Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF TERRY SYMONDS

1. I, Terry Symonds, Deputy Secretary, Health and Wellbeing, Department of Health and Human Services, of 50 Lonsdale Street, Melbourne in the state of Victoria, say as follows:
2. I am the Deputy Secretary of the Health and Wellbeing Division within the Victorian Department of Health and Human Services (**the Department**).
3. I have occupied my current role as Deputy Secretary, Health and Wellbeing since July 2017. My role includes policy and budget responsibilities for a range of public health and hospital services in Victoria, including mental health and public sector residential aged care services.
4. I am a Director on the Board of Eastern Melbourne Primary Health Network (**EMPHN**).
5. Attached to this statement and marked **TS-1** is a copy of my curriculum vitae.
6. I make this statement to the Royal Commission into Victoria's Mental Health System (**the Royal Commission**) in response to a letter dated 15 May 2020, being a request for a statement in writing.
7. This statement is true and correct to the best of my knowledge and belief. I make this statement in my professional capacity 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.
8. The statement is not made in relation to my role as a Director on the Board of EMPHN, nor is the statement made on behalf of EMPHN.

Background and qualifications

9. I have held a range of senior roles in the Department, including:
    a. Deputy Secretary, Strategy and Planning Division (2015-2017); and
    b. Director, Performance, Acute Programs and Rural Health (2011-2014).
10. I have worked in health services and government health departments in Queensland and Victoria for more than 25 years. These have included roles in non-government organisations (**NGOs**), mental health services and acute hospitals.
11. I have a Master of Health Studies, Graduate Certificate in Health Promotion and Prevention and a Bachelor of Arts, all from the University of Queensland.

Current role and responsibilities

12. I commenced as Deputy Secretary of the Health and Wellbeing Division (**the Division**) of the Department in July 2017.

13. On behalf of the Department, the Division currently leads on policy, strategy, funding and performance of Victoria's healthcare system, including hospitals, maternal and child health, early parenting centres, mental health and alcohol and drug services.

14. Improving health outcomes for Aboriginal people is a key responsibility for the Division, as is supporting innovation and better care through a lead role in digital health and, until recent structural changes to the Department, health and medical research and international engagement.

Scope of statement

15. I have been requested by the Royal Commission to provide evidence on my views in relation to governance, system design and funding, including the Department's revised commissioning approaches.

16. I note that the Royal Commission will also receive evidence in the form of written statements from other witnesses from the Department, including Ms Kym Peake, Secretary (the **Secretary**); Dr Neil Coventry, Chief Psychiatrist; Associate Professor Simon Stafrace, Chief Advisor, Mental Health Reform Victoria; and Robert Fiske, CEO, Victorian Health and Human Services Building Authority.

17. This statement is set out in five parts:

    a. Part 1 covers my views on the Department's role as steward of the mental health system and strategic commissioner of mental health services.

    b. Part 2 goes into more detail about how we can improve the planning, funding and performance management functions of the commissioning cycle.

    c. Part 3 provides some considerations about the stepped care model, including strengths and weaknesses of this approach, key service elements and possible improvements.

    d. Part 4 examines some of the key enablers that could be improved to better support the delivery of mental health services through a stepped care approach.

    e. Part 5, finally, is highly pertinent to the circumstances of 2020 and outlines the role of the Department in supporting the mental health of the Victorian community through emergencies.

18. Throughout this statement I make suggestions about optimal future arrangements for the future of the mental health system. These views are my own and not necessarily those of the Victorian Government.

INTRODUCTION

19. Reforming the mental health system is an ambitious task and, to better position the government to implement the recommendations of the Royal Commission, the Department is strengthening its role

as steward of the mental health system, as outlined in the Secretary's 2019 witness statement and evidence to the Royal Commission.[1]

20. Critical to this leadership role is the cycle of commissioning services for the Victorian community, which the Secretary described as three connected functions of planning, resourcing and performance monitoring.

21. This statement provides an opportunity to explore in greater detail the improvements we are currently making, as well as further opportunities the Department could explore, in our journey to optimise commissioning functions within a stepped care model for mental health services in Victoria.

PART 1: ROLE OF THE DEPARTMENT IN COMMISSIONING MENTAL HEALTH SERVICES

Mental health system stewardship

22. The Royal Commission has asked me to discuss the key stewardship objectives and core functions of Victoria's mental health system manager, both currently and in a future system.

23. The Department fulfils the role of system manager of Victoria's mental health system. Our key objectives and functions in performing this role are outlined in several statements to the Royal Commission, as well as in public policy documents and reporting.[2]

24. To paraphrase *Victoria's 10-year mental health plan*, our goal is a simple one – that all Victorians experience their best possible health, including mental health. In doing so, we focus on people who are disadvantaged and vulnerable, and ensure that people living with mental illness get the same respect and opportunities as everyone else.

25. I think that to achieve this goal, we need to shift our current systems and models towards a commissioning approach that delivers stepped care. As the system steward, the Department should set a strategic statewide framework for commissioning that is supported by statewide functions such as performance monitoring, planning, research and policy development, all of which will enable high quality local delivery of care across a stepped continuum, designed with people with lived experience, that meets the needs of consumers and their families.

The Department's evolving commissioning role

26. The Royal Commission has asked me to comment on what I think should be the objectives and features of commissioning in a redesigned mental health system, and how and why the Department is evolving to strengthen its stewardship and commissioning role.

---

1 Kym Peake, Witness Statement to the Royal Commission into Victoria's Mental Health System (2019).

2 For example, the Secretary's 2019 statement, the *10-Year Mental Health Plan* and other strategic documents such as *Victoria's Mental Health Services Annual Report*, the *Statewide Design, Service and Infrastructure Plan for Victoria's Health System 2017-2037*, and the *Victorian Health Services Performance Monitoring Framework.*

27. The objective of commissioning is to ensure that available resources are allocated to achieve best possible outcomes for the population served.

28. While commissioning is a contested term, I understand it as a set of linked activities that assess the needs of a population, specify the services required to meet those needs within a strategic framework, secure and fund those services, and monitor and evaluate the outcomes.[3]

29. While the Department has measured needs, set policy directions, developed service models, measured outcomes and so on, we have not done so in a joined-up way or used our funding as purposefully and precisely as we could to achieve outcomes. In that sense, I would say that the Department has operated more as a funder than a commissioner for health and mental health services. For example, our funding agreements have mostly reimbursed health services and other agencies on the basis of services provided rather than to commence or expand services that are needed but not yet in place or offered at the right level.

30. Commissioning has the potential to transform our ability to achieve outcomes for consumers, while also enabling innovation to flourish, and funds to be used efficiently. We are only at the beginning of this journey, and in this statement, I will offer some reflections on changes that we are making, and that I think we still need to make, to build a new mental health system for Victoria.

Our commissioning approach

31. As the Secretary's 2019 witness statement notes, the Department groups commissioning activities under three functions – planning, resourcing and performance monitoring:

    a. **Planning** – this involves both understanding health needs and demand for services, and evidence-based service model design and development to meet consumers' needs. It is critical that both consumers and clinicians are engaged directly in these activities.

    b. **Resourcing** – this involves both the design of funding models to incentivise and appropriately price the delivery of specified services, and the allocation of budget to specific services (regardless of the funding model). My focus in this statement is on the elements of resourcing that are within the control of the Department, acknowledging that government decisions on budget (for example, how much to allocate to mental health or health relative to other portfolios and priorities) are influenced by the Department's advice, for example on population needs.

    c. **Performance monitoring** – this involves monitoring and managing service performance to identify whether funded services are meeting identified need and performing to required standards, including in areas such as safety and timeliness of care. Performance monitoring should be seen as not just supporting accountability of service providers, but

[3] Helen Dickinson (2015) *Commissioning public services evidence review. Lesson for Australian public services*, Melbourne School of Government, University of Melbourne.

also enabling continuous learning and improvement of the system overall. The results of monitoring inform further planning and resourcing decisions, for example.

32. My view is that we should employ the principle of subsidiarity as we implement a commissioning model. While it is critical that government retains a strong statewide *strategic commissioning* role to ensure accountability to the community, and alignment and consistency of regional approaches; we should also work towards a system where regional *operational commissioning* is done as close to the community as possible while still retaining efficiencies of scale.[4]

33. In strategic commissioning, the system steward:

    a. **Plans** by assessing whole of population health needs, setting broad directions for system design (such as stepped care) and working with consumers and clinicians to define outcomes for the system and the standards of quality, safety and access that all providers must adhere to.

    b. **Resources** regional operational commissioners, with funding for services allocated according to need as determined by the population health needs assessment and sufficient capacity and capability for operational commissioners to do their job. The strategic commissioner may also be responsible for resourcing enablers and infrastructure at a whole of system level, such as a pipeline of future workforce.

    c. **Monitors performance** by measuring progress against statewide outcomes, monitoring quality and safety (including consumer reported outcomes), and holding regional operational commissioners to account for their performance against agreed indicators. The strategic commissioner would also be responsible for reporting to government and the wider community about system performance.

34. Regional commissioning bodies:

    a. **Plan** by conducting needs analyses of the specific needs of the region, in partnership with consumers, community and other local commissioners (for example of disability and aged care).

    b. **Fund** individual service providers to meet those needs, and develops the market where there are insufficient services.

    c. **Monitor performance** by holding service providers to account for outcomes, assessing quality and safety through data collection including consumer perspectives, and fosters service improvement, innovation and integration.

35. As we move towards this approach, the Department will retain responsibilities of both a strategic and operational commissioner. However, I believe that the Department's future role could more clearly focus on strategic commissioning, and our operational commissioning responsibilities might be better

[4] Helen Dickinson (2015) *Commissioning public services evidence review. Lesson for Australian public services*, Melbourne School of Government, University of Melbourne, p12.

conducted by more local actors working together. This could include, for example, Primary Health Networks (**PHNs**) and health services.

36. To do this, we will need to make the following improvements to how we function as a system steward:

    a. addressing variation and driving greater consistency of approaches across service platforms, so that resources are more equitably allocated, and the quality of service delivery and outcomes for consumers improve;

    b. quicker identification and resolution of performance issues through ongoing data analysis and closer engagement with our sector partners;

    c. greater consistency in the methodology for rolling out and overseeing new government initiatives and investments;

    d. a whole-of-system view of all health service platforms, enabling the Division to identify better practices across different settings and assist in more timely and integrated responses to incidences and performance; and

    e. streamlining commissioning processes and reducing duplication of effort.

37. Getting it right requires both the Department (as strategic commissioner) and regional operational commissioners to develop an expanded set of skills and knowledge to fulfil our changed roles and improve service outcomes.

38. At all levels, we will need a wide range of skills, including needs assessment, contracting, performance monitoring, accounting and budget management. Beyond generic commissioning skills, specialist knowledge is required to make coherent decisions and assist with more technical aspects of the role such as the stratification of patients according to risk, predictive modelling of demand, and the interpretation and assessment of service quality and outcomes. These competencies are not abundant or concentrated in the Department or any other candidate for a commissioning role, and will need a program of sustained development.

39. Beyond skills and knowledge, there are cultural changes required.

40. Successful commissioners must be excellent partners – they cannot do their job alone. It is critical that each step of the commissioning cycle, at both strategic and operational levels, is carried out in partnership with consumers, clinicians, other commissioners and community. In particular, our commissioning structures should support self-determination for Aboriginal people, and I discuss this further later in my statement.

41. The Division that I lead has taken initial steps to strengthen commissioning by developing more consistent approaches, reducing duplication and overlap within the Division (for example, establishing commissioning teams), lessening competing priorities for staff and helping them to deepen their specialisation and expertise.

42. I believe that, done well, commissioning can set a clear direction for the system, require consistency where appropriate, and ensure strong oversight of quality, safety and equity. Importantly, at the same

time it can increase local flexibility, responsiveness and innovation in the planning and delivery of care.

43. We will know that commissioning is working if we can see the following changes in our system:

    a. a focus on outcomes that matter to consumers and communities;

    b. a shift from a narrow health care model to a population approach to mental health;

    c. a stronger focus on networks and markets of services, rather than just individual providers;

    d. consumers and carers integrated into the system at all levels, with their needs and what matters to them reflected in service design and delivery;

    e. self-determination through a seat at the commissioning table for our Aboriginal communities;

    f. a shift for the Department from contract enforcer and top down decision maker to system enabler and convener for collective decisions;

    g. monitoring system-wide performance and providing improvement support rather than narrowly monitoring organisational performance against contracts; and

    h. locally driven innovation and development of services to fill gaps identified through joint needs analyses.

44. In designing a mental health system through a commissioning approach, we can look to other jurisdictions for inspiration and learning. For example, the National Health Service (**NHS**) in the United Kingdom has been developing and refining its commissioning structures to shift decision making to local organisations and support more joint commissioning to provide integrated systems of care.[5]

45. In Victoria, we are only at the beginning stages of moving to a commissioning approach to service delivery in mental health; but we are working towards being able to devolve funds and responsibilities to regional operational commissioners once we have the statewide settings and structures in place.

