WITNESS STATEMENT OF KYM LEE-ANNE PEAKE

I, KYM LEE-ANNE PEAKE, Secretary, Department of Health and Human Services, of 50 Lonsdale Street, Melbourne in the state of Victoria, say as follows:

1. I am the Secretary of the Victorian Department of Health and Human Services (**Department**). I commenced as Secretary of the Department in November 2015.

2. I make this statement to the Royal Commission into Victoria's Mental Health System (**Royal Commission**) in response to letter dated 14 May 2019, being a request for a statement in writing.

3. This statement is true and correct to the best of my knowledge and belief. I make this statement based on matters within my own knowledge, and documents and records of the Department which I have reviewed. I have also used and relied upon data and information produced or provided to me by officers within the Department.

Background and qualifications

4. Prior to my appointment as Secretary, I held a range of senior public service roles, including:

   4.1 Executive Director, Productivity and Inclusion at the Department of Prime Minister and Cabinet (September 2008-January 2010)

   4.2 Deputy Secretary, Higher Education and Skills Group at the Victorian Department of Education and Training (January 2010-November 2014)

   4.3 Lead Deputy Secretary, Strategy and Planning at the Department of Economic Development, Jobs, Transport and Resources, (December 2014-March 2015)

   4.4 Deputy Secretary, Governance Policy and Coordination at the Victorian Department of Premier and Cabinet (March 2015-November 2015).

5. I am the President of the Institute of Public Administration Australia (Victoria).

6. I have an Executive Master of Public Administration, a Bachelor of Arts (Hons) and a Bachelor of Laws, all from the University of Melbourne.

Scope of statement

7. I have been requested by the Royal Commission to provide evidence in relation to systems design and structural approaches within government to promote the delivery and reform of mental health and associated services.

8. This relates to the theme of 'prioritisation and governance of mental health services' being explored by the Royal Commission during the public hearings.

9. I note that the Royal Commission will also hear evidence from Mr David Martine, Secretary, Department of Treasury and Finance on this theme.

10. I also note that the Royal Commission has heard evidence from another witness from the Department, with Dr Neil Coventry, Chief Psychiatrist giving evidence in relation to access and navigation of the mental health system.

11. In this statement I do not provide detailed evidence about matters to which these other witnesses have referred, or will refer to, in their evidence to the Royal Commission. Accordingly, this statement should be read together with the above witness statements, the whole of government written submission, and other information filed by the Department with the Royal Commission.

12. Consistent with questions provided to me by Counsel Assisting the Royal Commission, the primary focus of my submission is on the responsibilities of the Department in relation to Victoria's public mental health system.

13. In this statement, it is my objective to provide an overview of the major challenges evident with the current design of the mental health system and outline potential reforms that the Royal Commission may wish to consider as part of their inquiry. It is also my intention to share my reflections from other significant system reform, as I believe this provides a useful framework for understanding how we can deliver an improved experience and outcomes for people experiencing serious mental illness and their families and carers. And improve the experience of the dedicated staff who work in our public mental health system.

14. To that end, this statement is set out in four parts.

    14.1 Part 1 provides a summary of the evolution of Victoria's mental health system and examines the key gaps that have emerged in the system over time. Some of the factors that may have contributed to the emergence of these gaps are also considered.

    14.2 Part 2 draws from the whole of Victorian Government submission to canvas potential outcomes, principles and priorities for improvements to consumer and carer experiences as an input to the Commission's deliberations.

    14.3 Part 3 focuses on learnings from other service delivery reforms on how to set reform programs up for success and maintain reform momentum in the longer term.

    14.4 Finally, Part 4 provides some reflections on improvements to governance and accountability, including in the role of the Department as the steward and system manager of the public mental health system.

15. It should be noted that the views on factors that have contributed to the emergence of existing treatment gaps (in Part 1), as well as the views contained in Part 3 and Part 4 of this statement are my views and not necessarily the views of the Victorian Government.

Part 1 – Context for reform of Victorian mental health services

16. As the Royal Commission has heard, poor mental health and mental illness affect all parts of the Victorian community and mental health needs vary across population groups. Mental health experiences are influenced by age, gender, sexuality, family situation, cultural background and the lived experience of trauma.

17. Departmental data shows that nearly half of all Victorians will experience a mental illness at some stage of their lives and about one in five will experience mental illness each year.[i]

18. Most (around 12 per cent of the population) experience lower acuity mental illness, around four per cent experience moderate illness and a further three per cent experience severe episodes of mental illness or enduring life-long serious mental health conditions.[ii]

19. Moderate and severe mental health conditions can have a significant impact on people's ability to live long and fulfilling live. In 2017 alone, more than 600 Victorians were lost to suicide[iii], more than double the road toll.

20. Poor mental health does not just affect individuals, it also has a broader impact on society. The National Mental Health Commission has estimated that the cost of mental ill-health to the economy is up to $40 billion a year, or more than two per cent of GDP.[iv] This is because people living with mental health conditions are less likely to be in employment than those without, leading to more people reliant on social services and income support. People in employment who do not access reasonable supports can suffer from absenteeism – impacting on productivity.

21. Nationally, the non-fatal burden of disease of mental illness (23 per cent of total burden) is comparable to the burden associated with musculoskeletal conditions (25 per cent).[v]

22. Our public mental health system is currently facing major challenges to cope with rapidly increasing demand, which is being driven by factors such as population growth, greater awareness of mental illness and changing patterns of drug use. In 2017-18, the number of people accessing clinical mental health services grew by 9.6 per cent on the previous year.[vi]

23. Public mental health services are predominantly supporting people who experience more severe mental illness, including life-long serious mental illness.

24. Many people face real barriers to accessing care when they are not considered to be in 'crisis'. When they do reach out for support, they often face difficulties navigating the complex system to find help.[vii] And they are not provided with adequate support to recover from an acute episode- protracting their ill health.

A summary of the evolution of Victoria's public mental health system 1992-2015

25. Before the 1990s, most mental health services in Victoria were delivered through government-operated, stand-alone psychiatric institutions.

26. In 1992, the Victorian Government embraced mainstreaming of mental health services as a key policy direction, with implementation continuing throughout the 1990s. Management of clinical mental health services was transferred from psychiatric institutions to the general health sector.

27. Through the 1990s the old institutions were closed, and inpatient units were opened in public hospitals. Resources were dedicated to the development and expansion of community clinical mental health services, organised on an area basis.

28. The Department led the development of a new construct for how public mental health services for people with serious mental illness should be delivered.

29. In recognition that serious mental illness is often a chronic, life-long condition, key aims of the new approach included:

    29.1 an area-based model of service delivery, with a view to connecting people to a continuum of health and social supports

    29.2 an early model of capitated funding (rather than transferring historical prices from institutional care into the new model)

29.3 new service interventions for people with chronic and serious mental illness, including crisis assessment and response, support for an acute episode, support for recovery and rehabilitation, and support for managing lifelong conditions to maximise wellness

29.4 a case management model to assist consumers of public mental health services to attain their clinical and personal recovery goals, including working with them to access the best services to support their recovery

29.5 fostering a peer workforce and support for consumers and carers to have a strong voice through representative bodies

29.6 connecting mental health services to other social services and informal supports to support people living with a serious mental health condition to lead a fulfilling life.

30. In the subsequent decade, investment was prioritised to building the capacity of new service models, integrating mental health with other health and social services provided by the Department; and supporting social and economic participation of people living with enduring mental illness.

31. For most of this period mental health responsibilities rested with the Minister for Health. System management functions were embedded within health functions of the Department. The Department worked closely with public health services, the clinical community and community-managed mental health providers to:

31.1 build the capacity of crisis assessment and treatment teams to provide immediate help during a mental health crisis

31.2 expand step up/step down services, managed through acute and community-managed non-government provider partnerships, to provide a community-based therapeutic setting for recovery

31.3 roll-out new prevention and early intervention programs, including children's conduct disorder programs, youth early psychosis services and specialist responses to young people living in State care

31.4 establish dual diagnosis services to better support people with co-existing substance misuse

31.5 strengthen psychiatric disability rehabilitation and support services to engage people living with enduring mental health conditions in purposeful daily activities, including support for employment

31.6 introduce the mental health court liaison service as the forerunner to the court integrated services program linking defendants to support services such as drug and alcohol treatment, crisis accommodation and disability services as well as mental health services.

32. By the middle of the first decade of the 21st century (approximately 2005), population growth and a growing community awareness of the prevalence of mental health conditions was increasing pressure on Commonwealth and state-funded mental health services.

33. Around this time, the Council of Australian Government (COAG) developed a national reform agenda focused on reforms in human capital, better regulation and competition as a means of raising living standards in Australia.

34. The human capital stream included actions to improve the delivery of health services and review Commonwealth-State specific purpose payments for the health system. It also aimed to improve workforce participation and productivity by reducing the incidence of illness, injury, disability and chronic disease in the population.

35. As part of the national reform, the first COAG National Action Plan on Mental Health was struck in 2006 – with the most recent version of this plan (the Fifth National Mental Health and Suicide Prevention Plan) released in 2017.

36. The first National Action Plan on Mental Health in 2006 led to investments by the federal government to increase the role of Medicare and general practitioners in supporting mental health.

37. In parallel, the Victorian Government created a dedicated Minister for Mental Health in 2006, supported by a discrete mental health division in the Department.

38. Since 2006, successive governments have retained the structure of a separate Ministerial portfolio for Mental Health. From 2006-2015 the Department mirrored this portfolio arrangement, maintaining a separate mental health division - noting that between 2009-2015 the Department of Health was separated from the Department of Human Services, with mental health responsibilities located within the Department of Health.

39. A new ten-year whole of government reform strategy - *Because Mental Health Matters* was released in 2009. Under this strategy, catchments were retained as a means of connecting clinical services, psychosocial supports and primary health care. There continued to be an emphasis on building community-based mental health services.

40. The strategy addressed the whole spectrum of mental illness and disorder and described responses from primary prevention through to crisis responses. Consistent with the National Action Plan, more emphasis was given to the role of general practice in the mental health system.

41. Applying a whole-of-community and whole-of-government focus, the strategy acknowledged the need to not only build the capacity of the mental health service system but the capacity of other sectors, including homelessness and justice sectors. This approach recognised the complex inter-relationships mental illness has with other health and social problems.

42. Following the release of the strategy, new service responses were initiated in specialist areas such as eating disorders, gender dysphoria and dual disability. Attention was given to the ways in which women and men experience poor mental health at different stages of life; and on the intersectionality of mental health and the experience of discrimination and trauma. And finally there was a strong focus on better coordination between different clinical and social support agencies – as well as with Victoria Police, courts and correctional services.

43. National reform continued through the National Mental Health Partnership Agreement finalised in 2012, which aimed to address service gaps and reduce the burden of mental illness in Australia. This National Partnership Agreement expired on 30 June 2016.

44. Between 2009 and 2015, priorities for service development included:

    44.1 initial tranche of the Child and Adolescent Mental Health Services (**CAMHS**) and Schools Early Action program for primary school aged student with behavioural problems

    44.2 strengthened treatment and support for perinatal mental health services in a range of settings and prenatal depression screening in maternity services

44.3 commencing the statewide coverage of the sub-acute Prevention and Recovery Care (**PARC**) service model and development of a new Youth PARC service model

44.4 new intensive clinical treatment and support packages for high need clients to provide an alternative response to admission to a secure extended care unit

44.5 the new Mental Health and Police Response to provide an integrated emergency management response to people experiencing a psychiatric crisis

44.6 creation of the Assessment and Referral Court (**ARC**) list in the Magistrate's Court to help people with a mental illness or other cognitive impairment to address underlying factors that contribute to their offending behaviour.

