strategy 2021–2024 includes additional investment of $1.3 million to provide up to 70 postgraduate scholarships, including 20 to AOD practitioners in 2022 to undertake postgraduate training such as a Graduate Certificate in Mental Health.

An integrated care capability pilot is also underway, led by First Step in partnership with 11 services across greater Melbourne to test the implementation of the Comprehensive Continuous Integrated System of Care model at each service. This project will identify service and workforce development requirements to enable provision of integrated care.

The AOD workforce will make a significant contribution to the new mental health and wellbeing system over the coming years. There are existing and predicted workforce supply challenges for the AOD sector, which will be exacerbated by planned mental health and wellbeing service expansion. It is therefore important to consider AOD workforce needs as part of this strategy.

In addition to funding 100 new positions in the AOD sector in 2020–21 to support vulnerable people who became disconnected from AOD services during the pandemic, the Victorian Government supports a number of AOD-specific capability building initiatives, including:

- a program of workforce development to support new workers entering the AOD sector
- AOD training for nurses
- scholarships for the Graduate Certificate in Addictive Behaviours
- professional development webinars
- delivery of the AOD Skill Set (four VET units of competency)
- AOD peer workforce development
- resources to assist services to support student placements
- support for addiction medicine and addiction psychiatry advanced trainees.

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6. Priority 1: **Building workforce supply**

Victoria's mental health and wellbeing workforce needs to grow significantly to deliver the treatment, care and support that Victorians need. Supply challenges need to be addressed both in order to meet increasing demand for mental health services and to prepare for changes to frontline service delivery as reforms are implemented.

The new system will shift demand patterns for mental health and wellbeing services, with most consumers using Local Mental Health and Wellbeing Services, and more intensive needs being met through Area Mental Health and Wellbeing Services and statewide services. Changed approaches to treatment, care and support, service delivery settings, and the anticipated reach of service offerings will all require the workforce to grow in a planned way.

The long-term objective is for Victoria's expanded mental health and wellbeing services to be delivered by a diverse, multidisciplinary workforce of the necessary size and composition. To achieve this, critical existing shortages must be addressed, and a pipeline must be built to grow the workforce.

Demand for services

Demand for mental health services has steadily increased over time and is at an all-time high. The coronavirus (COVID–19) pandemic has compounded demand for services, with the impacts expected to persist for many years. The pandemic has simultaneously exposed the sector to great stress; shown the sector to be capable of great innovation and flexibility; and resulted in broad recognition of the importance of mental health in community wellbeing.

Throughout consultations, stakeholders communicated overwhelmingly that workforce shortages are affecting workforce wellbeing and the ability of the system to meet demand for services and to deliver the high-quality treatment, care and support the workforce aims to provide.

Workforce requirements

The size of Victoria's mental health workforce needs to increase to keep up with current community demand for mental health services. In addition, it needs to grow substantially – and in a planned way – to deliver on the Royal Commission's recommendations.

As well as an overall increase in size, the profile of the workforce will change. New workforce cohorts will need to be created to deliver the expanded range of services and initiatives, and there may be changes to team composition. The distribution of the workforce will also transform as new services are established and shift the centre of mental health service delivery from acute, tertiary care to community-based treatment, care and support. Figure 8 sets out the types of roles which will be required in the reformed service system.

Building workforce supply: Priority action areas

Action area 1a	Action area 1b	Action area 1c	Action area 1d
Attracting people to mental health careers	Growing graduate, post-qualifying and transition training pathways	Building emergent and new workforces	Ensuring workforce meets regional needs

DOH.0003.0001.2016

Figure 8: Indicative workforce supply considerations

Local

- Allied health and other therapeutic roles across local services
- Lived experience and peer support roles
- Wellbeing support workers across local services
- Young career support positions
- Psychiatry and clinical psychology roles across local services

Area

- Specialist trauma practitioners
- Adult and older adult and youth mobile assertive outreach teams
- Expert older adult multidisciplinary teams
- Forensic community outreach teams and forensic transition teams
- Crisis response telephone/ telehealth workers
- Mental health crisis outreach teams
- Peer support worker roles across bed-based services, emergency department crisis hubs, and crisis respite facilities
- Specialist infant, child, youth and family mental health practitioners
- Wellbeing support workers
- Psychiatry, clinical psychology, allied health and therapeutic roles across bed-based and other area services

Statewide

- Mental health and addition specialist practitioners for the new statewide substance use or addition services
- Trauma education and development specialists for the new Statewide Trauma Service
- Specialist youth forensic mental health practitioners for the new Statewide Specialist Youth Forensic Mental Health Service
- Specialist suicide bereavement clinicians and peer support workers for state postvention bereavement support
- Specialist suicide prevention and response mental health practitioner and LGBTIQ peer support worker roles for the new LGBTIQ model of aftercare service

System wide

- Lived experience roles, including consumer and carer roles across a range of service needs and settings
- Koori mental health liaison officers across service settings
- 'Liaison' or 'peer' roles to support LGBTIQ and culturally diverse communities

Supply challenges

The scale of Victoria's mental health workforce challenge is large. Modelling shows a need for approximately 2,500 additional workers in the public mental health system over the next three and a half years to stabilise the system and implement funded reforms.

This modelling includes projections for existing disciplines in the public mental health system, and is based on state and national datasets, including the department's August 2021 Workforce Census. In addition to these 2,500 workers for existing disciplines, the reformed system will also require new workforce disciplines and roles, with further design work needed before demand for these workforce requirements can be estimated. This estimate does not include demand in adjacent settings such as the private sector, justice or education.

> **'Focus recruitment to industries that have portable skills. Particularly target people from industries that have been impacted by COVID-19 including hospitality, tourism and travel. These people can be recruited and trained to deliver low intensity interventions, life coaching, service navigation and peer groups.'**
>
> *Submission to Department of Health, August 2021*

There are shortages of mental health workers across most occupations and professional groups, with service expansion and an ageing workforce expected to add further challenges.

Addressing the challenge

Through these reforms, the Victorian Government is committed to making the mental health system better for all.

This means more jobs for nurses and psychiatrists, allied health and lived experience workers, as well as new disciplines to deliver new programs and services across the state.

Ultimately, this is about enabling all Victorians with mental illness and psychological distress and their families, carers and supporters to receive the care they need.

Important levers in ensuring sustainable workforce supply include:

- attraction and entry – promotion and marketing, education and training pathways, student places, and curriculum
- accreditation and employment – accreditation, registration, recruitment, workplace conditions and industrial relations
- development and retention – ongoing professional development, career pathways, incentives and credentialling.

These levers feature in the actions outlined below. However, achieving workforce reform will require multiple layers of government, professional bodies, unions, service providers and training providers to work together.

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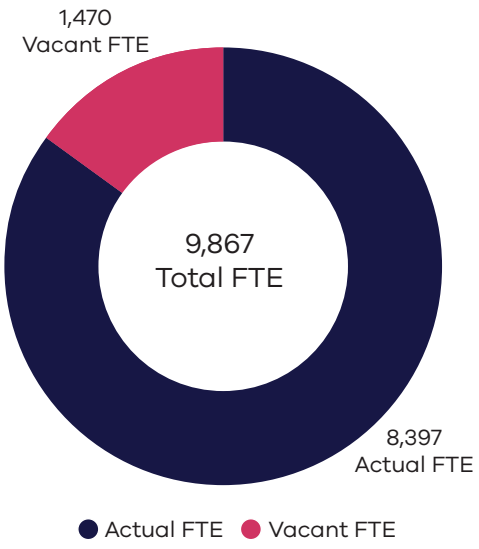
Figure 9: Public specialist mental health service overall vacancy rate (FTE)



Source: Service Census Survey dataset (2021). Melbourne peri-urban areas surround Metropolitan Melbourne and interface with rural or bush areas – they are neither urban nor rural in the conventional sense. There are six peri-urban areas in Victoria (Bass Coast, Baw Baw, Mansfield, Mitchell, Moorabool and Murrindindi).

Figure 10: Public specialist mental health FTE positions by region (actual and vacant FTE positions)

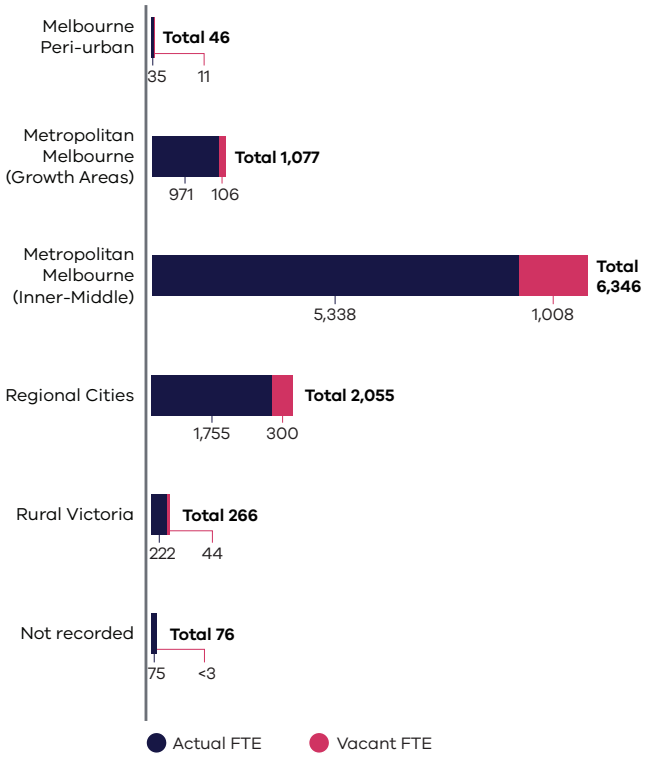
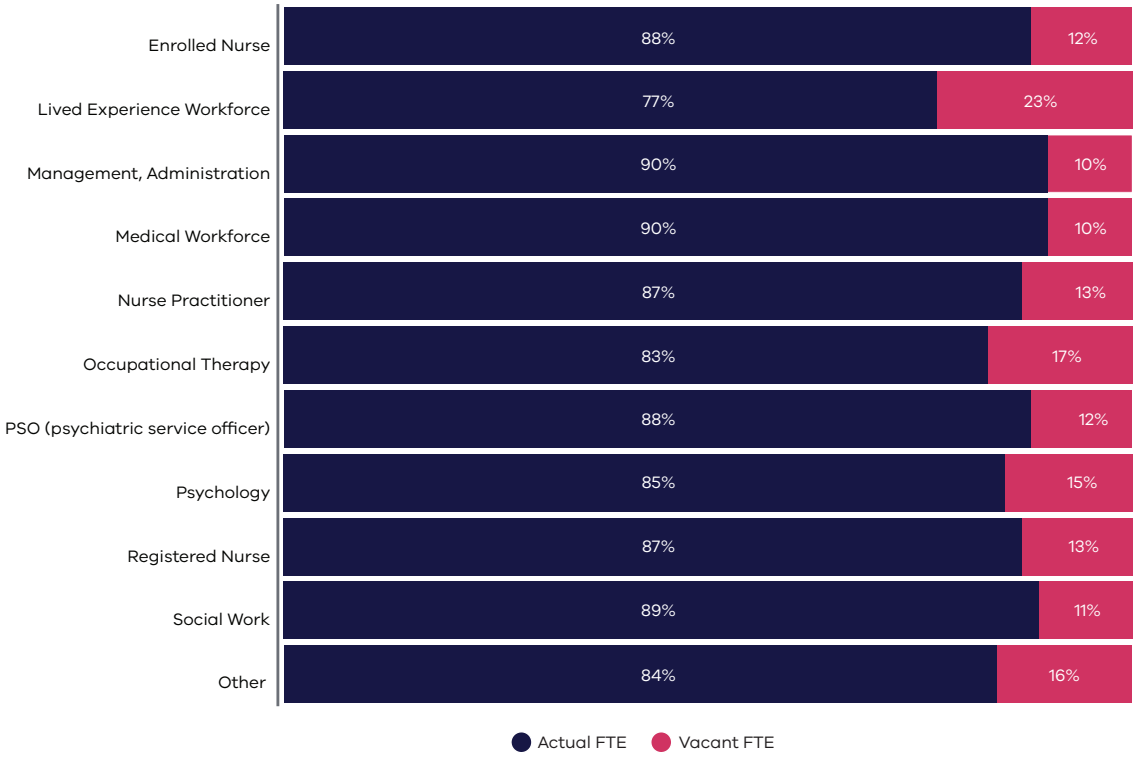


Figure 11: Public specialist mental service vacancy rate by professional discipline



Source: Service Census Survey dataset (2021). 'Other specific roles' refers to AOD workers / substance use and addiction support, child psychotherapists, welfare workers, youth workers, community development workers, community engagement workers, dieticians, eating disorder workers, music therapists and more. 'Generic clinical vacant roles' refers to generic vacancies.

Action area 1a: Attracting people to mental health careers

Positive and early exposure to the mental health system is one of the strongest indicators for pursuit of a mental health career, countering stigma and community perceptions of working in the mental health sector. Increasing awareness of mental health careers and the opportunities available in the sector is therefore a key focus.

In addition to attracting Victorians and interstate workers to the sector, Australia relies on overseas-trained mental health workers to meet its workforce needs. In Victoria, international recruitment is used to respond to shortages in both public and private settings and across metropolitan and rural health services. The coronavirus (COVID–19) pandemic has significantly interrupted this source of expertise, compounding workforce supply shortages in key professional groups.

> 'Develop strong linkages with universities and explore opportunities for innovative student placement models and pre-qualification initiatives...'
>
> *Submission to Department of Health, August 2021*

Actions outlined below seek to attract people from Victoria and interstate into mental health careers, pave the way to restore the international workforce pipeline, and provide additional exposure and understanding of the sector to potential workers.

