The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

RANZCP Victorian Branch 2026 Victorian State Election Platform

Strengthening the Pillars of Mental Health Reform

September 2026

Acknowledgement of Country

We acknowledge Aboriginal and Torres Strait Islander Peoples as the First Nations and the traditional custodians of the lands and waters now known as Australia, and Māori as tangata whenua in Aotearoa, also known as New Zealand. We recognise and value the traditional knowledge held by Aboriginal and Torres Strait Islander Peoples and Māori. We honour and respect the Elders past and present, who weave their wisdom into all realms of life – spiritual, cultural, social, emotional, and physical.

Recognition of Lived and Living Experience

We recognise those with lived and living experience of a mental health condition, including community members and RANZCP members and staff. We affirm their ongoing contribution to the improvement of mental healthcare for all people.

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness, and advises governments on mental health care.

Through its Strategic Plan 2026–2030, the College is committed to leading the transformation of how mental illness is understood, experienced, and treated. Psychiatrists are clinical leaders in the provision of mental health treatment, care, and support. They use a range of evidence-based treatments to support people in their journey of recovery.

The RANZCP is the peak body representing over 9,000 members in Australia and New Zealand and, as a bi-national college, has strong ties with associations in the Asia and Pacific regions. The RANZCP Victorian Branch supports 2,295 members across the state, including 1,632 qualified psychiatrists and 663 psychiatrists in training and affiliates.

Notes about this submission

The recommendations contained in this submission are based on consultations with the RANZCP Victorian Branch membership and committees. We acknowledge that language, and the way we use it, can affect how people think about different issues. We acknowledge the need to give due consideration to the words we choose when communicating with and about people with lived and living experience of mental health conditions. We recognise that people prefer a variety of terms, such as ‘client’, ‘consumer’, ‘patient’, ‘peer’ and ‘expert by experience’.

Contact

To discuss this document please contact:

Jo Balmforth
RANZCP Branch Lead (Victoria)
E: ranzcp.vic@ranzcp.org

Foreword

The Victorian Branch of the Royal Australian and New Zealand College of Psychiatrists is pleased to present its priorities for the next four years.

These priorities have been shaped by consultation with psychiatrists across Victoria, including clinicians working in metropolitan, regional and rural services, clinical directors, and the Chairs of our Faculty and Section Subcommittees. They reflect what our members are seeing every day in services, as well as their experience of the substantial reform undertaken since the Royal Commission into Victoria's Mental Health System.

There has been important progress.

Our members describe positive changes in practice and culture, the establishment and expansion of community services, the commissioning of new beds, greater recognition of lived and living experience, and much-needed growth in the mental health workforce. Victoria has invested substantially in a system that had been neglected for too long, and the foundations laid through the Royal Commission reforms should not be underestimated.

But neither should we mistake progress for completion.

Our members tell us that access to good mental health care remains too dependent on where a Victorian lives. Capacity has not always kept pace with population growth and demand. Acute adult services are again under considerable pressure, particularly in Melbourne's south-eastern suburbs. Community services remain unevenly developed, and gaps in rehabilitation, supported accommodation and specialist services continue to affect the ability of people to receive the right care at the right time.

There are also questions about whether some of the gains already made can be sustained. Workforce initiatives that have helped expand the psychiatry training pipeline are time limited. Persistent shortages affect psychiatrists and other parts of the mental health workforce. Research, clinical innovation and the development of specialist expertise need stronger and more durable support.

And increasingly, the challenge is not simply one of investment, but of governance and delivery.

Victorians should be able to see what the mental health system is achieving for the resources invested in it. There should be transparency about funding, including the Mental Health and Wellbeing Levy, and clear accountability for whether reform commitments are producing better access, better care and better outcomes. The roles of the Mental Health and Wellbeing Commission and the Victorian Collaborative Centre for Mental Health and Wellbeing need to be sufficiently clear and strong to support independent accountability, workforce development, research, innovation and continuous improvement. Within government, workforce, statutory oversight, quality and safety, service planning and commissioning need to operate as a coherent system rather than as fragmented functions.