45. The legislative and regulatory frameworks to support the delivery of high quality and safe mental health services were also modernised during this period.

46. The new Mental Health Act came into effect on 1 July 2014. One of the fundamental objectives of the Act is to protect the rights and dignity of consumers, placing them at the centre of their own treatment and care. Public mental health services must have regard to 12 principles when they deliver services, which promote supported-decision making, the least restrictive treatment and the meaningful involvement of families, carers and nominated persons.

47. The new legislation also strengthened system safeguards, creating a Mental Health Complaints Commissioner. The Commissioner was granted powers to investigate complaints relating to mental health service providers and undertake systemic inquiries into the quality and safety of public mental health services. The capacity of the Mental Health Tribunal (formerly the Mental Health Review Board) was also increased.

48. A second psychiatric opinion service and an independent mental health advocacy program were included as component parts of the system.

Service development and investment since 2015

49. Machinery of government changes in 2015 brought health and human services portfolios back together. This has supported a renewed emphasis on the intersections between health and other social services in targeting interventions and sustaining support for people with enduring complex needs.

50. In November 2015 the Victorian Government released a new ten-year mental health plan – designed to build on the *2009 Because Mental Health Matters* strategy. The new plan had a central focus on the role of the State in supporting people with serious mental health disorders and suicide prevention in a stepped care system.

51. The Plan did not outline the optimal level and mix of public mental health services or describe actions required to deliver a comprehensive stepped care model for Victoria.

52. Rather it outlined three waves of improvement to be progressed in the term of government, as follows:

52.1 the first wave of improvement, supported by the 2016-17 State Budget focused on suicide prevention, the mental health workforce, expanding child and youth services for children aged 0-12 and Aboriginal social and emotional wellbeing

52.2 the second wave of improvement, supported by the 2017-18 State Budget focused on critical demand issues in clinical services, improved forensic mental health service responses and primary prevention

52.3 the third wave of improvement foreshadowed longer term improvements, informed by a Mental Health Expert Taskforce. Expert advice, including through the Taskforce, led to a central focus in the 2018-19 Budget on investment in core services, as well as improving responses to people in crisis.

53. The Victorian Auditor-General has conducted a review of the Plan as part of their 2019 report, Access to Mental Health Services. The Department has accepted all recommendations made by the Auditor-General and provided estimated completion dates for the implementation of each recommendation.

54. Over the past five years, additional investment of approximately $1.9 billion has been allocated to the priorities outlined in the 10 Year Mental Health Plan. In addition, budget from the acute health output has also been prioritised to help manage mental health emergency department demand.

55. Investments in restoring core service capacity have been focused on:

55.1 increasing capacity for both inpatient services and community-based services for people experiencing severe mental illness

55.2 expanding community-based clinical responses, for example through expansion of PARC services and supports for new mothers experiencing peri-natal depression

55.3 expanding alcohol and other drug (**AOD**) treatment capacity by working towards doubling the number of residential treatment beds by 2020-21 and increasing funding for community-based services

55.4 expanding forensic mental health capacity

55.5 supporting eligible clients and providers transitioning to the National Disability Insurance Scheme (**NDIS**) and respond to gaps as the scheme matures.

56. Supported by this investment, innovations in service models have focused on:

56.1 trialling and scaling a Hospital Outreach Post-Suicidal Engagement model and other community-wide suicide prevention initiatives based on research undertaken by the Black Dog Institute

56.2 scaling mental health and Victoria police partnerships to deliver a more targeted and timely response to people needing urgent mental health support in the community

56.3 reducing pressure on hospital emergency departments through an integrated emergency department mental health and AOD hub model of care, which will provide multidisciplinary assessment and treatment at six major emergency departments

56.4 designing a new specialist mental health residential service for people with severe mental illness and co-existing intellectual disability, known as Transition Support Units

56.5 working with the Murdoch Children's Research Institute to consolidate the best available evidence on child mental health service responses

56.6 trialling approaches to embedding mental health clinical expertise on public housing estates and within residential care services for children in State care

56.7 working with the Victorian Aboriginal Community Controlled Health Organisation to deliver strategies to improve resilience, social and emotional wellbeing and mental health in the Victorian Aboriginal community

56.8 supporting psychosocial support programs, including Youth Residential Rehabilitation Services, Supported Accommodation Services focused on people who are homelessness, Aboriginal mental health, self-help and planned respite services as well as a set of social inclusion and homelessness initiatives.

Assessment of Victoria's mental health system against a comprehensive stepped care model

57. Substantial reform is required to improve the experience and outcomes of consumers of mental health services in Victoria. The intended shift to person-centred, rights-based and recovery-oriented service models and practice has not yet been realised.

58. The Victorian Government's submission to the Royal Commission measures Victoria's existing mental health system against a comprehensive stepped care model to examine access to evidence-informed services across the full continuum of services – from low intensity responses to specialist clinical care.

59. Using a stepped care model as a reference point also provides a perspective on how well people are supported to transition to higher or lower-intensity services as their needs change.

60. Consistent with evidence given by witnesses in early hearings of the Royal Commission, the Victorian Government's submission identifies five key gaps in the current design and capacity of Victoria's mental health system, which are preventing us from achieving good outcomes for Victorians.

61. Many of these gaps exist because current Commonwealth and State government investment lacks the capacity to address the full spectrum of stepped mental health care. While the Commonwealth funds a range of initiatives, a large amount of Commonwealth investment is directed towards mental health treatment in primary care. Conversely, the largest proportion of the Victorian Government's investment is directed to specialist clinical services, which treat approximately 72,000 people with more severe mental illness each year.[viii]

62. This has resulted in an **early engagement gap**, which exists because we are missing opportunities to use universal and wider social services, such as schools, specialist family violence services, housing and homelessness services and physical health services to identify, support and refer people to mental health treatment and support before their illness escalates.

63. Without supporting people early on, mental illnesses can become more entrenched and harder to treat. This generates further demand in the tertiary system and can increase the impact the condition has on a person's life, including on their education, employment, relationships and physical health.

64. There is also a **treatment gap for people with moderate or enduring mental illness,** which exists because our mental health system continues to lack step-up and step-down capacity.

65. For people whose illnesses (or episodes of illness) are too complex or enduring to be treated in primary care – but who are not considered severe enough to meet the high

threshold for specialist mental health services – there are few options for accessing support. This can often mean that they are left without help until their illness gets worse.

66. Despite the public mental health system's orientation towards people with acute mental health needs, there are still **treatment gaps for people with severe mental illness.**

67. As the Royal Commission has heard, constrained capacity in our acute mental health services means the threshold for accessing mental health services in the community is high. Many area mental health services have undertaken change and consolidation processes across teams, with the result that dedicated crisis assessment or mobile support teams are less common. This has led to a reduction in direct contacts and less capacity to adjust the intensity of responses as people's needs change. Melbourne's rapid demographic changes have placed particular pressure on services in growth corridors.

68. This pressure within public mental health services is creating a vicious cycle. A lack of community-based care is increasing emergency presentations and driving a need for more inpatient services – diverting resources from the community where care could have been provided sooner and more cost-effectively. Pressure on inpatient units is also driving shorter stays for typical patients. Earlier discharge is in turn putting more pressure on community mental health services, resulting in a 'revolving door' of readmissions to hospital.

69. While average lengths of stay in acute inpatient units are decreasing, there remain a significant number of long-stay patients in acute inpatient units who are not discharged due to a lack of stable housing or suitable sub-acute and non-acute bed-based alternatives.

70. For people whose offending is related to an underlying mental illness, a gap in the availability of treatment also risks people entering and becoming entrenched in the justice system.

71. There are also **treatment gaps for children and young people,** which mirror the gaps seen in the broader mental health system. This includes gaps in the delivery of prevention and early intervention activities, and inappropriate service responses for children and young people experiencing moderate to severe mental health needs. This is particularly pronounced for cohorts with complex needs, such as children and young people living with dual disabilities.

72. Governance, service entry thresholds and models of care vary for children and young people depending on the service catchment. This leads to inequity in access and adds to the complexity of the system for clients and families.

73. These treatment gaps are accompanied by wider **challenges in the foundations of the system,** including:

    73.1 fragmentation between the primary and specialist system, and navigation challenges posed by geographic catchments and differing models of care across the state

    73.2 funding mechanisms that are unresponsive to changes in population and needs of different cohorts, creating barriers to incentivising effective care

    73.3 a need to further develop governance arrangements, to overcome data limitations and still maturing approaches to demand modelling, impacting on advice to Government on investment decisions and outcomes monitoring

    73.4 workforce constraints, including difficulties recruiting and retaining skilled mental health clinicians, which hinders the delivery of care that is responsive to consumer needs

73.5 infrastructure that fails to respond to demand, emerging best practice and changing demographics.

Factors that have contributed to the emergence of these treatment gaps

74. As described in the Victorian Government's submission, the public mental health system has faced persistent challenges in keeping pace with demand and translating the best available evidence into practice.

75. As the Royal Commission heard during community consultations, conventionally there has not been 'parity of esteem' between mental and physical health. This lack of parity is not unique to Victoria. There is still significant stigma around mental ill-health,[ix] particularly for more complex disorders such as schizophrenia and personality disorders. This stigma is far more pronounced than for physical illness.[x]

76. This lack of parity and associated stigma is evident in the social determinants of mental illness, the poorer physical health outcomes faced by many people with mental illness, and the reality that too many people suffer in silence as a result of the stigma of mental health.

77. It is also evident in challenges in workforce numbers, in the treatment gaps evident across our mental health system, and in the fabric of mental health infrastructure, which falls behind general health care environments in terms of contemporary expectations.

78. Across all areas of government policy in most western democracies, it has proven challenging to target investment toward earlier intervention and prevention generally, and toward the social determinants of mental health in particular. Methods of measuring and monitoring long term returns on investment are less well developed in health and social services.

79. As a result, there has not been consistent investment in mental health services and infrastructure. Taking the example of community mental health services, while considerable growth funding was allocated to community mental health services in 2016-17 (2.3 per cent) and 2017-18 (7.0 per cent)[xi], this followed a period of zero growth funding over the three years prior.

80. New funding has often been allocated to smaller initiatives to 'patch up' service gaps, rather than to core service capacity.

81. Inadequate service planning and the inconsistent nature of funding has driven workforce and infrastructure pressures and gaps in services in growth corridors.

82. Further, the input-based funding models and performance frameworks applied to mental health have not optimised how available funding is used.

83. Building on this, while the mental health sector is fortunate to be well-serviced by experts who are leading in their fields, there are a broad range of views on the best way to design the system. This spans from the best governance and delivery models for clinical mental health services, to best-practice approaches outside of clinical settings.

84. A range of research organisations deliver valuable evidence on mental health and mental illness. However, there has not been a dedicated knowledge-sharing institute in Victoria that has been able to bring together the latest thinking on how to deliver system-level change. The new Centre for Mental Health Learning will address this in part, facilitating resource and knowledge-sharing and improving access to expertise for the frontline workforce.

85. While the case management model put in place in the 1990s aimed to provide a holistic approach to mental health care, it is now out-dated. Contemporary best practice in mental

health care involves more targeted interventions. For example, management of current medications used in the treatment of serious mental illness now requires more specialised input from medical and nursing practitioners than was the case previously.

86. There is also strong and consistent evidence supporting specific therapies and psychosocial interventions for people with psychosis and other severe forms of mental illness. These include a range of specialist therapeutic interventions, such as cognitive behaviour therapy to assist with managing symptoms, skills training, family education, therapy and support and assertive outreach when needed.