Strengths and limitations of regional operational commissioning

46. The Royal Commission is interested in my understanding of the strengths and limitations of regional mental health planning and commissioning.

47. 'Regional operational commissioning' can be described as the process of including service providers under a local or area-based (regional) governance structure, and delivering care based on a local needs analysis through a more coordinated process with providers. For example, PHNs are regional commissioners on behalf of the Commonwealth, given that they are responsible for commissioning services within a geographic area.

---

[5] The King's Fund, *What is commissioning and how is it changing?* (September 2019) <https://www.kingsfund.org.uk/publications/what-commissioning-and-how-it-changing>.

48. Regional operational commissioning should align with system-wide standards and shared accountabilities to ensure optimal, safe and equitable care across the state and the care continuum. This is particularly important to ensure that regional approaches to commissioning do not lead to uneven quality of service provision across the state.

49. We can see this approach working well in the context of cancer. Dedicated whole of system guidance and direction is set through the *Improving Cancer Outcomes Act 2014*, which requires the preparation of a cancer plan every four years. These plans set out clear system-wide goals over each four-year period, and articulate measurable outcomes, system supports and principles. However, local cancer care is to some extent commissioned and provided through integrated cancer services and regional cancer centres that operate across primary and acute providers by region and sub-region. This approach is working – we have met or are making progress towards the goals set in the first four-year plan.[6]

50. Although we are only at the beginning of operationalising this kind of model, I think it is worth exploring some of the strengths and challenges we have identified so far to inform the Royal Commission's thinking on future system design.

51. The main strength of regional operational commissioning is that it focuses on improving consumers' experience in receiving care, and ultimately their health outcomes, by ensuring services are targeted to local needs.

52. It should also lead to a greater focus on prevention and management of population health conditions before they become more acute and more expensive. It is therefore an effective and efficient way of achieving high quality care that is responsive to consumers' needs while ensuring value for money.

53. It also allows for variation in service profiles that respond to the unique population needs and market functions due to distinct client demographics, culture, rates of disease, service availability, service quality and levels of competition.

54. Ideally, funding from different sources would be pooled at the regional level. The regional operational commissioner would then allocate funding to providers using a commissioning framework. Outcome based accountabilities could be used to encourage providers to work together to provide integrated care.

55. Regional operational commissioning should also strengthen the role of clinicians, consumers, provider organisations and other local stakeholders in the process of planning and purchasing health care services. By being closer to the regional service system than a statewide commissioner, regional operational commissioners can develop rich relationships across services and communities, foster partnerships and work to fill gaps in the market.

56. Regional operational commissioning should use a variety of mechanisms to respond to local circumstances, including population needs analyses, service gap analyses, localised governance

---

[6] Department of Health and Human Services, *Victorian Cancer Plan* (Web Page) <https://www2.health.vic.gov.au/about/health-strategies/cancer-care/victorian-cancer-plan>.

arrangements, shared priorities and outcome accountabilities, shared funding, new procurement and payment models, and improved pathways of care to create a more joined up service system for consumers.

57. There are also challenges to implementing a regional operational commissioning model.

58. If funding is pooled from different sources, it can be difficult to reach agreement between different funders, which can limit the model's ability to meet its objectives. If funding is not pooled, flexibility to tailor service responses to local needs is hampered.

59. Hospital funding – the largest component of funding in health overall and in mental health – could be included in regional pooled funds, provided that funded activity remained eligible for funding formulas within the national joint funding model (either activity based or block funding). If local activity was not recognised within those existing arrangements, prior agreement to pool Commonwealth funds would need to be sought from the Commonwealth and the Independent Hospital Pricing Authority (**IHPA**).[7] Such agreement has not been easy to achieve in hospital avoidance programs for chronic disease. A lack of trust and debates over the technical aspects of alternate funding arrangements have long delayed progress on funding for hospital avoidance programs. The Royal Commission may accelerate reform with its recommendations in this area, so that funding for hospital care is available to regional commissioners for pathways and partnerships between hospital care and care in the community.

60. Another challenge will be building up the commissioning entities themselves. Commissioning is a specialised role and getting sufficient scale and skills in place would be essential. It would also be critical to have enough funding, and enough flexibility in commissioning, to meaningfully change incentives on providers and shape the regional service system over time.

61. These entities will also need to have the skills to build strong relationships between service providers within a region, with international experience showing that trust and cooperation between providers is an important pre-condition for successful regional commissioning.

A more coordinated and collaborative approach to commissioning

62. As the Royal Commission found in its interim report, collaboration and coordination at all levels must be improved to build an integrated, stepped care model. This is the Department's aim as stated through our shared vision and purpose, but this has not been enough to address the fragmentation and gaps in the current system.[8]

63. It is already the case that there are a number of commissioners – Commonwealth, state and local – who manage interdependent systems to deliver mental health care. By introducing regional operational commissioning arrangements, these commissioners can collaborate to develop shared needs assessments, aligned outcomes, and co-commissioning approaches.

---

7 See clause 10 and Schedule A of the National Health Reform Agreement – Addendum 2020-25

8 See, for example, *The Statewide Design, Service and Infrastructure Plan for Victoria's Health System 2017-2037*.

64. At all levels, the outcomes focus of commissioning will be an engine for collaboration. The outcomes that consumers and communities nominate as the most important cannot be achieved by any one service, or any one level of government. When there is a genuine shift towards outcomes, it heightens the incentive to collaborate.

65. At the regional commissioning level, the process of joint needs assessment and aligning the outcomes being purchased will drive collaboration between partners, and potentially enable pooled funding for co-commissioning.

66. Regional commissioning also requires strong relationships to be developed between providers and other stakeholders that are not feasible statewide. These relationships can then empower providers and other stakeholders to generate solutions and forge partnerships to meet common goals.

67. Provider-led initiatives can also drive collaboration at the local level, and can co-exist and complement regional operational commissioning. Many providers are very sophisticated and can play a key role in developing service offerings. To do this, we need to think about how we can provide direction and support them. This could include:

    a. using funding incentives to encourage providers to deliver innovative care or form partnerships to make better use of limited resources. This would include the provision of multi-disciplinary care, and multi-agency responses to individual consumers based on a holistic assessment of their needs;

    b. supporting provider development and promoting best practice – this is particularly important in regional and rural settings where there may be consumer access challenges or an absence of markets;

    c. supporting engagement between commissioners, providers and consumers with sufficient time to build trust and legitimacy, driven by clinician and consumer engagement in the commissioning process; and

    d. ensuring provider contracts outline that services should deliver sustained health outcomes, to avoid providers focusing on patients with the highest return for investment.

68. This broadened offering may include services provided by multi-disciplinary teams, accessed through complex and chronic condition care plans initiated by primary care providers, including GPs. It may also include community-led support services that could also be accessed through GPs and the use of social prescribing. All these services would be underpinned by strong processes to drive collaboration and coordination, to ensure that consumers are receiving the appropriate level and mix of services.

69. I would like to emphasise in particular the need for all partners to work together to develop regional collective needs assessments, with consumer input, that are published and used actively to guide investment. I would like to see us reach agreement with the Commonwealth that PHNs and Local Hospital Networks (**LHNs**) are required to work in a coordinated and collaborative way with other

regional commissioners, consumers and providers to develop only joint assessments, that all parties then use in determining service delivery arrangements.

70. I think that moving towards a commissioning approach will also support us to build an integrated stepped care system where collaboration between consumers, government, and service providers makes a meaningful difference to outcomes. Because stepped care is about the integration of multiple service offerings, it is particularly amenable to joint commissioning rather than being funded directly or commissioned by one body alone.

Integration of governance and commissioning arrangements for mental health

71. The Royal Commission has asked me to discuss, at a system level, the merits and limitations of integrating the governance arrangements for mental health services and broader health services, including the ideal level of integration or separation to achieve the best outcomes.

Integrated governance

72. People living with mental illness experience significantly poorer physical health than the general population, and their life expectancy is up to fifteen years less than the general population. Conversely, people with chronic ill-health are two to three times more likely to experience mental health problems such as anxiety, depression or psychological distress related to their physical illness. A separation of physical and mental health care at system and service levels would act as a further barrier to achieving good health outcomes for people with mental illness, and good mental health outcomes for people with chronic ill-health.

73. Some international jurisdictions have taken steps to integrate their general and mental health services, supported by governance structures that encourage holistic care. These jurisdictions point to evidence that integrated services improve treatment for co-morbid conditions, reduce stigma, and support more coordinated care for consumers.[9]

74. The scale and stability of Victorian health services is a key advantage of the current service-level governance arrangements, with mental health able to benefit from being part of a larger entity with established clinical governance frameworks, including robust processes for incident management, accreditation and oversight.

75. In addition to robust clinical governance, integrated arrangements mean mental health overheads are managed centrally, realising cost efficiencies. This includes corporate services such as finance, legal and human resources, cleaning, food and other 'back of house' services, as well as physical and information technology privacy and security arrangements. Any proposal for separation of local governance for mental health from existing health services would need to weigh carefully the required loss of funds from direct service delivery to establish new management and organisational structures.

---

[9] Victorian Government, *Productivity Commission Mental Health Inquiry: Victorian Government Second Submission – Response to the Draft Report* (2020) 17.

76. At the service delivery level, there are workforce and professional collaboration benefits in situating mental health service delivery within wider health services, particularly in creating a general healthcare workforce better skilled to respond to mental health issues. These factors would be difficult to realise if new, standalone mental health services were established.

77. For these reasons, it remains my view that health and mental health service delivery and governance should be integrated, not separated.

Integrated commissioning

78. As noted above, mainstreaming of mental health as a health speciality has long been a feature of governance arrangements in Victoria. It makes sense to take this approach with our commissioning arrangements too.

79. Doing so would demonstrate leadership to the health sector about the importance of integrating physical and mental health services to deliver more holistic healthcare and reduce stigma, so that mental health is treated in the same way as other health issues.

80. An integrated commissioning cycle also strengthens system leadership and stewardship functions by integrating the oversight, commissioning and performance management of healthcare and enabling a holistic approach to assessment, analysis and improvement opportunities. This enables a shared view with clearly articulated outcomes, and an understanding that responsibility for delivering improved mental health outcomes cannot be achieved through siloed approaches within the Department or the health sector.

81. The merits also include improved consistency in commissioning approaches, and the opportunity to achieve efficiencies in the commissioning cycle by merging and streamlining parallel Departmental processes across planning, resourcing and performance monitoring.

82. It also creates learning opportunities and the sharing of skills, experiences and capabilities across both systems, as mental health has a strongly embedded consumer focus, which contributes greatly to the continuous improvement element of commissioning, while acute health has a more robust funding model.

83. It is worth noting that the imperative to integrate commissioning is stronger at the regional operational commissioning level than at the strategic commissioning level. Put another way, the benefits of a dedicated mental health focus may outweigh the costs at the strategic commissioning or statewide level, even if that's not the case at the regional or local level. Provided that the strategic commissioner has support from both the Commonwealth and State Governments for commissioning to be integrated at the operational level, the benefits outlined above could be achieved through several strategic commissioners working together to provide clear guidance and accountability to regional commissioning bodies to deliver integrated services (for example, through the use of holistic performance indicators).

Integration between mental health and other, non-health services

84. Recognition of the social determinants of mental health must be the starting point for consideration of how mental health integrates with non-health services. There is growing evidence that mental health is shaped by the environments in which people live, and that social inequalities are associated with increased risk of many common mental disorders. Social determinants of mental health include socioeconomic status, past trauma, employment, housing, education, housing, drug use, physical health, and community connectedness. The cumulative impact of these factors increases the risk of mental illness, and some of these factors are also associated with increased likelihood of suicide.

85. While a similar level of integration with other service sectors such as housing, corrections, disability, AOD, child protection and other community services is not practical, there should also be mechanisms in place to ensure that clients are placed at the centre of services, with strong collaboration and coordination at all levels of policy, service design and implementation. Service systems can agree to higher level standards to achieve outcomes, yet allow flexibility in how these standards can be achieved through a range of different activities to meet local needs.

86. Service integration is a major policy priority for the Department, as articulated through our strategic plans.[10] By bringing the focus of service delivery back to the needs of consumers, families and their carers, services can address fragmentation between services, provide more holistic care and ultimately improve consumer outcomes.

Examples of integrated care initiatives

87. When service integration is done well, positive outcomes for consumers can be seen across a range of measures, along with improvements in system performance.

88. Looking to NSW, the Housing and Accommodation Support Initiative (**HASI**) is one example where positive consumer outcomes have been achieved through integrated service delivery. HASI is a partnership between NSW Health, NSW Department of Housing and NGOs which supports consumers with severe and chronic mental illness to access long-term independent housing in the community, along with mental health case management and accommodation support. The model helps clients with tenancy matters, mental health issues, and disability support.