Initiatives commenced and commencing

The local mental health workforce is the backbone of the reforming mental health and wellbeing system, but the demand for workers across the sector exceeds the current supply. To complement local and interstate attraction of new workers, the Victorian Government is working to restore the supply of international workers. International recruits and Australian healthcare workers currently located overseas are eligible for facilitated entry supports upon employment at a Victorian public health service. This includes up to 1,000 relocation subsidies of up to $2,000 in value. Additional relocation supports and funding for mental health workers moving to regional and rural locations are currently available.

A new domestic attraction campaign aims to encourage local and interstate clinicians to take up career opportunities in Victoria's reforming system. The campaign will be scaled up and expanded to target non-clinical and international workforces in the 2022–23 financial year.

Medium and longer-term actions

Over the long term, an attraction campaign will play a leading role in attracting new workers into the system. The campaign will be periodically refreshed to keep pace with reforms, with future iterations to include online recruitment support and department-led partnerships with recruitment agencies.

Resuming international recruitment at scale will also occur in the medium and longer term. To assist this, additional supports for international recruitment will be rolled out. This will include migration toolkits, community orientation, settlement supports and mentoring for migrants to promote their successful transition into the Victorian community and the public mental health and wellbeing system.

The Victorian Government will continue to advocate to the Commonwealth Government to address barriers to immigration for mental health professionals. Currently, age limits for permanent residency are an impediment to attracting much-needed specialists and leaders, and limits to working hours for international students can delay qualifications. Streamlined immigration pathways will also be sought to support the successful attraction of overseas professionals.

> 'Overseas and interstate workforce attraction will be key to us being able to enact the required growth in service provision.'
>
> *Submission to Department of Health, August 2021*

Action area 1b: Growing graduate, post-qualifying and transition training pathways

For most workforces in the mental health system, qualifying as a mental health worker takes time. To support training requirements and workforce growth, the system needs the right number of training positions and clinical supervision structures.

Mental health and wellbeing services need the capacity to support mandatory rotations in psychiatry training, and more senior psychologists are needed to fulfil the training requirements of probationary psychologists.

> 'Educational institutions and tertiary services need to work together to develop an appropriately trained workforce.'
>
> *Submission to Department of Health, August 2021*

In the psychiatry training pipeline there are particular challenges with the number of trainees exceeding the number of places in mandatory rotations in Child and Adolescent and Consultation Liaison Psychiatry, which results in delayed graduation for trainees.

In addition, Victoria has historically relied on international migration to augment local training shortages in key disciplines, and particularly in psychiatry. Victoria recruits Senior International Medical Graduates, however lower examination pass rates for this cohort means training places are filled but do not necessarily materialise into trained resources. As international recruitment again gains pace, additional training support needs to be provided to boost qualification rates for this cohort.

For allied health graduates – including psychology and social work students – high training hurdles impact on entry and completion, including the requirement for social work students to undertake 1,000 hours of unpaid placements, and significant supervision requirements for psychology. Removing these barriers, in collaboration with the Commonwealth Government, is a priority.

Experienced professionals from other areas of practice are well equipped to work in the mental health sector. To encourage recruitment of members from this cohort, clear transition pathways providing appropriate support are needed.

Attrition of experienced and senior allied health staff is also a key challenge. More senior career opportunities and supports will be needed to retain these professionals.

Initiatives commenced and commencing

The Victorian Government has invested $228 million over the 2020–21 and 2021–22 Victorian State Budgets to build a diverse and skilled mental health workforce. Across the five years from 2020–21 to 2024–25, the funding will support an increase to workforce supply by funding approximately 582 full-time equivalent entry positions. That has supported implementation for:

- **Postgraduate mental health nurse scholarships: $16.1 million** for up to 685 scholarships. This provides up to 140 scholarships annually, as recommended in the Royal Commission's interim report and assists in building a highly skilled and experienced specialist mental health nursing workforce. The scholarships offer those with an interest in mental health an opportunity to build on their foundational clinical skills and cover the full course fees of a Graduate Diploma in Mental Health Nursing for successful applicants from 2021.
- **Entry pathways for mental health nurses: $76.0 million** for up to 560 graduate mental health nurses (up to 120 graduates each year), and up to 40 nurses through the nurse transition program. This has allowed new mental health nurses to be trained from 2021 and continues to support capability and leadership development in the sector's largest clinical cohort and facilitates experienced general nurses interested in a career change to become mental health nurses.
- **Junior medical officer psychiatry rotations: $37.4 million** to provide a psychiatry rotation for 126 junior doctors in 2021, and up to 575 junior doctors in 2022 and 2023. Increasing junior doctors' exposure to psychiatry both improves their skills in mental health and promotes psychiatry as a vocational choice.

- **Prequalification initiative: $8 million** to provide jobs for allied health, nursing and medicine students to work part-time in mental health services while they study. The initiative supported 120 pre-qualification roles in 2021, and continue into 2022 to provide students with valuable experience working with consumers, families and carers and early exposure to the mental health sector, increasing the likelihood that they will choose a career in mental health.
- **Psychiatry leadership development: $2.3 million** to support leadership development for psychiatrists in the public mental health system. This program has supported psychiatrists to pursue professional development opportunities and in 2022 will build Victorian psychiatrists' leadership capability in priority reform areas, including co-leadership with consumers, carers and their families, change management, quality improvement and safety management.
- **Supporting psychiatry registrars to undertake mandatory rotations: $7.5 million** to support 43 psychiatry registrars undertake mandatory rotations in child and adolescent psychiatry in 2021 and 2022.

The Victorian Government has invested in a range of new initiatives to grow training pathways, given the time-critical need to build workforce supply. Initiatives include:

- **Graduate allied health positions: $34 million** for up to allied health graduates in psychology, social work and occupational therapy to work in mental health, with 132 graduates starting in 2022. This exceeds the interim report recommendation for 60 positions and will provide entry points into mental health and wellbeing services for allied health professionals who will have a key role in providing therapeutic and evidence-based treatments.
- **Expanded postgraduate scholarship program: $1.3 million** for up to 70 postgraduate scholarships for allied health clinicians, including 20 scholarships for clinicians providing AOD and integrated care, building on the postgraduate mental health nurse scholarship program. This investment will help provide integrated treatment, care and support to people living with mental illness and substance use or addiction, as per recommendation 35 of the Royal Commission's final report.
- **Psychiatry training support package: $4.5 million** to improve the capacity of the psychiatry training pipeline, through a new training group, continued support of mandatory training placements and new Directors of Training, including for addiction psychiatry and rural and regional services in 2022, as well as continue a training program to support specialist international medical graduates.
- **New graduate program for enrolled nurses: $4.6 million** for eight mental health nurse educators to train 40 enrolled nurses in key skills and capabilities. This will establish a clear pipeline for enrolled nurses to enter mental health, increase the nursing workforce and provide immediate relief in clinical services.
- **Transition program for experienced allied health and nursing clinicians: $12.2 million** to support mid-career practitioners to transition into mental health careers. The existing nurse transition program will be scaled up to support an additional 50 nurses, and a new program for allied health practitioners will see 30 clinicians commencing in 2022, with trainees supported by 16 educators.

Medium and longer-term actions

The workforce needs to grow significantly to deliver the Royal Commission's recommended reforms. Over the medium to longer term, promising and successful initiatives to address workforce supply will be adapted to respond to system needs.

In addition, Victoria will continue to advocate to the Commonwealth Government to reduce barriers to entry for the workforce through removing blockages in the training pipeline, including expansion of critical provision of training places, delivery of quality and fit-for-purpose course content, and support for placements in mental health settings. Further detail can be found under Spotlight: Collaborating with the Commonwealth and other partners.

Action area 1c: Building emergent and new workforces

Emergent and new workforces will be crucial in delivering holistic and person-centred treatment, care and support in the reformed service system.

Emergent workforces include the lived experience workforce, and workforces with capability in delivering integrated care for substance use and addiction. Workforce development pipelines for both of these workforces need to be scaled up and refined, and in some cases established.

New workforce cohorts are also needed to deliver consumer-centred care and new service models, such as expanded wellbeing supports in Local Mental Health and Wellbeing Services. Changing the workforce composition to include new professions, potentially including mental health-trained paramedics, counsellors and wellbeing roles delivered across tertiary and community settings, has the potential to mitigate current workforce pressures. It will be important to consider how other professions with transferable skills will be integrated with established disciplines, and how these new skillsets can best be used to meet consumer needs.

Initiatives commenced and commencing

The Victorian Government committed $40 million in the 2021–22 Victorian State Budget to support the consumer and carer lived experience workforces. Work has commenced on initiatives to address both supply and systemic supports, including:

- a new **lived experience peer cadet program** to promote career pathways for up to 100 lived experience peer cadet positions in mental health services. The program will promote career pathways for lived experience workforces in community mental health services, helping cadets studying a Certificate IV in Peer Work to gain valuable experience and mentoring in the sector, and will be expanded into clinical settings in future years.
- improved access to **supervision for lived experience workers** in clinical services and supporting architecture such as organisational benchmarking and readiness frameworks, micro-credentialling, scholarships, standardised training and development of a discipline framework. These systemic work programs will build system-wide and service structures for the lived experience workforces and lay the foundations for further expansion.
- funding two **lived experience workforce lead positions** at Victoria's consumer and carer peak bodies. Workforce leads at VMIAC and Tandem will strengthen consumer and carer perspectives on mental health workforce policy, ensuring that reforms are guided by the experience and expertise of lived experience workers. They will also liaise with members of the lived experience workforces to coordinate reform activities in partnership with the Department of Health.
- a **lived experience workforce – consumer and carer feedback** program is being piloted in 2021–22, and recognises the critical role of the lived experience workforce in engaging with consumers and carers at services. An initial investment of $1.3 million funded a 12–month pilot to improve the ways in which services use consumer and carer feedback. As part of the pilot, sites have recruited members of the lived experience workforce to collect, translate, share and utilise feedback as part of the services' performance improvement activities. Current pilot sites include 18 adult Hospital Outreach Post Suicide Attempt Engagement (HOPE) and two mental health hospital in the home (HITH) sites. Findings from the pilot will be used to help services understand how lived experience workers can improve and embed a responsive performance management approach.

Further information on work underway to support lived experience workforces can be found under Spotlight: Lived and living experience workforces.

Medium and longer-term actions

New services and models of care – including a Lived Experience Residential Centre, Statewide Trauma Centre and Local Child and Youth Hubs – will be established over the medium to long term. An understanding of the workforce supply needs of the reformed system will develop in parallel and will inform statewide service planning and future iterations of this strategy.

There will be a continued focus on opportunities for new workforces in the reformed mental health system, and on support for existing workforces to maximise their scopes of practice.

Once the foundations for emergent and new workforces are in place, the focus will move to the scale of the workforce pipeline.

Previous investment in capacity building initiatives, including the Lived Experience Organisational Readiness and Discipline Framework, will support retention and allow for future investment and growth to be sustained.

Action area 1d: Ensuring workforce meets regional needs

Supply challenges are exacerbated in rural and regional areas. This is not unique to Victoria, with rural and regional areas nationally struggling to fill vacancies and provide supportive workplaces for staff and adequate supervision to trainees.

A number of incentives and supports will encourage mental health professionals to train, live and work in regional and rural communities.

> 'We would like to challenge the narrative that careers in rural and regional areas offer less opportunities than those in urban regions… With fewer competitors and resources in rural and regional areas, workers can have a broad range of experiences and progress their career in ways that may not be possible in an urban setting.'
>
> *Submission to Department of Health, August 2021*

Initiatives commenced and commencing

A relocation grants pilot program, administered by the Rural Workforce Agency Victoria, is underway. The program supports mental health workers to move and settle in rural and regional Victoria, taking up roles in public specialist mental health services. The program offers financial incentives to cover relocation costs.

The following initiatives aim to attract mental health and AOD workers to rural and regional Victoria through:

- **Workforce incentive grants:** encourage and support mental health workers to relocate, settle and remain in rural and regional areas. Qualified workers recruited to priority, hard-to-fill positions within state-funded mental health services will be eligible for grants equal to $3.2 million over two years. The grants will refine the relocation grants pilot to offer a higher incentive and an expanded and more flexible range of items for reimbursement, including childcare, school fees and vehicle costs.
- **Integration support for workers and their families:** Ensuring candidates are adequately supported prior to employment, during relocation while they settle into local communities is key to long-term retention. A new $2.6 million program will provide pre-employment and integration support to help individuals and their families to settle into their new communities by connecting them to essential services, social and professional opportunities.
- **A pilot incentive program** to attract the AOD workforce into rural and regional services will be developed in collaboration with stakeholders, with access to incentives commencing in early 2022.
- **A pilot internship program** for students studying allied health courses or a Certificate IV in AOD. Rural and regional AOD services will teach job-ready skills and prioritise interns from culturally and linguistically diverse and LGBTIQ communities. This will be developed in collaboration with stakeholders and rolled out in 2022.

Medium and longer-term actions

Rural and regional workforce incentive program offerings will be further developed and refined based on a review of implementation in 2022 and 2023. From 2023, the incentive scheme will be refreshed to support successful components of the early program, and consider opportunities for new components, through a planned scale-up in line with the $10.5 million allocated in the 2021–22 Victorian State Budget.

The incentive scheme refresh will be undertaken alongside improved workforce planning, supported by the establishment of Regional Mental Health and Wellbeing Boards, which will focus on localised workforce needs and ensuring workforces are reflective of local communities.

