Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF ROBERT KNOWLES

I, Robert Knowles, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided to me by others, I believe such information to be true. The views expressed are my own and should not be seen to reflect the views of any organisation with which I am associated.

My background

2 Throughout my career I have held a number of positions relevant to health care policy and reform.

3 I was a member of Victoria's Legislative Council from 1976 to 1999. From 1992 to 1996, I was the Victorian Minister for Housing and Aged Care. From 1996 to 1999, I was the Victorian Minister for Health and Aged Care.

4 I currently chair the of Board of The Royal Children's Hospital Melbourne (appointed in 2012).

5 I am a member of the boards of Drinkwise Australia Ltd (appointed in 2011), Global Health Ltd (appointed in 2011), Silver Chain (appointed in 2011), Penington Institute (appointed in 2009), Murdoch Children's Research Institute (appointed in 2012), Beyond Blue (appointed in 2017) and Great Ocean Road Health (appointed in 2019).

6 I am a member of the Victorian Medical Workforce Advisory Council.

7 I was previously a Commissioner of the National Mental Health Commission and former Chair of the Mental Health Council of Australia. I was a member of the National Health and Hospital Reform Commission which completed its work in 2009. I have also previously acted as the Aged Care Complaints Commissioner.

My initial exposure to mental health issues in the community

8 I was first exposed to the issue of mental health as a member of Parliament. There were two psychiatric hospitals in my electorate, being hospitals in Ballarat and Ararat. I often had people experiencing mental health issues come in to my electorate office.

9 At around this time, there were a number of reports of appalling abuse in mental health institutions. I was also aware of concerns about having mental health institutions in a

community, particularly the impact on the community if people with mental health issues were placed in a residential facility and not provided with adequate care. It was my observation that mental health institutions were run from Melbourne with no local accountability.

Deinstitutionalisation in Victoria

10 The Kennett Government (of which I was a part as Minister for Housing and Ageing) was elected with an agenda of budget repair. While the original catalyst for reforming mental health service delivery in Victoria was the need to achieve savings, myself and the late The Hon. Marie Tehan (the then Minister for Health) formed the view that it was possible to deliver more services, and better care, for less money. This was in part because mental health institutions were expensive to run, including because they incurred significant expenditure maintaining their buildings and grounds.

11 One advantage we had at that time was that the Federal Government was running the Better Cities program. This program provided funding for capital works to encourage State Governments to undertake projects which achieved urban regeneration. As the old mental health institutions were often situated on prime sites with a large amount of land, we were able to use the Better Cities funding to build new fit-for-purpose community based mental health facilities and then sell the vacated site.

12 The Department of Health also recruited personnel from the Department of Treasury to work on mental health reform. This brought ‘fresh eyes’ to the issues facing mental health service delivery.

Mental Health catchments

13 In addition to mainstreaming mental health services in Victoria, the Kennett Government wanted to ensure that mental health services were readily available across the State, rather than requiring people to move to the relevant service. At that time, mental health services were centralised around cities and regional centres. The Department of Health developed a comprehensive plan for distributing mental health services geographically throughout Victoria). This involved dividing the State into 28 areas and distributing funding to those areas.

14 The combination of mainstreaming, a focus on community care and more widely available services which Victoria adopted was recognised as forward thinking at the time. However, the model of having mental health service catchments eventually took on a rigidity which was to its detriment. This has resulted in poorer outcomes. Mental health patients (particularly) need to have confidence in their care provider, so when they are not given a choice as to where they are treated, they lose faith in the system and this results in diminished care.

Mainstreamed, local accountability

15 The old system of mental health institutions separated mental illness from all other types of illness. In implementing a policy of mainstreaming, it was important not to treat mental health as somehow different to physical health. In my view, we should not compartmentalise the treatment of mental health. We treat physical health as unrelated to oral health and mental health, and yet both oral health and mental health have ramifications for physical health. Those that have chronic disease will often also have a mental health issue. We cannot and should not treat physical health and ignore mental health, and vice versa.

16 As part of mainstreaming, our view was that we should treat the governance of mental health services in the same way we treat the governance of physical health services. Victoria had devolved the governance of physical health service delivery to local health organisations and it seemed reasonable to also give those organisations responsibility for mental health service delivery. The idea was to achieve the integration of healthcare in its totality by devolving governance to local health organisations. It was considered that local governance was a way of achieving accountability in a way that the old system could not deliver.