89. An evaluation of HASI in 2012 reported positive consumer outcomes across a wide range of measures, including considerable reductions in mental health inpatient hospitalisations by users of the program, along with shorter stays, decreased psychological distress, improved life skills and housing stability. Consumers also showed an increase in engagement with services such as

[10] See for example, Department of Health and Human Services (Vic), *Department of Health and Human Services Strategic Plan* (July 2019); Department of Health and Human Services (Vic), *Health 2040: Advancing Health, Access and Care* (November 2016); Department of Health and Human Services (Vic), *Roadmap for Reform: Strong Families, Safe Children* (April 2016); Department of Health and Human Services (Vic), *Statewide Design, Service and Infrastructure Plan for Victoria's Health System 2017-2037* (October 2017).

community mental health, GP and allied health services and positive changes in social participation, community engagement, and involvement in education and voluntary or paid work.[11]

90. Canterbury, New Zealand is another example where integration of health and social care has led to reduced pressure on acute services and strengthened community-based service delivery. To address rising costs and long waiting times in hospitals, the District Health Board for Canterbury (**DHBC**) redesigned the health and social services system through the creation of a clear vision, a sustained investment in providing staff and contractors with the skills needed to innovate, and new forms of contracting.

91. The change has been driven by the motto 'one system, one budget'. Social care comes under the umbrella of health boards in New Zealand, and the existence of a single health and social care budget has been a further enabler for change. It has helped the DHBC to give effect to its plans without the complication of aligning funding streams from different agencies.

92. As a result, pressure on hospital services has been relieved and there has been reduced use of care homes. The DHBC has made a concerted effort to increase investment in services delivered in the community, both to avoid inappropriate hospital admissions and to ensure timely discharge from hospital. This is underpinned by a primary care system that has long performed well, and is now even stronger.

93. There are also some promising projects in Victoria that aim to tackle fragmented care and improve access to services. For example:

    a. Health Aging Service Response: Eastern Melbourne PHN funded project to support consumers aged 65+ years (or 55+ years for Aboriginal people) with mild to moderate mental illness who live independently in the community or in Residential Aged Care Facilities, considering 'whole of person' needs and catering to consumers who do not meet the criteria for tertiary care.

    b. Common Clients Reform Project: establish an integrated service model for people who use multiple services across the health (including mental health), justice and social service systems to better meet their needs, with the aim to reduce their contact with the justice system.

    c. Support and Safety Hubs: help victims of family violence by bringing together access points for family violence services, family services and perpetrator/men's services.

    d. Victorian Fixated Threat Assessment Centre (**VFTAC**): identify and assess individuals who may have a mental illness and who pose a threat to public safety due to their risk of engaging in potentially violent behaviours; facilitate effective interventions by police,

[11] Social Policy Research Centre for NSW Health and Housing NSW, *Evaluation of the Housing and Accommodation Support Initiative (HASI)* (Final Report, September 2012).

mental health services and other relevant agencies; and, through these measures, prevent these individuals from progressing to violent action.

Integrated care for co-occurring mental health and AOD issues

94. Integration of service delivery is particularly important where consumers are experiencing co-occurring mental health and AOD issues, often referred to as a 'dual diagnosis'.

95. As the Royal Commission is aware, the high prevalence of co-occurring mental health and AOD issues is well established. However, it is estimated that less than 12 per cent of people with co-occurring disorders receive treatment for both conditions.[12]

96. This type of comorbidity presents unique diagnostic and treatment challenges, with both conditions interacting to maintain or exacerbate the other.[13]

97. In Australia over the past 10 years an evidence base has begun to emerge to better inform approaches to comorbid mental health and AOD issues. However, evidence remains limited with traditional approaches of treating the disorders separately prevailing in siloed research and clinical domains.

98. During this time, the acute mental health care sector has been de-skilled in relation to AOD issues. Workforce shortages, problematic siloing of the two sectors and historical culture and practice approaches have led to limited opportunities for integrated care.

99. An integrated care approach in this context is premised on both conditions being treated concurrently, preferably by one provider. This approach can ensure internally consistent treatment with common objectives, which can explore the complex relationship between conditions. This single point of contact reduces the burden on the individual, along with potential communication problems and discordant treatment philosophies, reducing the chance of clients falling through treatment gaps.

100. In Victoria, the Victorian Dual Diagnosis Initiative made significant gains in the further development of mental health and AOD workers, agencies and sectors' capacity to recognise and respond effectively to people experiencing co-occurring mental health and substance use concerns and related issues. However, this program has lost momentum and, as outlined in their submission to the Royal Commission, would require updating and refinement, co-design and implementation support were it to continue.[14]

101. There has been some recent activity to support consumers with a dual diagnosis as part of the Department's rapid expansion of access to residential rehabilitation services for AOD. Two providers

---

[12] Catherine Foley, 'Collaborating with Clinicians and Consumers to Improve the Uptake of Integrated Care in a Residential Mental Health Rehabilitation Unit: A Co-Design Approach', *National Drug & Alcohol Research Centre* (Blog Post, December 2018) <https://ndarc.med.unsw.edu.au/blog/collaborating-clinicians-and-consumers-improve-uptake-integrated-care-residential-mental-health>.

[13] Ministry of Health (NSW), *Effective Models of Care for Comorbid Mental Illness and Illicit Substance Use: Evidence Check Review* (August 2015).

[14] Victorian Dual Diagnosis Initiative, Submission to the Royal Commission into Victoria's Mental Health System (2019).

have been funded to pilot a new specialist residential service for people with dual diagnosis until 2021-22:

a. Vahland House in Bendigo: eight beds (Bendigo Health); and

b. Westside Lodge in St Albans: twenty beds (Western Health).

102. However, this is not enough, and it is my view that the Royal Commission should consider a comprehensive approach to dual diagnosis. In doing so, I would encourage the Royal Commission to consider the work of the National Drug and Alcohol Research Centre (**NDARC**) when considering core components and activities that can enhance collaboration between mental health and AOD services and improve the delivery of care for people with co-occurring disorders.[15]

PART 2: IMPROVING THE COMMISSIONING CYCLE

103. The Royal Commission has asked about the role of the Department across the commissioning cycle, from planning, funding, performance monitoring through to reporting. In this part of my statement I will consider the three elements of the commissioning cycle that outlined in Part 1 in more detail, and suggest improvements that the Royal Commission could consider in designing future commissioning arrangements.

Planning

104. The Department's commissioning functions should be informed by a strong understanding of demand for mental health services, so that services and infrastructure can be appropriately directed to address need.

105. The Department does not have adequate systems in place to capture data about current service system capacity, demand and delivery. Significantly, there is no mechanism in place to record unmet demand, such as waiting lists or data from mental health triage services identifying those who seek access to public mental health services but do not meet the threshold for treatment.

Understanding demand for mental health services

106. For joined-up regional operational commissioning to be effective, we need to capture both met and unmet demand by analysing data from all the partners who are involved in the delivery of mental health services: PHNs, GPs, community health services, NGOs, and so on, all informed by consumers.

107. At a national level, the National Mental Health Service Planning Framework (**NMHSPF**) strategic planning tool provides an agreed national language for mental health services and national average benchmarks for optimal service delivery across the full spectrum of mental health services. It is a

[15] Catherine Foley, 'Collaborating with Clinicians and Consumers to Improve the Uptake of Integrated Care in a Residential Mental Health Rehabilitation Unit: A Co-Design Approach', *National Drug & Alcohol Research Centre* (Blog Post, December 2018) <https://ndarc.med.unsw.edu.au/blog/collaborating-clinicians-and-consumers-improve-uptake-integrated-care-residential-mental-health>.

relatively comprehensive model of the mental health services required to meet population needs, and is designed to help plan, coordinate and resource mental health services. It also allows users to estimate need and expected demand for mental health care and the level and mix of mental health services required for a given population.

108. Unfortunately, the NMHSPF's usefulness in Victoria is limited for the following reasons:

    a. it is unable to provide analysis of local sociodemographic characteristics in Victoria and their impact on service needs;

    b. it assumes adequate and complementary access to other service systems such as housing and AOD, despite these services being in high demand and facing their own resource and system challenges; and

    c. it inflates child and youth community-based activity estimates.

109. Other factors that create significant challenges in forecasting demand for mental health services in Victoria include the legacy status of the Client Management Interface and Operational Data Store (**CMI/ODS**) as I discuss further below in this statement; and a lack of standardised data collection across all the steps of mental health service provision as well as the methodology employed for demand modelling.

110. To this end, the Department has worked with Aspex Consulting through 2019 and 2020 to develop a new demand modelling tool (**the Aspex tool**), which builds on a revised long-term forecast model to more accurately predict long-term demand and provides the capability to predict how changes in service intensity and utilisation will impact on forecasted demand.

111. The completed Aspex tool was only recently provided to the Department at the time of preparing this statement. Planning is underway to use the tool to translate useful planning framework components, including features of the NMHSPF, into the Victorian context and begin testing scenarios to inform future system planning.

112. The Aspex tool is a promising start, but it too is limited by the quality of the data that we can put into it. To accurately capture both the demand (met and unmet) and true capacity of Victoria's whole mental health system, we need to be able to provide robust and timely data across the whole system, so that the Department, as system steward, can deliver informed service and infrastructure plans that adequately prepare the system for future demand.

113. Furthermore, given the complexity of needs for those presenting to our mental health services, improved access to linked data should be used to better understand which other government services consumers are using, to both identify demand for mental health services at an earlier stage and build a greater picture of consumers' overall needs.

Service and infrastructure planning

114. As with funding for services, capital investment is mostly decided through the budget process. However, service and infrastructure planning, including asset renewal, has generally been entity based – that is, at the service level rather than the state or regional level. In particular, the planning

process for asset renewal has comprised a bottom up approach where individual health services identify needs through asset management plans and observation of defects in their existing assets, and provide this information to the Department. Capital projects are then prioritised by government based at least partly on risk, condition and funding availability.

115. As many mental health facilities are embedded in public health services, mental health capital planning and asset renewal has been tied to planning for the health services of which they form a part. This has meant that mental health planning has been a subset of master-planning for each health service, and there has been less opportunity for stand-alone community mental health services to be part of the planning process.

116. In my view, the biggest issue with entity-based planning is that it does not take a wide enough view of how all available services and assets can best meet the needs of the population; rather, it tends to assume that all demand should be met from the existing services (who lead the planning).

117. The Department is working to strengthen the planning of service responses at a statewide, regional and local level. The Statewide Design, Service and Infrastructure Plan for Victoria's Health System 2017-2037 articulates the key design principles, priorities for action, and features of locality plans at metropolitan, regional and local level.

118. Consistent with the statewide plan, the Department is increasingly moving towards a region and locality-based planning approach rather than the usual approach for most capital projects, which have occurred at an individual health service entity-based process.

119. A regional approach allows consideration beyond a single entity to understand the service availability and gaps across a geographical area. In turn, this enables a coordinated approach to address gaps, achieve efficiencies of scale, and ensure an appropriate range of service capacity and capability across the region.

120. This is consistent with my view that the state should set the strategic parameters for service and infrastructure planning to ensure consistency in quality and access. At the regional level, operational commissioning structures should ensure that PHNs, the state, the Commonwealth and health services work together to prepare joint assessments of need, including unmet need, that are developed with consumers, publicly available, and acted upon.

121. The work the Department has undertaken to establish geographic 'clusters' to support the health response to COVID-19 provides a platform for a regional approach to planning. Clusters, which I elaborate on in Part 4 of this statement, are a regional governance arrangement whereby partnerships between entities delivering healthcare in a local area are formed to better coordinate the delivery of services.

122. Beyond the pandemic, clusters offer the opportunity for a regional population health approach to planning and delivering care. The new public health functions that have been devolved to local areas could be viewed as a first step towards a population view of planning and delivery across a catchment, rather than on an entity basis.

Funding

123. Funding is a feature of all government related service delivery, but in the context of commissioning, it is used as a tool that can incentivise and appropriately price the delivery of mental health services.[16]

124. The overall amount of public funding available for service delivery is set by government through budget decision making processes. Although those decisions are not the responsibility of departments, they are to some extent amenable to departmental influence, through for example the quality and depth of analysis in a department's budget submissions, and the level of confidence that a department is able to provide government about the return on previous investments. Systems with funding models that better enable them to demonstrate the links between the investment of additional resources, the delivery of additional services, and the outcomes of such delivery are in a stronger position to advocate for scarce public funds in the budget processes of government.

125. The Department's monitoring of performance and outcomes is dealt with in a later section of this statement. In this section I will focus on how the Department allocates funds to mental health services, including what we refer to as a funding model.

Current approach to funding

126. Following deinstitutionalisation in the mid-1990s, the funding for mental health services was allocated by redistributing the budgets of decommissioned institutions according to a weighted population formula, which included factors for socio-economic disadvantage, the density and structure of the population. This once-off redistribution was not accompanied by a mechanism for annual adjustment to reflect population growth or change, or any other drivers of demand for mental health services, such as population ageing and co-morbid drug use, which has led to inequities in funding arrangements over time.