For the next government, we believe the task is not to begin another redesign of Victoria's mental health system. It is to finish what Victoria started.

That means consolidating what is working, addressing the gaps that have become apparent through implementation, and ensuring that services promised on paper become services that Victorians can actually access. It means moving from reform measured principally by announcements, expenditure and new structures to reform demonstrated through access, quality, equity and outcomes.

Our priorities are consequently framed around a simple question: what should every Victorian be able to expect from their mental health system, regardless of where they live?

They describe the services and workforce that need to be available, but also the conditions required to sustain them: strong clinical and lived-experience leadership, an appropriately skilled workforce, transparent investment, research and innovation, effective governance, meaningful measurement of outcomes, and clear accountability for delivery.

The November 2026 Victorian election provides an important opportunity to take stock. It should not become a contest over whether to abandon the direction established by the Royal Commission and start again. It should be an opportunity to determine how Victoria completes that work, corrects what is not working, and makes the substantial investment of recent years deliver more consistently for the community.

The RANZCP Victorian Branch is non-partisan. We engage with all political parties and will work constructively with whichever party or parties form government after the election.

Victoria has already made a significant commitment to building a better mental health system. Over the next four years, the test should be whether that commitment can be translated into something tangible: a system in which Victorians can have confidence that timely, high-quality mental health care will be there when they need it, wherever they live.

That is the next phase of reform. And it is time to deliver it.

A/Prof Simon Stafrace
Chair, RANZCP Victorian Branch

About this election platform

The Royal Australian and New Zealand College of Psychiatrists (RANZCP, the College) Victorian Branch represents more than 2,295 psychiatrists and trainees working across Victoria's public, private, community, and academic mental health settings. The RANZCP is the peak body for psychiatry across Australia and New Zealand. Its Victorian Branch brings a distinct perspective grounded in clinical care, workforce realities, and service integration — shaped by what Victorians need from their mental health and wellbeing system, and the practical conditions required for Victoria's reform to succeed.

This election platform was developed through consultation with Victorian members, including a statewide member survey and a dedicated consultation with clinical directors, statewide specialists, academics, and the Victorian Faculty and Section Subcommittees. It builds on the Branch's recent budget submissions and is grounded in the RANZCP Strategic Plan 2026–2030, which commits the College to leading the transformation of how mental illness is understood, experienced, and treated.

The Branch's purpose in this election year is straightforward: to help ensure that mental health reform remains focused on what is tangibly delivered, and that all sides of politics are held accountable for implementation, funding, system performance, and the real-world outcomes experienced by people living with mental illness, their families, carers, and supporters.

The case: returning to who reform was started for

Victoria has led the nation on mental health reform. The Royal Commission into Victoria's Mental Health System set out a once-in-a-generation blueprint, and since 2021 the Victorian Government has backed it with an unprecedented investment program. These are real achievements, and the Branch acknowledges them.

But reform is not yet secure.

The Royal Commission was explicit about who reform was for. Victorians living with serious, complex, and enduring mental illness were placed at the centre, and the blueprint was built around them. As the program has grown, that purpose has become harder to see. Investment has spread across a wider system without a clear line back to the people it was designed to serve. Finishing what Victoria started means returning to who it was started for.

Nor have the gains been evenly distributed. Where capital and workforce investment reached, services have grown and clinicians report real improvement. Where it did not, services have stagnated or gone backwards, and statewide specialist mental health services are the clearest example. The system that has emerged is incompletely integrated across tiers and sectors, and dependent on time-limited funding that creates structural fragility. Programs lapse without replacement. Clinical governance is inconsistently applied. Workforce pipelines and training capacity are not keeping pace with demand. Too often, the care people need is not there when and where they need it.