17 There was a great deal of apprehension to the effect that, by devolving governance to local health organisations, the dollars allocated for mental health service delivery might be swallowed by acute physical health care service delivery. As a result, maintaining a separate mental health budget was seen as important both for preserving resources in the mental health system but also for ensuring that the services kept a focus on those with complex needs, and not an unbalanced focus on less complex needs. The system which Victoria adopted was therefore to have a single, local decision-maker which was accountable for health service delivery, but separate budget pools for ‘physical’ and ‘mental’ health services.

18 This caused some difficulties. For example, an early reform was to fund Psychiatric Departments which, by their nature, frequently interact with other areas of the hospital particularly the Emergency Department. If a Psychiatric nurse is based in an Emergency Department, he or she would be part of the mental health cost base. When I was Minister for Health there were constant complaints about having to run separate acquittal processes for small expenses. One of the suggestions which we (unfortunately) accepted was to roll funding for mental health into the overall funding of health generally. We ultimately found that this meant mental health services were starved of funding as the funding was swallowed up by physical health services.

Vision for post-deinstitutionalisation mental health services

19 The vision of community-based mental health care in the 1990s was to move Victoria towards 20th century institutions away from 18th century institutions. The vision had three main components.

20 First, we wanted to provide a more immediate response for mental health issues. The background was that there had at the time been a number of police shootings where the person shot by police had a mental illness. We established crisis assessment teams (CATs) that were to be the 'frontline response' with the idea being that these would be staffed by experienced mental health workers who were confident to deal with these situations. Over time, the CATs became staffed with people who had limited experience and police have progressively resumed their role as the frontline response.

21 Second, we wanted an appropriate distribution of the service system across the State. We did not want services only concentrated in Melbourne or other major centres.

22 Third, we wanted a smoother transition from hospital back into community living following treatment.

23 A further element of the vision was that – over time - we wanted to attract a different kind of person to work with people with a mental illness. Individuals who worked in the old mental health institutions were not best placed to implement community-based care. Nonetheless we needed to draw many of the initial staff for the community-based care offering from the existing employees.

Community attitudes

24 There was not necessarily a groundswell of public support for deinstitutionalisation and there were some concerns. There were some people who had become so institutionalised that it was thought they would never return to the community, and there were particular facilities for those people. Up until the 1990s, the mental health institutions were all that existed for mental health care – so there were people who were completely institutionalised who may not have needed to be living in an institution. The thinking was that over time these people would be able to transition out of institutions due to community-based care – ie there would be fewer people who had become institutionally dependent. However, experience has shown that there are some people who will never return to complete independent living.

25 There were attitudes at the time which were opposed to deinstitutionalisation. There was community concern about institutionalised people being transferred to independent living. There were relatives of people in mental health institutions who had concerns about these people living outside institutions.

How was deinstitutionalisation prioritised within government?

26 Victoria's move towards community-based care was widely regarded as representing best practice and providing materially improved outcomes for users of public mental health services. However this reform was supported by the budgetary requirements occurring at the same time as the Better Cities program. This was the key to prioritising this initiative.

Prioritisation of mental health

Is mental health under-prioritised in our system?

27 The mental health system has never been adequately funded. Often mental health seems to receive just the standard incremental funding increase each year, rather than getting the resources that it actually needs. By way of example, I was on the National Health and Hospital Reform Commission and I am aware that mental health represents about 16% of the burden of disease, but we spend about 9% of the health budget on mental health. We do very little to provide child mental health services. Approximately 50% of mental health issues emerge in childhood, and 3 out of 4 children with a mental health condition receive no treatment for the condition.

Why is mental health under prioritised?

28 There are a number of reasons why mental health in the past has not been adequately prioritised.

29 First, physical diseases such as cancer and cardiac disease receive more attention than mental health. It is my observation that a lot of stigma associated with conditions such as depression has been removed but such stigma has not been removed from the psychotic end of the spectrum of mental health illnesses. The general community is still mostly concerned and alarmed by psychotic illnesses.

30 Medical research funding tends to go into cancer and cardiac issues and diabetes, not mental health. If good researchers are not attracted to mental health issues, mental health issues do not receive research funding and if good researchers do not attract funding, mental health issues do not attract good researchers.