127. In an effort to address these inequities, each year the Department measures population by total mental health emergency department presentations and the Socio-Economic Indexes for Areas (**SEIFA**) Index of Relative Socio-economic Disadvantage (**IRSD**) weighting.

128. This assessment allows the Department to conduct an annual review of the distribution of clinical community (ambulatory) care funding to adjust allocation of new or growth funding to health services. Over time, this has worked to partially offset historical inequities, while primarily allocating funds toward historical service utilisation.

Activity-based funding

129. As the Royal Commission will be aware, the Department is currently developing an activity-based funding (**ABF**) for mental health.

---

[16] Kym Peake, Witness Statement to the Royal Commission into Victoria's Mental Health System (2019) 30.

130. Activity-based funding is essentially a mechanism for transparent and auditable funding of public services and, when priced according to consumer-level costing systems, can fund service providers according to the true cost of delivering services.

131. This model will provide greater accountability for use of scarce resources, and its primary objective is to incentivise efficient use of funding. It also provides a clarity on how much has been spent on what in terms that the Department of Treasury and Finance understand, which will strengthen the case for increased investment in mental health by government.

132. Another advantage of activity-based models is the direct connection they make between the price of activity commissioned and the cost of that activity, as revealed by consumer-level costing data. In this way it allows us to hold mental health services financially accountable for efficient use of the funds they receive.

133. In my view, a nationally consistent approach to ABF should be developed as quickly as possible. I note that IHPA is working towards trialling a form of ABF for community mental health services in 2021-22.

Using payment arrangements to incentivise behaviour

134. When designing and implementing any new funding model, commissioners must be attentive to any perverse incentives that may arise. How we fund services matters because payment arrangements, whether mental health or otherwise, can encourage or discourage certain actions that may affect our ability to achieve the best outcomes for consumers. Funding models can also signal a priority for certain policy objectives over others. Activity based funding, for example, is a funding model well suited for driving technical efficiency, but in isolation does little to drive a focus on outcomes or integration of care.

135. The Royal Commission may like to consider the following ideas to incentivise services:

    a. dedicated funding for knowledge translation to boost provider capacity to improve practices;[17]

    b. leadership from the system manager and executive support within services to take risks and empower teams to make local decisions; and

    c. use of ABF to monitor the outcome of specific interventions and funded service levels on individual consumers and, over time, to shape funding incentives or disincentives to encourage those interventions.

136. More importantly, the Royal Commission could also look to combining activity-based funding with other funding models. I believe that a combination of models is appropriate for the combination of policy objectives that must be considered by commissioners and service providers.

---

[17] Vikki Leone, Louise Modica and Sue West for the Centre for Community Child Health, *The Melbourne Children's Knowledge Translation and Research Impact Project: A Framework for Action* (Final Report, 2017) 17-20.

137. In acute care, the Department has implemented the HealthLinks initiative, which uses a capitated funding model to incentivise health services to deliver more effective types of care in settings other than hospital. The idea is that while people with chronic and complex needs are often admitted to hospital, there is great potential to reduce this need for hospitalisation, and improve consumer outcomes, through better use of integrated community-based care and active management of people's health needs.[18]

138. Early evaluations of HealthLinks have shown that it has been successful in improving patient outcomes, reducing hospitalisations, reducing expenditure and improving clinician's experience.

139. Mental health conditions are currently out of scope; however, it is worth exploring whether a similar model that incentivises earlier and community-based treatments could improve outcomes for mental health consumers.

140. It is important to note that the current model works by incentivising individual providers to rearrange their funds – purchasing non-hospital care in order to reduce the costs of hospital care. The model would need to be carefully re-designed if it is used to create incentive structures across clusters of services in a regional operational commissioning environment.

Value-based funding for a future mental health system

141. The move from funding for efficiency to funding for outcomes has been well described in literature associated with the concept of value-based health care, and I consider that a value-based health care model for funding would be a welcome part of a future mental health system.

142. Value-based health care is a framework for organising health systems around the concept of maximising the outcomes that matter to patients, relative to the total end to end cost of care.[19]

143. Jurisdictions around the world are increasingly introducing value-based health care as a strategy to deal with challenges such as a growing and ageing population, increases in chronic diseases, rising health care costs, health inequalities, unwarranted variation in care and health outcomes, and increasing patient expectations.

144. Experiences in European jurisdictions that have implemented value-based health care show that improving consumers' outcomes reduces their future care needs. A logical extension of this is that it reduces the future burden on the system and can reduce other significant social and economic costs associated with ongoing health issues.

145. It is worth noting that value-based health care is most effective when the entire care pathway is in scope, so that there is the opportunity to provide treatment to consumers at the stage where it can

---

[18] Norm Good (CSIRO), 'HealthLinks Chronic Care – Evaluation: First year results' (Presentation, Victorian Integrated Care Forum, 20 June 2018) 2.

[19] Safer Care Victoria, *Local and international perspectives on value-based health care* (Web Page June 2019) <https://www.bettersafercare.vic.gov.au/news-and-media/local-and-international-perspectives-on-value-based-health-care>.

have the biggest impact at the lowest cost. This is often in primary care, where effective care can prevent the need for more intensive interventions, such as hospitalisation, by two-thirds.

146. However, we do not currently have the pre-requisite system-level and service-level enablers to implement value-based health care in our mental health system, and we will need to address these before we can implement a truly value-based funding system.

147. These enablers include:

    a. a strong understanding of clinical costings and service utilisation data;

    b. a set of measurable consumer outcomes that are self-reported and demonstrate the health and happiness of consumers, as well as clinical indicators that show improved population wellbeing;

    c. workforce engagement and buy-in; and

    d. flexibility in funding, to be able to incentivise the right kind of outcomes for consumers.[20]

148. If we can build these enablers into our system, I think that, with adequate service- and system-level support, a value-based health care approach to funding has great potential to improve outcomes for consumers while also increasing efficiency of funding.

Performance monitoring, data and reporting

149. Performance monitoring is the third key function in the commissioning cycle and an integral part of maintaining an accountable and continuously improving mental health system. Performance monitoring is a powerful tool to drive better outcomes for consumers and provide stronger oversight across the entire mental health system.[21]

150. The objectives of effective performance monitoring are:

    a. holding funded agencies accountable to government and to the community;

    b. ensuring quality and safety for consumers, their families and carers, and the workforce;

    c. improving efficiency in how funds are allocated across the system; and

    d. supporting services to continuously improve their performance.

Performance monitoring

151. Performance monitoring is an important component of both strategic commissioning and regional operational commissioning. At both levels, performance monitoring should focus on outcomes, and support system and service improvement to achieve those outcomes.

152. The performance of Victoria's mental health system is measured through two related suites of activity:

---

[20] Ricarda Milstein and Jonas Schreyoegg, 'Pay for Performance in the Inpatient Sector: A review of 34 P4P Programs in 14 OECD Countries' (2016) 120(10) *Health Policy* 1125.

[21] Kym Peake, Witness Statement to the Royal Commission into Victoria's Mental Health System (2019) 33.

a. System monitoring through reporting on outcomes and budget measures: these provide accountability from government to the community by articulating a shared vision for the mental health of Victorians, reporting on how we are tracking against that vision, and acquitting against budget commitments.

b. Service monitoring through performance management frameworks and service agreements: these provide accountability from health services to government and the community by enabling a consistent approach to monitoring service performance against agreed indicators.

153. At the system level, the Royal Commission will be aware that an outcomes framework for mental health in Victoria was first articulated in *Because mental health matters*, the Victorian Mental Health Reform Strategy 2009-2019. It is my experience that, as research and data evolve over time and increase our understanding, outcomes frameworks must also be iteratively updated and improved to reflect consumer experiences, contemporary priorities and evidence. As we learn more about how to measure experiences and outcomes, we will keep improving the mental health outcomes framework, and the indicators that sit under it.

154. At the service level, performance monitoring arrangements are articulated through the Victorian Health Services Performance Monitoring Framework (**VHSPMF**), which sets out how the government monitors Victorian public health services and hospitals, including mental health services. It describes the performance expectations and mechanisms used by the Department and outlines the strategic and operational aspects of monitoring and improving health service performance.

155. Under this framework, the Department also supports health services and their boards to monitor performance and prioritise mental health service delivery through the following levers:

a. Statement of Priorities (**SoP**);

b. feedback mechanisms, such as regular meetings;

c. support for boards; and

d. audit and review mechanisms.

156. At the service level, performance monitoring provides a strong signal about the state's priorities to health services. For mental health to receive an appropriate amount of attention from services, we need to ensure that we measure the things that we want to see improve.

157. The recently developed Mental Health Performance and Accountability Framework (**PAF**) will go some way to achieving this, by providing mental health service delivery specific performance indicators and reporting for mental health.

158. In practice, the PAF provides a structure and a set of indicators that can be used for regular monitoring of the implementation of mental health policy, performance of clinical mental health services, and the individual outcomes for people receiving mental health treatment and care. To support these activities, the indicator set that underpins the PAF will be used to develop reports, provide data to services, and guide performance discussions with services.

159. I also note, as an overarching comment, that performance monitoring should be structured to take equity into account across all levels and domains of activity – that is, the minimisation of avoidable differences in health and mental health outcomes between groups or individuals. This can be done by ensuring that, wherever possible, the data that underpins measures is analysed for different population groups and sub-groups across the determinants of health, the health system and health status.

160. I believe that, working alongside the VHSPMF, the PAF will be a critical tool in ensuring that the Department and its funded services have a clear and evolving framework to measure our progress against implementing the Royal Commission's recommendations.

161. As the Royal Commission is aware, health services are accountable to government on the basis of performance indicators drawn from the VHSPMF, articulated through a yearly SoP.

162. Although I believe that, in their current form, SoPs have been an effective tool to drive service performance, particularly in physical health, I do think they could be improved to better enable performance oversight of both individual mental health services and the broader mental health system.

163. As a companion to the VHSPMF, the PAF will support health services to include an appropriate balance of mental health indicators in their SoPs and in their strategic planning more broadly. This will be particularly important for improving performance monitoring and continuous improvement of community health services.

164. In Victoria, health services boards and CEOs are ultimately responsible for the health services' performance against the yearly SoP agreement. The Department and its agencies support CEOs and boards to build skills and capabilities in clinical governance and other information required to ensure high quality and safe care. This is done through the delivery of training, guidance and resources for skill building in governance, leadership, and risk management.

165. To confidently understand and prioritise mental health, boards need to understand the clinical governance of mental health in the same way they understand the clinical governance of acute services. [22] To remedy this, I think we need to ensure that boards consider community and acute mental health expertise when looking at their breadth of experience, and take action to address any gaps through member selection and upskilling.

166. Victoria has a statutory requirement that each public health service board establish a community advisory committee.[23] While the current guidelines for these committees do encourage health services to prioritise appointing consumers who represent the diversity in their communities, there is no specific requirement to include consumers with lived experience of mental health services.[24]

---

[22] Felicity Topp, Witness Statement to the Royal Commission into Victoria's Mental Health System (2019) 8.
[23] *Health Services Act 1988* (Vic) s 65ZA(1)(a).
[24] Department of Health and Human Services (Vic), *Community Advisory Committee Guidelines: Victorian Public Health Services* (May 2006) 9.

167. These guidelines could be strengthened to require the community advisory committees to include consumers and carers with lived experience of mental health issues, to ensure that boards are able to understand and respond to the mental health needs of their local communities.

168. I hope it is clear that I strongly support managing the mental health system according to clear objectives that are monitored at a service and system level. However, I note that any system that is managed by measuring outcomes and objectives brings with it a risk of encouraging perverse behaviours at all levels, particularly if progress towards outcomes is flagging.

169. One of way of addressing this issue that I think has merit is to build independent external scrutiny and oversight into the system design. An interesting example of this approach is New Zealand, which has recently established an independent Mental Health and Wellbeing Commission in response to their own inquiry into their mental health system.[25] This Commission will provide system-level oversight of mental health and wellbeing as a way of ensuring that the government of the day is held to account for the mental health and wellbeing of people in New Zealand. In this way, the Commission contributes to effective strategic or system wide commissioning.

Data and reporting

170. Effective commissioning depends on the availability of fit for purpose, timely, high quality data, drawn from an appropriate range of sources and research methods, if they are to be effective in driving improved outcomes for consumers.

171. It is critical that system managers are open to learning from other jurisdictions by scanning work being done locally, interstate and internationally. While there is no one jurisdiction that is clearly excelling in mental health service performance monitoring for improving outcomes, we adapt evidence and ideas that make sense to implement in Victoria.

172. In Victoria, as the Royal Commission will be aware, Victorian Agency for Health Information (**VAHI**) is responsible for providing reliable, accurate and actionable data and information to stimulate quality and safety improvements across both the health and mental health sectors.