87. These interventions are not systematically embedded in models of care, or in the way that services are funded.

88. In addition, clinical experts have not reached consensus on the most effective care for some consumer cohorts – for example for younger children.

89. This is a problem shared at the national level. A large study of Australians with serious mental illness found that less than one quarter receive evidence-based treatments, and that there is a poor association between people's suitability to benefit from interventions and the receipt of those treatments.[xii] The Fifth National Mental Health and Suicide Prevention Plan also identifies the need to develop mechanisms to support the translation of research into practice.

90. Contested views on available evidence and inadequate systems for translating evidence into practice have been exacerbated by the fact that the Department has typically not had consistent mechanisms to support ongoing engagement with experts or people with lived experience to inform our thinking about reform opportunities.

91. Various committees have been established over time to provide advice to government on different reform agendas. For example, an expert taskforce was established to help shape reform activities being delivered under the 10 Year Mental Health Plan. Similarly, lived experience advisory groups have been convened to hear directly from consumers and carers on the development and implementation of the policies and programs.

92. However, these committees have typically been established for a time-limited period or to focus on a discrete reform agenda or program. In the case of people with a lived experience of mental illness, much of this engagement has centred around work already underway, meaning we have missed opportunities to support genuine co-production with consumers and carers.

93. Positively, there are efforts underway to address this issue, with a lived experience advisory group – co-chaired by the Department and chief executives from peak bodies Tandem and the Victorian Mental Illness Awareness Council – being established to facilitate early and ongoing engagement with consumers and carers on strategic policy and program development. However, this is only the first step; greater efforts are required to embed consumer and carer voices across the broader system.

Part 2 – Potential areas for focus by the Royal Commission

Outcomes sought from Victoria's mental health system

94. The Royal Commission has heard compelling evidence that the mental health portfolio requires systemic reform that achieves enduring impact.

95. A shared view on desired outcomes of reform will be critical to inform decisions on policy settings, service models and the development of clinical practice. An outcomes-driven

approach will also enable government and the community to gauge whether our services are making a positive difference in people's lives.

96. In 2016, the Department developed an outcomes framework comprising all of our portfolio responsibilities. The outcomes framework is reflected in the Department's strategic plan, and identifies the outcomes we want to see for people and for service systems. The outcomes framework sets out outcome domains and key result areas, that provide narrative targets. More detailed outcome indicators enable us to measure and monitor how all of the department's services and functions contribute to achieving the best health, wellbeing and safety of Victorians so they can live a life they value. The outcome indicators measure our impact on Victorian population as a whole and for vulnerable groups in particular.

97. A whole of government approach to embedding outcomes in budget and strategic planning processes is under development.

98. The Department has been making progress in moving towards an outcomes-driven approach for mental health. The *mental health outcomes framework,* first articulated in *Because mental health matters* and further developed for the 10 Year Mental Health Plan, was a good start in defining outcomes for consumers, the system as a whole and the broader population.

99. The outcomes and suite of indicators established by this framework cascade from the Department's outcomes framework, and continue to be monitored and reported on in the *Victoria's Mental Health Services Annual Reports*. Some new measures and indicators recently have been added. The outcome domains in that plan include:

99.1 Victorians have good mental health and wellbeing

99.2 Victorians act to protect and promote health

99.3 Victorians living with mental illness have fulfilling lives of their choosing including opportunities to participate in the economy

99.4 All services are flexible and responsive to people living with mental illness, including their families and carers, and the workforce is supported to deliver this.

100. The Victorian Government submission to the Royal Commission elaborates on these domains, including some example measures.

101. Further work is needed to refine our indicators – including those captured within Statements of Priorities – and develop systems that support the collection of the information we need to measure progress. We also need to do more to make sure we are measuring progress across broader parts of government, including in the education and justice settings.

Principles to guide system design and operation

102. The Victorian Government submission also sets out potential principles to guide the development of a stepped care model and improve the functioning of the mental health system. These align with and aim to support the achievement of the outcomes described above.

103. Under these principles, a future system would be designed so that mental health treatment and care:

103.1 is recovery-focused, person-centred, effective and evidence-informed

103.2 delivers the best possible outcomes for each individual in the safest and least restrictive setting possible

103.3 respects each person's goals and their right to live without the stigma and burden often associated with long-term care

103.4 is actively managed by connected local providers so that it can be quickly scaled up and down to meet each individual's changing needs.

Putting in place the missing elements of a stepped care model

104. The Victorian Government submission identifies potential areas of focus to address current gaps in Victoria's mental health system and improve access to comprehensive, integrated and person-centred care. The ideas put forward in that submission are summarised below.

105. In summary they would involve the State, through the Department, working with:

105.1 Commonwealth agencies to address service gaps across a comprehensive stepped care model

105.2 public mental health services to design and deliver a new model of community-based care for people experiencing moderate to severe mental illness, or living with enduring serious mental disorders

105.3 the mental health clinical community, researchers and academic organisations to support greater application of leading practice in models of care across the mental health system

105.4 other Victorian government portfolios and agencies to better link mental health services to other service platforms and lift the mental health literacy of workforces in other service sectors

105.5 the community to continue to reduce stigma and discrimination

105.6 people with a lived experience of mental illness, as well as their families and carers, to ensure that services are person-centred and responsive to their needs.

Strengthening primary care

106. Strengthening mental health care in primary settings in Victoria would support greater early intervention, allow more people experiencing lower-acuity illnesses to be managed in primary care settings and reduce future demand in the specialist mental health system.

107. Efforts to improve primary mental health responses could include building the capacity of primary care practitioners to identify, assess and support people with low to moderate acuity illness, or developing new service models in primary care. This includes identifying and responding to suicide risk in primary care settings.

108. It could include strengthening the connection between primary care and specialist mental health services, either through developing secondary consultation models or enhancing pathways to better support people stepping up or down from specialist services.

109. It could also include developing new models for the treatment of co-occurring mental illness and problematic AOD use, as well as other comorbidities, in primary care settings.

110. Given their important role in mental health promotion, suicide prevention and early intervention, efforts to strengthen primary mental health care should be pursued in collaboration with primary health networks.

Expanding access to care and continuing to refine service models

111. Expert and consumer advice tell us that community based mental health services can achieve better consumer outcomes in a cost-effective way.

112. In the short term there is a continuing need to build on investments in the last three State budgets to relieve acute inpatient demand.

113. In the medium term, a reformed community model is required to improve consumer outcomes and relieve pressure on acute inpatient units.

114. More appropriate entry points are needed to avoid people attending emergency departments as their 'first port of call' for acute symptoms of mental illness, including redesign of existing triaging models.

115. More clinical support is required within existing models of sub-acute and residential care. Non-acute care could also be enhanced to provide people with higher acuity conditions and complex behaviours with access to appropriate care in a more therapeutic setting.

116. New flexible service delivery models are also needed in the community to better recognise and respond when people's needs change over time.

117. This should include improved approaches to assertive outreach to provide additional support for consumers with severe symptoms and high complexity to stay engaged with their care plan and with service providers.

118. There is also a need to build on the existing approaches to dual diagnosis services and improve the responsiveness of the mental health system to the needs of consumers with both mental health and AOD problems.

119. Greater use of peer-based approaches alongside and part of clinical and community-managed models of care could also be considered.

120. For people with enduring and severe mental illness, other jurisdictions have also supported individuals' ability to self-manage and recover more quickly from serious mental health episodes through additional psychosocial rehabilitation and disability support.

Better using other service systems to promote and support mental health

121. Universal health services, maternal and child health, housing and homelessness services, early childhood and education services and many other parts of the broad health and social services system need to be better equipped to support mental health and identify the early signs of mental illness.

122. Continuing to build mental health capability of a range of professionals and embedding mental health supports within other service platforms is an opportunity to better use these services to support mental health and respond to mental illness.

123. This could include initiatives that reduce risk factors associated with mental illness, such as place-based prevention approaches that target locations with higher rates of suicide, family violence and socioeconomic disadvantage.

124. Improving the interface between the mental health system and other social and justice service systems would enable a more seamless and holistic response. Strengthened referral pathways, coordination of care and multidisciplinary teams could contribute to improved interfaces.

Enhancing child and youth mental health

125. As the Royal Commission has heard, consistent age groupings in the clinical mental health system would improve consistency in practice and make the child and adolescent mental health system easier to navigate.

126. There is considerable potential to expand proven family-inclusive practice models in child and youth mental health. Given mental disorders often emerge in a person's late teens or early twenties, some Victorian child and youth clinical mental health services have already extended their services to the age of 25.

127. Priorities for service development could include:

127.1 achieving state-wide coverage of services for young people with, or at risk of, early psychosis

127.2 building on clinical engagements, and system mapping and functional analyses such as that contributed by the Murdoch Children's Research Institute, that have been progressed in the past 18 months to resolve an appropriate model of care for younger children

127.3 continuing to develop shared care models for children and young people who have experienced significant trauma

127.4 as for adults, further developing dual diagnosis models for young people to combine alcohol and drug and mental health service responses.

128. There are also opportunities to build on existing service platforms (such as headspace, schools, TAFEs and universities) to better support children and young people to develop resilience and strong emotional skills, as well as supporting a stronger approach in sectors dealing with families, such as parenting services, community services and refugee health services.

Strengthening the foundations of the system

129. In addition to addressing gaps in the availability and appropriateness of services, there is a need to reconsider the features that support the operation of the system.

130. Governance, data and information systems, workforce, infrastructure and supporting research and innovation are all critical enablers that underpin the delivery of high-quality and safe specialist mental health services.

131. Further detail on opportunities to improve governance and accountability settings is provided in Part 4 of this statement.

PART 3 – Embedding reform – learnings from other reforms

132. In this part of my statement, I make general observations drawing on learnings from other service delivery reforms. In Part 4, I make specific reflections on improvements to governance and accountability of mental health services.

Clarity of purpose and priorities

133. This Royal Commission presents an important opportunity to undertake the necessary reforms to promote the delivery and reform of mental health services and improve mental health and wellbeing for all Victorians.

134. Enduring social and service delivery reforms tend to address a problem that is well defined and broadly acknowledged as important to tackle.

135. Providing a clear purpose and direction for change helps to focus collective efforts on actions that will have the greatest strategic impact.

136. Contemporary policy approaches use **outcomes** to help target and frame reforms - to create that collective sense of purpose, importance and direction.

137. The broad and inclusive terms in which outcomes are articulated respects the contributions of different professions, sectors and organisations – helping to coalesce efforts across functional and professional boundaries.

138. Experience shows that outcomes should focus on what we want to achieve for people, not just what we deliver to them, how we operate, or how much we spend. The *National Plan for School Improvement* that was developed following the *Review of Funding for Schooling 2011* (the Gonski Review) is a good example of what happens when reform is focused on inputs. The architect, Mr David Gonski AC, has himself stated that the funding plan was too easily associated with processes rather than intended outcomes for students. This makes the task of implementing reforms that much more difficult.

139. Alongside clearly articulated outcomes, a small number of guiding principles can help all of the actors in a service reform to strategically coalesce around policy and system design options and trade-offs that will invariably arise.

140. When drafted in a meaningful way, principles help to spell out the explicit values that should guide policy and operational decision-making, but also articulate what people should expect from services. In this way they can support predictability in decision-making at an individual, service and system level.

141. Using the example of the NDIS, providing choice and control to people with a disability, their families and carers, was a major feature that many people wanted to see achieved through the establishment of the scheme. While there have been set backs and implementation issues, I would suggest that clearly articulating this principle – which resonated with people's values - has kept many engaged during the delivery of this transformational work.