31 Second, there is not a full appreciation of the treatment possibilities in mental health. The community does not have a strong sense of the positive outcomes which can be achieved through providing timely, appropriate treatment to individuals who are experiencing mental health issues. Sometimes, there is sense that Government should worry more about medical conditions that can be cured, as oppose to those that can only be managed or improved.

32 Third, we do not appreciate the cost to society of not dealing with the issue of mental health.

33 Fourth, we do not currently treat mental health as a mainstream health issue, and we need to do so if mental health is to be adequately prioritised. As part of this, in my opinion, it is essential that person who runs the 'health' budget must also be accountable for mental health service delivery.

Within mental health, which areas are under prioritised?

34 In my experience, treatment for serious but not acute mental health conditions is consistently under prioritised. For people with less severe mental health issues, most services are provided outside the public health system. Society has made many gains in its response to depression and anxiety (with treatment often being provided in the private system). Public mental health care may be available for individuals with complex psychotic conditions at the other end of the spectrum although it is also grossly underfunded. There is a yawning gap in the middle, comprising people who are too unwell to receive effective treatment from the private sector alone, but whose conditions are not severe enough to receive timely treatment in the public system. These individuals often experience mental health issues as a chronic illness, or together with other chronic illnesses.

35 I do not think we will solve the under-prioritisation of services for individuals with chronic mental illness by looking at the mental health system alone. If we accept that chronic disease is a big issue, we should acknowledge that people with chronic disease often also have mental health issues.

Do governance and accountability structures affect prioritisation?

36 In my view the way responsibility for mental health is allocated does affect prioritisation. Mental health should be understood as a significant component of health generally. The siloing of mental health by creating separate accountability structures (including at ministerial level) can work against it being prioritised.

37 When mental health is "mainstreamed", it forces the public health system to grapple with the challenges it creates more directly. To illustrate, if we have a child at The Royal Children's Hospital with a severe mental health issue with associated behavioural issues, we may need to close all beds around that child – which is hugely costly. This kind of situation forces us to think about how we partner with organisations to treat that child in a different way which reduces the cost. We have to confront the issue at least because of its interaction with other demands on resource.

38 Underneath the single point of accountability for health inclusive of mental health, my view is that mental health funding and service delivery should have its own budget and reporting lines. Otherwise it is almost inevitable that funds will drift from mental health services into physical health services.

What would it look like to appropriately prioritise mental health?

39 First, there needs to be an acceptance that a capital injection will be required to build more appropriate facilities – for example Emergency Departments which provide appropriate support for those presenting with mental illness. Without modifications, the bright lights and chaos of an Emergency Department are unsuited for a person experiencing an acute mental health episode.

40 Second, if mental health were mainstreamed it would be necessary to prevent funding for mental health drifting from non-acute to acute services. One way of doing that would be to run and fund community-based health separately to bed- or hospital-based mental health care. In that way, mental health would be mainstreamed within these separate community-based and bed-based healthcare programs. In this model, there would be explicitly community-based and bed-based separate funding programs with the appropriate acquittal requirements.

41 'Step-down' beds would sit within the community-based healthcare program because there needs to be a smooth transition from hospital to community. Ideally, the same service provider should provide step-down beds and community-based beds. Discharging patients from step-down beds often occurs because the bed is required for another patient rather than because the current patient is ready to commence the next phase of his or her treatment in a community setting. By requiring the same provider to have a place in community treatment ready before discharge, we would remove one of the barriers to treatment continuity.

42 I am neutral as to whether community care should be delivered by the public system directly, or alternatively via funding packages that follow the patient and can be used by public or private providers.

43 Third, thought should be given to a 5-year program which sets out what will be the priority for the next 5 years. There will need to be a lead time and time to develop concepts and organisations. The organisations are in a cottage industry, rather than a properly structured organisation – we need more capacity in community-based mental health services. The staffing mix will need to be thought through.

44 In establishing such a program, I consider that community-based healthcare must be the priority over bed-based care. There is typically pressure to build more beds. I accept that this will need to happen in mental health services, but community-based care

should be the priority otherwise community-based care will never be developed. Community-based care should be the first priority in a funding sense.