Poor mental health costs Victoria an estimated $14.2 billion every year. The Productivity Commission has shown that targeted mental health reform returns many multiples of its cost: its priority reforms, requiring up to $2.4 billion nationally, were modelled to deliver up to $17 billion in annual benefits. Community-based assertive outreach for people with serious mental illness returns more than $8 for every $1 invested.

In a fiscally constrained environment, the temptation is to fund mental health through short-term, time-limited programs. This is the expensive option. When programs lapse, the costs do not disappear; they move downstream into emergency departments, acute beds, workforce attrition, housing instability, and the justice system, where they compound. Under-resourced services and an under-supported workforce are a form of accumulating debt, and the interest is paid by Victorians with the most serious mental illness and by the workforce who care for them.

The same logic applies to the Mental Health and Wellbeing Levy. A dedicated revenue source carries a dedicated obligation: which is to show Victorians what it raises and where it goes. The Branch therefore urges all parties to move on from stop-start reform, and to commit not simply to new announcements, but to recurrent, ring-fenced investment in the pillars that make reform durable: connected clinical care, recovery pathways, a health-led crisis response, and specialist psychiatric services, each resting on the workforce that delivers them, and to the transparency that lets Victorians see whether that investment is reaching them.

The platform at a glance: what Victorians should be able to expect

This election platform sets out four priorities and four reform principles that the Branch asks all parties to commit to. Each is detailed in the pages that follow.

1

Care that follows the person, not fragmented services

A statewide clinical strategy defining minimum standards for the clinical treatment, care, and support delivered by publicly funded mental health and wellbeing services, including access to contemporary, evidence-based treatments in the public system.

2

A pathway to recovery, not a revolving door

Delivery of Royal Commission Recommendation 12 and the outstanding supported housing commitment, with supported housing for people with serious mental illness as a named election commitment.

3

A health response, not a default crisis pathway

Delivery of the Royal Commission's health-led crisis response in full: crisis hubs, safe spaces, urgent mental health care centres, and home-based alternatives to admission.

4

Specialists who stay, not services that quietly shrink

A long-term Mental Health and Wellbeing Workforce Strategy with sustained implementation funding, covering the whole specialist team, with new positions funded in full and supervision written into positions from the outset.

The reform principles: indicators of delivery

Integration and shared care, governance and safety, diverse, skilled and sustainable workforce and digital capability and information infrastructure.

The reform principles: indicators of delivery

Four principles underpin every priority in this platform. They are neither separate nor peripheral concerns. The principles describe the conditions under which any commitment in this document will either succeed or quietly fail, and they are the indicators against which the Branch will judge whether reform is delivering what it promised.

i Integration and shared care.

Integration is the architecture every priority depends on. Pressure in the current system sits at the interfaces: between specialist mental health, primary care, private psychiatry, alcohol and other drug services, crisis, rehabilitation, and the Locals. Every commitment sought here should strengthen those interfaces, not add another fragment.

ii. Governance and safety

Reform requires governance that balances safety, accountability, therapeutic purpose, recovery, and human rights. That includes cultural safety, so First Nations Victorians and people from all communities can access care without experiencing racism, discrimination, or cultural harm, alongside occupational safety for the workforce and clinically sound approaches to risk. It also requires governance at the system level: existing oversight bodies with the mandate and independence to assess implementation and report transparently, so progress can be judged on evidence rather than announcement. The test is not a periodic inquiry into what went wrong, but the standing capacity to know how delivery is going.

iii. A diverse, skilled, and sustainable workforce.

A workforce spanning clinical, lived and living experience, peer, psychosocial, nursing, and allied health roles is the foundation of reform delivery. The Royal Commission was explicit about this, recommending a diverse and multidisciplinary workforce with the capacity to meet the needs of an expanding system. That commitment remains unevenly implemented, and sustained investment at every level is the test of whether it is being kept.

iv. Digital capability and information infrastructure.

