ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Melbourne Town Hall, Yarra Room,
90-130 Swanston Street,
Melbourne, Victoria

On Thursday, 25 July 2019 at 10.00am

(Day 18)

Before: Ms Penny Armytage (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Ms Lisa Nichols QC
Ms Georgina Coghlan
Ms Fiona Batten

1 MS NICHOLS: Good morning, Commissioners. The next
2 witness is Mr Andrew Greaves, the Auditor-General of
3 Victoria. I call him now.
4
5 <**ANDREW MARK GREAVES, sworn and examined: [10.02am]**
6
7 MS NICHOLS: Q. Mr Greaves, are you the Auditor-General
8 of Victoria?
9 A. I am.
10
11 Q. Before your appointment in 2016, were you the
12 Auditor-General of Queensland between 2011-2016?
13 A. I was.
14
15 Q. Before that, did you hold various roles in the
16 Victorian Auditor-General's Office?
17 A. I did.
18
19 Q. What did they include?
20 A. I was the Assistant Auditor-General in charge of the
21 Performance Audit Group more recently, and before that the
22 Assistant Auditor-General in charge of the Financial Audit
23 Group.
24
25 Q. Have you had over 30 years' experience in the public
26 sector in external and internal auditing at federal, state
27 and local government levels?
28 A. I have.
29
30 Q. Have you prepared a statement at the Royal
31 Commission's request?
32 A. I have.
33
34 Q. I tender the statement with its attachments.
35 [WIT.0001.0064.0001] Mr Greaves, could you explain briefly,
36 what is the role of the Auditor-General as an independent
37 officer of the Victorian Parliament?
38 A. The primary role of the Auditor-General is to provide
39 assurance to the Parliament about the efficient and
40 effective operation of the public sector, and in
41 discharging that role I undertake two important functions:
42 my office undertakes financial audits which examine and
43 report on the reliability of financial information that's
44 reported by the public sector, but my office also
45 undertakes performance audits. In that performance audit
46 function we examine variously, either at an entity or
47 program or activity level, the efficiency, economy and

1 effectiveness of those various activities and the extent of
2 their compliance with laws and regulations.
3
4 Q. What's the relationship between the Auditor-General
5 and Parliament?
6 A. I am an independent officer of the Parliament, and
7 that is set out in the Constitution Act of Victoria. I
8 have a relationship with an oversight committee, which is
9 the Public Accounts and Estimates Committee. In relation
10 to the Public Accounts and Estimates Committee, they
11 oversight both my budget and my annual work and I must
12 consult with that committee on both of those matters.
13
14 Q. What's the relationship between the Auditor-General
15 and the executive arm of government?
16 A. The intent, as described and set out in the
17 Constitution and also in the Audit Act, is that I cannot be
18 directed in the discharge and performance of my duties and
19 functions. The intent there is that, as an independent
20 officer of the Parliament, I am separate from, and
21 independent of, the executive.
22
23 Q. The Auditor-General is not permitted to comment on the
24 merits of government policy; is that correct?
25 A. That's correct. There's actually a legislative
26 provision in the Audit Act itself which precludes me from
27 commenting on or questioning the merits of government
28 policy objectives. I take that as therefore a prohibition
29 generally, whether in a report or in public, on questioning
30 the merits of government policy objectives.
31
32 Q. Thank you. Your office has recently published two
33 audit reports in relation to the Mental Health Act and the
34 mental health sector: the first being Access to Mental
35 Health Services published in March 2019, and the second
36 being Child and Youth Mental Health published in June 2019,
37 and those two are annexed to your statement?
38 A. They are.
39
40 Q. Can I ask you about the Access Report first, what was
41 objective of that audit?
42 A. The primary objective of the Access Report, as the
43 title would suggest, was to understand to what extent those
44 who require it have access to mental health services in
45 Victoria.
46
47 Q. What was your overall conclusion, Mr Greaves?