142. A shared view on the central features of a redesigned system (including how one service delivery system interfaces with other services) and new service models can then assist in determining where to put the most effort to improve outcomes.

143. More detailed design work will involve defining the groups of people using a service system to better understand their characteristics, the full range of services they typically interact with, and the mix, intensity and interdependencies in service responses necessary to deliver improved outcomes.

144. Effective change programs fostered by government invariably have some resonance with the motivations and frustrations of those delivering services – albeit that history, custom, practice, incentives and rules might all act as powerful forces for the status quo. They are also grounded in feedback from the people using services about what matters to them.

145. Theory of change models are a useful way to bring outcomes, guiding principles and a view on the critical system, service and practice elements together. Combining systems thinking (breaking the system down into its component parts and using data and evidence to better understand where to focus improvement efforts) with design thinking (focusing on the people we are creating a system for, to build up solutions that will improve their experience and results) helps to define the actions likely to have the most impact on addressing challenges and advancing desired outcomes.

146. Finally, it is important for practical, implementable actions to operate at a system and a practice level. Actions identified in a theory of change should help in the translation of principles and evidence into practice to deliver a better experience and result for an individual service user. But they should also change the structure and incentives of the delivery system as a whole - to enable these improvements to be replicated for all service users.

Managing implementation

147. New organisational capabilities are often required to manage implementation. It is important to ensure the right skills mix in leadership teams responsible for the detailed design and stewardship of reforms. A mix of strategic policy, service design and service delivery experience are all important. Too much of the former without the latter can result in big picture thinking that struggles to translate into real change on the ground. Too much of the latter can result in a perspective that is too embedded in the status quo.

148. Finding the right tempo for reform is also critical – many service delivery reform programs falter in implementation.

149. In my experience the **pace and staging** of reform needs to be finely calibrated.

150. Where the case for change is widely accepted and there is political, stakeholder and community acceptance that the proposed response is broadly appropriate – it is important to get started and deliver early social outcomes.

151. Systemic reform takes time and needs to take account of the on-the-ground realities of service delivery – for example workforce supply and readiness and infrastructure capacity.

152. Disability and family violence reforms have both encountered significant challenges in growing a skilled workforce and designing new service models, which has impacted on an ambitious roll out schedule. Similar challenge exists in the mental health system. There are already shortages in the mental health workforce, and challenges across the community services sector more broadly. Operationalising new services or innovative new models of care will require a concerted effort to grow the scale of the workforce in the immediate term. Managing system capacity will also be required in the short term as we build the foundations for transformational system change.

153. In my experience, an adaptive approach to managing a complex service delivery reform program can assist in building capacity, prioritising early actions to address critical gaps, and testing new approaches before bringing them to scale.

154. This is not the same as piloting small scale initiatives without a long-term plan for scaling.

155. Nor does it mean abandoning careful upfront planning. Considered sequencing provides an opportunity to respond to the dependencies between areas of reform – for example each part of a stepped care model in mental health and between the range of services someone with mental illness is likely to interact with.

156. Senior leaders in the Department are conscious of the importance of drawing connections between service delivery reforms that are currently underway across multiple portfolios that can contribute to better outcomes for people with mental illness. In particular, there are important connections between this Royal Commission and other service initiatives and system-level reforms in health, child and family, disability, housing and aged care sectors), as well as the work of the federal Productivity Commission in examining the effect of mental health on people's ability to participate in and prosper in the community and workplace, and the effects that mental health has more generally on the economy and productivity.

157. An adaptive approach to planning and delivery provides an opportunity for delivery risks and success factors to be identified and mitigated, including:

157.1 anticipating inter-organisational challenges that may emerge

157.2 identifying whether there are new configurations of interests that can be cultivated to champion the changes being made

157.3 clarifying the big system settings that need to be consistent and establishing the local mechanisms to make the reform work at a local level

157.4 growing service capacity and developing new service models, without compromising quality and safety.

158. The reality is service delivery reform often occurs with imperfect evidence and with gaps in system foundations. Unexpected opportunities can emerge as technologies and evidence evolve and new service models and ways of working are tested. Invariably some reform ideas do not deliver the anticipated impact.

159. It is therefore important that we do not lock ourselves into long, inflexible delivery cycles or a 'set and forget' mentality to policy settings.

160. Agile project management methodologies are emerging as the most appropriate means of managing complex reform programs that need to be more iterative. These methods prioritise iterative planning and learning cycles, enabling government and service delivery partners to have line of sight on flows of funding and decision-making, while enabling policy and service adjustments to be made more quickly.

161. For mental health services, an adaptive approach provides an opportunity to test emerging evidence and build stronger consensus on what works.

Measuring success

162. As well as providing shared direction for service delivery reform, an outcomes framework can provide a shared view on whether the aims of the reform are being achieved. This allows clinicians, managers and government actors to monitor when things are not working and make necessary adjustments to policy settings and service delivery as they go

163. Performance targets are a common method for measuring success. Appropriate targets can help all actors in a service system to remain focused on long-term strategic goals in areas where short-term pressures would otherwise mean goals may not be achieved.

164. They can provide information to system managers and government decision-makers on whether reforms are on track and having the intended impact. They can also assist those responsible for direct service delivery to know what needs to happen to plan, monitor and deliver change, while also increasing accountability for delivering value from public investment.

165. To work effectively, targets need to be clearly defined and quantifiable, have credible baseline data and specify the data source and timescale. There are important limitations in the use of targets, especially for complex service systems. These include risks that numeric targets:

165.1 prioritise actions that are more easily measurable, ignoring measures of wider service system change

165.2 change peoples' behaviour, with perverse results

165.3 narrow a reform focus, inhibiting system level integration

165.4 are stated as averages, and ignore cohorts and places requiring specific attention

165.5 are set to the wrong driver - due to the difficulty of attributing impact to specific interventions

165.6 reduce flexibility to changing evidence or contexts by focusing effort on process rather than achievement of an outcome.

166. Where it is not, or not yet, appropriate to set targets for the reasons above, outcome indicators remain useful for articulating the nature and direction of change towards an outcome.

167. Aspirational statements from a community or client's point of view can reinforce the broader vision, encouraging innovative policy interventions to achieve the outcome intended.

168. Outcomes can be measured indirectly where direct measures are unavailable, through the use of proxy measures or measures of processes linked logically and through evidence to better outcomes.

169. Reporting of adverse events in health care is an instructive example – we strive publicly to reduce avoidable harm but also know that this will only be achieved through greater reporting of things that go wrong. It would be disastrous to set arbitrary targets for reducing the number of adverse events reported in hospital, since this would undermine the very reporting efforts that are key to improving safety. However, process measures such as the number of near misses reported might help us measure reporting culture and staff comfort in speaking up.

170. When it comes to complex service delivery systems, there is considerable consensus in outcomes literature produced by the World Bank, OECD and academic and public policy experts that targets are often best expressed as an ambition rather than numeric value.

171. System level indicators that speak to the service system reforms required to enable the achievement of person-centred outcomes are a useful mechanism to set direction and enable stronger coalitions and partnerships. Such indicators can improve transparency, increase accountability, promote a stronger focus on what matters and ensure a long term focus.

172. For example, the World Health Organisation has recommended to 'avoid overly simplistic quantitative targets' for health improvement strategies. The WHO uses the language of targets as a way to define a desired outcomes for a population – similar to the way Victoria uses outcome domains and key results. The WHO then uses indicators to reflect progress towards meeting the desired end goal. They do this because of the lag between interventions and the impact on people's health and wellbeing. The targets are described as 'reductions' or 'increases' – to specify the direction of change required, without a numerical prescription.

173. This is the same approach as has been adopted by jurisdictions such as New Zealand, Virginia and Canada. Scotland and New South Wales have adopted more numeric targets. Interestingly Scotland began its outcomes journey by tracking national targets, outcomes and indicators to provide a consolidated view of economic progress. The Scottish Government no longer reports on their targets on the basis that:

173.1 not everything which affects an outcome or an indicator can be controlled or even influenced by the government

173.2 some services are easier to measure than those that supply complex services like education and health

173.3 they found significant limitations on the amount and type of data that could be collected, and the amount of effort of time that could be put into collecting accurate and timely information.

Sustaining momentum

174. Public policy implementation literature emphasises that the success of even the best-designed policies depends on the motivations and capabilities of the people who co-create the reform.

175. Enduring service delivery reforms have tended to have a **strong, stable public institution** that values the proposed changes and is invested in their success.

176. My view is transformational change is more likely to become embedded if such an institution is directly involved in the delivery of the reform (not only in advising on or oversighting the change). Invested management, front line workforces (and where relevant boards), are more likely to identify practical solutions to overcome road blocks or unintended consequences of a change.

177. If we look at the example of reducing the road toll, the establishment of the Transport Accident Commission (**TAC**) in 1987 delivered a strong public institution that had an ongoing interest in the delivery of reform. The TAC has been able galvanise key partners and adapt policy responses to address the road toll over time, which has been central to driving change and sustaining reform efforts over the longer term.

178. Within the Victorian health system, the introduction of activity-based funding in 1993 represented a landmark shift in the way that funding was allocated to Victorian public hospitals. If the sector did not have well-established, stable public hospitals responsible for service delivery at this time, it is unlikely that Victoria would have been so successful in delivering this transformational change. As we can see, activity-based funding continues to be a feature of the Victorian health system and has now been rolled out nationally.

179. It can be difficult for new institutions to form and lead transformational change.

180. For this reason, if a logical institution does not exist, it can be appropriate to consider whether a discrete section of an existing organisation can be repurposed or given an elevated role in owning or driving the delivery of new service models and pathways.

181. Enduring service delivery reforms have also enjoyed **broad stakeholder and community support, backed by political leadership.**

182. Looking at a recent example, the Royal Commission into Family Violence has influenced how different parts of government and the service sector work together to respond to family violence.

183. Drawing on the powerful stories of people with a lived experience can help to connect to the need for reform – building a community empathy and expectation of response.

184. This community resolve, combined with the leadership of key political leaders – in particular, the Victorian Premier and Minister for Prevention of Family Violence – and ultimately backed by Cabinet and cross-party support of the parliament – has made the difference.

185. Government's engagement with people with lived experience of family violence and with broader community groups has crystallised a policy view that relationships ought to be safe, respectful, empowering and nurturing – not robbing people of their compassion, the ability to develop their own personal abilities, or their opportunity to make their own choices and pursue their own aspirations.

186. And that the role of government in family violence is both to promote respectful relationships and gender equality as societal norms; and to offer protection and support where economic, emotional or physical abuse occurs.

187. A broadly accepted view on what 'ought to be', what needs to change and how government can contribute, has been helpful to narrowing the field of policy questions and options.

188. This is important because early and sustained social outcomes can help to sustain community interest, which is essential for maintaining political authorisation to effect change.

189. For instance, the introduction of Medicare, Australia's universal healthcare system, has now endured for over 35 years and is internationally recognised as a leading policy achievement. Medicare was ultimately introduced after over a decade of extensive policy debate, with key design questions and potential criticisms having had the opportunity to be aired and responded to.

190. While public support was still mixed in advance of implementation, the popularity of Medicare grew quickly, with Australians experiencing more affordable access to care. As public support grew, stakeholders who may have initially opposed the scheme realised the strong community interest in maintaining a universal healthcare system.

191. To take another example, over recent decades, the concerted effort of several key partners has seen a massive reduction in the rate of Victorians who smoke regularly, with this figure now at an all-time low.[xiii] However, this progress was not always so assured.