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SPOTLIGHT

7. Capability Framework

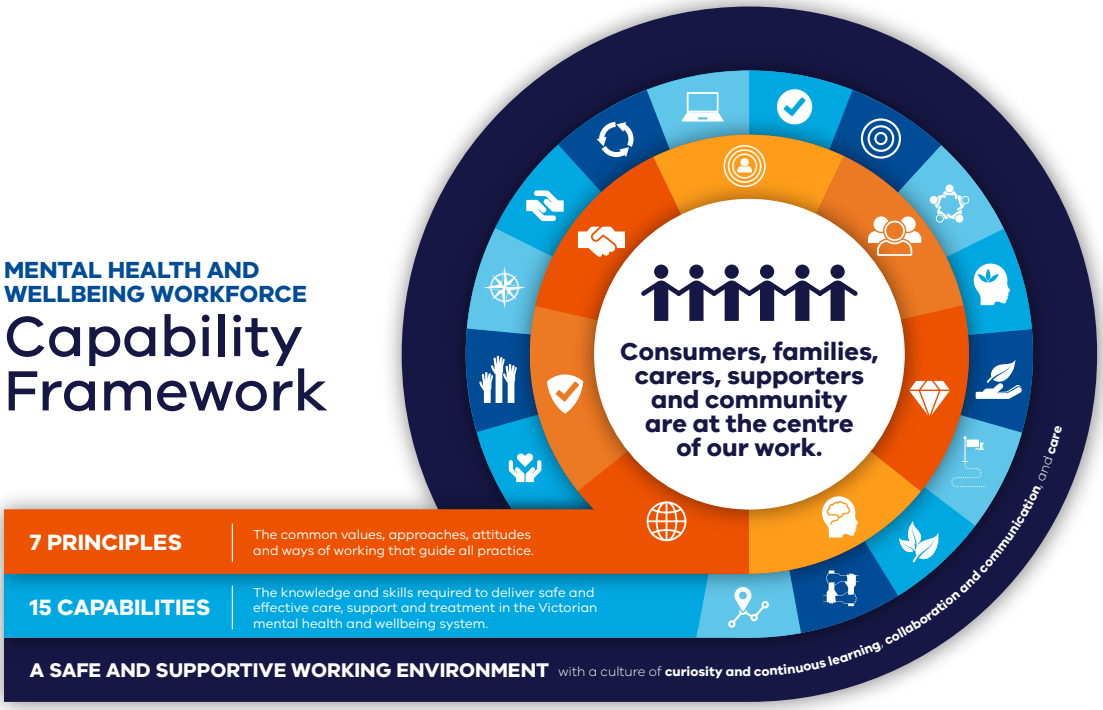
The Victorian Mental Health and Wellbeing Workforce Capability Framework sets out the skills, knowledge and ways of working that the workforce will require in the new integrated and responsive mental health and wellbeing system.

The Capability Framework recognises the diverse, multidisciplinary and evolving nature of the mental health and wellbeing workforce, and articulates what is required to deliver high-quality, compassionate and person-centred care and support to consumers and their carers, families and supporters. It delivers on recommendation 58(2) of the Royal Commission's final report, and is designed to be a practical and living framework. The framework aims to provide a common language for all members of the health and wellbeing workforce – regardless of professional discipline, background, role and setting – and to generate a sense of collective identity and reciprocal responsibility for how treatment, care and support is delivered in Victoria.

A framework for now and for the future

The Capability Framework sets out seven practice principles and 15 priority capability domains to guide the professional practice of all those who work in, or interact with, the mental health and wellbeing system—regardless of setting, role, or level of specialisation. The practice principles represent the common values, approaches and attitudes required when working with individuals, their personal support networks and colleagues. The capability domains encompass the knowledge and skills required of every professional, in addition to the specific capabilities required of treatment, care and support professionals, specialist and technical professionals, and service managers and leaders.

The first iteration of the Capability Framework represents a point in time at the beginning of a ten-year reform journey. It will be reviewed and revised to keep pace with emerging and evolving needs of the Victorian mental health and wellbeing system and workforce.



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8. Priority 2: **Building workforce skills, knowledge and capabilities**

The mental health and wellbeing workforce needs the right capabilities, skills and knowledge to deliver the highest quality care to consumers. Throughout consultations, sector stakeholders strongly communicated the need to invest in capability and professional development as part of a suite of actions to support wellbeing and aid worker retention.

In rebuilding the mental health and wellbeing system, new and enhanced capabilities will need to be developed across professions, roles and settings. A comprehensive and networked approach to building capability across the whole workforce will support access to priority learning and professional development activities and educational resources in collaboration with training providers, statewide services and others.

The long-term objective of this priority area is for the workforce as a whole to have the capabilities, skills and knowledge to provide safe, effective and collaborative care to consumers.

Initial actions will focus on capabilities that are universal across the system and workforces, as well as building specific skills needed in disciplines and service settings.

Final report recommendation 58: workforce capabilities and professional development

The Royal Commission recommended that the Victorian Government:

1. through the Department of Health, by the end of 2021, define the knowledge, skills and attributes required of a diverse, multidisciplinary mental health and wellbeing workforce, starting with the priorities as described by the Royal Commission
2. develop a Victorian Mental Health and Wellbeing Workforce Capability Framework as a component of this
3. detail the approach to capability development across the mental health and wellbeing workforce as part of the workforce strategy and implementation plan
4. build on the interim report's recommendation 1 and enable the Collaborative Centre for Mental Health and Wellbeing, in collaboration with training providers, mental health and wellbeing services and people with lived experience, to coordinate learning and professional development activities across the whole mental health and wellbeing workforce.

Capability: Priority action areas

Action area 2a	Action area 2b	Action area 2c	Action area 2d
Ensuring education and training meets the needs of the community	Embedding a system wide capability focus	Improving capability through ongoing training opportunities	Ensuring workforce reflects and responds to diverse communities

Action area 2a: Ensuring education and training meets the needs of the community

There are significant education and training bottlenecks that require Commonwealth support to solve

The mental health workforce is highly skilled, and demands a contemporary education and training program that reflects this. The Victorian Government does not control all the strategic and operational levers needed to create and sustain a sufficient workforce pipeline – many of these levers rest with the Commonwealth Government and national bodies.

Currently, the specialist skills for clinical mental health work require professionals in most disciplines to undertake training in addition to their generalist qualifications. While this creates valued opportunities for immersive learning and development for clinicians, it places a significant burden on the State and health services to support job-readiness through graduate programs and does not reflect the significance and prevalence of mental illness as a health issue. For example, recent reports indicate that Victorian universities are graduating thousands of psychology students who never qualify to practice, with only a small percentage completing the necessary six years of university and on-the-job supervision and training.

Fewer than one per cent of students go on to complete masters programs despite the demand for services. Undergraduate psychology students compete for a handful of places in honours and masters programs, then face the challenge of finding a placement to complete their 1,500 hours of practical training, including one-on-one supervision.

Working together to jointly address challenges with Commonwealth and national bodies

Structural pressures on the mental health and wellbeing workforce need to be urgently resolved to ensure a sufficient workforce pipeline for Victoria.

Unlike the education sector, accreditation levers are not held by the State or Commonwealth Governments. Training programs are accredited by different bodies for each professional discipline.

Several professions require registration with the Australian Health Practitioner Regulation Agency (Ahpra) to be able to practice.

To ensure the workforce is equipped with the right skills, knowledge and capabilities, and that investments in tertiary qualifications meet the needs of the mental health system, action needs to be taken to ensure:

- appropriate accreditation, registration and training requirements
- availability of high-quality education and training programs with appropriate curricula
- support for graduates in specific disciplines to complete the additional education and training required to transfer into clinical mental health roles
- support for health services to undertake their role in graduate training programs.

Progress in each of these domains will require extensive work with the accrediting bodies for each discipline, Aphra, training and education providers, and the Commonwealth Government.

Initiatives commenced and commencing

The Commonwealth Government is leading development of a ten-year National Medical Workforce Strategy and a National Mental Health Workforce Strategy, which will consider the quality, supply, distribution and structure of Australia's mental health workforce. The Victorian Government is working closely with the Commonwealth on both strategies and will continue to advocate to the Commonwealth for actionable implementation plans.

Establishment of the Mental Health Higher Education Reference Group

A Mental Health Higher Education Reference Group will be established to tackle immediate and medium-term priorities in the Victorian education and training sector in a partnership approach between the Victorian Government and the sector. This recognises that the Victorian Government does not hold all critical education and training levers. The group will be co-chaired by the Department of Health and the Department of Education and Training and comprise representatives from Victorian universities and training organisations that deliver mental health-related courses.

Areas of focus may include providing early, positive exposure to mental health content in undergraduate degrees to encourage graduates to take up roles in the sector, expansion of clinical research roles, recognition of prior learning for allied health and redesign of mental health content in educational pathways where required, particularly for generalist courses.

National efforts on priority education and training areas

The Victorian Government will advocate to the Commonwealth on priority education and other matters that require a national effort, including:

- expediting the National Mental Health Workforce and National Medical Workforce strategies with actionable implementation plans
- increasing Commonwealth Supported Places for core disciplines, including postgraduate training in psychology and expediting training pathways (for example, by running parallel university coursework/registrar pathways, and considering a consolidated two-year intensive postgraduate (qualifying) training model)
- leading reviews of undergraduate mental health course content that impacts graduate job-readiness in the key disciplines of nursing, social work, and occupational therapy
- incentivising and setting targets for student placements in mental health settings, and funding appropriate placement supports within training institutions
- developing postgraduate training in contemporary mental health therapies to reduce the burden on health services to fund foundational skill development
- providing additional supports for undergraduate placements, particularly in rural and regional settings, through prioritising course offerings and reducing Higher Education Contribution Scheme fees
- improving job-readiness and the acquisition of contemporary skills, knowledge and capability to practice in mental health by reviewing and re-designing mental health curricula, as well as setting standards for undergraduate training in core disciplines
- identifying and removing barriers to the completion of training for clinical psychologists and psychiatrists.

The Victorian Government will also work with Colleges and professional bodies on training requirements, including:

- mandatory training requirements for psychiatrists: advocating to the Royal Australian and New Zealand College of Psychiatrists to remove the requirement to undertake rotations in Child and Adolescent and Consultation Liaison Psychiatry, where there are more trainees than positions available and doctors are delayed in qualifying
- social worker placements: students are currently required to complete 1,000 hours of unpaid placements, which is a barrier to qualifying. The Victorian Government will advocate to the Australian Association of Social Workers to recognise paid work hours of practice for postgraduate qualifying students and introduce parallel coursework and placements to expedite the pathway.

Standardising regulation and registration schemes

The Victorian Government will ask regulators and key registration bodies to consider standardised registration schemes and registration of overseas-trained practitioners, including:

- registration of psychologists: currently, only Registered Psychologists trained in New Zealand can apply for registration. Psychologists from other countries with comparable training standards are required to undertake additional probation and high-cost supervision to qualify. This is a disincentive for overseas trained professionals to practice in Australia. The Victorian Government will advocate to the Australian Psychological Society to recognise registration for psychologists registered for practice in the United Kingdom, the United States, Ireland, and Canada, and to review of eligibility for other countries.
- statutory registration scheme for social workers: in contrast to comparable jurisdictions, Australia does not currently have a statutory registration scheme for social workers. Absence of title protection and safeguards compromises quality and safety, and limits how this discipline functions within the mental health sector. The Victorian Government will advocate to Ahpra for a statutory registration scheme for social workers.

Medium and longer-term actions

Changes to training and accreditation requirements need to happen at a national level. Over the medium to longer term, the Victorian Government will continue to work with the Commonwealth Government and the professional bodies and Colleges that accredit training programs, and advocate to Ahpra for the registration of counsellors and mental health nurses.

Action area 2b: Embedding a system wide capability focus

Specific new and enhanced capabilities will be needed to deliver consumer-focused, recovery-oriented care in the reformed system. Some will be core, whole-of-workforce skills, whereas others will be specific to disciplines and service settings.

A system wide approach will be taken to building capability. This will allow areas of need to be identified in a coordinated way, and support and training that addresses those areas to be provided.

> **'More creative and robust training and professional development structures and models are required.'**
>
> ***Submission to Department of Health, August 2021***

It will also promote consistency across disciplines and services, and better equip services to provide care for their communities by ensuring that core elements such as diversity and cultural safety are incorporated in training.

This whole-of-system approach to capability will support the workforce to develop the collective skills, knowledge and values needed to deliver cohesive multidisciplinary care.

Initiatives commenced and commencing

The Victorian Collaborative Centre for Mental Health and Wellbeing

The Victorian Collaborative Centre for Mental Health and Wellbeing is currently being established, with the *Victorian Collaborative Centre for Mental Health and Wellbeing Act* passed by the Victorian Parliament in November 2021. The legislation provides for representation of people with consumer and carer lived experiences on the skills-based board and an innovative co-director model of executive leadership. The Collaborative Centre's interim board will be in place by mid-2022.

Upon establishment, the Collaborative Centre will have capability uplift responsibilities, including:

- conducting interdisciplinary research alongside service delivery
- developing, translating and sharing best practice across the system
- educating the mental health workforce through coordinating and delivering practice improvement, training, and professional development programs, and
- driving exemplary practice for the full and effective participation and inclusion of people with lived experience across the mental health system.

The Collaborative Centre will play an important role in ensuring an adaptive, coordinated mental health system for all Victorians.

Regional Mental Health and Wellbeing Boards

Eight interim regional bodies are currently being established and will precede the establishment of legislated Regional Mental Health and Wellbeing Boards. The interim regional bodies will provide locally-informed advice to the Department of Health as it plans, develops and funds a range of mental health and wellbeing services in each region.

This advice will contribute to an understanding of capability needs and development across the state and assist in monitoring improvement.

Statewide service for people living with mental illness and substance use or addiction

A new statewide service for people living with co-occurring mental illness and substance use or addiction will be established by the end of 2022, delivering on recommendation 36 of the Royal Commission's final report. The service will build on the foundations of the Victorian Dual Diagnosis Initiative and will provide integrated care to people with co-occurring mental health and substance use or addiction challenges, as well as education and training to enhance workforce capability in this area across the sector. Further information can be found under Spotlight: Supporting workforce capability to provide integrated care.