173. VAHI provides regular reports to health services, including about mental health, targeted at both executive and board members, to monitor performance and drive improvement. The data and analysis provided by VAHI enables health services to reflect on their performance, identify opportunities to improve, and monitor their progress.

Consumer outcomes data

174. It is also important that we capture the outcomes and experiences that are meaningful to consumers, families and carers if we are to improve service performance.

---

[25] Ministry of Health (New Zealand), Mental Health and Wellbeing Commission (Web Page) <https://www.health.govt.nz/our-work/mental-health-and-addictions/government-inquiry-mental-health-and-addiction/mental-health-and-wellbeing-commission>.

175. In Victoria, consumer outcome measurement is most commonly done through Patient-reported outcome measures (**PROMs**) and Patient-reported experience measures (**PREMs**).

176. In Victoria, the Your Experience of Service (**YES**) survey instrument is the strongest mechanism for capturing PROMs and PREMs from consumers, including clients of community-based services. It aims to help mental health services and consumers to work together to build better services.[26]

177. The YES survey reach could be expanded by including children down to 12 years and including adults over 65 years.

178. Work is also underway to introduce a Carer Experience Survey (**CES**) to provide specific information about mental health carers. This has been delayed due to the COVID-19 pandemic, but is anticipated to run in 2020-21.

179. One other means to engage boards with the consumer experience is providing opportunities for them to hear personal stories, delivered in writing or in person, as part of performance oversight. These stories might be from a consumer, carer, family member, visitor or staff member.

180. These are small steps, however, and I think we can do more to aggregate consumer outcomes and feedback and use them, along with other data and inputs, to drive improved performance at both the system and service level. A Commission, as in the case of New Zealand, may champion and support that.

181. Finally, it is important that outcome measures are not narrowly defined by diagnoses or treatments, or even confined only to mental or physical health. Mental illness can have multiple contributing factors and precipitants, and social and physical health conditions have consequences for mental health. Outcome measures in mental health should ideally be combined with others, to capture the widest view of health and wellbeing.[27] This would allow consumers and professionals to evaluate together the supports and services provided in the context of a person's whole life, and make decisions about next steps in recovery.

CMI/ODS

182. As noted further below, the primary source of data from Victorian mental health services is collected via the CMI/ODS. This system has captured activity data over a 20-year period, which allows studies of multiple-year care journeys for clients with similar severity and clinical conditions, including their long-term treatment outcomes.

183. However, data collection – and therefore analysis, synthesis and dissemination – is significantly hampered by the legacy CMI/ODS data system, which does not currently collect a complete set of data to support performance monitoring. Unfortunately, there is a long lead-time to make any changes

---

[26] Australian Institute of Health and Welfare (Cth), *Mental Health Services in Australia* (21 July 2020) <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/national-mental-health-committees/mental-health-information-strategy-standing-committee/your-experience-of-service-survey-instrument>.

[27] The 'flourish' measure developed by Harvard University's Institute for Quantitative Social Sciences is one example: <https://hfh.fas.harvard.edu/measuring-flourishing>.

to CMI/ODS, which limits the Department's ability to make improvements to collect data to inform policy and practice.

184. In particular, it would help if services were able to improve reporting of family-focused treatment and if consumers receiving treatment are parents. For example, as part of its service agreement, the Families where a Parent has a Mental Illness (**FaPMI**) program completed a one-time statewide audit of whether providers are delivering family inclusive treatment and shared the report with psychiatrists to inform their practice. It would be preferable for FaPMI to collect such data through CMI/ODS, but making the necessary changes would take up to a year.

185. Improved access to data could also assist clinicians in delivering treatment. For example, services input a lot of data into CMI/ODS, but they cannot easily produce live reports or graphs in a timely way to track progress and outcomes. If this functionality was available, clinicians could use 'live' trend data with clients in sessions and in clinical reviews to track clinical- and consumer-rated outcomes and progress. A new system could support clinicians to contemporaneously enter outcome measures and data from a service contact with a consumer.

186. I would like to see the rich longitudinal data contained in CMI/ODS used in studies to help to identify the most appropriate interventions or treatments and other important drivers in consumers' recovery. Findings from such studies can help to develop effective policies and encourage best practice across services.

187. As the custodian of multiple data sets across both health and human services, the Department has access to a rich amount of data that, when linked, is an important way to improve evidence-based policy development, planning and service delivery.

188. For these reasons, it will be important for the Victorian Collaborative Centre for Mental Health and Wellbeing – to be established in response to a recommendation in the Royal Commission's interim report – to work closely with VAHI and the Department to have access to CMI/ODS data, along with any new data that may be generated through new systems.

PART 3: SERVICE DESIGN IMPROVEMENTS TO SUPPORT A STEPPED CARE APPROACH

Strengths and weaknesses of stepped care

189. The Royal Commission has asked me to comment on the strengths and weaknesses of stepped care models for mental health.

190. The Victorian Government supports a stepped care approach to the design of the mental health system, and the gaps we need to address to achieve this are described in the Whole of Victorian Government (**WoVG**) submission to the Royal Commission.

191. Stepped care brings the focus of care onto the consumer and allows greater opportunity for services to be oriented around the unique needs of individuals.

192. On a pragmatic level, aligning Victoria's mental health system design to the nationally agreed model of stepped care will support a cohesive approach between Commonwealth-funded primary care, as guided by PHNs, and state-funded community and acute care. This will, in turn, facilitate access to a wider range of services across a seamless continuum of care.

193. Stepped care also supports efficiency in the use of government funds through appropriate use of resources, aiming for the least intensive, least costly interventions as clinically appropriate. Stepped care is therefore a cost-effective approach to delivering care, as it optimises resource allocation.[28]

194. A stepped care model also has benefits from a clinical perspective, because it aims to create a complete system of care that maintains a recovery focus irrespective of the stage of illness or level of treatment intensity.

195. The stepped care model recognises that individuals seeking help for mental health issues are not a homogenous group and that different environmental and psychosocial factors can influence mental health and support and treatment needs at different times. Stepped care brings the focus of care onto the consumer and allows greater opportunity for services to be oriented around the unique needs of individuals.

196. Limitations with stepped care are largely related to how the model is implemented at the operational level, rather than limitations with the model itself. There is currently great diversity in operational-level service delivery models, arrangements and system capacity. As with any system or service design model, when elements of a stepped care system do not perform as intended, challenges arise.

197. This diversity has arisen because, unfortunately, there are gaps in the evidence base – or at least a lack of consensus on the evidence – about key service delivery considerations such as:

    a. how many clinicians and which disciplines should be involved in care;

    b. when people should be stepped up and down in intervention intensity and based on what criteria; and

    c. who should conduct initial assessments, noting the importance of such assessment in determining at which level of intervention intensity a consumer enters support or treatment.[29]

198. The resulting variability in how stepped care is operationalised can influence the model's effectiveness and the outcomes achieved. The stepped care model is particularly sensitive to on-the-ground decision-making, where local factors play a pivotal role in a consumer's pathway – a statewide strategic commissioning framework, strong clinical governance, collaborative operational

---

[28] Fiona Yan-Yee Ho et al, 'The Efficacy and Cost-Effectiveness of Stepped Care Prevention and Treatment for Depressive and/or Anxiety Disorders: A Systematic Review and Meta-Analysis' (2016) 6(1) *Scientific Reports*.

[29] Timothy Carey and Raechel Damarell, 'A Systematic Review Investigating the Comparative Effectiveness and Efficiency of a Multi Clinician Stepped Care Workforce vs. a Single Clinician Stepped Care Workforce for Delivering Psychological Treatments' (2018) 4(2) *Annals of Behavioural Science.*

relationships and service delivery supported by clear and consistent guidance would minimise this variability.[30]

199. There are also workforce challenges in ensuring that strong, positive therapeutic relationships between service providers and consumers are maintained as consumers move between steps of care. Similarly, consumer preferences and previous experiences with specific services, including individual clinicians, can alter a treatment pathway for better or worse. There is also a risk that, if services are not working from a consistent, evidence-based framework, consumers may be referred to higher or lower intensive treatment options that do not adequately meet their need.

200. In addition to these key determinations at the operational level, system capacity constraints and the relationship between services can also impact the model's effectiveness. The stepped care model assumes there are adequate resources available for all steps in the model, and that appropriate referrals and collaboration occurs, however this is not always the case.

201. For example, a lack of capacity or capability in primary care or community-based treatment means that people often miss out on early lower intensity care, and therefore end up entering the system at crisis point. In Victoria, community-based mental health services that can provide early intervention to prevent conditions worsening are significantly constrained, resulting in consumers entering the system needing a higher level of intensity intervention at the more costly end of the system.

Determining how much of each type of care consumers need

202. As I have highlighted, a key challenge of the stepped care model is the lack of standardised, evidence-based guidance to support services to determine the right intensity and duration of care for consumers across the course of their treatment.

203. The Royal Commission may wish to consider two foundational principles when thinking about how such guidance could be developed:

    a. **Least burden**: effective low-intensity treatments are offered first with high-intensity treatments only offered to consumers who are at risk to self or others, have a previous history of treatment failure, or do not improve with initial treatment.

    b. **Scheduled review**: enabling patients to step up to more intensive treatments, step down to lower level intensity interventions, or change to another intervention within the same step. Scheduled reviews should use objective outcome measures to assist decision-making.[31]

204. Evidence-based guidance is also required to support service and clinical decision-making in the following areas:

---

[30] David A Richards et al, *Developing Evidence-Based and Acceptable Stepped Care Systems in Mental Health Care: An Operational Research Project* (Final Report, NIHR Service Delivery and Organisation Programme, August 2010).

[31] David A Richards et al, 'Delivering Stepped Care: An Analysis of Implementation in Routine Practice' (2012) 7(3) *Implementation Science.*

a. optimal number of steps;

b. range of treatments within steps;

c. duration of interventions;

d. under what circumstances patients might bypass low-intensity treatments and be referred directly to higher intensity treatments;

e. degree to which stepped care systems should be responsive to local context; and

f. process of decision-making about 'stepping up' to a higher intensity of care or 'stepping down' to a lower intensity.

205. I would also suggest that the Royal Commission consider the care profiles developed under the National Mental Health Services Planning Framework (**NMHSPF**). These include a baseline for the average time and quantity of treatment required during a 12-month period (minutes, hours or days) for 155 different care profiles.[32]

206. While not explicitly designed for incorporation into a stepped care model, the care profiles may provide further evidence-based guidance and allow a level of standardisation or uniformity to reduce implementation challenges associated with the current variance in operationalising the stepped care model.

207. Workforce structures and capabilities are also a key factor in determining levels of care. For example, in Australia and the United Kingdom, new workforces have been introduced to assist in the implementation of the stepped care model. In Australia, the role of 'coach' – similar to Psychological Wellbeing Practitioners (**PWP**) used in the United Kingdom – is used in lower intensity interventions as part of the NewAccess program, which is funded by the Commonwealth Government and delivered by service providers commissioned by PHNs.[33]

208. I am aware that there are some alternative models to stepped care, such as the clinical staging care model and stratified models of care. However, my knowledge of these models is not such that I can offer a view on them.

209. Given that the stepped care approach is both nationally agreed and endorsed by the Victorian Government, and that challenges with this model in meeting the needs of the community are related to investment and implementation rather than the model itself, I am supportive of identifying solutions to existing problems with the model rather than Victoria taking a different approach to its mental health system design.

---

[32] National Mental Health Commission, *National Mental Health Services Planning Framework* (2011).
[33] BeyondBlue, *About NewAccess* (Web Page, 2020) <https://www.beyondblue.org.au/get-support/newaccess/about-newaccess>.

Primary care's role in mental health

210. The Royal Commission is interested in my views on the best ways to strengthen primary care responses and opportunities to create better pathways between primary care and other services.

211. Most people seek help from GPs as a first port of call for a range of health issues, including mental health concerns, as the Royal Commission recognised in its interim report.[34] For this reason, primary care plays a critical role as a gateway into stepped care, by identifying mental health issues, providing low level interventions, referring to other services when clinically indicated and maintaining oversight of care as consumers move through steps of care. However, the primary care sector has been underutilised in its role in mental health care.

212. Enhancing the role of primary care in mental health is therefore key to broadening the range of services provided to mental health consumers and addressing critical service gaps such as meeting the needs of the 'missing middle'.

213. Due to the split of funding between state and Commonwealth governments, enhancing the role of Victorian primary care providers in mental health is inextricably tied to the Commonwealth. We should look to partnerships and opportunities to undertake joint or co-commissioning with the Commonwealth through PHNs to close the missing middle gap.

214. The strategic commissioning framework should articulate how partnership arrangements with PHNs and other area based primary care services should be strengthened through a shared vision that incorporates joint regional planning, shared governance and joint or aligned commissioning.