192. When VicHealth was established by the Victorian Parliament as part of the *Tobacco Act 1987,* smoking was common in offices, restaurants and public places, and tobacco advertising was the accepted norm. Thirty years on, increased prevention messaging about the health impacts of smoking has led to a major cultural shift, which has facilitated progressively tighter regulatory control and built the momentum we have today in reducing the impact of smoking on the health of Victorians.[xiv]

193. In each of these examples, policy reforms were able to demonstrate early social outcomes that were widely valued. They were also able to sustain this performance over time, even in the face of changing circumstances. The social outcomes achieved conferred political legitimacy to maintain the policy and continue investing.

The stewardship role of government

194. Making progress in improving the lives of people facing complex social issues requires government to assume a duty of care and stewardship of the services designed to support them. How government exercises this role needs to be consistent with the values-based principles established for the whole reform.

195. Key stewardship functions include:

195.1 governance and program management

195.2 performance and accountability

195.3 program assurance and support for continuous improvement.

196. There are two separate but related governance functions that are important to achieve good outcomes when delivering public policy and services. This includes:

196.1 institutional governance, which is the overarching architecture that establishes roles, responsibilities and accountabilities for the making of public policy, the delivery of services and the achievement of outcomes

196.2 service-level governance, which comprises the forums and processes to engage with stakeholders to inform government decision-making, facilitate collaboration between service providers in a complex service system and acquit a duty of care for people accessing government funded or delivered services.

197. Strong **institutional governance arrangements** – at the Ministerial and senior public service levels – are essential to ensure all relevant portfolios of government are engaged in the policy development and implementation process. Specifically:

197.1 at the national level, Council of Australian Governments (COAG) forums and bilateral relationships support engagement with the Commonwealth

197.2 at the Ministerial level, Cabinet Committees and Taskforces can promote collaboration and integration across portfolio areas, which can otherwise be difficult under existing ministerial arrangements

197.3 at the departmental level, interdepartmental committees and other senior executive forums, such as the Victorian Secretaries Board, can create shared accountability for delivering integrated cross-government policy.

198. These governance mechanisms create fora to drive leadership on policy design at senior levels of government. They can also help to foster collaboration and facilitate coordination of efforts between and across governments, which helps to ensure that different partners are working efficiently in delivering on agreed reform activities.

199. The Royal Commission into Family Violence and the Royal Commission into Institutional Responses to Child Sexual Abuse both emphasised the need to build shared accountability for health, wellbeing and safety of people in vulnerable circumstances. This is also likely to be a recurring theme in the current Royal Commission into Aged Care Quality and Safety and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

200. **Institutional level governance** is also critical to build shared accountability and clarify roles and responsibilities of service providers.

201. The experience of implementation of the NDIS is illustrative of the importance of strong institutional level governance where multiple sectors and jurisdictions need to be engaged to achieve this aim for people living with a disability. There is an increasing recognition of a critical role for the COAG Disability Reform Council to oversight progress in improving mainstream interfaces – with individual COAG councils supporting detailed work on actions required to resolve funding and delivery interface issues.

202. Robust institutional governance should also include mechanisms to monitor the quality and safety of services. Complaints handling, safeguarding and quality oversight and improvement functions all play a critical role in the exercise of government's duty of care to people accessing publicly funded and delivered services.

203. Quality issues that emerged during the rapid growth of the vocational training market in Victoria are illustrative of the importance of developing effective safeguarding systems alongside funding and delivery reforms.

204. It is also important to **align incentives with performance and accountability mechanisms** to support service providers to deliver activities that align with the outcomes sought. This involves:

204.1 drawing on evidence from an investment model to direct and prioritise whole-of government funding to improve the outcomes of consumers

204.2 developing funding models that offer greater flexibility for services to meet complex or multiple needs, including by supporting providers to better integrate the services they deliver across different portfolios

204.3 linking funding reform to performance and accountability measures that support the measurement of outcomes and consumer and carer experiences.

205. Modern accountability mechanisms, informed by comprehensive service data and clear intended outcomes, support greater oversight and continuous improvement to the quality and safety of services.

206. This approach to continuous improvement can be facilitated through **independent monitoring of progress and dedicated support for continuous improvement**. For example:

206.1 establishing an independent monitoring body can help to provide assurance to both the government and the community about sector capability and performance and can help to foster continuous improvement. Looking at a recent example, the Inspector General for Emergency Management was explicitly established to identify where improvements can be made in the state's emergency management arrangements and work with the sector to learn and improve

206.2 Department-led activities are another key piece to support continuous quality improvement. The Chief Psychiatrist and Safer Care Victoria are existing machinery that can be deployed to support providers with continuous improvement efforts.

207. **Robust service-level governance** enables the service providers co-creating social outcomes to collaborate to translate evidence into practice, support continuity of care and link consumers of their services to an appropriate mix of services and support.

208. This level of governance is also important to build feedback loops to inform ongoing service improvement and government policy and investment decisions.

209. Experience from the family violence reforms that are applicable to shifting to a person-centred, rights-based and recovery-oriented practice and a comprehensive stepped care model of mental health care have shown the importance of:

209.1 ensuring that people who have lived experience are supported to safely engage with the reform process

209.2 local engagement mechanisms, including with front line workers, to providing critical feedback loops for government and enable continuous improvement

209.3 purposeful stakeholder mechanisms to test and advance more detailed policy and service design

209.4 establishing a shared vision between, and the respective roles and responsibilities of, institutional and service-level governance structures

209.5 developing a common understanding of the level of consistency and local adaptability appropriate for service models and pathways – and how this may change over time

209.6 providing consistent access to information about the phasing and sequencing of implementation activities

209.7 establishing effective communication channels to maintain a conversation to influence attitudes and sustain community engagement in reforms

209.8 inclusive and equitable policy and service design is required to diverse communities who have fundamentally different experiences of service systems.

Complementing service delivery reforms with community-led initiatives

210. Finally, it is important to note that while most of this statement is focused on service delivery reform, improving the lives of people facing complex social issues also relies on access to natural supports from within their community.

211. Community activities that connect people and activate these natural sources of support are important complements to formal service delivery.

212. For example, evidence shows that:

212.1 people are more likely to find work through friends than an employment service[xv]

212.2 living in a supportive community increases the likelihood of good health[xvi]

212.3 loneliness and social isolation contribute to more frequent reliance on health services[xvii]

212.4 stronger neighbourhoods have significantly lower rates of crime.[xviii]

213. There is emerging evidence about the types of community-led governance that can build supportive and inclusive attitudes to people facing complex social challenges and generate social connections. [xix]

214. Community-led initiatives focus on identifying the strengths in a community (such as skills, capability, passions and knowledge) and activating these strengths to deliver protective and preventative impacts. A natural community may be a peer group, or a physical community within a geography.

215. In this case, government's role should be facilitative – for example providing infrastructure, data and some flexible funding.

216. The Victorian Government has implemented a range of place-based initiatives that target entire communities to address issues that occur unique to a local area, rather than focus on

service delivery alone. A recent example of this is the establishment of the Latrobe Valley Authority to oversee the response to the closure of Hazelwood power station.

217. These types of activities are most durable and effective when they are conceived of and carried out by individuals and associations that are part of a community. They create opportunities to achieve better outcomes for Victorians by empowering communities to find solutions to local challenges, building on local strengths toward outcomes that matter to them.

Part 4 – What this means for governance and accountability of mental health services

218. As articulated across this statement, strong institutional governance is required to drive systemic reforms that cut across the responsibilities of different levels of government and different sectors.

218.1 As I noted in Part 2 of this statement, in exercising its steward and system manager responsibilities, the Department can facilitate improvements in the delivery and impact of services by working with a range of partners, including Commonwealth agencies, mental health services, researchers and academics, other Victorian Government departments and the community. The Department should also work with the Victorian community, and people with a lived experience of mental illness and their families and carers.

219. Delivering on these opportunities requires ongoing reflection on the most appropriate governance at both system and local levels for the public mental health system within a comprehensive stepped care system.

220. The Royal Commission has already heard evidence on the potential benefits and risks of integrating and separating mental health governance and accountability functions from the broader health system.

221. It may be helpful to break this question down further to consider the optimal level of integration or separation in relation to:

221.1 system leadership and stewardship functions such as policy development, system oversight and commissioning and performance management of services

221.2 service-level governance, focused on optimal service delivery at a local level.

222. This part of my statement provides reflections on each of these aspects of governance and accountability – grouped under themes provided to me by Counsel Assisting the Royal Commission.

System leadership and stewardship

223. Under the *Mental Health Act 2014* (the Act), as Secretary of the Department I am responsible for:

223.1 developing and implementing mental health strategies, policies and guidelines

223.2 monitoring and evaluating the performance, standards and outcomes of mental health services

223.3 promoting awareness in relation to mental illness and mental health

223.4 facilitating research into mental illness and related fields

223.5 promoting coordination between mental health service providers and providers of other health, disability and community support services.

224. In practical terms, this means policy and program officers of the Department, the Victorian Agency for Health Information, Safer Care Victoria, the Chief Psychiatrist and the Victorian Health and Human Services Building Authority all play critical roles in:

224.1 advising the Victorian Government on the appropriate policy settings to support optimal system design

224.2 supporting the Minister for Mental Health in communicating strategic objectives and directions for the public mental health system and its role and responsibilities within a comprehensive stepped care model

224.3 commissioning the delivery of services, through:

(a) planning services, infrastructure and workforce to meet mental health needs across Victoria

(b) making resourcing decisions

(c) monitoring the performance of services and outcomes for Victorians

224.4 establishing effective research and evaluation mechanisms to translate the best available evidence into appropriate service models, workforce models and clinical practice

224.5 monitoring and improving the quality and safety of care delivered across Victorian health systems, including through analysing and sharing data with clinicians and hospital managers and governing Boards

224.6 working with colleagues from the Commonwealth Government, other states and national bodies to advance stepped care models and develop nationally consistent professional regulation and funding and performance methodologies.

225. Under the Health Services Act, the governing Boards of Public Health Services play a leadership role in governance of local service delivery, including:

225.1 managing efficient and effective systems for patient care within their own health service

225.2 collaborating with primary and specialist care providers in their catchment to integrate care pathways for consumers

225.3 contributing to the development and sharing of evidence, including through clinician-led research

225.4 commissioning of community based mental health services within state-wide policy parameters.

226. The relationship, or balance, between system and local governance described above is fundamental to achieving outcomes for clients and the community.

227. Two events have catalysed a significant shift in the focus and resourcing of the department's system leadership responsibilities since 2015. The first was a cluster of tragically avoidable perinatal deaths at Djerriwarrh Health Services that lead to the Targeting Zero review of

hospital safety and quality assurance released in October 2016. The second was an unprecedented surge in asthma and respiratory distress after a severe thunderstorm in November 2016.

228. Both have led to a strengthening of the Department's stewardship responsibilities, with work continuing to strengthen engagement with health service CEO's and clinicians and improve our internal capabilities, particularly relating to commissioning.