Statewide Trauma Service

A new Statewide Trauma Service will be established by the end of 2022, as set out in recommendation 23 of the Royal Commission's final report. The new service will deliver the best possible mental health and wellbeing outcomes for people with lived experience of trauma. As part of its functions, the service will develop and deliver training that will enhance the capability of the mental health and wellbeing workforce to provide trauma-informed care.

Release and embed the Victorian Mental Health and Wellbeing Workforce Capability Framework

The Victorian Mental Health and Wellbeing Workforce Capability Framework defines the skills, knowledge and capability needed by a multidisciplinary workforce. This will support coordinated and consistent training across the system, particularly in relation to specific reform priorities including workforce culture, workforce diversity, workplace and professional practice, and to lifting capability in areas such as physical health in mental health services.

Stakeholder feedback highlighted the importance of implementation support to ensure the framework results in practice change and higher quality service delivery to consumers. Implementation of the framework will commence in the first quarter of 2022. This will provide practical and translatable support for the workforce to assess and grow the required capabilities at an individual, team and organisation level.

Tools and guidance will be developed to integrate the new framework into practice at individual, team and service levels, supported by $570,000 in funding.

To assist implementation, additional resources will be developed, including consideration of a training program, practice tools and guidance. An interactive web platform will also be scoped to support implementation.

Further detail about the framework can be found under Spotlight: Capability Framework.

Medium and longer-term actions

Statewide capability entity

A new capability entity will be established to lead a whole-of-mental-health workforce approach to capability development and training, as described by the Royal Commission in its final report. The entity will be auspiced by the Victorian Collaborative Centre for Mental Health and Wellbeing.

The capability entity will work collaboratively with the Department of Health and educational, academic and specialist service organisations, and build on the work of the Centre for Mental Health Learning to:

- help create learning, development and professional supports for senior clinical and specialist educator roles in the new service system
- develop resources and professional supports for priority workforce groups
- in partnership with service providers and education providers, increase rural and regional access to learning and development
- help the workforce make the most of high-quality professional learning opportunities to strengthen priority capabilities and support career and leadership pathways
- coordinate learning and development activities and access to specialist knowledge and expertise across services, professions and geographic areas
- integrate lived experience expertise in the design and delivery of professional learning opportunities
- increase the availability of learning and development.

Work will be undertaken in association with the Collaborative Centre to consider the most appropriate design for the capability entity.

Action area 2c: Improving capability through ongoing training opportunities

Once members of the workforce commence in the mental health and wellbeing system they need to be continually equipped with new and enhanced skills to deliver high-quality care. Needs will vary across professions, specialties, roles and settings, however there are common capabilities that are fundamental for all those working in the sector.

There is an immediate need to build new knowledge and skills and enhance existing capabilities in a number of areas, including mental health legislation and human rights, family- and carer-inclusive practice, reflective practice and professional practice supervision, trauma-responsive practice, and cultural responsiveness. Lifting capability in these areas will be key to achieving culture change and promoting best practice in service delivery in the reformed system.

Activities will focus on training, leadership within services and disciplines, and supports such as professional practice supervision.

As highlighted by stakeholders, there is a need for professional collaboration across service and geographic boundaries, and to support individuals in specialist roles to connect with others in their field. Specific initiatives therefore support skill sharing and innovation across services.

Initiatives commenced and commencing

The Victorian Government invests $30 million annually in workforce development for the mental health and AOD workforces. The funding ensures services have training and academic capacity and provides access to statewide training and development from specialist providers. This funding also enables the Centre for Mental Health Learning to support coordination of workforce development, facilitate statewide leadership networks and communities of practice, and to identify and deliver activity aligned with strategic priorities.

In addition, the Victorian Government has funded a range of activity, including:

- strengthening supervision
- supporting leadership and co-design capability
- increased support for psychiatry trainees
- development of mental health leaders.

Strengthening supervision

Two frameworks – *Consumer Perspective Supervision: a framework for supporting the consumer workforce* and the *Family Carer Perspective Supervision Framework* – have been co-produced for the lived experience workforce. Development and delivery of training related to these frameworks is underway, support for consumer perspective supervisors is in place, and the infrastructure to connect lived experience workers with discipline-specific supervisors has been created.

Implementation of Victoria's clinical supervision framework for mental health nurses is continuing. Activities for the next two years will be informed by implementation planning workshops and a community of practice, and will include support for Standards of Practice and training programs.

To support implementation of the Royal Commission's interim report recommendation to provide foundational mental health skills for junior doctors, psychiatry registrars are also being supported to upskill through clinical supervision training, with a program designed by the Royal Australian and New Zealand College of Psychiatrists.

Supporting leadership and co-design capability

Communities of practice are in place to support Specialist Family Violence Advisor positions in mental health and AOD services and Clinical Nurse Consultants.

The 2019–20 Victorian State Budget invested $1 million in psychiatry leadership development, providing Victoria's public sector psychiatrists with professional development opportunities. A psychiatry leadership development program is also being established, led by the Royal Australian and New Zealand College of Psychiatrists.

Co-design capability building workshops were commissioned by the Department of Health and delivered to mental health and AOD workforces over 2021–22. In addition, a co-design lead role has been established at the Centre for Mental Health Learning to support mental health services with co-design planning and capability.

Increased support for psychiatry trainees

Recent initiatives to better support psychiatry trainees include:

- The establishment of two key positions to support training, funded through the 2019–20

Victorian State Budget: a Director of Training for Specialist International Medical Graduates, based at Goulburn Valley Health, and Directors of Advanced Training for addiction psychiatry and medicine at Turning Point.

- An exam preparation support program for Specialist International Medical Graduates. This program was piloted in 2020, significantly increasing exam pass rates.
- 43 Child and Adolescent Psychiatry rotations funded in the 2020–21 Victorian State Budget to ensure trainees progress through training without delay.

Development of mental health leaders

Designated workforce lead positions have been established to cultivate leaders within the mental health system:

- A codesign lead (a designated lived experience role) has been established at the Centre for Mental Health Learning. This position will provide co-design and co-production support to members of the mental health workforce who are leading co-design projects.
- Across the state, 31 clinical nurse consultant positions provide leadership for staff and teams in inpatient units. The consultants act as mentors to other staff and have the clinical experience to address priority issues such as consumer and staff safety and support vulnerable consumers presenting with high level needs.

Training and development for Infant, Child and Youth Area Mental Health and Wellbeing Service workforce

The 2021–22 Victorian State Budget allocated $2.5 million over four years for training and development to support new and existing workers as part of the establishment of new Infant, Child and Youth Area Mental Health and Wellbeing services. Scoping is currently underway to identify training and development requirements, with training available to access from early 2022.

Statewide coordination of the Child and Adolescent Mental Health Service Autism Program

Since the release of the 2019 Autism State Plan the Department of Health has provided funding to Mindful as the statewide coordinator for the Child and Adolescent Mental Health Service Autism Program to build capacity and capability to assess and diagnose autism, with increased funding provided in 2021–22. Mindful delivers Autism Spectrum Disorder training in assessment, diagnosis and early intervention for mental health services to all clinicians in the public and private sector.

Medium and longer-term actions

Workforce capability needs – particularly in relation to multidisciplinary care – will evolve in tandem with system reforms. Priority training needs will therefore be regularly assessed at both a discipline-specific and whole-of-workforce level.

Over the medium to longer term, the Department of Health will continue to work with stakeholders, the Collaborative Centre and the statewide capability entity to ensure investment in training and professional practice supports continues to meet consumer and system needs.

Collaboration with professional colleges, education institutions and regulators will be critical for ensuring that training pathways are responsive to capability needs.

Over the medium to long term, work will continue to identify and build both the whole-of-workforce and discipline-specific targeted skills needed to deliver service and system reforms.

Action area 2d: Ensuring workforce reflects and responds to diverse communities

Victoria's diverse and marginalised communities can experience additional barriers to accessing mental health care, despite being some of Victoria's most vulnerable. To better meet the needs of communities, Victoria's mental health workforce needs to be more representative, and more responsive to those it serves.

Across all professional disciplines, roles and settings, people from diverse backgrounds – including Aboriginal, LGBTIQ, workers with disabilities and culturally diverse workers – need to be represented to enable care to be provided in culturally safe, inclusive, and appropriate ways. This needs to be complemented by other strategies to build broader workforce capability to respond to the specific needs of priority populations, and to build culturally safe and inclusive workplaces.

DOH.0003.0001.2032

'By requiring clinicians and other mental health service providers to reflect upon their own cultural identity and biases in relation to how they interact with other practitioners and consumers, culturally safe practices can help to safeguard all stakeholders engaging in mental health care from experiencing exclusion, discrimination or other effects of power imbalances.'

Submission to Department of Health, August 2021

Initiatives commenced and commencing

Specialised care for vulnerable people who need intensive support

As part of a $5.7 million package to deliver more specialised care for vulnerable people who need intensive support, Victorian Transcultural Mental Health (VTMH) at St Vincent's Hospital received funding to expand its training programs. As culturally and linguistically diverse communities are less likely to engage with mainstream mental health services, this service improves the cultural sensitivity of mental health services across the sector.

The funding allows VTMH to deliver its training, which focuses on building capability more widely so services can reach more diverse Victorian communities whose members are living with mental illness.

Work is also underway with stakeholders in Aboriginal and Torres Strait Islander communities to expand the Aboriginal social and emotional wellbeing workforce across Aboriginal community-controlled organisations and to improve the cultural safety and responsiveness of mainstream mental health services. Further detail can be found under Spotlight: Aboriginal social and emotional wellbeing workforce.

The Diverse Communities' Mental Health and Wellbeing Framework and Blueprint for Action

The Diverse Communities' Mental Health and Wellbeing Framework and Blueprint for Action will be launched by the end of 2022 and will complement this strategy and the Victorian Mental Health and Wellbeing Workforce Capability Framework.

In developing the framework, consideration will be given to supporting workforce diversity planning both within organisations and across the system, to identifying different roles and care models which support culturally responsive practice and increased service accessibility of diverse communities, and to the need for targeted workforce pipeline programs for priority population groups.

Medium and longer-term actions

The Diverse Communities' Mental Health and Wellbeing Framework will set short- and long-term strategic priorities for delivering safe and inclusive mental health treatment, care and support in Victoria, including supporting the capability uplift of ethno- and cohort-specific services. Importantly, the framework will help drive ongoing organisational- and service-wide capacity building and culture around responsiveness to diversity, inclusion and equity.

DOH.0003.0001.2033

SPOTLIGHT

9. Aboriginal social and emotional wellbeing workforce

> **'Aboriginal self-determination is respected and upheld in the design and delivery of treatment, care and support, and where Aboriginal people can choose to receive care within Aboriginal community-controlled organisations, within mainstream services or a mix of both. Irrespective of where treatment, care and support is delivered for Aboriginal people, communities and families, it is fundamental that it is safe, inclusive, respectful and responsive.'**
>
> *Royal Commission into Victoria's Mental Health System, Final Report, volume 3, p. 143.*

Aboriginal Victorians experience disproportionate rates of mental illness, trauma and suicide compared to the non-Aboriginal population. Meeting current levels of need and the expected growth in service demand for Aboriginal people and communities requires a highly skilled and adequately resourced social and emotional wellbeing workforce.

The Royal Commission recommended expanding Aboriginal social and emotional wellbeing (SEWB) workforces across Aboriginal community-controlled organisations and improving the cultural safety and responsiveness of mainstream mental health services.

Key initiatives to address these recommendations cover areas of supply, capability, wellbeing and system enablers:

- a minimum of 30 scholarships awarded by 2024 for Aboriginal SEWB workforces to obtain clinical and/or therapeutic mental health qualifications
- establishing and expanding multidisciplinary SEWB teams in Aboriginal Community Controlled Health Organisations with statewide coverage within five years
- the Aboriginal Mental Health Traineeship Program which provides a pathway for Aboriginal Victorians to enter the clinical mental health workforce. Clinical placements are undertaken within mainstream mental health services while trainees complete a bachelor degree in mental health. Ongoing employment is offered with the service on completion of this specialised program
- clinical and therapeutic positions funded to expand the social and emotional wellbeing workforce in Aboriginal community-controlled organisations (ACCOs)
- establishment of an Aboriginal Social and Emotional Wellbeing Centre to support mental health and social and emotional wellbeing services with:
  a. clinical, cultural and organisational governance planning and development
  b. workforce development for Aboriginal and non-Aboriginal workers
  c. guidance, tools and practical supports for building clinical effectiveness in assessment, diagnosis and treatment for Aboriginal peoples
- establishment of two co-designed healing centres
- Koori Mental Health Liaison Officers funded to provide culturally safe and responsive advocacy and support for Aboriginal people during their time in hospital and during follow-up care.

DOH.0003.0001.2034

10. Priority 3: **Supporting the safety, wellbeing and retention of the mental health and wellbeing workforce**

Workforce safety and wellbeing is a key enabler of high quality and safe practice, ultimately ensuring better experiences and outcomes for consumers and their families, carers and supporters. It is also critical for workforce retention.

Many factors impact on worker wellbeing, with members across the workforce communicating their experiences of fatigue, workload and burnout, and how these have been compounded by the stress of the coronavirus (COVID–19) pandemic.

The long-term objective of this priority is for Victoria's mental health and wellbeing services to be safe for all, promote respect and collaboration, prioritise wellbeing, and support workers to apply their full range of professional skills.

New actions to address this priority will focus on better data collection, improved governance and accountability for workforce wellbeing, and expanded wellbeing supports. The Mental Health Workforce Wellbeing Committee, to be established in response to recommendation 59 of the Royal Commission's final report, will be the vehicle for identifying, monitoring and addressing health, safety and wellbeing needs.

Longer-term actions will aim to address fatigue, workload and burnout, and support positive wellbeing through better monitoring, oversight and support.