Victoria's mental health system cannot coordinate care, measure outcomes, or support shared care and supervision without fit-for-purpose digital infrastructure. That includes regional and rural services, where digital reach is the only way to close the distance. This is a system enabler across every priority, not a standalone ask.

Priority 1: *Care that follows the person, not fragmented services*

Connected clinical treatment, care, and support. Treatment, care and support that responds to a person's needs and preferences and does not stop at the boundary of a service, a sector, or a postcode. Done well, this is what makes reform real for the people who need it most.

Victorians need access to the full range of evidence-based treatment, care, and support wherever they enter the system, and as their needs change over time. The current system lacks the architecture to make this possible. Families, carers, and supporters carry the consequences of that fragmentation, holding continuity the system does not. If this were cancer, the absence of treatment, care, and support options in the public system would be unthinkable. The same standard must apply to mental illness.

Victorian psychiatrists consistently identify the same structural gaps. There is no statewide model of care or minimum clinical standards for community mental health services, and what a person can expect varies by postcode and provider. The clinical capability of Mental Health and Wellbeing Locals does not yet align with the service framework they were designed around. Investment since the Royal Commission has not been evenly distributed across the life course, and members identify youth and young adult services as the clearest example: demand has grown fastest where capacity has grown least.

People with serious mental illness and co-occurring substance use disorders are still passed between services rather than cared for at a single point. Many lack a regular GP and cannot afford private psychiatry, yet shared care models that would bridge that gap remain underdeveloped. Access to contemporary, evidence-based treatments — from novel therapies to structured long-term psychotherapy — is severely constrained in the public system, where most training takes place.

"Families, carers, and supporters carry the consequences of that fragmentation, holding continuity the system does not."

$14.2 billion

annual economic cost of poor mental health in Victoria

The Branch calls on all parties to commit to a statewide clinical strategy defining minimum standards for the treatment, care and support delivered by publicly funded mental health and wellbeing services, including access to contemporary, evidence-based treatments in the public system, so every Victorian knows what they can expect.

- Integrated clinical capability in Mental Health and Wellbeing Locals, with clear clinical governance and accountability, responsive to local needs and preferences
- Shared care architecture connecting psychiatry, general practice, private psychiatry, Locals, and alcohol and other drug services, including integrated care for people with co-occurring substance use disorders
- Equity of investment across the life course, so that reform reaches infant, child, youth, adult, and older adult services

Priority 2: *A pathway to recovery, not a revolving door*

Rehabilitation, recovery and supported housing. Recovery is not possible without somewhere to go. With genuine investment in the full continuum, Victorians with serious and complex mental illness can have a real pathway forward, not just discharge.

Victorians with serious and complex mental illness deserve a pathway to recovery, not a revolving door through acute care, unstable housing, and crisis. The Royal Commission recognised this, recommending innovative models of rehabilitation and recovery and committing to supported housing places for people with serious mental illness. Neither has been delivered at the scale promised, including a housing commitment of more than $40 million that remains outstanding.

Under 3%

Victorian rental properties affordable to a person on income support

The absence of a continuum is not an abstract gap. Clinical leaders describe Victorians occupying secure extended care beds for years at a time because there is nowhere to step down to, and people with co-occurring substance use, cognitive impairment, and unstable housing are excluded by models of care never designed for them. Between the forensic system and community units, access to medium secure rehabilitation is a persistent bottleneck: people who no longer require forensic-level security, but cannot yet be safely supported in an open setting, are held in forensic beds longer than clinically necessary, or discharged into services not designed for their level of need.

Where models exist, they have not been sustained. Rehabilitation programs for people with co-occurring mental illness and substance use were piloted and allowed to lapse. Where they operate, homeless outreach teams reduce hospital admissions, emergency presentations, and justice involvement — yet they exist only in inner-city services. These service limitations sit inside structural barriers well beyond the health system.