215. I would like to make special mention of self-determination for Aboriginal communities. Under current arrangements, Aboriginal Community Controlled Health Services (**ACCHOs**) are contracted to deliver services by PHNs in a similar way to mainstream organisations. This arrangement is limiting Aboriginal self-determination and therefore is having a negative impact on Aboriginal health.[35]

216. It is my strong view that ACCHOs need to be part of the stepped care model in their own right and be considered as independent organisations, not only as subcontracted providers. This would give them an equal voice at the table in joint needs analyses, planning and pathway development. This is vital to enable ACCHOs to enact Aboriginal self-determination at a local level, enabling them to deliver holistic and culturally appropriate healthcare to Aboriginal people.

Financial incentives

217. There are opportunities for the Commonwealth to provide stronger incentives for the primary care sector to increase its engagement in mental health through the Medicare Benefits Schedule (**MBS**) and other arrangements, such as initiatives that use patient enrolment and bundled payments.

---

[34] *Royal Commission into Victoria's Mental Health System* (Interim Report, November 2019) 68.
[35] Coombs, D. *Primary Health Networks' impact on Aboriginal Community Controlled Health Services*. Aust J Publ Admin. 2018; 77: S37– S46. https://doi.org/10.1111/1467-8500.12357

218. The declining value of Medicare rebates has impacted the viability of some primary care services that support mental health. This is particularly acute in rural and regional primary care practices, where the communities they support are often under financial pressure from events which simultaneously impact on mental health and wellbeing, such as drought and bushfires.

219. The introduction of the Commonwealth's Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (**Better Access**) initiative was a significant step forward in recognising the financial barrier for individuals in accessing mental health treatment, as well as putting primary care in a key position to engage with consumers about their mental health.

220. However, the level of support provided under the Better Access initiative is not adequate for many people.[36] The difference between the health professional's fees and the Medicare reimbursement results in an out-of-pocket expense for the consumer if the practitioner does not bulk-bill, as do any sessions beyond the 10-session limit. This is not affordable for many Victorians, leading people to ration their 10 sessions throughout the calendar year, rather than seeking treatment when they require it.

221. Lifting the cap on the number of treatment plan sessions in the Better Access initiative would, alongside other changes, improve a consumer's continuity of care, reduce the risks associated with mental health needs going unmet, and provide links between primary care and a range of specialist mental health providers in their local area.

222. Taking the Better Access initiative approach a step further, another way to increase the focus on mental health in primary care settings is through voluntary patient enrolment. This approach is used in several countries with comparative health systems including Denmark, New Zealand and Canada.

223. Patient enrolment generally involves the GP enrolling patients of theirs who would benefit from the program, or a patient nominating a GP or a primary care practice who provides enhanced care and support for their chronic conditions. In return for this additional support, the GP or practice receives regular payments.[37]

224. Such bundled payments generally offer a lump sum to treat a specific diagnosis on the basis of expected cost. Services, or different elements of care, are grouped together into the one payment. This approach is different to fee-for-service, where services are provided on a transactional basis. It offers an alternative funding model that can incentivise care providers to coordinate care to achieve better outcomes for consumers, such as improved continuity of care and better management of their health information, while reducing health care costs.

225. To date there has been limited utilisation of this model in Australia, but it has been tested through the Diabetes Care Project, the Coordinated Veterans Care Program and the Health Care Homes initiative.

---

[36] Productivity Commission, *Mental Health* (Draft report, October 2019) vol 1.

[37] Department of Health (Cth), 'Statement from the Chair – MBS Review Recommendations Accepted by Government', *Health.Gov.Au* (Web Page, 4 April 2019) <https://www1.health.gov.au/internet/main/publishing.nsf/Content/statement-from-the-chair-mbs-review-recommendations-accepted-by-government>.

226. The Health Care Home initiative is particularly interesting. A Health Care Home is a medical practice, such as a GP practice or an Aboriginal community-controlled health service, that acts as the 'home base' for the coordination, management and ongoing support for people with chronic and complex conditions.

227. The interim evaluation of Health Care Homes included positive early indications reported by patients, practice staff and carers. This includes patients reporting high levels of trust in their GPs and that they appreciate changes that make it easier for them to access care, while carers reported improved experiences in their interactions with the medical practice and benefits for the person they care for. Practice staff reported increased opportunities for autonomy and responsibility for nurses and less pressure on GPs, as well as better team coordination and opportunities to strengthen relationship with patients.[38]

228. Ultimately, a key lesson from the trial of Health Care Homes is that joint governance and accountability arrangements take time to establish. Further, it takes time to implement change and build trust – the importance of allowing enough time at the commencement of such initiatives for participating services to be properly prepared and putting the right arrangements in place to support them should not be underestimated.[39]

Strengthened referral pathways

229. For primary care to fulfil its role in a stepped care approach as a gateway into services, it is critical that there are clear referral pathways between primary care and other steps delivered in settings such as area mental health services and hospitals.

230. One example where clear referral pathways have improved coordination of care between primary and acute health is HealthPathways, a free online manual and portal funded by PHNs and used by clinicians. It provides a clinical pathway for GPs for various diseases, and assists in referral and best practice approaches tailored to the local context.[40]

231. HealthPathways uses a collaborative and structured approach to coordinating patient care across the acute and primary care interface and brings together GPs, specialists, nurses and allied health professionals to discuss optimal assessment and management of common medical conditions, including when and where to refer patients. New pathways are constantly developed with existing pathways peer-reviewed to reflect changing clinical evidence, technological advances and the local health service system.

232. While mental health and AOD are two elements that have been incorporated into many local HealthPathways in Victoria and Australia, they are not yet universal. I would advocate for HealthPathways to be broadened and linked directly to the acceptance and management of referrals

---

[38] Health Policy Analysis for the Department of Health (Cth), *Evaluation of the Health Care Homes Program* (Interim Report, 2019) vol 1, 8-9, 17.

[39] Health Policy Analysis for the Department of Health (Cth), *Evaluation of the Health Care Homes Program* (Interim Report, 2019) vol 1, 8-9.

[40] 'What is HealthPathways?', *HealthPathways Community* (Web Page) <https://www.healthpathwayscommunity.org/About>.

to hospitals and specialists, and that these pathways are measured in routine data collection to understand the impact on consumer outcomes.

233. Promotion of HealthPathways as part of a stronger focus on mental health in the primary care sector would support faster access to a range of useful resources and local services for GPs.

234. Another example of ways to strengthen referral pathways for primary mental health care is social prescribing. Social prescribing provides primary care practitioners with a referral pathway to a range of low-cost, low intensity supports that improve health and wellbeing. It encourages the uptake of evidence-based, non-pharmacological and low-cost treatments for mental illness, and can also improve wellbeing through reducing loneliness, among other issues. It is also something that can easily be done across metropolitan, rural and regional areas.

235. For example, based on the UK NHS social prescribing model, IPC Health, a community health organisation in the western suburbs of Melbourne, is trialling social prescribing in the Brimbank area. Preliminary results showed that consumers engaged in the trial had self-reported increased wellbeing indicators.

Workforce initiatives

236. To utilise an MBS or PBS funded item, a consumer needs to be able to access a member of the workforce that can deliver that item. Access to MBS services, particularly for lower-income consumers, has also been undermined by the non-indexation of Medicare rebates over a long period, resulting in prohibitive co-payments, as mentioned above, and reducing the availability of bulk billing.

237. One means of improving equity of access to MBS or PBS is through action at the medical workforce level, for example through programs to incentivise retention of GPs in regional areas or under-serviced metropolitan areas.

238. Initiatives that deliver enhanced supports to the primary care workforce can strengthen the role of primary care in supporting a stepped care approach to mental health care. These include:

    a. GPs could support more people through the introduction of a GP psychiatry sub-speciality. A GP psychiatrist sub-speciality could be introduced by adding a third level of accredited training to the existing two levels set by the General Practice Mental Health Standards Collaboration. The RACGP has previously indicated its support for this sub-speciality. To provide appropriate remuneration for private GPs and incentivise the take up of this sub-speciality, the Victorian Government could advocate to the Commonwealth to give GPs who undertake such training access to MBS items that are currently only available to psychiatrists, such as rebates for longer consultations to deliver therapeutic care.

    b. In the primary care setting, there is an opportunity for general practice registered nurses (**RNs**) in particular, to be better utilised across the spectrum of mental health needs. RNs have training and skills in holistic health care delivery and are a larger and more affordable workforce than others, such as doctors and psychiatrists. They could play a

stronger role in community-based and primary care to support people with mild to moderate mental health needs to overcome barriers to accessing the support they require, including geographic barriers.[41]

c. To support primary care providers to confidently support the cohort of people in the missing middle, and to address the service gap between the primary and acute systems, secondary consultation from clinical mental health services could be made available to primary care providers to support these providers in diagnosis and treatment. Secondary consultation and specialist in-reach services could assist primary care providers with the diagnosis, treatment and management of consumers with acute conditions and medication regimens. This could be funded through adding items to the MBS that facilitate and incentivise flexible case-conferencing and in-reach services by a variety of specialist mental health professionals.

Area mental health services

239. In Victoria, public clinical mental health services are delivered by area mental health services, which are organised and delivered within geographically defined catchments. Area mental health services are also streamed by age, with different catchments and models for children and adolescents, adults, and aged persons.

240. Area-based health services should be a key part of a stepped care model, but commissioning and catchment arrangements will need to be reformed to achieve that. In this section I will address how I think commissioning needs to change; I address the geographic nature of catchments in the section on enablers for stepped care.

241. Community-based treatments delivered through area mental health services need to be strengthened to capitalise on early intervention opportunities and decrease pressure on acute inpatient beds, freeing up acute care for people with higher acuity conditions and complex behaviours.

242. Regional operational commissioning arrangements should include accountability for both bed-based and community mental health functions, with incentives for each commissioning region to focus on managing demand for preventable emergency department presentations by actions taken earlier along the continuum of care.

243. This direction is partly supported by the current arrangements whereby a single entity (i.e. a health service) is responsible and accountable for both bed-based and community mental health functions with an inherent incentive for that entity to focus on managing demand for preventable emergency department presentations by actions taken earlier along the continuum of care.

---

[41] See for example the Commonwealth-funded Mental Health Nurse Incentive Program where mental health nurses provided consumers with flexible, one-on-one treatment and support, in collaboration with GPs (Department Health and Ageing (Cth), *Healthcare Management Advisors: Evaluation of the Mental Health Nurse Incentive Program* (2012)).

244. That is, there can be a dual focus on providing community-based services to intervene and reduce psychosocial stressors and prevent psychiatric crises that drive presentations and admissions, while also not discharging consumers too early or without appropriate support in place that may result in a re-admission.

245. I think that community health services should play a greater role in delivering mental health services through a stepped care model. Community health services provide a wide range of both universal and targeted health and social services. They are either integrated with public health services, or independent registered services that are companies limited by guarantee.

246. I agree with cohealth in its submission to the Royal Commission, where it argues that community health services are particularly well placed to deliver increased mental health services at the mild to moderate level of acuity. Community health services work from a social model of health, which means that they are knowledgeable and experienced in providing integrated care that addresses the holistic needs of consumers. They understand their local communities, and are thus often better at engaging with vulnerable communities than larger public health services or other government services.

Streaming in area mental health services

247. The Royal Commission has asked me to discuss streaming, its design principles and implementation considerations.

248. Streaming of mental health services is a way to tailor treatment for cohorts of people who have common characteristics and needs. Streams of care can be defined by consumer demographics such as age, cultural background or gender, and/or by other characteristics such as the consumer's level of acuity, diagnosis or behaviours.

249. In Victoria, by definition, area mental health services are streamed by acuity, as generally the impact or severity of the condition rather than a specific diagnosis triggers access. Further streaming within those services occurs based on age, as outlined in the section above.

250. I am broadly supportive of retaining age-based streaming for area mental health services, alongside complementary statewide services for lower demand or higher clinical acuity and complexity services.

251. However, as with health care overall, I think that specialised or streamed services should sit within a continuum of services across the steps of care. At all points of care, assessments should be patient focused and able to identify and address a range of needs that may be impacting on a consumer's mental health.

252. As the Royal Commission has heard, there also needs to be consideration given to ensuring that consumers are safe and supported to recover, which may at times mean further streaming for some consumers along gender and behavioural lines.

253. A further challenge with streaming is that by sorting consumers into categories, challenges arise for those who may fall into multiple streams, along with the risk that treatments offered will not address the intersectional factors in a person's life that may be impacting on their mental health. To mitigate such challenges and risks, it is worth considering some principles to guide streaming.

Principles underpinning approaches to streaming

254. In its interim report, the Royal Commission proposed that future planning will need to consider how mental health services can better support the streaming of cohorts with different needs, moving beyond basic considerations of age and acuity. I agree that we need further consideration of these treatment streams, and system supports must be in place for different streams to be effective and viable.

255. Fundamental to an alternate streaming approach are enablers, such as physical infrastructure and workforce capabilities, that are cohort-specific to support the system to appropriately treat different streams. This could include ensuring that services offering treatment predominantly for one stream have access to expertise to be able to address consumers' intersecting needs.