Wellbeing:
Priority action areas

Action area 3a

Establishing workforce wellbeing monitoring and supports

Final report recommendation 59: workforce safety and wellbeing

The Royal Commission recommended that the Victorian Government:

1. by the end of 2021, establish an ongoing Mental Health Workforce Wellbeing Committee to address occupational health and safety needs, co-chaired by the Department of Health and WorkSafe Victoria that will:

   a. identify, monitor and address existing physical safety and wellbeing risks as well as those that may emerge throughout the reform process; and

   b. develop tailored monitoring approaches for the psychological health and safety of staff in the mental health and wellbeing workforce.

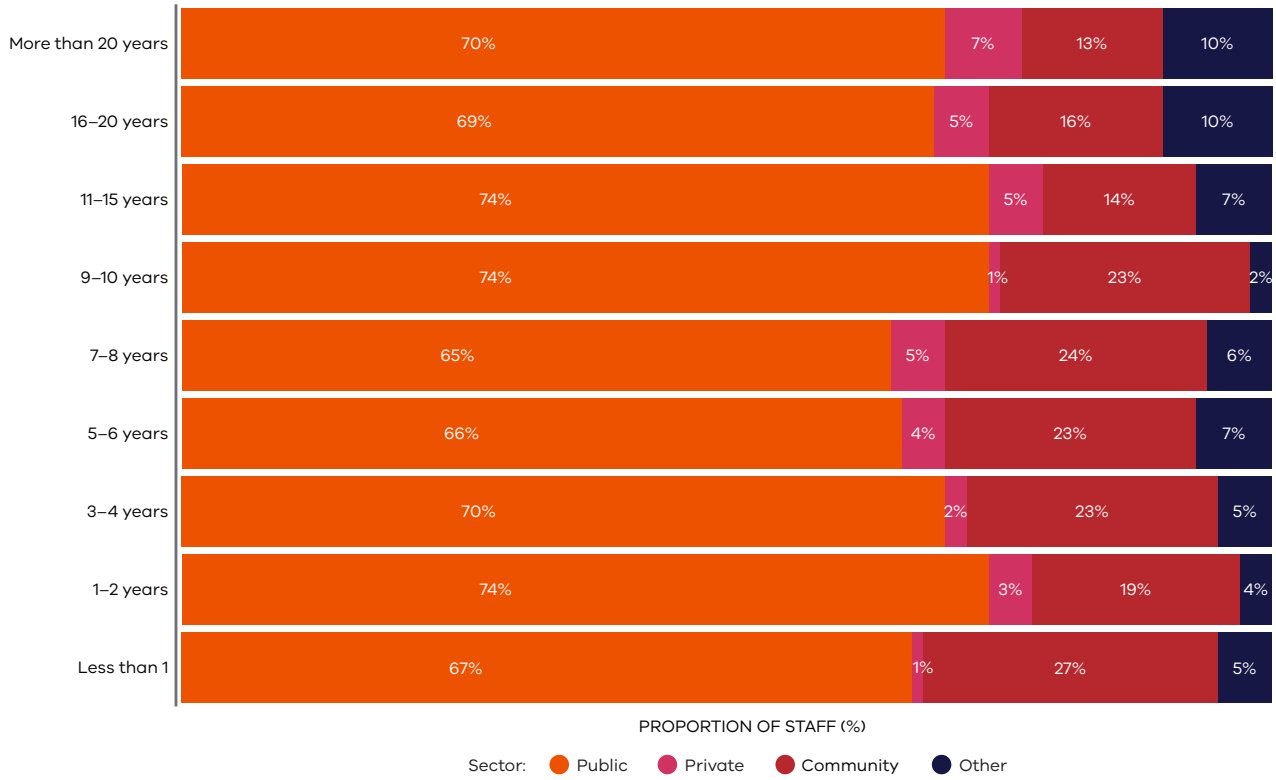
3. work with service providers, workers (including lived experience workers), unions, representative and professional bodies to set clear expectations and implement a range of measures to support the professional wellbeing of the mental health and wellbeing workforce, as described by the Royal Commission in its final report.

4. beginning in 2021, work with the Mental Health Workforce Wellbeing Committee to monitor workforce wellbeing outcomes at least once a year.

Current wellbeing of the mental health workforce

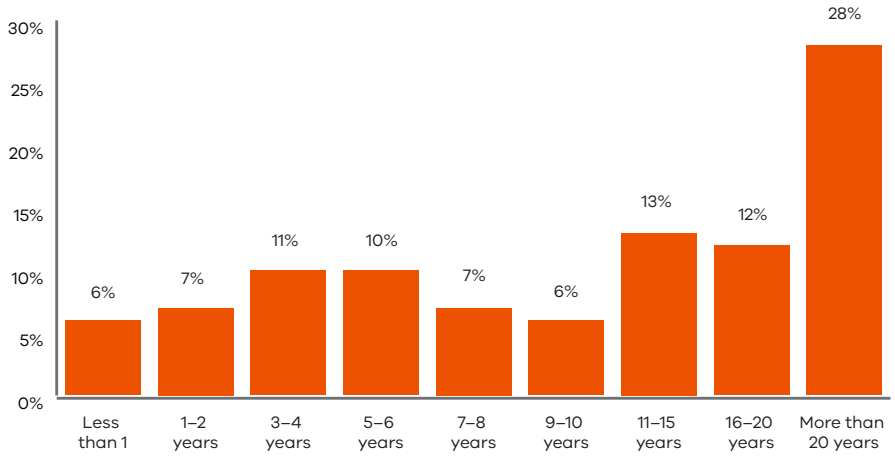
A mental health workforce personnel survey was carried out in October–November 2021, asking mental health workers in public, community and private settings to give feedback on their experiences of working in the sector. The findings set out below will inform workforce planning and provide insights into what is needed to attract, train, support and retain a stronger workforce for Victoria's reformed mental health system.

Figure 12: Surveyed mental health and wellbeing professionals (proportion) by years of experience and sector



Source: Department of Health (Victoria) Personnel Survey Dataset (2021)

Figure 13: Years of experience across surveyed mental health and wellbeing professionals (proportion)



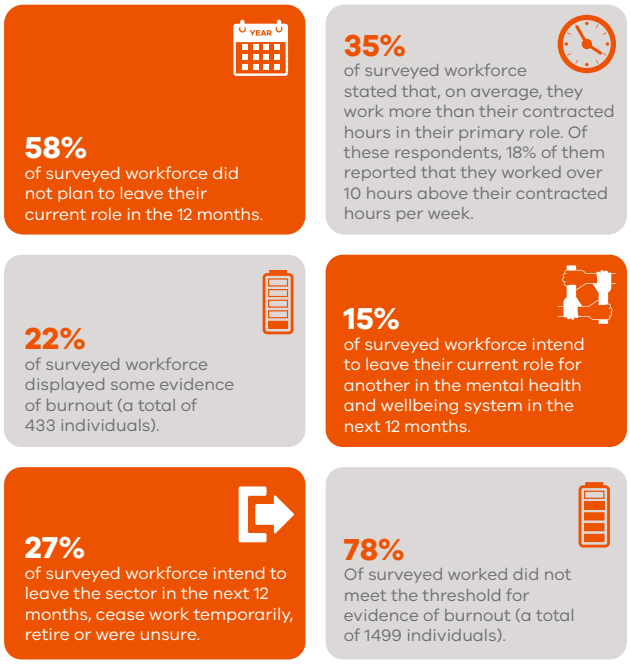
Source: Department of Health (Victoria) Personnel Survey Dataset (2021)

DOH.0003.0001.2036

Figure 14: Motivations to work in the sector (survey respondents)

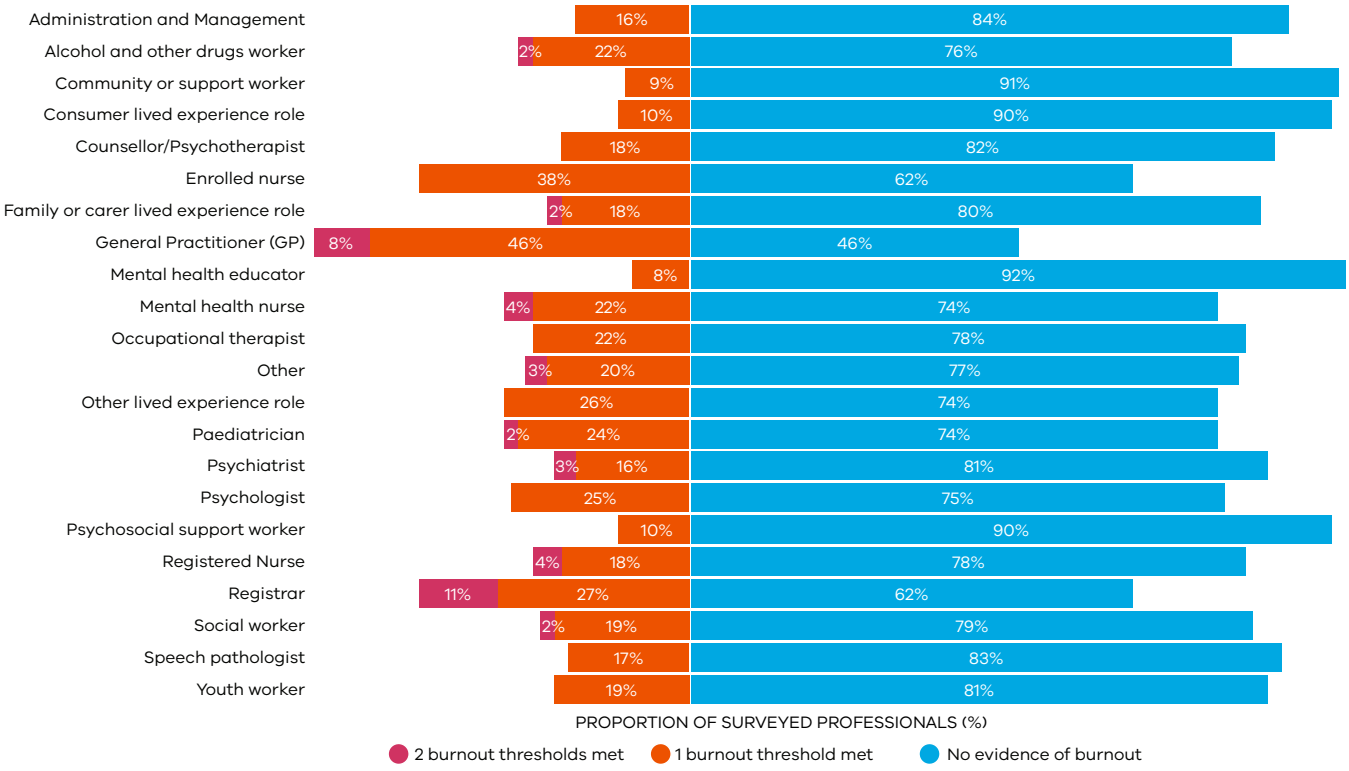
Source: Personnel Survey Dataset (2021). Note: Personnel Survey respondents were asked what their motivations were for working in the mental health and wellbeing system and were able to provide up to 3 responses. N = 1932.

Figure 15: Workforce wellbeing summary (survey respondents)



Source: Department of Health (Victoria) Personnel Survey Dataset (2021)

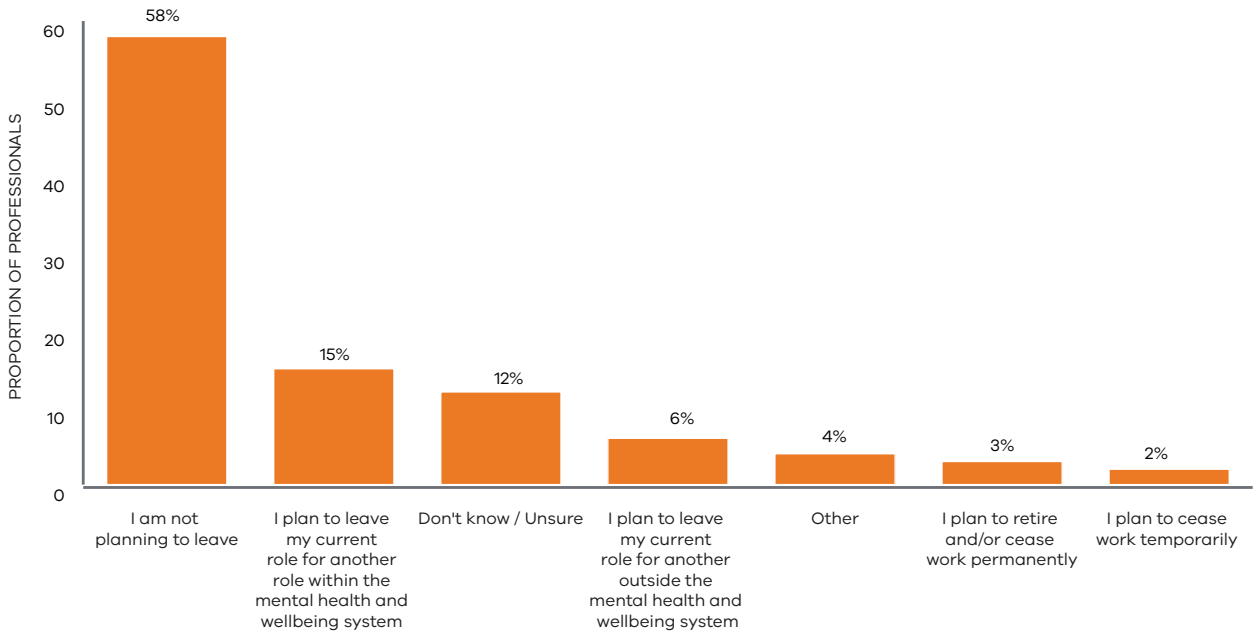
Figure 16: Evidence of burnout across survey respondents by professional discipline



Source: Department of Health (Victoria) Personnel Survey Dataset (2021). Note: The above chart represents the evidence of burnout that may be present within the workforce. Calculated by collating the results from the three MBI sub-scale thresholds (emotional exhaustion, depersonalisation, and personal accomplishment).