A recent rental affordability assessment found people relying on income support, including people living with disability, continuing to be priced out of the private rental market across the state, with no real improvement year on year. For someone leaving an acute admission, that is the difference between a discharge plan and a recovery pathway. Being priced out of housing means being pushed further out, and often priced out of care as well: the further someone moves from established services, the harder it is to reach them, and assertive outreach barely operates beyond the inner city.

"For someone leaving an acute admission, that is the difference between a discharge plan and a recovery pathway."

The Branch calls on all parties to commit to delivering Royal Commission Recommendation 12 and the outstanding supported housing commitment, with supported housing for people with serious mental illness as a named election commitment.

- Step-down, continuing care, and secure extended care capacity delivered in every health service network catchment as a continuum, with consistent statewide models of care and flexible lengths of stay
- Medium secure rehabilitation capacity, together with the community rehabilitation and outreach capacity for people to step down into, with a defined statewide model of care, eligibility criteria, and length of stay expectations
- Reinstating and expanding rehabilitation models for people with co-occurring mental illness and substance use disorders
- Extending assertive homeless outreach teams beyond inner-city services, including to regional and rural Victoria

Priority 3: *A health response, not a default crisis pathway*

A health-led crisis response. When crisis strikes, too many Victorians end up in emergency departments, held by families, carers and supporters with no support behind them, or in the hands of police. Victoria has the architecture to build something better, and the investment to match the ambition is what is missing.

The Royal Commission's recommendations 8-10 for a responsive, compassionate crisis system remain largely unrealised. Victorians in acute distress still default to crisis pathways not designed for them, or to a police response that should be the exception rather than the rule. The people most affected are those with serious mental illness and complex needs, often alongside cognitive impairment, unstable housing, or substance use. For them, an emergency department is the least suitable place to be, and frequently the only one available.

The bed base has not kept pace with population growth. In 2025-26 only 40 per cent of mental health-related emergency department presentations met the four-hour benchmark, against a target of 81 per cent. In Melbourne's south-east, Branch clinical leaders estimate a gap of approximately 90 beds, which is why 20 to 30 people can be found waiting in emergency department corridors on any given day. Pressure at the front door is felt at the back: when there is no bed available, people with the most complex needs are discharged before they have recovered enough to manage in the community, and many return in crisis within weeks. Capacity is what allows care to be completed rather than interrupted. The Victorian Auditor-General's audit of emergency mental health services, due to report in March 2027, will bring these pressures into sharp focus.

40% against a target of 81%

mental health ED presentations meeting the four-hour benchmark

In regional and rural Victoria, the problem takes a different form. Where the nearest acute mental health bed is hours away, admission means leaving your community, and a family that wants to be present has to travel and pay for somewhere to stay. Emergency departments in regional and rural hospitals hold people for longer because there is nowhere closer to send them, and the crisis alternatives that would prevent an admission in the first place, urgent care centres, hospital-in-the-home, and in-home crisis support, are largely metropolitan. A health-led crisis response that stops at the edge of Melbourne is not a statewide response.

For them, an emergency department is the least suitable place to be, and frequently the only one available."

The solutions are not hypothetical. Urgent mental health care centres in other jurisdictions are producing early evidence of reduced emergency department presentations, while hospital-in-the-home and peer-supported in-home crisis care offer genuine alternatives to admission for people who can be safely supported at home, with clinical support that reaches the household rather than leaving families, carers and supporters to carry it alone. Neither replaces the beds needed by people in acute crisis with complex needs. Relieving pressure at both ends is what makes a health-led crisis response work: fewer people waiting for a bed they need, and fewer admitted who could be well cared for elsewhere. The next government should be ready to respond with funded action.

"Clinical support that reaches the household rather than leaving families, carers and supporters to carry it alone."

The Branch calls on all parties to commit to delivering the Royal Commission's health-led crisis response in full — crisis hubs, safe spaces, and urgent mental health care centres in key locations, and home-based alternatives to admission including expanded hospital-in-the-home and peer-supported crisis care for people in crisis and their families, carers, and supporters.