229. The Department has made structural and resourcing changes to improve its capabilities in designing and actively managing the health and community services systems and leading service and system improvements. These include:

229.1 establishment of Safer Care Victoria to support health services in achieving quality and safety improvements, incorporating Better Care Victoria to fund the testing and scaling of innovations and the creation of new clinical engagement mechanism including a new mental health clinical network

229.2 establishment of the Victorian Agency for Health Information to provide greater access to health performance information to patients, carers, clinicians and health service administrators

229.3 establishing whole of department governance processes to monitor risk and outcomes, supported by a new risk framework, outcomes framework and strategic and investment planning cycle

229.4 consolidation of Departmental data analytics functions to build data linkage capabilities and business intelligence services for the Department as a whole

229.5 establishment of the Centre for Evaluation and Research, bringing together diverse experience and expertise from academic, policy and service delivery backgrounds to provide a clear evidence base for the Department to deliver policy, programs and services for Victorians

229.6 establishment of the Victorian Health and Human Services Building Authority, which develops the strategic pipeline of infrastructure projects to meet growing demand, focussing on delivery, reporting and community engagement in relation to the health and housing infrastructure agenda, including mental health

229.7 rolling out a new 'OurImpact' platform to support stronger project management and oversight of the impact of service delivery reforms, with the ability to capture, track and manage corporate and service performance data to provide timely reports and oversight on performance and risk across various outcomes, commitments and priorities

229.8 transitioning to an adaptive program management approach to the delivery of the Department's reform agenda, seeking to provide senior decision-makers with a comprehensive view of the delivery of major reforms, identify which projects are delivering outcomes, any barriers to delivery, and any interdependencies across major reform programs to help with prioritisation and sequencing of projects.

System leadership through commissioning

230. Questions provided by Counsel Assisting predominantly relate to functions commonly understood together as a cycle of commissioning for services to the community. This cycle can be thought of - in simple terms - as three connected functions of planning, resourcing and performance monitoring and it is critical to our system leadership role.

231. The cycle commences with **service and infrastructure planning**. This involves assessing need, comparing current services to need and then identifying gaps that might be priorities for investment.

232. **Service model design and development** involves drawing together leading evidence to design service models that can meet the identified needs of consumers

233. **Resourcing** involves the procurement or funding of services, drawing on careful design and specification of service models that would meet need, and consideration of how these would be provided. Funding models, prices and incentives are all considerations for resourcing.

234. **Performance monitoring** is the means by which a commissioner evaluates whether funded services meet identified need (including in specifications like quality). In modern public sector commissioning, performance monitoring is usually connected to improvement so that service systems do better over time.

235. The Department fully accepts our responsibilities to perform all of these critical functions. I set out below incremental improvements we have made in relation to each function, and how I think we can go further, especially to connect these functions in a strong and deliberate cycle that drives continuous learning and improvement in services to the community.

236. I also explain, however, why I do not consider that these are functions for which the Department has sole responsibility or which can be performed in isolation for mental health care.

Service and infrastructure planning

237. The commissioning functions of the Department commence with system-wide service and infrastructure planning.

238. The Auditor-General has identified a continuing need to deepen the evidence and analytical base to enhance service and infrastructure planning.

239. Service planning must be adaptive to account for population growth, the fiscal environment of the time, new evidence and emerging models of practice.

240. Service planning for mental health services has been challenged by rapid population growth – with general population growth significantly exceeding whole of government forecasts in recent years. Additionally, gaps across a stepped care model are driving additional demand for emergency mental health care. Mental health presentations to Emergency Department departments are growing at roughly double the rate of growth for other presentations.

241. In recent years, the Department has undertaken more detailed internal analysis on the design, service and infrastructure planning required for Victoria's clinical mental health system over the next twenty years.

242. This analysis has drawn on the National Mental Health Service Planning Framework (**NMHSPF**) – a population planning model that produces resource estimates to guide mental health service planning.

243. While a valuable tool, there are limitations of the NMHSPF. It does not provide an analysis of local sociodemographic characteristics and impacts these might have on the need for services.

244. More effective service planning needs to take account of the continuum of mental health needs across a stepped care model.

245. The Fifth National Mental Health and Suicide Prevention Plan committed all levels of government to work together to support collaboration between public health services and primary health networks to undertake this local analysis. To overcome fragmentation in mental health service planning related to different levels of government and different sectors of the health system, joint planning guidelines were approved by the Australian Health Minister's Advisory Council in October 2018.[xx]

246. The Fifth National Mental Health and Suicide Prevention Plan recognised that a joint approach to regional commissioning of a stepped care model would *'represent a fundamental reconceptualisation of the role of a National Mental Health Plan as one that sets an enabling environment for regional action, instead of dictating change from the top down'*. There is a timetable for the first round of plans to be complete by mid-2020.

247. Local work has commenced, with public consultation underway in some parts of the state and alliances forming between public health services and Primary Health Networks (**PHNs**) in most others. The Department recognises our key authorising and enabling role to promote partnership across levels of government, and we are continuing to work with all PHNs and health services to ensure a consistent approach to delivery of regional plans. We have agreed a Memorandum of Understanding for data sharing with PHNs and meet bi-monthly with PHN and health service representatives to coordinate the initiative.

248. The establishment of the Victorian Health and Human Services Building Authority in July 2017 has deepened the Department's infrastructure planning and delivery capability. There has been an increasing focus on incorporating and prioritising mental health service provision into entity service planning, campus master planning and designs of hospital developments and other community health facilities. For example, mental health is now incorporated in the design planning for major health service projects across the state and in proposed new community hospitals. For all of these, the actual funded scope and configuration is of course a matter for government decision-making.

249. Ongoing improvements to infrastructure planning involve:

    249.1 enhancing the analytical base for informing government's investment decisions for mental health infrastructure

    249.2 embedding mental health infrastructure needs into broader planning for government capital projects, including within the health system, in both the community and hospital sectors and across wider portfolios such as education and justice

    249.3 a stronger focus on planning for outpatient facilities as the preferred mode of treatment delivery and to support the substantial investment in community mental health services since 2016-17

    249.4 applying analysis of population and service developments to inform capital investment decisions for government

    249.5 building an investment model which enables micro-simulation of the impacts of different investments on consumer outcomes and system costs.

Service model design and development

250. Following the identification of population-level need, as a commissioner the Department is responsible for providing clarity as to appropriate models of care, with a focus on what funded services are expected to deliver.

251. Safer Care Victoria has a significant responsibility in deepening the engagement with clinicians and consumers in the development of service models. This is currently achieved through the statewide clinical networks. The role of the clinical networks is multifaceted and includes the identification of clinical care variation through review of best available data, the identification of best practice, the development of guidance to the sector and to ensure that clinical knowledge works together with consumer experience when informing improvement of the system.

252. Victoria has 11 statewide clinical networks. Some have been in existence for 10 years; stroke, emergency for example. The mental health clinical network has been operational with clinical and consumer leadership through its governance committee since early this year. The clinical networks have developed a method for engagement and development of service models. This has been tested on a large scale with the development of the statewide endovascular clot retrieval protocol and associated Victorian Stroke telehealth service, and the extracorporeal membrane oxygenation (**ECMO**) proposal currently being considered by the Department.

253. On a smaller scale, it is being tested in its targeted improvement program for stillbirth (Safer baby collaborative), and third and fourth degree perineal tears (Better births for women collaborative). The common feature of these programs is the use of expert clinicians and consumers to review data, seek best evidence and knowledge. The outcome of this engagement is then tested and developed further in partnership with the wider community of clinicians and consumers to arrive at a service model.

254. The Department then has a role in the assurance of the model through the Office of the Chief Psychiatrist and a facilitative role in supporting the adoption of leading practice across the system.

255. Aside from the work of clinical networks to standardise current practice, the Department also works with experts, consumers and the wider sector to provide guidance on delivery of new initiatives, including in mental health. For example, the current rollout of new mental health / alcohol and other drug hubs in emergency departments requires as a first step the development of documented standard features that must be in place for each of the hubs, including eligibility criteria, staffing levels, high level pathways of care and built environment. Guidelines for the hub have been drafted by the department with input from the sector. Similarly, when behavioural assessment rooms in emergency departments were funded and rolled out by the department over the last two years, a model of care and specifications were developed with expert input and published by the Department.

256. While system-wide service model development is necessary, there is also benefit in retaining flexibility in implementation to support tailoring of models to address local needs. Health services have a role in engaging with the expertise of their local community, including people with lived experience of mental illness, to shape what will work in a community. Allowing for reasonable local variation and clinical discretion are key to allowing innovation to emerge across the system.

Resourcing

257. The second key function involved in commissioning services for the community relates to resourcing. This includes advice to government through the annual budget process on service and infrastructure priorities identified through planning.

258. It also includes development and specification of service models, allocation of budget provided by government to agencies and the design of funding models that incentivise and appropriately price the delivery of specified services.

Prioritisation

259. Annual budget processes require governments to make difficult trade-offs between long term and emerging priorities. An example of this is the aftermath of the Black Saturday bushfires which required the government of the day to shift resources towards the recovery of affected communities. The Department must do careful work to help inform government of the day to make these decisions.

260. Informed by experts, our recent analysis has indicated that there is a need to better incentivise the right mix of services needed to meet clinical standards, based on evidence of the services most likely to achieve the best outcomes for consumers. System reconfiguration to better support a stepped care model has focused on:

260.1 increasing community mental health service availability

260.2 expansion of sub-acute and non-acute mental health beds

260.3 interim action to alleviate pressure on acute mental health beds, with the intent for lesser reliance on acute beds over time.

261. As outlined earlier in my statement, recent annual budget outcomes for service and infrastructure expansion have reflected these directions. Since 2016-17 there has been considerable investment in specialist mental health community services. This reflects both planning advice from the Department and policy decisions of government to shift focus towards care in community settings and support consumers to avoid hospitalisations for severe mental illness.

262. Targeted infrastructure investments have been made in:

262.1 the establishment of 250 beds in Prevention and Recovery Centres (since 2008-09), including development of a new Women's PARC and a new youth PARC

262.2 30 parent infant beds for new parents and pregnant mothers experiencing perinatal depression (since 2013-14)

262.3 the expansion of Thomas Embling Hospital (18 beds since 2015-16)

262.4 the expansion of mental health services in the New Footscray Hospital (26 additional beds).

263. Projects are also underway to modernise existing facilities, including refurbishment at Frankston Hospital and planning for the upgrading of the Swanston Centre at Barwon Health. These facilities are amongst the large proportion of existing mental health acute inpatient accommodation built in the 1990s, on acute hospital campuses as the first wave of deinstitutionalisation.

Funding model design

264. Design of funding models for service delivery to drive better care is a key requirement of commissioning. The mental health funding model in Victoria has remained essentially unchanged since deinstitutionalisation in the 1990s, but serious work is underway to address this.

265. For physical health care, our funding models moved more than twenty years ago to activity based funding (**ABF**). ABF allocates funding to hospitals based upon the number and mix of

patients they treat. If a hospital treats more patients, or patients whose condition is more complicated and their care is more resource intensive, their funding is increased.

266. ABF is also described as a form of output funding, because funding is conditional on episodes of care being delivered – hospitals are not paid for "inputs" such as beds or staff, unless and until they deliver care to patients (outputs). The benefits of ABF for incentivising treatment and rewarding both efficiency and effort are well known.

267. Mental health funding in Victoria has always been based on inputs, such as bed days and community hours, or a historical formula for block funding. As a consequence, mental health funding has not adjusted over time for changes in the type, mix and volume of service consumers. These settings also do not support health services to respond and intensively treat the most acutely unwell patients.

268. ABF relies upon robust classification systems to measure the complexity of patients and their care, and these cannot simply be transferred from acute admitted care. Since 2013, the Independent Hospital Pricing Authority (**IHPA**) has been leading national work on the development of a national ABF model for mental health, with the intention of implementing or testing/shadowing an ABF model for Commonwealth funding to the States from 2020-21. The Department is working closely with IHPA and is on track to test the new national model next year in Victoria.

269. An ABF model will direct resources according to levels of need, improving targeting and equity in funding allocation across the state, and making funding contingent on delivering the services required (as per case-mix funding for acute inpatient services), but I would emphasise that ABF is the beginning and not the end of our journey on funding reform.