DOH.0003.0001.2037

Figure 17: Intentions to leave the sector across survey respondents



Source: Department of Health (Victoria) Personnel Survey Dataset (2021)

Figure 18: Motivations to leave the sector across survey respondents

Source: Department of Health (Victoria) Personnel Survey Dataset (2021)

Action area 3a: Establishing workforce wellbeing monitoring and supports

Actions to improve the wellbeing of the workforce focus on workplace safety, professional practice supports and professional development.

Everyone has the right to feel safe and supported at work. This action area therefore promotes workplace safety at a system wide and organisational level, which is essential for the physical and psychological wellbeing of workers, consumers, and families, carers and supporters.

> 'Establish preventative wellbeing programs to help workforce develop their own wellbeing knowledge and capabilities, build resilience, understand role of self-care and self-compassion.'
>
> *Submission to Department of Health, August 2021*

Professional practice supports also play a vital role in workforce wellbeing, as do access to professional development and career pathways. These opportunities are essential for ensuring staff are equipped to deliver effective treatment, care and support, and will be critical to sustaining the mental health and wellbeing system over time.

Initiatives commenced and commencing

Supporting better wellbeing outcomes requires a multifaceted approach, and work has already started on a range of initiatives to improve workforce safety and wellbeing.

Monitoring workforce safety and engagement

Formal monitoring of workforce wellbeing is integral to achieving a safe work environment and delivering safe, high-quality care. In 2020, the annual People Matter Survey for public sector health workforces was extended to measure mental health workforce engagement, job and work-life balance satisfaction, career development, stress and psychological safety. Preventing and managing occupational violence will be a future focus.

A prototype of the annual workforce wellbeing survey was rolled out during 2021 as a component of the mental health personnel survey. The workforce wellbeing survey will provide essential information to the Department of Health, and will assist the Mental Health Workforce Wellbeing Committee, described further below, to monitor wellbeing outcomes. The Mental Health Workforce Wellbeing Committee will continue to provide advice to the department on how the workforce wellbeing survey can best be tailored to capture the wellbeing of the workforce.

Healthcare worker wellbeing centre

In February 2021, the Chief Clinical Officers at Safer Care Victoria launched the Healthcare worker wellbeing centre as part of the Victorian Government's $9.8 million healthcare worker wellbeing package.

This virtual wellbeing centre, the first of its kind in Australia, is a place where all healthcare workers can find support, helplines and resources. Mental health people managers and leaders can access 'bite sized' wellbeing learning modules, as well as Health Care Wellbeing Resources developed in partnership with the Chief Mental Health Nurse.

Mental health and AOD Workforce Wellbeing Grants

Forty Workforce Wellbeing Grants totalling $338,000 were awarded to the state-funded mental health and Alcohol and Other Drug workforces as part of the Keeping Victorians Connected and Supported – Mental Health and Wellbeing Coronavirus Response Package in May 2021.

The grants funded initiatives that supported staff teams to come together, improved physical spaces, and provided additional supervision, reflective practice and training sessions. Staff attended self-care and resilience workshops and Hand-in-Hand Peer Support, emotional CPR and psychological safety and supervision training. Outdoor relaxation spaces, staff wellbeing zones, wellness kits, 'Little Bag of Calm' sensory aids and Big Feels at Work program podcasts all improved staff wellbeing. A further $700,000 in grants have been provided in 2021–22.

Safety and wellbeing in the coronavirus (COVID–19) pandemic

In 2020, the Victorian Government established the Healthcare Worker Infection Prevention and Wellbeing Taskforce to keep workers safe and well during the coronavirus (COVID–19) pandemic. Taskforce actions contributed to a reduction in the number of healthcare worker infections through the Respiratory Protection Program. The Department of Health provided specific guidance to mental health services to protect and provide surge support to the workforce to deliver essential services. Resources and training to establish a COVID–safe work environment, infection control, the selection, fit and use of personal protective equipment, zoned care and quarantine nursing models were a key focus.

A Hospital Surge Support Allowance was also established in October 2021 to better support nurses, paramedics and doctors working hard on the frontline to protect Victorians during the Covid-19 pandemic. The allowance is paid to patient-facing healthcare workers, providing direct care in public hospital services and Ambulance Victoria, to ensure highly skilled staff are well supported to deliver world class patient care

Safewards

The Safewards model and associated interventions have been highly effective in reducing conflict and containment and increasing a sense of safety and mutual support for staff and consumers. Led by the Chief Mental Health Nurse, the model was initially rolled out statewide across all units in 18 mental health services, and was followed by a trial in three emergency departments in 2019 and 2020. The model will be trialled in two general health services during 2021 and 2022.

Professional leadership through mental health nurse communities of practice

Senior Mental Health Nurses from across the state participate monthly in a community of practice with the Chief Mental Health Nurse and the mental health team in Safer Care Victoria, providing a forum to consult and advise the Chief Mental Health Nurse on current professional issues.

Chief Mental Health Nurse also hosts a community of practice for the Clinical Nurse Consultant group. Members of the group have a key role in promoting safety for in inpatient units and supporting the roll-out of Safewards, Reducing Restrictive Interventions and recovery-oriented practice.

Safety for all

Safer Care Victoria is the statewide agency for safety and quality improvement for Victoria's public healthcare system. 'Safety for all' is an initiative of the Mental Health Improvement Program within Safer Care Victoria which will respond to the Royal Commission's key quality improvement priorities.

Within Safer Care Victoria the Chief Mental Health Nurse and the mental health team will focus on safety initiatives including the reduction of seclusion and restraint practices, improving gender safety and the reduction of suicide in services.

Safer Care Victoria will partner with Victorian mental health and wellbeing services to ensure 'Safety for all' in mental health inpatient units. Expressions of interest are currently open to join the planning phase of this initiative, with improvement activities in chosen mental health inpatient units commencing from March 2022.

Sector-led network for occupational safety

Safer Care Victoria, through the Chief Mental Health Nurse and the mental health team, is supporting a number of sector leaders to come together in a forum to support and review training to increase occupational safety.

Mental Health Workforce Wellbeing Committee

The Mental Health Workforce Wellbeing Committee is being established in response to recommendation 59 of the Royal Commission's final report, with its first meeting to occur in 2022. The committee is responsible for monitoring, identifying and addressing safety and wellbeing issues, and will have responsibility for the annual workforce wellbeing survey.

The committee will be jointly led by the Department of Health and WorkSafe Victoria, and will comprise senior representatives from both bodies as well as Safer Care Victoria, the Mental Health and Wellbeing Commission and representatives from the sector including professional colleges, unions and mental health service employers.

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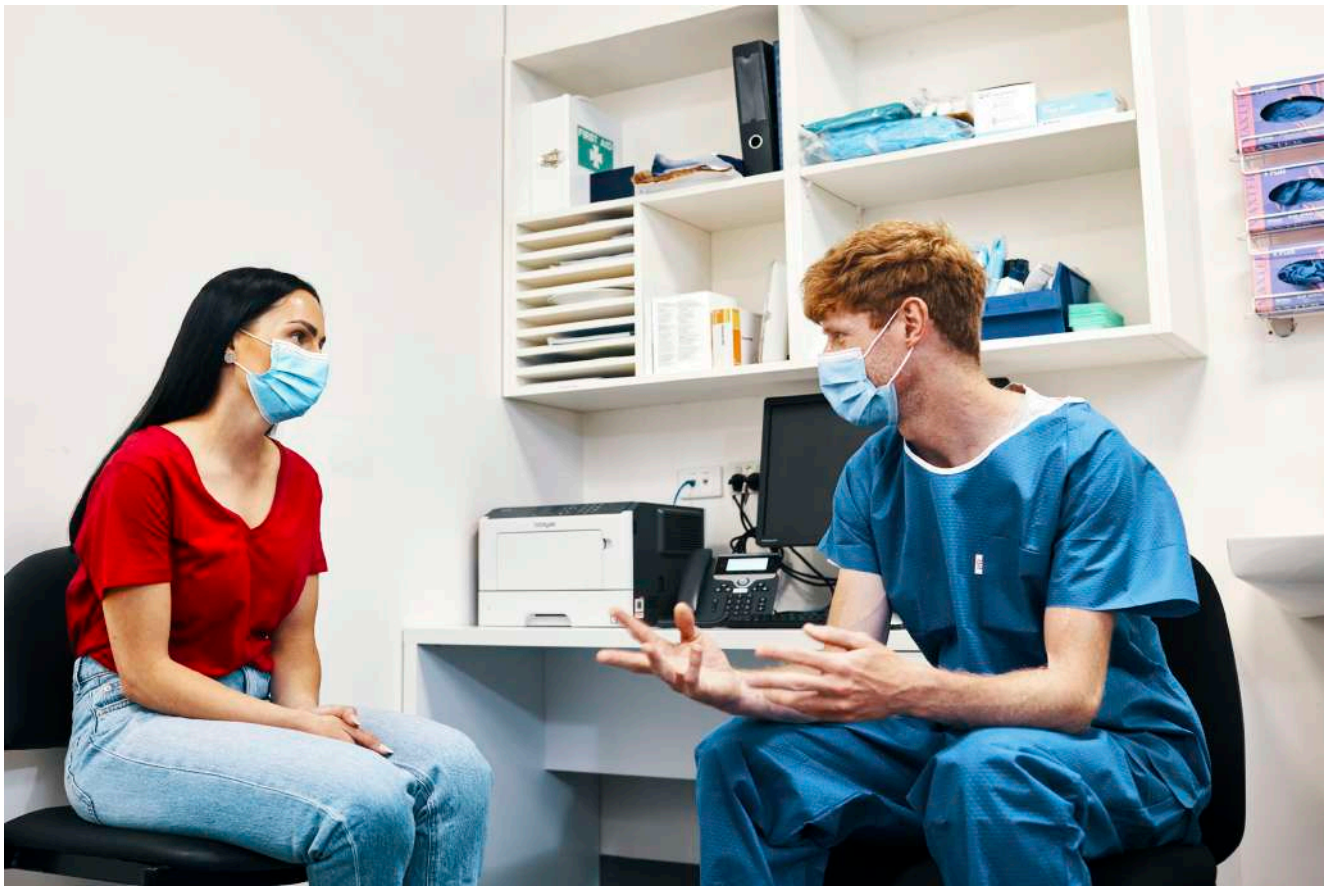
Pay and working conditions to attract, retain and support the mental health workforce

The Public Mental Health Services Enterprise Agreement 2020–24 aligns with recommendations of the Royal Commission with a focus on recruitment and retention, gender equity, and health and wellbeing. Changes to the Agreement will improve conditions for workers employed in Victoria's public specialist mental health services and support the priorities of this strategy. Changes include:

- pay increases (of three per cent for nurses; and two per cent plus an annual retention payment for all other employees) which will aid wellbeing and retention of the existing workforce
- an additional week of annual leave for all weekend workers, and 2.5 days of additional annual leave for health professionals to align with nurses
- improved access to long service leave, including pro rata access at seven years
- development of multi-level classification and salary structure lived experience workforces that will improve career pathways, attraction and retention
- inclusion of new roles including speech pathology and art therapy, Aboriginal traineeship arrangements, nursing indigenous health cadetship arrangements and mental health engagement worker arrangements
- increased parental leave and professional development leave, including study leave entitlements
- introduction of clinical educators for Parent and Infant Units to support workforce capability
- introduction of designated Mental Health Director of Nursing positions for each mental health service where they do not already exist
- enhanced administrative staffing for acute inpatient services.

Medium and longer-term actions

Into the future the Mental Health Workforce Wellbeing Committee will have carriage of developing, monitoring and implementing medium- and longer-term priorities to address mental health and wellbeing workforce wellbeing and safety needs, building on the range of activities already underway and regular workforce wellbeing survey data.



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SPOTLIGHT

11. Rural and regional incentive

The Royal Commission highlighted the ongoing workforce challenges that rural and regional areas experience across primary, secondary, and tertiary mental health services. This has not been unique to the mental health sector, with broader health services across the state experiencing ongoing challenges. In recent years, the Victorian Government has directed investment to the workforce through key initiatives such as the Regional Health and Human Services Workforce Development Program.

Work is underway on an incentive scheme to alleviate mental health workforce shortages and attract and retain new workers into rural and regional areas. This will deliver on *Recommendation 40: Providing incentives for the mental health and wellbeing workforce in rural and regional areas* of the Royal Commission's final report.

The 2021–22 Victorian State Budget allocated $10.5 million over four years to the Rural and Regional Workforce Incentive Scheme. The budget also included $3.2 million to deliver time limited rural and regional workforce incentive grants while a more fulsome incentive scheme is developed.

Incentives have been designed to be concrete, multifaceted and complementary, and deliver a mental health and wellbeing workforce with the capability and expertise to meet the needs of communities in rural and regional areas:

1. Workforce relocation and incentive grants

These will encourage and support mental health workers to relocate, settle and remain in rural and regional areas. Suitably qualified workers recruited to priority, hard-to-fill positions within state-funded mental health services will be eligible for grants. The grants will be flexible to support costs such as accommodation, relocation, childcare, school fees and vehicle costs for recipients.

2. Integration support for workers and their families

Ensuring candidates are adequately supported prior to employment, during relocation and to settle and integrate into local communities is key to long-term retention.

Pre-employment and integration support will be provided to connect individuals and their families to essential services and to create social and professional connections needed to settle into their new community.