1 A. I'll now refer, if I may?
2
3 Q. I'll direct you to paragraph 21 of your statement, if
4 that assists?
5 A. That will. The overall conclusion was that the
6 Department of Health and Human Services has done too little
7 to address the imbalance between demand for and supply of
8 mental health services in Victoria.
9
10 Q. And in substance, what were your findings in brief?
11 A. The major findings: a lack of sufficient and
12 appropriate system level planning, investment and
13 monitoring over many years. That the current 10-year
14 mental health plan outlined few actions that demonstrate
15 how the Department would address the demand challenge that
16 the 10-year plan articulates.
17
18 That the priority informed areas identified in the
19 plan do not adequately reflect the underlying issue of lack
20 of system capacity and, as a result, the Department has
21 made almost no progress in addressing the supply and demand
22 imbalance.
23
24 That there are few measures in the outcomes framework
25 for the plan that directly capture performance against
26 providing access to services or increasing service reach.
27
28 That there is sufficient evidence that there are not
29 enough mental health beds in Victoria to meet current or
30 future demand.
31
32 That advice from the Department to government,
33 supported by multiple Departmental Commission reviews,
34 clearly articulates the existing funding and infrastructure
35 gaps, but the Department's progress has been slow and the
36 most important elements of change such as funding reform,
37 infrastructure planning, catchment area review, and
38 improved data collection have only just or not yet
39 commenced.
40
41 That the Department has made little progress closing
42 the significant gap between Area Mental Health Services
43 costs and the price they are paid by the Department to
44 deliver mental health services.
45
46 And also, in addressing historical inequities in
47 funding allocations that do not align to current

1 populations and demographics.
2
3 That the bed day costs of the AMHSs are higher than
4 the price DHHS pays, and they do not receive the necessary
5 funding to meet demand.
6
7 That there are shortcomings in the data collection
8 system including lack of functionality and low usability,
9 which often results in duplication of data collection.
10
11 That the Department's approach of approximating demand
12 gives rise to a significant risk that, without the
13 inclusion of data from the triage system and unregistered
14 clients, the Department does not adequately capture the
15 extent of mental health illness in the population and the
16 true unmet demand.
17
18 That the public mental health services are subject to
19 an input-based funding model which is not sensitive to
20 unmet demand, the needs and complexity of the mental health
21 services client cohort, contemporary population data and
22 all demographic changes.
23
24 And that the introduction of activity-based funding in
25 mental health services has been on the agenda in Victoria
26 for over five years and, although some reform has been
27 proposed, without adequate quantum of funding and the staff
28 and infrastructure required to deliver those services,
29 there is a risk that the intended outcomes will not be
30 achieved.
31
32 Q. Thank you, Mr Greaves. We'll return to those shortly.
33 Can I now ask you about the Child and Youth Mental Health
34 Report. What was the objective of that audit?
35 A. The objective of that audit was to determine whether
36 child and adolescent mental health services effectively
37 prevent, support and treat child and youth mental health
38 problems. We focused on clinical mental health services
39 for young people with moderate-to-severe mental health
40 problems.
41
42 Q. What did you find overall?
43 A. Overall, that not all Victorian children and young
44 people with dangerous and debilitating mental health
45 problems received the services that they and their families
46 need.
47

1 Q. What were your further findings in substance?
2 A. In substance the key findings were that specialist
3 child, adolescent and youth mental health services do not
4 meet service demand or operate as a coordinated system.
5 There is no strategic framework to guide and coordinate the
6 Department or health services that are responsible for
7 child and youth mental services, CYMHS. Problems with the
8 CYMHS performance monitoring system created oversight gaps
9 for the Department, which leaves it unable to address
10 significant issues that require a system level response.
11
12 The Department does not sufficiently understand the
13 system and the challenges it faces; its lack of
14 understanding contributes to a climate of uncertainty and
15 distrust, which inhibits systematic improvement and creates
16 significant variability and inequity in the care that
17 children and young people receive.
18
19 The Department has predominantly taken a one size fits
20 all approach to mental health systems' design and
21 monitoring which does not adequately identify and respond
22 to the unique needs of children and young people.
23
24 Q. Now, Mr Greaves, the recommendations in your report
25 directly addressed the issues that you found, but you've
26 said in your statement to the Commission that often issues
27 of that kind are symptomatic of some deeper causal problem.
28 You've conducted a root cause analysis of sorts and
29 identified two factors that you say are systematic and are
30 worth considering: can you say what they are?
31 A. The two factors which I see as root cause factors, and
32 so first order factors, relate to the role of the
33 Department in a devolved service delivery environment, and
34 the second one is the performance measurement framework and
35 systems that are used to monitor and measure performance.
36
37 Q. Can you address the role of the Department first and
38 say why you think that is a first order issue?
39 A. The reason I came to that conclusion was, not just
40 looking at this report, but looking at other reports that
41 we have tabled variously since 2005 that relate to the
42 Department and also to reports that other people have also
43 tabled in relation to the Department, such as the Duckett
44 Review; which point to a longstanding debate, if you like,
45 about what is the proper role of the Department as the
46 systems steward, as it is now variously described, or the
47 system owner, vis-à-vis the service delivery arms which are