270. While ABF has strong benefits in terms of driving efficiency and rewarding effort, it also has well known limitations for dealing with chronic disease and long-term care. This is obviously relevant for funding of mental health care, as it is for other forms of chronic disease.

271. The Department – again, working closely with the IHPA – is aiming to extend and connect payments for specific episodes of care to form packages or bundles of care, that might be more responsive to needs that vary over time and better support continuity of care across settings.

272. Our experience in acute care is that robust, output based funding models provide a "common currency" across the Department, the Department of Treasury and Finance and government for budget advice on growth to meet service demand.

273. Ahead of new funding models, we have to some degree aligned effort across our acute and mental health teams in drawing on expert advice to assemble demand analysis and identify growth funding required to maintain service delivery.

274. The resulting advice has supported increased allocations for mental health in recent budgets. As noted previously, specific provision in mental health budgets for growth in demand has seen the appropriation for mental health services increase from an annual growth of 3.8 per cent in 2015-16 to 8.5 per cent in 2019-20.

275. Recent investments have been targeted towards meeting critical clinical service demand through additional acute and subacute beds, increased community services hours, strengthening the mental health workforce and emergency department mental health and alcohol and other drug hubs.

276. The Auditor-General has recently reported on the adequacy of funding for acute mental health inpatient beds as compared to other acute inpatient beds funded by the Department. This drew on analysis commissioned by the Department.

277. In response to that analysis, the acute bed day rate for mental health has now increased to $835.87 for 2019-20 (up from $712 per day in 2018-19 and $689 per day in 2017-18). While further adjustments are required over time, the revenue versus cost ratio is now sitting at around 70 per cent (comparing current bed day funding with current available cost data; up from approximately 62 per cent in 2017-18 – based on the then funded bed day rate and available cost data), in comparison to the wider acute episode price to cost ratio of just over 80 per cent. Acute prices are supplemented with other government grants and across all service lines, public health services top up government funding with own source revenue to meet the costs of care.

278. The Royal Commission has heard evidence about potential cross-subsidisation of resourcing from other services to acute mental health services. Department analysis of operating revenue and expenditure from publicly available 2016-17 and 2017-18 health service financial accounts indicates that mental health services are being cross-subsidised internally by health services. As noted earlier, an ABF funding model with more robust classification and pricing will better incentivise appropriate care.

Performance monitoring

279. The third critical function for commissioning is the monitoring and management of service performance.

280. As noted recently by the Auditor-General, there are opportunities for the Department to improve the performance monitoring of funded services and wider oversight across the mental health system.

281. Victorian public health services are subject to annual funding and service agreements, known as Statements of Priorities (**SOP**). These include budget information, Key Performance Indicators (KPI) and agreed local actions on statewide strategic priorities. SOPs are agreed between the Board Chair of each health service and the Minister for Health (in consultation with the Minister for Mental Health).

282. There are currently seven specific mental health KPIs that are included within health service SOP agreements:

    282.1 readmission rates

    282.2 seclusion events (three indicators, as measured separately for child and adolescent, adult and aged)

    282.3 post-discharge follow-up (three indicators, as measured separately for child and adolescent, adult and aged).

283. It is important to note that while seven (of roughly 50) KPIs within the SOP are specific to mental health care, access to care for mental health patients is also measured in five other indicators such as time to treatment in and time to discharge (percent within four hours and number within 24 hours) from the emergency department.

284. The government's expectations of timely access to care are no less for mental health patients than they are for others, although the capacity of the acute system to meet mental and physical health care demand differs significantly. An additional performance indicator – transfer to a mental health bed within eight hours – is measured and reported by the department to call attention to significant delays for this cohort.

285. In 2019-20, a strategic priority of 'supporting the mental health system' will be included in all SOPs, with health services required to outline actions that 'improve service access to mental health treatment to address the physical and mental health needs of consumers'. This is

required for all health services, including those that do not deliver a specialist mental health program, reflecting the expectation of these services to deliver effective screening and referral pathways.

286. The Victorian Health Service Performance Monitoring Framework (**PMF**) outlines how the Department currently monitors the performance of health services against requirements of the SOP and a wider range of diagnostic performance data The PMF provides for regular reporting of benchmarked results to health service CEOs and Board Chairs, and escalation and intensification of department scrutiny and intervention as required.

287. The arrangements outlined above reflect an integration of mental health accountability and performance monitoring with those in place for other services. The Department considers this is necessary but not sufficient for ensuring parity in Board and wider health service attention to mental and physical health care.

288. In addition, the Victorian Agency for Health Information (VAHI) has developed 'Inspire' reports which are designed to support a focus on safety and quality performance among clinicians and service management through reporting on clinical variation. A mental health focused Inspire is released twice yearly.

289. The mental health system has also progressed work to understand the experience of consumers in accessing the mental health system, chiefly through the national YES (Your Experience of Service) survey. This annual survey seeks to gather information from consumers about their experience of care, helping system managers, services and consumers to improve services.

290. As the Auditor-General has recently observed, there are opportunities to continue to improve performance monitoring at both an individual service and system level. A new Performance and Accountability Framework for mental health services is under development and intended to reflect directions of the new National Performance Framework for mental health services.

291. The Framework currently includes sixteen outcome areas, and 35 indicators, ranging from levels of psychological distress to the suicide rate. Metrics to examine educational outcomes for children and young people with mental illness, and income support for adults with mental illness, are in development.

Performance management

292. As a system manager and commissioner, the Department must also act on results of performance monitoring to address emerging service gaps and poor performance.

293. The PMF includes a risk assessment tool and provides for regular meetings – monthly or quarterly - between the Department and Health Service executives to review performance and risks. Mental health is a focus of performance conversations when KPIs have been breached or there are emerging issues.

294. Dedicated meetings to discuss mental health performance are also held biannually with individual health services. This provides an opportunity for deeper strategic oversight and monitoring of mental health programs.

295. In addition to the formal performance oversight mechanisms, the Department applies a risk-based and graduated approach to performance management.

296. The Department recognises that its activities and responses need to be appropriate to the nature of issues that arise. As such, it works within a framework that features an escalating and proportionate spectrum of interventions.

297. From time to time there are more significant issues that impact on one or more of four domains of the Department's PMF:

297.1 high quality and safe care

297.2 strong governance, leadership and culture

297.3 effective financial management

297.4 timely access to care.

298. Examples include where there is consistent poor performance against a KPI or when a quality, safety or cultural issue is repeatedly raised about a service.

299. In these cases, immediate engagement with the health service is initiated to agree remedial action. For example, health services are required under the PMF to immediately inform the Department of any patient who spends more than 24 hours in an Emergency Department.

300. Other actions may include:

300.1 convening of teleconferences of senior clinicians and health services executives to raise awareness of system pressures and troubleshoot solutions across health services

300.2 the Chief Psychiatrist conducting a clinical practice audit or clinical review, and providing recommendations to foster improved practice, with implementation monitored through on-site visits

300.3 the Minister appointing an appropriate delegate with mental health expertise to the governing Board of a health service to support remediation efforts and provide independent advice to the Minister on progress

300.4 the Department maintaining more regular oversight until identified issues are resolved.

301. The Department also maintains a state-wide mental health inpatient bed management platform which can be accessed by public mental health services. Updates are to be provided daily by all inpatient services. This provides an avenue for the Department to view emerging system pressures, and to put in place responses to try to manage emerging issues.

302. The Chief Psychiatrist plays a critical role in monitoring the provision of mental health services in order to improve quality and safety. In addition to individual service reviews and actions described above, the Chief Psychiatrist can conduct system wide clinical audits and practice reviews in response to identified performance issues.

303. Commissioners should monitor not only agency performance but also available signals for emerging issues and changes in demand. The Department in 2018 provided funding to the Coroners Prevention Unit (**CPU**) within the Coroner's Court of Victoria for sophisticated analysis of cases reported to the Victorian Suicide Register.

304. The funding agreement provides for the Department to receive detailed data relating to suicide deaths by municipality and at a statewide level, and for the CPU to conduct prospective suicide surveillance to identify potential suicide clusters in the community at an early stage, with a particular focus on young people, and spatial and temporal clusters.

305. Beyond immediate responses, the Department also ensures that performance data informs annual budget advice to government.

Public reporting on performance, outputs and outcomes

306. Mental health performance data is published quarterly and is publicly available on the Victorian Health Services Performance (published by VAHI) and Mental Health Performance Indicator Report (published by the Department) websites.

307. In addition to service level performance monitoring, departmental objectives, indicators, outputs and their performance measures are also reported in annual Budget Papers and in departmental annual reports tabled in Parliament.

308. Output measures reported in state budget papers are designed to report on performance against allocated budget. This means that reported performance reflects targets that are achievable with available funding allocated through the Budget process.

309. As noted in part 3 of my statement, fit for purpose outcomes measurement is important to provide transparency and accountability through the delivery of long-term reform programs.

310. Given the systemic nature of change required in Victoria's mental health system, cross-cutting accountabilities between levels of government and sectors, and gaps in the availability of reliable data, some caution must be applied in determining the appropriate approach.

311. As seen in the United Kingdom, focusing on numeric targets within the health care system can produce adverse results. A rigid focus on efficiency measures has given rise to quality issues and risks of unsafe care.

312. Without careful design, numeric targets can also serve to widen health inequalities by encouraging service providers to direct effort to less complex consumers, given the greater likelihood that serving this cohort will result in improved performance levels.

313. To date, numeric targets in health and mental health reporting in most Australian jurisdictions have tended to focus on access to care in emergency departments (including for mental health patients) and elective surgery.

314. Consistent with the advice of the WHO, the outcomes framework in the 10 Year Mental Health plan seeks to provide a clear direction about what matters most, setting ambition through narrative targets and indicators.

315. Outcomes and indicators were designed in consultation with the Outcomes and Evidence Team within the Department of Premier and Cabinet, and most importantly with the mental health sector and community. The mental health annual report was created as a mechanism to track progress and make all actors in the system more accountable, while raising awareness and confirming community expectations.

316. Priority was given to system level outcomes to measure the service system reforms required to enable the achievement of person-centred outcomes. Part 3 of this document cites evidence guiding decisions around appropriateness of numerical targets, including neglect of "non-target" measures, distortions in clinical behaviour to achieve arbitrary targets and data manipulation.[xxi]

317. This is consistent with the outcomes approach and architecture released by the Department of Premier and Cabinet.[xxii]

318. The mental health outcomes framework cascades from the Department's own outcomes framework[xxiii], which guides out strategic planning and advice to government on investment.

319. The Department was an early adopter of an outcomes approach, developing an outcomes framework covering all of our portfolio responsibilities in 2016. This framework has continued to be refined and published in our strategic plan.

320. The Executive Board tracks 25 patient and client outcomes and 42 system-level outcomes on a quarterly basis. These key results are grouped under five domains:

    320.1 Victorians are healthy and well

    320.2 Victorians are safe and secure

    320.3 Victorians have the capabilities to participate

    320.4 Victorians are connected to culture and community

    320.5 Victorian health and human services are person centred and sustainable.

321. Under these domains there is a specific outcome focused on mental health – 'Victorians have good mental health' and a range of consumer and system level indicators relevant to mental health reform.

322. The focus of the outcomes framework presented in Victoria's Mental Health Annual Report is largely on people with severe mental illness. This group of people, who experience illness such as schizophrenia, bipolar disorder and severe depression, make up the majority of people who use public mental health services.