In addition to the broader health workforce initiatives for rural and regional attraction, the following initiatives are underway or planned for mental health and AOD services:

- a relocation grants pilot in 2020–21 to support workers to move and settle in rural and regional areas
- incentives for attracting the AOD workforce into rural and regional services
- internship program for allied health and AOD Certificate IV students in rural and regional AOD services
- additional support for psychiatry trainees in rural areas.

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12. Priority 4: **Building system enablers for excellence in workforce**

Workforce reform must be underpinned by sophisticated data systems, strategic planning capabilities, and support to enable the workforce to deliver treatment, care and support that meets consumers' needs.

To deliver the best outcomes, there needs to be a centralised and comprehensive approach to workforce data collection and analysis, and for a reliable evidence base to understand, plan and respond to workforce needs as the system undergoes reform. The move away from crisis-driven care will require mental health and wellbeing professionals to be supported to work across their scopes of practice and deliver effective multidisciplinary care.

A dedicated workforce planning and strategy function within the Department of Health, along with ongoing workforce data collection, analysis and planning, will provide the policy, planning and technical capability needed to improve system planning and sustainability, as required by recommendation 57 of the Royal Commission's final report.

Initial actions will focus on improving workforce data and planning models; developing more sustainable workforce pipelines; and building workforce capacity to provide holistic and multidisciplinary care. Actions will also recognise and consolidate recent improvements to working conditions, raised by stakeholders throughout the consultation process as having an important impact on workforce attraction, retention and wellbeing.

Over the longer term, these foundations will enable government to better identify and respond to need in different parts of the system, and to drive future workforce reforms. The focus will shift to supporting the workforce to deliver high-quality, holistic and evidence-based care, which will both benefit consumers and assist workforce wellbeing and retention.

In addition, there will be a focus on ensuring the system is better able to sustain itself. Historically, workforce demand has largely been met through programs that 'top up' the system, and the system itself has limited capacity to regenerate. Reform brings an opportunity to change this, by strategically embedding the roles of training professionals into new model of care design.

System enablers: Priority action areas

Action area 4a	Action area 4b
Improving system planning and sustainability	Shaping the workforce for the future

Action area 4a: Improving system planning and sustainability

Data has a fundamental role in workforce planning. As noted in the Royal Commission's interim report, a reliable evidence base is crucial to planning and shaping the workforce needed to deliver system wide change.

> 'Data collection [needs to be a priority] to ensure a deeper understanding of the workforce, skill levels and location.'
>
> *Submission to Department of Health, August 2021*

Improved data is required to understand workforce supply, composition and distribution demands and gaps, and to respond to these needs and risks into the future. At present, access to data about the diversity of the mental health workforce is limited, especially for those occupations not regulated by Ahpra. Consistent data about workforce size, composition, and educational attainment is also lacking for the community and private sectors.

For effective system-level planning, it is critical to understand workforce drivers and needs at the local, area and statewide level, as well as population growth and demographic changes, global workforce trends and discipline-specific challenges.

Modern data systems are needed to support up-to-date data capture, sophisticated analysis and system-level planning. These will be integral to understanding the funding, resourcing and workforce requirements of the mental health and wellbeing system, reducing inequalities in service access and experiences, and improving mental health outcomes.

Initiatives commenced and commencing

Improving data capture and analysis

The Royal Commission's interim and final reports highlighted the need for a robust and ongoing mechanism to capture and monitor mental health workforce data. Reliable data is essential to making informed decisions about workforce planning and new initiatives, and so changes are needed to the way in which workforce data is collected, analysed and used.

In 2021, the Victorian Government launched two key projects to implement part of recommendation seven of the Royal Commission's interim report, namely:

- A mental health workforce personnel survey – a new workforce personnel survey, carried out in October–November 2021, asked mental health workers in public, community and private settings to give feedback on their experiences of working in the sector. Survey results will inform workforce planning and provide insights into what is needed to attract, train, support and retain a stronger workforce for Victoria's reformed mental health system.
- A mental health workforce census for all specialist public mental health services – the census was carried out in August-September 2021, with services asked to provide total numbers of full-time equivalent staff (actual and vacancy) and headcount numbers for staff employed across all locations, disciplines, settings and sub-specialties, as well as those employed in education, administration and management positions.

Data from the two projects form the basis for the workforce profile above, and will contribute to immediate and longer-term workforce planning.

Medium and longer-term actions

Using data to inform workforce planning

Work over the medium to long term will build on these projects, to produce longer-term data sets and analytics which can be used to identify supply, composition and distribution demands and gaps. In future years, these point-in-time data sets will be expanded to include community mental health services, in line with reform priorities.

This data will also be shared with Regional Mental Health and Wellbeing Boards to enable them to take a data-informed approach to local workforce planning and development.

Lived experience workforce data and accountability

The Royal Commission's interim report recommended a program of work to expand the lived experience workforces and enhance workplace supports for their practice. As part of this, data will be used to measure organisational attitudes and the experience of lived experience workers.

Understanding and measuring the experience of the lived experience workforces is a new challenge for the sector. It is important to understand the different types of roles with the consumer and family-carer workforces, which include peer workers, consultants, advisors, and education and research roles.

It will also be important to capture data that represents all members of the workforces, and to use this data in quality improvement activities and to track changes over time as the Royal Commission recommendations are implemented and the lived experience workforces expand.

Over the medium to long term, this data can be used to support organisations' operations and could be linked to funding agreements, accreditation and accountability frameworks.

Funding model reform

The Royal Commission identified funding reform as a critical mechanism for encouraging the provision of mental health and wellbeing services that consumers, families and supporters value and the equitable allocation of resources. The new ways of funding recommended by the Royal Commission for trial and implementation include activity-based funding – linking provider funding directly to the volume and type of services delivered, which in turn is linked to the profile of consumer needs which the services are designed to meet. The Royal Commission also recommended trialling bundled funding models (funding for a care pathway, not just an episode within that pathway) as well as capitation models (individualised care packages which enable more complex needs to be more flexibly addressed through a range of health and non-health care and supports). The Royal Commission envisaged that the major steps towards implementation of activity-based funding would commence in 2022, while work to develop and trial other funding models would occur in the medium term (to 2026).

Through linking service funding more explicitly to demand, these new funding models will contribute to workforce planning. In particular, activity-based funding models can directly translate the estimates of service demand into budget planning and allocation processes.

Action area 4b: Shaping the workforce for the future

The Royal Commission highlighted the need to increase support for mental health and wellbeing workers to be able to use their diverse skillsets, by optimising scopes of practice across a broad range of professions. Enabling specialist professionals to work across teams and services to provide genuinely multidisciplinary care will have a positive impact on workforce wellbeing and retention, as well as the quality, breadth and continuity of care available to consumers, families, carers and supporters.

While there is an immediate priority to grow the total workforce, which will provide the much-needed capacity to shift from crisis-driven to holistic and therapeutic service provision, there is an additional need to engage in a broader conversation about the scopes of practice that will be most effective to support innovative models of care for a transformed mental health and wellbeing system in Victoria.

Definition:
'Full and optimal scopes of practice'

This strategy uses the term 'full scope of practice' to mean the full range of skills that a mental health professional has been trained in and is competent to perform.

The strategy uses 'optimal scope of practice' to talk about the most effective configuration of professional roles and responsibilities within a team or service. This is determined by considering other team members' relative competencies and the skills they are trained and competent to perform.

Source: Royal Commission into Victoria's Mental Health System, Final Report, volume 4, p. 483

Reform of system architecture and service design is an opportunity for Victoria to innovate and reform roles to increase discipline representation to utilise the skills of a broader range of workers, and to re-design jobs and create new roles that free up capacity from skilled professionals to perform their specialised function.

New and emerging workforces – including paramedics, consumer wellbeing support officers and counsellors, who have the skills that will support new models of care – need to be built to help stabilise the workforce.

Over the medium to longer term, actions will focus on optimising professional roles and scopes of practice across teams and services, enabling mental health and wellbeing workforces to use their diverse skillsets effectively and in a way that meets consumer needs.

Initiatives commenced and commencing

Community mental health engagement workers

In 2018–19, additional resources were introduced into public clinical community mental health services for a new role to be implemented to complement the existing services provided by clinicians and peer workers. These new roles, known as community mental health engagement workers, take on some of the logistical aspects of engaging and supporting consumers and their families/carers. Newly graduated health practitioners who are nurses (registered and enrolled), social workers and occupational therapists are eligible to be employed in these roles.

These time limited roles create an additional pathway for health professionals to enter the mental health workforce, and are a valuable asset in enabling community clinicians to prioritise their focus on therapeutic engagement with consumers and their families/carers.

Pre-qualification positions

The introduction of pre-qualification employment programs in mid–2021 across ten of Victoria's specialist mental health services for students of nursing (registered and enrolled nurses), allied health (social work, occupational therapy and psychology) and medicine has been another key vehicle to support optimized practice. While promoting mental health as a career, the program also frees valuable clinical resources through the support provided by the pre-qualification employees across a range of tasks.

The program is being implemented throughout 2021–22 in mental health services out across metropolitan and regional Victoria, with over 100 participating students.

Establishment of a new Workforce Reform Taskforce

An immediate priority to support and optimise workforce practice is the establishment of a new Workforce Reform Taskforce. The taskforce will have responsibility for directing workforce reform activities, and considering how models of care, the introduction of new roles and workforces, and system planning can improve opportunities for Victoria's mental health and wellbeing workforce to work across the full breadth and depth of their trained scopes of practice to improve consumer outcomes.

To be established in 2022, the taskforce will also consider the administrative demands of mental health practice, guide the introduction of new workforces described in Priority 1: Building Workforce Supply, and consider how career progression opportunities outlined in this strategy can further optimise workplace practices. Future versions of the strategy will rely on this advice to understand the alignment of workforces across settings and service types, as well as the integration and alignment of practice areas between existing and new disciplines.

The taskforce will comprise the department's Chief Psychiatrist and Chief Mental Health Nurse as well as unions and professional bodies. The taskforce will work collaboratively with the workforce, professional bodies, stakeholders, and advisory groups, including the new Mental Health and Wellbeing Workforce Education Reference Group.

Medium and longer-term actions

Future iterations of this strategy will respond to the taskforce's advice on how various practice areas complement and support consumer, carer and system outcomes; the distribution of workforces across settings and service types; and the skills and workforces that should be prioritised in the next stage of reform.

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SPOTLIGHT

13. Collaborating with the Commonwealth and other partners

Collaborating with strategic partners to achieve change

There are many factors that influence the supply, distribution, retention, and experience of the mental health and wellbeing workforce. Levers are held by multiple parties and achieving a mental health workforce of the right skills, size, composition, and distribution will require decisive action from the Commonwealth and other national bodies to ensure the potential of Victoria's investments are maximised and all Victorians receive the care they need and deserve.

As described in Figure 19, this will include multiple layers of government, professional regulatory and worker representative bodies, education and training providers, services and peak bodies. The Victorian Government will actively work across these layers and with all partners to achieve the priorities and action areas described in this strategy.

Working with the Commonwealth Government and professional bodies

Collaboration between the Commonwealth and Victoria to align the Victorian Mental Health and Wellbeing Workforce Strategy and the National Medical Workforce Strategy, National Mental Health Workforce Strategy, and proposed National Mental Health Workforce Data plan is essential. This includes coordinated action using the levers within each jurisdiction's control to support and strengthen the workforce with a priority focus on increasing workforce supply. Recognising that responsibility for workforce is shared, the Commonwealth must:

- incentivise delivery of mental health training programs by increasing Higher Education Commonwealth Supported Places in core disciplines, including the availability of psychology honours and masters positions
- improve job-readiness and the acquisition of contemporary skills, knowledge and capability to practice in mental health by reviewing and re-designing mental health curricula, as well as setting standards for undergraduate training in core disciplines
- fund the development of contemporary postgraduate mental health therapies training to reduce the burden on health services to fund foundational skill development
- incentivise and set targets for student placements in mental health settings and fund appropriate placement supports within training institutions
- expand allied health graduate programs in Commonwealth funded services and support the development of allied health graduate programs and standards in community non-government organisations
- expand university debt reduction schemes for health practitioners in rural and regional areas to include allied health practitioners working in public mental health settings
- review the standards being used by the counsellor and psychotherapist peak bodies and provide recommendations for regulation and scope of practice to apply nationally
- increase permitted paid working hours for students
- increase age-limits for eligibility for permanent residency
- expedite permanent residency and graduate visa applications
- fund support programs for Senior International Medical Graduates

Ensuring a secure pipeline for a contemporary mental health and wellbeing workforce will also require improved transparency and action on training and regulation processes, including:

- the Royal Australian and New Zealand College of Psychiatrists to take immediate action on poor examination processes and pass rates, supports to International Medical Graduates, and removal of

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pipeline-blocking mandatory rotations in Child and Adolescent Psychiatry and Consultation Liaison Psychiatry

- the Australian Association of Social Workers to review 1,000-hour unpaid student placement requirements, and consider the introduction of paid registrar programs or recognition of paid work toward placement hours
- the Australian Psychological Society to recognise registration of psychologists registered for practice in the United Kingdom, the United States, Ireland, and Canada, and undertake a review of eligibility for other countries
- Ahpra to align registration of social workers with other comparable jurisdictions to ensure title protection and safeguards to maximise the value of social work in the delivery of therapies across all settings.