45 Fourth, we need to be realistic about the energy to deliver a 5 year reform program, especially when these services are currently in a siege mentality. With any reform program, there is reform fatigue and this needs to be managed.

46 Fifth, DHHS might think about how they put mental health into their Statements of Priorities that they require hospitals to sign. Clearer mental health objectives would assist with prioritisation.

47 By way of example, I consider that the current governance model at The Royal Children's Hospital has allowed us to appropriately prioritise mental health. I came to my role as Chair knowing that this was a gap in the health system. There was an acceptance amongst the staff that it was a gap and, in the development of our Strategic Plan, we discussed what more we could do. We have made some significant achievements in improving the effectiveness of our mental health services at The Royal Children's Hospital over recent years.

Community engagement around reform

48 Politics is influenced by public perception. There are a number of factors which affect the way mental health is perceived. By way of example, there can be a perception that most crime is caused by people with mental illness, which is wrong. People with mental illness are more likely to be the victim. Sometimes there is also a sense of helplessness on mental health. I have heard comments to the effect that it would be easier to simply lock people with mental health away and deal with it that way.

49 In these circumstances, we need some mental health champions. Professor Patrick McGorry AO has been a great champion for youth mental health. The mental health system needs more of this type of advocacy.

50 Advocacy from a broader professional perspective might counterbalance certain perceptions of mental health. A message of hope can be conveyed, rather than a message of despair. Mental health professionals need to be more prominent in the debate.

51 We need to think more broadly than the health system as well. By way of example, there are a number of children with mental health issues who do not engage in education and that can be a path to deterioration. There should be a partnership between health and education to see how we can provide care and support to keep these children connected to the education system. Once a child becomes disconnected from education, it is very hard to get them connected again.

52 We also need to allow specialisation to occur within the mental health system. In the physical health area, we have some services which have developed a specialist understanding, for example of cardiology or some cancers. This has not occurred to the same extent in mental health. By way of example, I am aware of one hospital which have pushed an initiative to develop a female mental health specialisation. That is almost unique, which is surprising. We need to free up the system in that respect. We need to think about how specialisation might fill the gap between primary care and acute care. If I consider the professional landscape of mental health services, it is surprising to observe a lack of specialist resources, even in areas of pressing, current need (for example eating disorders in children and addiction)

53 The case for investment in mental health services would be assisted by strong advocacy by the health sector generally. Again, the critical point is to recognise that mental health is a mainstream health issue. This message is crucial to ensuring mental health gets the attention it deserves.

Measuring outcomes assists in improving mental health services

54 In my experience, better monitoring of outcomes assists with directing resources effectively.

55 The public mental health service within The Royal Children's Hospital has developed a more outcome-based focus. This is a success which has been developed by leading clinicians within the hospital. Certain clinicians have been very active in promoting outcome-based care and focusing treatment decisions on optimising outcomes. The Royal Children's Hospital is not provided any incentive for adopting this approach. We measure outcomes at a clinical level with Board oversight, but there is no KPI at a DHHS level for us to be measured against in this area.

56 There are lots of ways to measure outcomes in healthcare. If patients are given more choice, patients will tend to go where they will get better outcomes. To make this work in a practical sense a funding package might need to be follow the patient. There might be a need to strike a balance between encouraging choice and providing some funding certainty, and the services that provided better outcomes would be rewarded.

Conclusions

57 In mental health, there has been a lack of focus on where it is most needed. It is time to move the conversation to a different part of the system. There is service availability for mental illness associated with anxiety and depression. Beyond Blue are involved in bringing together these services – so that part of the system is evolving quite well. It is the rest of the system that I hope the Commission will focus on, including the 'missing middle' and the 'hard end' of the spectrum of mental illness.

58 When I reflect on deinstitutionalisation in Victoria, I have no doubt that it has improved the lives of many people in our community. The features of the system we established to replace these institutions were chosen for sound reasons, including the geographic regions for mental health and the decision to give Health Services control of community-based services in their area. What has happened in the interim is an inevitable drift of priority from community based care to acute care, and from services targeting mental health to services targeting physical health, and the drift has been allowed to go on for too long. The Area Mental Health Services have become rigid, with people being turned away because of where they live. The system was once leading and innovative. We need to overcome the current state of crisis before we can redesign. Once we do so there is opportunity for innovation and improved outcomes.

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print name Robert Knowles

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