256. This also means developing new models of care for those who are not currently well-supported by the system, such as non-forensic consumers who pose a risk to others, consumers with a dual-disability or dual-diagnosis, or older Victorians who are not having their needs met through existing residential services.

257. Safety and quality need to be the paramount guiding principles in making these decisions. Later in this part, I discuss capability frameworks, which can be a useful way of ensuring that services have the right mix of skills, infrastructure and equipment, clinical support services and clinical governance to safely deliver the scope of services described for any particular stream.

Considerations for specific streams

258. While I am broadly supportive of retaining age-based streaming for area mental health services, alongside complementary statewide services for lower demand or higher clinical acuity and complexity services, I think that some reform is needed in their design.

259. Children and young people need a different mental health service response to adults. A new approach to child and youth mental health services should include:

    a. Developing a shared understanding, language and referral approach across service sectors;

    b. creating robust, age-appropriate pathways across and between all types of services, including clarifying roles and responsibilities; and

    c. focusing on developmentally appropriate and family-centred care (rather than demarcating by age).

260. Likewise, aged persons mental health services require specific expertise, as older people face special physical and mental health challenges. Mental health problems in the aged are under-identified by health-care professionals and older people themselves, and the stigma surrounding these conditions makes people reluctant to seek help. For these reasons it will be important for the Royal Commission to consider how to improve aged care mental health access and quality, including an emphasis on better outreach into aged care services.

261. More streaming for gender specific services (inclusive of transgender and gender diverse people) should be considered to improve safety and enable delivery of more appropriate care. Many inpatient facilities do not allow appropriate segregation of consumers or have equipment to manage sexual safety breaches. Outdated acute and residential infrastructure is impeding services from offering gender-specific environments, which increases the risk of sexual and physical assault.

262. I also think we could further develop the consultant-liaison role in the treatment system. This would enable consumers to receive specialised treatment for a health or mental health diagnosis, without having to be sitting within that stream. This is particularly important for complex consumers and those with a dual diagnosis.

263. In practice this would mean that a consumer receiving bed-based treatment for post-natal depression who also required treatment for bulimia would be able to have targeted interventions by a dietician and psychologist for an eating disorder in their current setting – rather than be moved to a setting that treated a stream of women with a dual diagnosis of bulimia and post-natal depression.

264. The functional benefit of this approach is that the system would not need to stream for every diagnosis, nor would a consumer need to forgo treatment for their 'less severe' diagnosis.

265. I would also note that there is also currently a degree of streaming in the provision of mental health services for cohorts that are known to require very specialised modalities of care and tailored services, such as LGBTIQA+ Victorians and refugees. However, these services are piecemeal and do not always have enough capacity to meet demand. There will always be a tension between delivering streamed services for vulnerable cohorts, and building capabilities within broader mental health services to improve safety and recovery outcomes for vulnerable consumers.

266. The response need not be an either/or approach – rather, the key principle here is to provide choice for consumers, so that they can choose to access a streamed service specific to their needs (even if it is not in their local area), or they can choose to access a more local service where they can still have confidence that they will feel safe, welcomed, and understood.

Statewide services

267. In addition to the area-based services described above, a number of specialist mental health services are delivered on a statewide basis. Statewide services have an important role to play in system leadership, direct care, consultation, education and training, and research and innovation.

268. However, some of our current statewide services have become fragmented and unable to meet demand over time due to historical decisions and funding allocations, and not necessarily based on statewide system design and strategic planning.

269. There is also disparity among statewide services in terms of their structure and maturity. Some statewide services provide a full breadth of services, from direct service delivery to consumers through to research and workforce capability building. However, others are more limited in their offering.

Determining which services should be delivered on a statewide basis

270. The Royal Commission has asked that I explain the rationale for why certain services are delivered on a statewide basis.

271. The key driver of determining whether a mental health service should be delivered at the catchment level or at a statewide level (or somewhere in between at a broad regional level) is the ability to deliver safe, high-quality care. This should be the primary principle underpinning decision-making.

272. There is a complex array of considerations in making this determination. These include service demand (including both volume and distribution), the technical expertise required to deliver the service, the capability of the workforce in relation to that technical expertise (and the ability to attract that workforce), and the cost of delivering the service (including infrastructure costs).

273. I believe there is merit in exploring whether a capability framework for mental health services in Victoria would be beneficial to guide decision-making and investment in mental health services, including decisions about which services should be delivered locally and which should be delivered at a statewide level, and to ultimately strengthen our ability to provide accessible, safe and high-quality care to our consumers.

274. The Department has committed to developing and implementing capability frameworks for major clinical streams in its Statewide Design, Service and Infrastructure Plan for Victoria's Health System 2017-2037.[42]

275. We are currently developing capability frameworks for the following clinical streams:

    a. renal services;

    b. urgent, emergency and trauma services;

    c. surgical and procedural services; and

    d. cardiac services.

276. A capability framework in relation to maternity and newborn services already exists.[43] It was first published in 2010, with the most recent Maternity and Newborn Capability Framework released in March 2019.

277. It is worth noting that five other Australian states and territories (New South Wales, Queensland, Western Australia, South Australia and Tasmania) have capability frameworks in place that include mental health frameworks or modules.[44]

---

[42] Department of Health and Human Services (Vic), *Statewide Design, Service and Infrastructure Plan for Victoria's Health System 2017-2037* (October 2017) 52.

[43] Department of Health and Human Services (Vic), *Capability frameworks for Victorian maternity and newborn services* (March 2019).

[44] See, Department of Health (WA), *Clinical Services Framework 2014-2024* (2014); Queensland Health, *Clinical Services Capability Framework*; South Australia Health, *Clinical Services Capability Framework*; Department of Health (Tas), *Tasmanian Role Delineation Framework and Clinical Services Profile*; New South Wales Health, *Guide to Role Delineation of Clinical Services* (2019).

PART 4: ENABLERS TO SUPPORT A STEPPED CARE APPROACH

Geographic catchments for clinical mental health services

278. The Royal Commission is interested in my views on geographic catchments and how they should be configured in a future system.

279. Defining service delivery through geographic location supports continuity of care and enables service models to be adapted for different communities. Catchments are useful tools to clarify service obligations, especially for consumers who are not assertive in their own help seeking and not attractive to providers.

280. However, I think that the current catchment arrangements no longer offer an adequate basis for providing accessible, sustainable and mainstreamed specialist mental health services. They include multiple clinical mental health service entities that, in many cases, lack a clear geographical relationship with the broader health services responsible for them.

A cluster-based approach to clinical mental health service delivery

281. I think that we should take the opportunity of leveraging the work that has been done through our COVID-19 response to develop partnership arrangements, or clusters, that support better coordination between primary and acute specialist mental health care to support a stepped care approach.

282. I am suggesting here that the catchment system could be replaced by mental health services being incorporated in the health service clusters. This would mean that mental health services are better aligned with health services to support integrated regional operational commissioning. This opens up potential for co-commissioning and joint work across the spectrum of care from primary to acute.

283. The geographic 'clusters' of health services that we have recently implemented are arranged in a 'hub-and-spoke' model. This model incorporates public and private hospitals, with other health providers as necessary. Each cluster has a lead health service tasked with playing a significant role in the coordination of all public and private hospitals within the cluster.

284. Each cluster is required to establish a planning, implementation and operational group. These groups include representatives of each public health service, each private hospital group, PHNs, community health services and the Department – all of whom are necessary to provide stepped care in a mental health context as well. These groups are responsible for determining the optimum model for utilising services within the cluster system, identifying requirements to support this model and coordinating treatment.

285. The clusters have been established with the following considerations in mind:

    a. population size and demography;

    b. geographic sprawl;

    c. health service activity;

d. alignment with PHN catchments;

e. health service boundaries and networks; and

f. referral pathways and relationships.

286. The overarching service system design and principles are intended to enable clusters to effectively plan for designation and flows in a way that responds to local relationships, patient movement and the level of demand in the system.

287. This experience has shown how it is possible to bring the whole of the health system together to plan and coordinate services, including both acute and community-based health services and PHNs.

Catchment size

288. If mental health services are to align with this new approach to health service clusters (which I think they should), we will also need to consider whether they are of sufficient scale and geographical coverage to meet the mental health needs of the communities they serve.

289. Mental health catchment areas need to have adequate critical mass to ensure the benefits gained from economies of scale or capacity to offer an appropriate range of safe and high-quality services are not lost.

290. The question of catchment size must also be viewed from a geographic perspective. This is more pertinent when considering mental health catchments in regional and rural areas. As with broader health and human services, there is an inherent tension with the need for critical mass to deliver safe and effective treatment, and ensuring consumers in outlying areas are not disadvantaged due to the need to travel great distances to access care.

291. I think the hub and spoke model that we are employing in the clusters has potential to address this tension, by enabling 'outpost' services to leverage the benefits of scale while still delivering local services.

Relaxing catchment boundaries

292. There also should be a relaxation of, or less rigid approach to, catchment boundaries to promote consumer choice, and to support greater access for consumers where, for geographic reasons, their designated health service is in fact not the service that is most convenient for them to attend.

293. The current catchments structure requires consumers to live within the geographic boundaries of a clinical mental health service to access treatment from that service. Anecdotally, we know that consumers are accepted into treatment by 'out of catchment' services on a case-by-case basis. However, in these instances, there can be a lack of service coordination when these consumers need access to multiple services across catchment borders.

294. Reducing the risk of consumers falling through the gaps can be achieved through a 'No Wrong Door' approach. The principle of this approach is that every door in the public support service system should be the right door, with a range of services being accessible to everyone from multiple points of entry.

This commits all services to respond to an individual's needs either by providing direct services or linkage and case coordination, rather than sending a person from one agency to another.[45]

295. The 'No Wrong Door' approach could be applied to the cluster model through a relaxation of, or less rigid approach to, catchment boundaries. This would promote consumer choice, and could support greater access for consumers who, for geographic reasons, their designated health service is in fact not the service that is most convenient for them to attend.

296. As a final comment on catchment arrangements, whatever future arrangements are put in place, it is important that the consumer and their experience are central to design decisions. Consumers should not be refused service. They should not be required to re-tell their story countless times. And the services they need should be easy to find and accessible.

The role of technology in improving care

297. The Royal Commission has asked me to discuss the ideal role of technology and the barriers I perceive in implementing digital and telehealth approaches.

298. Digital technology is a critical enabler for all aspects of commissioning for a stepped care model of mental health care. It provides flexibility in how care is delivered; and enables the capture and transfer of real-time rich information and data to both support better delivery of care across the stepped continuum, and to monitor, analyse and improve performance and outcomes at both the system and regional operational commissioning levels.

299. Indeed, we have seen rapid innovation and take-up of digital health technologies, and we should take this opportunity to embed ongoing funding and support for technology both to deliver care, and also to collect data and information.

Using technology to deliver care

300. The use of telehealth and digital technology provide opportunities to increase innovative and integrated approaches to care and can improve consumer experiences of care. For example, the use of telehealth technology has showed promise in improving service integration, supporting the work of multidisciplinary teams, and facilitating shared care approaches.[46]

301. However, there needs to be ongoing research to underpin evidence-based implementation of new modalities of care. The types of digital technology currently available will continue to increase and evolve and provide new opportunities to enhance the delivery of mental health care, and our systems will need to evolve along with them.

302. While I am broadly optimistic that increased use of digital platforms, including telehealth, will play a part in a more effective and integrated mental health system, I think it is critical that the following

---

[45] 'Mental Health Charter', *No Wrong Door, South Western Sydney PHN* (Web Page) <https://nowrongdoor.org.au/mental-health-charter/>.

[46] Karl A Stroetmann et al, *How can telehealth help in the provision of integrated care?* (Health Systems and Policy Analysis, Policy Brief 13, World Health Organisation, 2010).

principles are considered when designing digital mental health interventions and related workforce development:

a. a focus on high quality and safe services that are delivered in line with established standards of care;

b. digital technology use in mental health is informed by the experience of consumers, their families and carers;

c. recognition that digital technologies are not always a clinically appropriate platform, and the applicability of telehealth to specific service types and patient cohorts should be considered when designing interventions; and

d. appropriate education and training strategies are put in place to build workforce capability and confidence to use telehealth and other digital technology in service delivery approaches.

Mental health IT infrastructure and data capabilities

303. The Department's current information technology structure for mental health service data collection is outdated and no longer fit for purpose. Significant investment is required to redesign how we manage case information and collect data, both to improve care for individual consumers, but also to provide robust and useful data that can be used at both the system and service level to improve performance monitoring.

304. Current IT infrastructure and data capabilities for mental health are unable to support contemporary best practice approaches to service delivery in Victoria.

305. For designated clinical mental health services in Victoria, the CMI/ODS is the statewide information system for all registered mental health consumers.

306. When deployed twenty years ago, CMI/ODS was the first of its kind to provide a statewide individual electronic record in one IT system that provided real time access to consumer contact with mental health services. This technology was far superior to that of the broader health system at that time.