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SPOTLIGHT

Figure 19: Workforce reform roles and responsibilities

Who	Responsibility
Commonwealth Government	• setting national strategic direction • primary care access through Primary Health Networks and general practitioners, and Medicare rebates for psychologists • funding and regulation of the tertiary sector • responsibility for immigration levers which support recruitment and retention
Victorian Government	• funding public and non-government mental health services • system design and policy development • responsibility for service quality and safety mechanisms
Regional Mental Health and Wellbeing Boards	• supporting regional workforce planning, including relating to supply, capability and wellbeing activities • selecting providers of mental health and wellbeing services, including new providers and partnerships • holding mental health and wellbeing service providers to account and improving performance over time
Australian Health Practitioner Regulation Agency and National Registration Boards	• setting standards and policies that registered health practitioners must meet • conducting registration and compliance processes • investigating complaints against registered practitioners
Professional peak bodies and colleges	• defining training and education standards and continuing professional development requirements • administering self-regulated practitioner schemes • representing members
Education providers	• developing, designing and delivering education and training programs
Unions and industrial stakeholders	• protecting the integrity of the trade or group they represent • negotiate pay and working conditions • ensuring the health and safety of workers is protected
Health and community services providers	• delivering treatment, care and support services • employing, supervising, and supporting staff • create safe and supportive work conditions and environments to attract and retain mental health and wellbeing workforces

14. Implementation

The Royal Commission has set a long-term vision for the future of the mental health and wellbeing workforce, however essential elements of the system – including models of care – are yet to be designed and established. The mental health system will undergo rapid change as these critical elements come online, so at this point in time it is difficult to predict long-term workforce needs with accuracy.

The strategy leverages the experience of the sector to build on proven initiatives and prototypes, but also creates opportunities for innovation that will require further collaboration, testing and evaluation – and input from both the mental health and wellbeing workforce and lived experience voices.

The Victorian Government has committed to refreshing the strategy every two years to ensure that it reflects the changing needs of the system, the community, and of the mental health and wellbeing workforce.

An approach based on learning, innovation and collaboration

Implementation of workforce reforms will be underpinned by human centred design approaches with the diverse voices of the community, clinical, community, and lived and living experience workforces, and the voices of consumers, families, carers and supporters.

Measuring progress against outcomes

This strategy sets out the Victorian Government's commitment to outcomes-driven workforce reform. It underpins the approach to delivering on the Royal Commission's vision, outlined in *Mental Health and Wellbeing in Victoria: Our priorities and progress in system reform and delivery*, released in October 2021.

Work is underway to develop a Mental Health and Wellbeing Outcomes and Performance Framework as recommended by the Royal Commission in its final report. It will be essential to measure the impact of initiatives to build workforce supply, capability and wellbeing and of system enablers, and this work will allow progress against key outcomes to be tracked.

Aligning the strategy to improved outcomes will be supported through implementation of recommendation 65 which seeks to embed evaluation and the building of an evidence base for reform activities as an underlying feature of reform. In line with this, initiatives proposed in the strategy will be accompanied by data collection, improved data and reporting standards and the production of evaluation reports to understand the impact of these programs.

Communicating progress

Regular updates will be provided as these vital workforce reforms are delivered. Significant milestones, announcements, events and opportunities will be shared with all Victorians through media releases, news articles and the mental health reform website, as well as through direct emails to key partners and stakeholders.

Regular and ongoing feedback will be sought from the sector about the preferred content, frequency and platforms for communications and updates.

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Overview of key priorities and actions

1. Building workforce supply

Action area	Initiatives commenced and commencing	Medium to longer-term actions
a Attracting people to mental health careers	• A new attraction campaign for local and interstate clinicians	• Expanded international recruitment campaign • Rollout of additional supports for international recruitment
b Growing graduate, post-qualifying and transition training pathways	• Postgraduate mental health nurse scholarships • New entry positions for mental health nurses • Junior medical officer psychiatry rotations • Prequalification initiative to employ allied health, nursing and medicine undergraduates • Psychiatry leadership development • Supporting psychiatry registrars to undertake mandatory rotations • Expanded allied health graduate program • Psychiatry training support package • New graduate program for enrolled nurses • Transition program for experienced allied health and nursing clinicians	• Adapt and implement at scale successful and promising initiatives
c Building emergent and new workforces	• a lived experience peer cadet program • improved access to supervision for lived experience workers in clinical services • funding two lived experience workforce lead positions at Victoria's consumer and carer peak bodies • a lived experience workforce – consumer and carer feedback program	• Once the foundations for emergent and new workforces are in place, the focus will move to the scale of the workforce pipeline
d Ensuring workforce meets regional needs	• Relocation grants program • Workforce incentive grants • Integration support for workers and their families • A pilot incentive program for the AOD workforce • A pilot internship program for allied health and Certificate IV AOD students in AOD services, prioritising interns from diverse communities	• Refreshed workforce incentive program

DOH.0003.0001.2051

2. Building workforce skills, knowledge and capabilities

Action area	Initiatives commenced and commencing	Medium to longer-term actions
a Ensuring education and training meets the needs of the community	• Supporting the Commonwealth Government's development of a ten-year National Medical Workforce Strategy and a National Mental Health Workforce Strategy • Establish a Mental Health Higher Education Reference Group • Advocate to the Commonwealth on priority education and training areas • Seek standardised registration schemes and registration of overseas-trained practitioners	• Work with the Commonwealth, professional bodies and Colleges on necessary changes to training, accreditation and registration
b Embedding a system wide capability focus	• Work to establish the Victorian Collaborative Centre for Mental Health and Wellbeing • Establishment of Regional Mental Health and Wellbeing Boards • Statewide service for people living with mental illness and substance use or addiction • Establishment of Statewide Trauma Service • Release and embed the Victorian Mental Health and Wellbeing Workforce Capability Framework	• Establish the new statewide capability entity, under the auspices of the Collaborative Centre for Mental Health and Wellbeing
c Improving capability through ongoing training opportunities	• Strengthening supervision for lived experience workforce, mental health nurses and psychiatry registrars • Supporting leadership and co-design capability in family violence, psychiatry leadership and organisational level • Increased support for psychiatry trainees • Development of mental health leaders • Training and development for Infant, Child and Youth Area Mental Health and Wellbeing Service workforce • Statewide coordination of the Child and Adolescent Mental Health Service Autism Program	• Identify and build on skills needed at both a discipline-specific and whole-of-workforce level
d Ensuring workforce reflects and responds to diverse communities	• Specialised care for vulnerable people who need intensive support • Development of the Diverse Communities' Mental Health and Wellbeing Framework and Blueprint for Action	• Continue to consider workforce capability needs to better respond to diverse communities as reforms are implemented

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3: Supporting the safety, wellbeing and retention of the mental health and wellbeing workforce

Action area	Initiatives commenced and commencing	Medium to longer-term actions
a Establishing workforce wellbeing monitoring and supports	• People Matter Survey and mental health workforce personnel survey to monitor workforce wellbeing • Launch of the Healthcare worker wellbeing centre • Mental health and AOD Workforce Wellbeing Grants • Ensuring safety and wellbeing in the coronavirus (COVID–19) pandemic • Continued roll-out of the Safewards model • Professional leadership through mental health nurse communities of practice • Implementation of the 'Safety for all' initiative • Sector-led network for occupational safety • Establish the Mental Health Workforce Wellbeing Committee • A new Public Mental Health Services Enterprise Agreement 2020–24	• Ongoing monitoring of workforce safety and engagement

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4: Building system enablers for excellence in workforce

Action area	Initiatives commenced and commencing	Medium to longer-term actions
a Improving system planning and sustainability	• Improving data capture and analysis through the mental health workforce census and personnel survey	• Produce data sets and analytics to identify supply, composition and distribution demands • Establish lived experience workforce data benchmarks • Commence implementation of activity-based funding and develop and trial other funding models
b Shaping the workforce for the future	• Community mental health engagement workers • Pre-qualification employment program for students of nursing, allied health and medicine • Establish a Workforce Reform Taskforce	• Taskforce to advice on priorities for the next stage of reform

15. Appendices

Stakeholder engagement

Workforce forum The forum was held in July 2021 and brought together a broad range of stakeholders including community and clinical services, peak bodies, professional bodies, academic institutions and more to identify challenges and priorities for the workforce strategy.	**146 attendees**
Workforce Technical Advisory Group An external advisory body established to provide expert input into the development of the strategy and the progression of the workforce reform agenda, particularly around implementation barriers and risks.	**23 members**
Targeted engagement workshops Six targeted engagement groups were established across the workstreams of workforce supply, capability, wellbeing and rural and regional workforces. Membership brought together consumers, carers, clinicians, regulators, and subject matter experts who participated in a series of workshops to test ideas, validate assumptions and generate innovative solutions to the problems identified by the Royal Commission.	**219 people across six workshops**
Public consultation process Members of the public and sector stakeholders were invited to provide additional submissions through the Engage Victoria portal.	**41 submissions received**
Workforce census and personnel survey A separate workforce census survey was undertaken throughout August–September 2021 with participation from specialist mental health services to gather data about the workforce. In October 2021, workers across the mental health sector were invited to participate in a survey that provides insights into demographic mental health workforce data, as well as gathering information on worker wellbeing and feedback on the Capability Framework.	**All 19 Victorian specialist mental health services completed the workforce census, with 1,932 personnel survey responses received**

Members of the Workforce Technical Advisory Group

The Mental Health and Wellbeing Workforce Technical Advisory Group provided specialised and expert advice on implementation of the Royal Commission's recommendations relating to workforce, which informed the development of *Victoria's mental health and wellbeing workforce strategy 2021–2024*.

Standing membership of the group includes:

Member	Organisation	Expertise
Lyn Morgain (Chair)	Oxfam Australia	Mental health, non-government sector
Craig Wallace	Victorian Mental Illness Awareness Council	Consumer perspective
Marie Piu	Tandem	Carer perspective
Gaby Bruning	Victorian Aboriginal Community-Controlled Health Organisation	Indigenous communities and workforces
Adriana Mendoza	Victorian Transcultural Mental Health	CALD communities and structural inequality
Simon Ruth	Thorne Harbour Health	LGBTIQ
Madeleine Harradence	Australian Nursing and Midwifery Federation	Nursing union
Leon Wiegard	Australian Services Union	Social and community services sector, NDIS
Paul Healey	Health and Community Services Union	Union for specialist mental health, disability and drug and alcohol workforces
Associate Professor Genevieve Pepin, PhD	Occupational Therapy Australia	Occupational therapy workforce
Rachel Reilly	Australian Association of Social Workers	Social Workers
Rosemary Kelly	Victorian Psychologist Association	Psychology workforce
Angus Clelland	Mental Health Victoria	Statewide peak body
Astha Tomar	Royal Australian and New Zealand College of Psychiatrists	National psychiatric workforce
Dr Roderick McRae	Australian Medical Association	Medical workforce
Morton Rawlin	Mental Health Professionals Network, Royal Australian College of General Practitioners	General practitioners
Chris Hynan	Victorian Dual Diagnosis Initiative	Dual Diagnosis
Sam Biondo	Victorian Alcohol and Drug Association	AOD and dual diagnosis sector
Ruth Vine	Personal Capacity	Psychiatrist and Commonwealth Department of Health
Dr. Zena Burgess	Chief Executive Officer, Australian Psychological Society	Psychology workforce
Andrew Tomlinson	Director, System Reform, Tandem	Carer lived experience
Rick Corney	Senior Peer Support Worker at Ballarat Community Health	Consumer lived experience
Dan Stubbs	Victorian Disability Worker Commissioner	Disability Workforce

Glossary

Language and words are powerful and have different meanings for each person.

There is no single set of definitions used to describe people's experience of their mental health, psychological distress or mental illness. This diversity is reflected in the many words used by people to express their experiences.

There is also diversity in the ways mental health and wellbeing workforces describe themselves, their knowledge, skills and ways of working with consumers, carers, families, and supporters.

Words can have a lasting impact on a person's life, both positive and negative.

Words are also deeply questioned and nuanced, with many perspectives on terminology. The language used through this document aims to be inclusive and respectful.

Carer	Means a person, including a person under the age of 18 years, who provides care to another person with whom they are in a relationship of care.
Consumer	People who identify as having a living or lived experience of mental illness or psychological distress, irrespective of whether they have a formal diagnosis, who have used mental health services and/or received treatment.
Family	May refer to family of origin and/or family of choice.
Good mental health	A state of wellbeing in which a person realises their own abilities, can cope with the normal stresses of life, can work productively and is able to contribute to their community.
Lived experience	People with lived experience identify either as someone who is living with (or has lived with) mental illness or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness or psychological distress. People with lived experience are sometimes referred to as 'consumers' or 'carers'. It is acknowledged that the experiences of consumers and carers are different.
Mental health and wellbeing system	The addition of the concept of 'wellbeing' represents a fundamental shift in the role and structure of the future system. In the future mental health and wellbeing system for Victoria, mental health and wellbeing refers to the absence of mental illness or psychological distress and to creating the conditions in which people are supported to achieve their potential. The focus on the strengths and needs that contribute to people's wellbeing is purposeful. To achieve balance between hospital-based services and care in the community, the types of treatment, care and support the future system offers will need to evolve and be organised differently to provide each person with dependable access to mental health and wellbeing services, and links to other supports they may seek.
Mental illness	A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory. It acknowledges that mental illness can be described using terms such as 'neurodiversity', 'emotional distress', 'trauma' and 'mental health challenges'.

Psychological distress	One measure of poor mental health, which can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness. This is consistent with the definition accepted by the National Mental Health Commission.
Scopes of practice	This strategy uses the term 'full scope of practice' to mean the full range of skills that a mental health professional has been trained in and is competent to perform. The strategy uses 'optimal scope of practice' to talk about the most effective configuration of professional roles and responsibilities within a team or service. This is determined by considering other team members' relative competencies and the skills they are trained and competent to perform.
Social and emotional wellbeing	Being resilient, being and feeling culturally safe and connected, having and realising aspirations, and being satisfied with life. This is consistent with Balit Murrup, Victoria's Aboriginal social and emotional wellbeing framework.
Treatment, care and support	This phrase is used to present treatment, care and support as fully integrated, equal parts of the way people will be supported in the future mental health and wellbeing system. In particular, wellbeing supports (previously known as 'psychosocial supports') that focus on rehabilitation, wellbeing and community participation will sit within the core functions of the future system.