- Crisis support that reaches families, carers, and supporters, including access to advice and clinical backup out of hours, and follow-up after a crisis episode
- Inpatient bed growth matched to population need, guided by statewide bed and demand modelling that is published and updated regularly, with an immediate response to the acute bed shortfall in Melbourne's south-east, which Branch clinical leaders estimate at approximately 90 beds
- Evaluation and expansion of emergency department alcohol and other drug–mental health hubs across all major hospitals in Victoria.
- A funded response to the Victorian Auditor-General's emergency mental health services audit

Priority 4: *Specialists who stay, not services that quietly shrink*

Specialist psychiatric services. Every Victorian with serious, complex, and enduring mental illness deserves access to specialist psychiatric care in the public system, wherever they live. That depends on Victoria's ability to attract people into public psychiatry, train them here, and keep them here. Victoria's specialist workforce is a genuine asset the next government should choose to retain and grow.

Specialist mental health services exist for the presentations that general services are not designed to manage: the most severe, complex, and enduring. Victorians living with psychosis, severe mood disorders, eating disorders, personality disorder, perinatal mental illness, co-occurring substance use disorders, and trauma may need care that only a specialist service can provide, delivered by teams that are resourced, geographically distributed, and sustained. For those Victorians, there is no alternative when services are underfunded or understaffed. Most cannot afford private care, and no other part of the system is equipped to support them.

Victoria's statewide specialist services are unique and, in Branch consultations, described as the envy of other jurisdictions. They are also quietly diminishing. Clinical service directors report outpatient waitlists of six to twelve months at some statewide services, and funding model changes applied without consultation have shifted specialist resources toward inpatient and crisis services at the direct expense of community and outpatient care.

The Royal Commission envisaged specialist services with a balanced commitment to clinical care, teaching, and research. Clinicians describe the reality in most services as 95 per cent clinical and five per cent all other responsibilities expected of them. Clinical academic positions have been under rolling review for years, creating chronic instability, while the Victorian Collaborative Centre operates well below the scale it was established to achieve. Landmark collaborative initiatives, including Transforming Trauma Victoria, remain unfunded.

224

FTE Victorian psychiatrist

shortfall projected by 2033

Keeping specialist services viable is a workforce question with three parts: attracting, retaining, and training. Attracting people into public psychiatry depends on the system offering the full range of roles Victorians rely on, including statewide specialists, academics, supervisors, and system leaders. Retaining them depends on conditions that make those roles sustainable over a career, in metropolitan, regional, and rural Victoria alike. And none of it works for psychiatrists alone: specialist care is delivered by teams, alongside mental health nurses, allied health professionals, social workers, and lived and living experience, peer, and psychosocial colleagues.

"When those services are underfunded or understaffed, there is no alternative."

Victoria's investment in the psychiatry training pipeline, sustained through successive budgets, is a genuine strength, and it means more Victorians can be seen by a psychiatrist when and where they need to. Training, however, is the part most exposed. Almost all psychiatry training in Victoria happens in the public system, which means the state's future specialist workforce depends on services having the capacity to teach, supervise, and support trainees. When teaching and supervision time is squeezed to the margins of a clinical load, that capacity erodes quietly and the consequences arrive years later, in the form of Victorians who cannot get an appointment. Regional and rural training pathways matter for the same reason: psychiatrists who train in regional and rural Victoria are more likely to stay and practise there.

Victoria has more psychiatrists per head of population than any other state, and demand to train here now exceeds what the system is funded to take. In 2026, almost 300 people applied for 118 Victorian training positions, and more than 100 suitable candidates missed out. Services have the community need and, with proper investment, the capacity to take them. The Commonwealth's own modelling projects a Victorian specialist shortfall of 224 full-time equivalent psychiatrists by 2033 once the people who need care but are not currently receiving it are counted.