307. Since then, investment in IT systems and infrastructure has focused on broader health without incorporation of mental health service needs or planning for interoperability.

308. In my view, high-level considerations for any future IT system solutions for mental health would build on key functions of the CMI/ODS, including the legislative requirements of the Mental Health Act, 2014 and retaining real time and statewide access to data for all services involved in a consumer's mental health care.

309. However, an ideal future IT system would also include data from, and be accessible by, all health services involved a consumer's care, including community-based and acute services providers, EDs, primary care providers and NGOs providing mental health services.

310. The Royal Commission should be aware, however, that reform of this scale will be significant to capture the breadth of services involved in the mental health continuum and consumer pathways. It

would be of benefit for such work to occur in parallel with the Department's approach to broader health IT capability and infrastructure and ongoing digitisation program that aims to drive reform by focusing on:

a. digital clinical systems – improving patient safety and clinical effectiveness;

b. transparent clinical information – sharing improvements, safety and research;

c. clinical-grade integration and interoperability;

d. smarter data use – driving preventive health and early intervention; and

e. self-managed care – enabling people to access better information and have more control over their own care.[47]

311. Importantly, the program to digitise health care also recognises the need to create connected health and social services systems focused on the person and their individual care needs.

Shared care consumer records

312. The Royal Commission has also asked for my views on shared care consumer records, their potential challenges and benefits and implementation considerations.

313. Improvements in digital technology can also lead to improvements in how we collect and share individual consumer records, which in turn is a key enabler for stepped care. In recent years, there has been increased support for careful sharing of information between service providers to support improved service integration, higher quality care for consumers, and enhanced identification of risk.

314. Information sharing through shared records has also been raised as an enabler of increased safety and improved service delivery though the recommendations of numerous reviews and inquiries.[48] The draft report of the Productivity Commission inquiry into mental health also found that expanding the use of digital records in the mental healthcare system would facilitate greater information sharing and improve consumer experience.[49]

315. For the purpose of this statement, I define a 'shared care record' as a digital health and/or social service record that can be accessed by multiple services providers – including health, mental health and potentially other social services (as opposed to a single provider case management tool) – and sometimes also by consumers themselves.

---

47 Department of Health and Human Services (Vic), *Digitising Health: How Information and Communications Technology Will Enable Person-Centred Health and Wellbeing Within Victoria* (August 2016).

48 See for example, *Royal Commission into Family Violence: Report and Recommendations* (Summary and Recommendations, March 2016) 20, 46-8; Commission for Children and Young People 2016, Neither seen nor heard: Inquiry into issues of family violence in child deaths 8; Royal Commission into Institutional Responses to Child Sexual Abuse, vol 8 2017.

49 Productivity Commission, *Mental Health* (Draft report, October 2019) vol 1, 66.

Benefits and challenges of shared care consumer records

316. Investing in shared care consumer records brings many potential benefits for consumers, service providers and system stewards, such as:

    a. improved experiences of receiving care for consumers across the stepped care continuum, as effective information flow means care is more likely to be experienced over time as coherent and linked;[50]

    b. improved safety, for example by providing immediate access to information about current medications;

    c. empowering consumers to take a proactive role in managing their health, which is demonstrated to improve both clinical outcomes and patient satisfaction;[51] and

    d. enhance risk management efforts for those at risk of self-harm and/or harm to others.

Principles and enablers to underpin a shared care consumer record

317. I encourage the Royal Commission to consider the following principles that I believe should underpin any approach to shared care consumer records:

    a. Safety: records must be kept, stored and used in ways that protect and preserve the safety of clients;

    b. Consumer and clinical engagement: co-design with both consumers and clinicians will be critical to ensuring that any shared care consumer record project is successful;

    c. Privacy: any records solution must find an appropriate balance between privacy, safety and service delivery imperatives; and

    d. Integration: records would ideally be interoperable across mental health service settings at a minimum, but preferably across all health and social services.

318. Further, I have observed from other information sharing projects across government in recent years that the following enablers will be critical to the success of any shared care consumer records projects, and must be considered in design and implementation:

    a. legislative reform so public health services can securely share the health information required for safe patient care;

    b. upgrade of CMI/ODS to boost technological capability; and

    c. practice and culture change to support the above two reforms.

---

[50] Jeannie Haggerty, Rj Reid and Rachel Mckendry for the Canadian Health Services Research Foundation, *Defusing the Confusion: Concepts and Measures of Continuity of Healthcare* i-iv (Final Report, March 2002).

[51] 'Benefits of Shared Digital Health Records', *Australian Digital Health Agency* (Web Page) <https://www.digitalhealth.gov.au/get-started-with-digital-health/digital-health-evidence-review/benefits-of-shared-digital-health-records>.

PART 5: SUPPORTING THE MENTAL HEALTH OF COMMUNITIES THROUGH EMERGENCIES

How the Department supports the mental health of Victorians through emergencies

319. The Royal Commission has asked about the Departments role in supporting the mental health of Victorians in the lead up to, during and after an emergency or natural disaster.

320. I have mentioned various impacts of the COVID-19 pandemic numerous times during this statement, and I think it is appropriate to acknowledge here how difficult 2020 has been for the Victorian community. The pandemic, which overlapped with the devastating bushfires over the 2019-2020 summer, has had longer-lasting impacts on us than on other parts of the country. The toll this is taking on our collective mental health cannot be underestimated.

321. The Department plays a leadership role in supporting the mental health of Victorian communities and individuals before, during and after emergencies, including natural disasters. I have also been heartened by increased collaboration with the Commonwealth through recent disasters such as the 2020 Bushfires and the COVID-19 pandemic.

322. While I am proud of the work we have done to support Victorians through these emergencies, I would, however, like to see a more strategic and planned approach to managing mental health in emergencies.

323. As a foundational principal, our approach to responding to workers needs to foreground engagement with affected communities and workers so that on the ground priorities and approaches are responsive to the situation. Government can support this approach by giving as much flexibility in funds as possible, and devolving control to those communities affected by emergencies.

324. This approach will support communities to make sense of what happened and to rebuild community connections and resilience. Activities can then be locally driven and involve activities across a range of organisations such as community health centres, local councils, early childhood education and care centres and schools.

Trauma-informed approaches to service delivery

325. The Royal Commission is also interested to know about trauma and recovery after emergencies and natural disasters.

326. The notion that experiencing traumatic events can affect mental health grew out of observations of distress experienced by people who had been in wars and other serious civilian crises. Trauma has therefore long been a consideration in emergency management response and recovery activities.

327. This understanding of the impacts of trauma on mental health, including the impacts of adverse childhood experiences, has, over time, led to an increased focus on the need for trauma-informed care in service delivery settings beyond emergency management, and across other service systems

such as education, maternal and child health, child protection, housing, disability, aged care, and family violence among others.

328. The mental health impacts of emergencies are not limited to affected communities – frontline workers are also at risk of experiencing poor mental health outcomes as a result of experiencing vicarious trauma. We have seen this with the recent COVID-19 pandemic, which has had an enormous impact on healthcare workers both in Victoria and overseas. We have heard, for example, of increased anxiety and burn-out, and a loss of trust in health services and systems.

329. I think it is imperative that short- and long- term emergency responses must also keep the mental health and wellbeing of frontline workers in scope. For example, the recently established Healthcare Worker Infection Prevention and Wellbeing Taskforce has a specific focus on improving the care for and wellbeing of our healthcare workers.[52]

330. Despite increased focus and research on the impacts of trauma, it is my view that translating these new areas of trauma and mental health research and practice into emergency management settings is still an area for improvement for government.

331. For example, the stepped care model for mental health could also be used to guide how support is provided after emergencies.

332. A stepped care model for mental health response and recovery after an emergency would recognise that consumers who are distressed following such events may need short-term access to intensive interventions to stabilise. Following a period of intensive management, a consumer can usually step down to less intensive treatment and self-management. The impact of trauma can be lifelong, and as such, the response and treatment of a person affected by trauma or adverse experiences should reflect this and be of an appropriate intensity and duration. This approach could be articulated through the Emergency Management Manual Victoria and sub-plans, and would align with a broader re-design of a stepped care mental health system.[53]

333. Conversely, learnings from research into trauma associated with emergencies can also inform the design of the mental health system. Trauma-informed approaches to care should be a foundational part of the whole mental health system, not just in the context of emergency management.

334. One example of this approach that has worked well in Victoria is the My Relational Trauma Informed Learning program, delivered by Deakin University in partnership with the Centre for Women's Health at the Royal Women's Hospital.[54] The program was developed in response to recommendations from the Royal Commission into Family Violence for the development of universal trauma-informed

---

52 Department of Health and Human Services (Vic), Healthcare worker infection prevention and wellbeing taskforce <https://www.dhhs.vic.gov.au/healthcare-worker-infection-prevention-and-wellbeing-taskforce>.

53 Emergency Management Victoria, *Emergency Management Manual Victoria*.

54 'My Early Relational Trauma Informed Learning (MERTIL): Maternal Child Health Nurse Informed Learning Platform', *Melbourne Children's* (Web Page) <https://www.melbournechildrens.com/atp/translation/mertil/>.

practice.[55] The program upskills maternal and child health nurses, so they are better able to identify, assess and respond to early relational trauma within the families they support.

CLOSING REMARKS

335. In this statement, I have identified a range of opportunities to strengthen the current Victorian mental health system. In doing so, I have focused, as the Royal Commission asked me to, on the Department's role as steward of the current Victorian mental health system and strategic commissioner of its services.

336. I have taken this opportunity to argue that a commissioning approach would transform our system for the better. This will require a shift in how our mental health system is conceived and designed that has the potential to achieve better outcomes for Victorians while also being more efficient, innovative and responsive to consumers.

337. This would be a significant change for the Department, and while we have started on this journey, we are not there yet. When we get there, my vision is that the Department, as strategic commissioner, will set system wide aspirations, and regional operational commissioning bodies will be empowered to achieve them.

338. I have also offered some more detailed suggestions for how we can improve our mental health system through the commissioning cycle of planning, resourcing and performance monitoring activities to ensure that commissioning is as effective and efficient as possible.

339. I've noted that Victoria supports the national agreed approach of a stepped care model for mental health service delivery, and have proposed improvements to both system design and underpinning enablers that will centre on the experience of consumers and improve entry points and pathways between existing steps of care. I have also noted where further investment may be required for this to happen.

340. Finally, I provide some information about the role of the Department in supporting the mental health of communities throughout emergency situations – a discussion that is very relevant as Victorians deal with the immediate and long-term mental health impacts of the COVID-19 pandemic, following on from the 2019-20 summer bushfires.

341. At the heart of my statement, and of my own work in guiding the Department's stewardship of the mental health system, is my belief that we must build the future system in partnership with consumers and their families, Aboriginal communities and our broader communities. It is easy to focus on the nuts and bolts of system design and commissioning structures, and it is important to get these things right, but we must never forget to hardwire in the aspirations of the people we serve through everything we do.

---

[55] Deakin University, 'Australian-First Program to Upskill Nurses in Childhood Trauma Prevention' (Media Release, 23 March 2018).

342. The impact of mental ill-health on our community is profound, and I am privileged to play a role in supporting Victorians to live fulfilling and rewarding lives, regardless of their mental health. I am looking forward to receiving the Royal Commission's recommendations and working with my colleagues and in partnership with people with a lived experience of mental ill-health to implement them.

sign here ►

print name Terry Symonds

date 2 November 2020

Royal Commission into Victoria's Mental Health System

ATTACHMENT TS-1

This is the attachment marked 'TS-1' referred to in the witness statement of Terry Symonds dated 2 November 2020.

TERRY SYMONDS |CURRICULUM VITAE

FURTHER EDUCATION

- Executive Fellows Program, Australian and New Zealand School of Government, 2011.
- Master of Health Studies, School of Population Health, University of Queensland, 2006.
- Graduate Certificate in Community Mental Health, Department of Psychiatry, University of Queensland, 2000.
- Bachelor of Arts, University of Queensland, 1989 – majors in Government, Sociology.

EMPLOYMENT HISTORY

Department of Health and Human Services

- Deputy Secretary, Health and Wellbeing (2017 - present)
- Deputy Secretary, Strategy and Planning (2015-2017)
- Director, Performance, Acute Programs and Rural Health (Jul 2011 – 2014)
- Manager, Acute Programs (Aug 2009 – Jul 2011)
- Manager, Surgical Services Program (Aug 2007 – Aug 2009)

Melbourne Health

- Manager, Redesigning Care and Patient Access Unit (Feb 2006 – August 2007)
- Service Development Coordinator, Critical Care Services (Feb 2004 –Feb 2006)

Queensland Health

- Principal Project Officer, Office of the Director General (June 2003 – Jan 2004)
- Principal Project Officer, Mental Health (March 2003 – June 2003)
- Training and Evaluation Coordinator, Community Forensic Mental Health Service (February 2002 – March 2003)
- Project Officer – Suicide Prevention (Nov 2000 – Feb 2002)