323. The Department is progressively developing sources of data to enable better outcomes reporting. Since 2015-16 the Department has also been collecting data against the Health of the Nation Outcomes Scale (HoNOS). The HoNOS is a clinician rated instrument comprising 12 simple scales measuring behaviour, impairment, symptoms and social functioning.

324. Collection of HoNOS is a reportable KPI in inpatient and community care. Mean HoNOS and change in HoNOS is reported for community clients. These KPIs are not currently included in key performance reports due to inconsistent collection but are intended for future performance reporting.

The level of integration in institutional governance arrangements

325. Over the last few years we been thinking deeply about the best structural approach within the Department for mental health stewardship functions in relation to wider health stewardship functions.

326. Machinery of government changes in 2015 brought health and human services portfolios back together within the Department. This has supported a renewed emphasis on the intersections between mental health and other social services in targeting interventions and sustaining support for people with enduring complex needs.

327. In early 2016, the Department's stewardship and system management responsibilities for mental health were re-integrated into wider health functions. The Mental Health Branch was brought into the broader Health and Wellbeing Division, which is responsible for leading the development of policy, strategy, workforce, funding and performance in relation to Victoria's hospital and healthcare system.

328. This structural integration acknowledges the similarities between mental health and health, for example approaches to managing lifelong or chronic conditions.

329. The aim has been to capitalise on the connections between the governance and institutional arrangements for mental health and physical health to enable the application of stewardship models that apply across broader health system. It has also prompted consideration of the potential to adopt consolidated funding, planning and budget processes that draw on practice for acute health more generally.

330. From my perspective, the Mental Health Branch has benefited from broader expertise on funding models, business case development, and demand modelling held within the wider Health and Wellbeing Division. At the same time, the wider Health and Wellbeing Division has been able to learn from the strong expertise and experience of the Mental Health Branch in how best to engage people with lived experience in the development of policy and design of services,

331. Although there remain opportunities to continue strengthening this alignment, several benefits have emerged from this change. For example, as noted earlier in this statement, in recent years some of the structure and discipline applied to health system budgeting have been brought across to mental health – including how to present business cases for growth, rather than presenting input bids – which has had a tangible impact in securing funding for demand growth.

332. As noted above, there has been a stronger focus on mental health in SOPs issued to Victorian health services, with seven indicators specific to mental health now included.

333. Further, mental health is now part of core performance discussions with health service CEOs and governing Boards. While there is more to do in supporting leaders and Board members, this arrangement sees strong public institutions with well-developed corporate governance practices taking responsibility for the oversight of mental health service delivery. It also provides opportunities for integrated care and economies of scale that may not have been available if separate governance arrangements were in place.

334. While there are synergies to combining health and mental health system stewardship and oversight functions, there are still some elements of mental health system oversight that need to remain separate and bespoke.

335. For example, the Mental Health Act establishes certain regulatory obligations and requirements that are specific to mental health. These include the principles enshrined in the Act that guide the provision of mental health services and support people living with mental illness to make and participate in treatment decisions. Further, the Act establishes a regulatory regime for compulsory treatment for people who are severely ill and require immediate treatment.

336. Further, the Act sets out specific roles and powers of the Office of the Chief Psychiatrist. As the Chief Psychiatrist noted in his witness statement, these include, among other things, to:

336.1 develop standards, guidelines and practice directions for providing mental health services

336.2 develop and provide information, training and education to promote improved quality and safety

336.3 conduct investigations in relation to the provision of mental health services by mental health service providers.

337. At a national level, the Mental Health Principal Committee of the Australian Health Ministers' Advisory Council (and appropriate sub-committees focused on quality and safety, information and performance, and suicide and self-hard reduction) plays an important role in facilitating national collaboration. From my perspective, while it is important to have a dedicated commonwealth/state forum for mental health, it is valuable to have this body reporting through to CEO's of Commonwealth and State health departments. This provides a more direct advisory link to Ministers and access to annual allocations of a cost-share budget to advance national reform work.

338. A focus on mental health by the Independent Health Pricing Authority, Australian Commission on Safety and Quality in Health Care and the Australian Digital Agency provides access to capabilities to advance national work on funding models and performance indicators.

339. The National Mental Health Commission provides a specialist agency to advance targeted work on sharing evidence of emerging leading practice and models of care and whole of government, whole of community approaches to suicide prevention.

Service level governance

340. Finally, it is important to consider the governance mechanisms required to support operational governance, quality oversight and co-ordinated service delivery at the local level.

341. Under current governance arrangements, health service boards, CEOs and clinical managers play an essential role in overseeing the delivery and performance of clinical mental health services.

342. During evidence presented to the Royal Commission to date, reflections have been made on the most appropriate service-level governance settings for mental health service delivery. This includes the reflection on the degree of integration between the mental health system and wider health system in at the local level.

343. In my view, there have been benefits of a more integrated approach to service-level governance. As noted earlier, the scale and stability of Victorian health services creates opportunities that may not otherwise be possible if there were separate governance arrangements in place for mental health and acute health services.

344. For instance, mental health services are able to access the wider clinical governance frameworks of public health services, including robust processes for incident management, accreditation and quality oversight.

345. Given the devolved nature of the Victorian health system, there are some differences in service-level governance approaches in place across local areas. For example:

345.1 Barwon Health has established a mental health board sub-committee to support quality improvement processes and facilitate the board's input and attention to reform activities underway.

345.2 Eastern Health and the Eastern Melbourne PHN have been working together to design an integrated service-level governance model to lead the development a joint regional mental health plan. This involves a consortium of over 20 different human service organisations with a focus on issues such as collaboration, access and coordination, and shared care.

346. Looking across the wider health system, Victoria's Integrated Cancer Services provides an example of an innovative mechanism that could be considered to improve local service coordination and integration.

347. Integrated Cancer Services bring together hospitals, community-based services, private practitioners, researchers and consumers to plan and deliver cancer services within a geographic area. They have a focus on encouraging collaborative approaches to evidence-based service development and on promoting patient participation in all improvement work.

348. Together, Integrated Cancer Services form the Victorian cancer clinical network and are a critical platform for implementing cancer reform.

349. These examples demonstrate opportunities to strengthen service-level governance arrangements to better support service coordination. I believe there are opportunities to design new models of governance that involve private sector specialists, as well as public health services and primary care in the management of care pathways. As with any service deign, the input of people with a lived experience of mental illness, including carers and families, is important.

350. In further developing service-level governance for mental health, the Royal Commission has heard evidence about the strengths and challenges with the current catchment models.

351. I believe catchments present a useful feature of the organisation of service delivery.

352. Defining geographic service delivery supports continuity of care and enables service models to be adapted for different communities. These arrangements also enable clear clinical accountability for all patients, especially involuntary patients.

353. There are opportunities to better align catchments to population needs, including through re-examining boundaries, enabling some greater flexibility and applying stronger regional planning and ABF over time to better match resources to need.

354. Health services provide operational and clinical governance for public mental health services.

355. For any specialist area of health care it is important to have sufficient scale to deliver safe and effective care. Given the number and variation in size of health services, most health services will need to rely on another health service to access clinical mental health care.

356. Having governance and operational responsibility for mental health service delivery across the campus and catchments of another health service relies on strong collaboration to ensure smooth operations. Opportunities for improvement may include:

356.1 ensuring there are appropriate mechanisms to give each governing board assurance about the quality and safety of care

356.2 strengthening the operational interfaces between emergency departments and acute services, including access to inpatient beds

356.3 additional engagement and collaboration on infrastructure planning for mental health on specific hospital campuses

356.4 Adjustments to some operational governance responsibilities where this would deliver more responsive clinical care.

Concluding remarks

357. This statement highlights a series of gaps that exist in the current design of Victoria's mental health system and suggests some priority opportunities to better support people at risk of or experiencing mental illness.

358. Delivering earlier interventions and providing truly person-centred and integrated care will require strong collaboration with the Commonwealth and other partners to address the fragmentation that currently exists in the mental health system.

359. It will require a concerted effort to listen to the voices of people who have a lived experience of mental illness, including families and carers. It will also require a dedicated focus on meeting the broader health and social needs of people impacted by poor mental health.

360. Applying my learnings from other significant system reform to the context of mental health, I have sought to highlight what I consider to be some key considerations in setting complex service delivery reforms up for success in the short and longer term.

361. Firstly, I do think that it will be vital that we are clear about the outcomes we are seeking to achieve from reforms to mental health system from the very beginning. This includes the outcomes we want to see for consumers, the system level and for the broader population. This is important to help us understand whether our services are making a difference in people's lives.

362. My view is that we need to link these outcomes to a clear theory of change that defines the problems we are seeking to address and aligns these with the agreed directions for reform.

363. If outcomes are to drive decision-making, work will need to occur early to ensure we have the measures and systems in place to monitor the impacts of new service models and structural changes in how people interact with mental health services.

364. The pace and sequencing of reform matters. The scale of reform required to address existing issues in the mental health system will involve fundamental system change.

365. Early actions that enable us to tangibly improve the experience and outcomes of people living with mental illness will be critical to building support and sustaining the political legitimacy of the reforms.

366. There is also a need to establish the fundamental preconditions of a stepped care system. This will require new service models, governance mechanisms and funding models – alongside dedicated attention to workforce and infrastructure - to enable sustained improvement over time.

367. Experience tells us that a strong, stable and committed public institution, involved in the delivery of services, is best placed to encourage the momentum to maintain reform efforts over the longer term.

368. Aligning incentives and performance accountabilities to desired outcomes will be important for all the services in the mental health system.

369. Similarly, strong institutional and service-level governance will be necessary to enable close monitoring, rapid feed-back loops and the ability to adapt to changing circumstances to sustain social outcomes.

370. I do not think there is a one size fits all to whether institutional and service-level governance should be integrated into a broader health and social services architecture or managed separately.

371. There are some bespoke commissioning and stewardship functions that are important to be maintained separately – such as the Chief Psychiatrist and the design of a bespoke funding model. A separate mental health strategy, output structure and performance framework is important to create dedicated attention and accountability. Generally, I think there are economies of scale and capability from leveraging the broader health governance architecture for commissioning, clinical governance and co-ordination of service delivery.

372. Finally, given the importance of social determinants of mental health – and the need to improve how people are supported to transition to higher or lower intensity care – intersections with other social policy reforms will be important. We continue to work closely with the National Disability Insurance Agency and the Commonwealth public service to improve interfaces between mental health and the NDIS. There is also parallel reform work that may be relevant to the Commission's deliberations arising from the Family Violence Royal Commission, fifth national mental health plan and national health reform.

373. Opportunities to complement service delivery reform with different approaches, steeped in community development and revitalisation may also hold promise in promoting mental health, and creating positive social networks to support people to lead fulfilling lives.

374. The Department is cognisant of the need to continue improvement of our system leadership and stewardship functions such as policy development, system oversight and commissioning and performance management of services.

375. This statement identifies areas where further work is required to improve capabilities in relation to several key system management functions of the Department, particularly as a commissioner of mental health services.

376. While incremental improvements have been made in relation to several functions, there is potential to develop a strong and deliberate commissioning cycle that drives continuous learning and improvement in services to the community.

377. As the Commission advances its thinking on the key features of a future system, and the most important actions to establish these features, the Department is committed to continuing to provide information about parallel policy developments.

378. It is my hope that these reflections will assist the Royal Commission in forming its recommendations on how to deliver a reimagined mental health system.

379. I look forward to working with the Royal Commission, the Victorian community and most importantly people who have a lived experience of mental illness, including families and carers, as we seek to improve the mental health system.

sign here ▸ Kym Peake

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date 24/7/2019

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