"The consequences arrive years later, in the form of Victorians who cannot get an appointment."

Supply is also concentrated where the population already is. Nationally, metropolitan areas have around 17 full-time psychiatrists for every 100,000 people. In small rural towns, the figure is closer to one.

Demand is moving the other way. Nationally, contacts with specialised community mental health services rose by more than a million between 2013–14 and 2022–23, and schizophrenia is the most commonly recorded principal diagnosis for working-age adults accessing those services. The people specialist services exist for are presenting in greater numbers, at a time when the workforce to care for them is projected to fall further behind.

The Branch calls on all parties to commit to a long-term Mental Health and Wellbeing Workforce Strategy with sustained implementation funding, covering the whole specialist team: psychiatry, mental health nursing, allied health, social work, and the lived and living experience, peer, and psychosocial workforce, with new positions funded in full, realistic recruitment timelines, and supervision support written into positions from the outset.

- Sustained investment in the lived and living experience, peer, and psychosocial workforce, including a funded psychosocial workforce strategy, and in mental health nursing, allied health, and social work development within public specialist services, with meaningful action on occupational violence and workplace safety
- Recurrent, ring-fenced funding for the psychiatry training pipeline: training positions funded to meet demonstrated community demand, including Directors of Training, funded supervision and clinical teaching time, and incentives for regional and rural pathways
- Reviewing the impact of funding model changes on statewide specialist services, and restoring capacity for outpatient, community, and consultation activity
- Clinical academic roles and research capacity, with protected non-clinical time and funding certainty, including translational research and robust evaluation of models of care, and the Victorian Collaborative Centre resourced to the role it was established to perform
- Pathways and conditions that retain psychiatrists in public psychiatry across metropolitan, regional, and rural Victoria, framed around community need, equity, and system stewardship

Delivery, outcomes, and accountability

The Branch does not approach this election asking whether reform has succeeded or failed. Mental health reform is complex, generational work, and Victoria has made genuine progress that deserves to be acknowledged and protected. The question for all parties in November is different: will the next government make that progress durable?

That means recurrent funding rather than announcements that lapse.

It means clinical governance and statewide standards rather than a system that varies by postcode.

It means greater transparency about whether investment is actually improving access and outcomes.

It means a workforce — clinical, lived and living experience, peer, psychosocial, and allied health — that is supported to stay in the system and grow with it.

And it means measuring what matters: the real-world outcomes experienced by people living with serious, complex, and enduring mental illness, their families, carers, and supporters.

It also means being able to see whether investment is improving access and outcomes. Implementation should be independently assessed and transparently reported so that progress can be judged on evidence rather than simply on whether a program or capital project has been announced. The Branch asks all parties to commit to independent, published reporting on system performance, planning, and improvement, and to annual public reporting of mental health revenue and expenditure.

Victoria has already had its inquiry, and it does not need another blueprint. What it has lacked is a reliable way of knowing whether the findings are being delivered. That requires the Mental Health and Wellbeing Commission to have the mandate, independence, and resourcing to assess implementation and report its findings publicly, and the Victorian Collaborative Centre to be resourced to build the evidence base that tells Victoria what is working.

"Measuring what matters: the real-world outcomes experienced by people living with serious, complex, and enduring mental illness, their families, carers, and supporters."

The objective is not simply to deliver a specified number of beds or programs. It is to ensure that a person experiencing a mental health crisis gets the right care, from the right service, at the right time. People experiencing mental illness, and the families, carers and clinicians who support them, should be able to trust that the right care will be available when and where it is needed. Five years after the Royal Commission, too many Victorians still cannot rely on that promise being fulfilled.

The next four years provide an opportunity to finish what Victoria started: to consolidate the gains already made, close the gaps in access and outcomes, and build a mental health system that delivers consistently across the state. The Victorian Branch of the RANZCP is committed to working constructively with whichever party or parties form government after November 2026 to make that ambition a reality.

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