1 the health services themselves and those that are out in
2 the community health space.
3
4 So we asked ourselves during those two reports that
5 we've mentioned why certain actions hadn't been taken, why
6 reviews and reports had continually raised issues, and yet,
7 there did not seem to be any response to those issues.
8
9 And in those reports and in other reports that I
10 referred to, such as most recently the report we did on the
11 right of private practice arrangements in public hospitals,
12 we have often had the response that "it is not our role",
13 this being the Department, "it is not our role". And
14 variously when we ask, in terms of that role, the one
15 factor that in my experience stands out is the monitoring
16 and oversight of the system.
17
18 I know previous Auditors-General have characterised
19 this as an oversight deficit. And so, we've had a debate,
20 a longstanding debate between Auditors-General and the
21 heads of those agencies about, to what extent is it
22 necessary and appropriate for the centre, the Department,
23 which effectively sets policy, sets strategy, funds the
24 system, to then monitor and oversight the system to
25 understand to what extent strategy is being given effect
26 to, how well those funds are being used.
27
28 But more importantly, in the context of providing full
29 and frank advice to the government of the day, how well
30 informed is the Department about present system capability
31 and present system performance.
32
33 And it's not consistent, but variously we've had these
34 debates over the years about, to what extent should I be
35 monitoring, I being the Department, to what extent should
36 we be monitoring, to what extent should we be oversighting?
37
38 Quite often we hear, "Well, it's a devolved system",
39 and in the devolved system we let the managers manage.
40 It's not appropriate for us to say how they should spend
41 their money. We don't always see that policy consistently
42 applied anyway.
43
44 But my deeper and perhaps more systematic problem that
45 I have with this goes to this whole issue of appropriate
46 accountability: where should the accountability lie for the
47 outcomes that are being achieved by the system?

1
2 And the features that I see specifically that are
3 exhibited in the health and human services system relate to
4 the funding of that system, and in two parts: the
5 operational funding - my reports identified that the amount
6 of funds that are being provided to the health services do
7 not cover the cost of the provision of those services.
8
9 The other feature of this system, of course, is that
10 the capital funding is entirely controlled by the
11 Department, that the health services obtain operational
12 funds but capital funding is a separate matter. So, in
13 terms of planning for infrastructure and delivery of
14 infrastructure, accountability should properly rest with
15 the Department in my estimation, and I also wonder how you
16 can properly hold the health service to account, knowing
17 that you haven't fully funded them to deliver the services
18 you've asked them to deliver.
19
20 And, while it is appropriate to say that the hospital
21 is the best place to manage access, they are in one sense
22 best placed to manage access because they are the service
23 providers, but in another sense, if they have to
24 effectively rob Peter to pay Paul to actually pay for that,
25 then they're not best placed to manage access, so the
26 system owner must take some accountability and
27 responsibility for that. And so, this to me is a
28 systematic matter that we need to consider in the whole
29 design of the system: where does the accountability sit?
30
31 Q. Can I just take you back, Mr Greaves, and ask - and
32 you've been expressing a number of these things in the form
33 of questions: can I ask for your views about where the
34 accountability should sit, or perhaps put a different way,
35 you referred to an oversight deficit before. What should
36 be the characteristics, in your assessment based on your
37 experience, of the oversight and leadership function of the
38 Department in relation to mental health?
39 A. Well, oversight is predicated on obtaining the
40 performance information you need, the service performance
41 information you need, to understand service performance,
42 and of course to obtain information about the outcomes or
43 the impacts of the delivery of those services.
44
45 So, accountability must sheet home to the Department,
46 for establishing appropriate systems, to capture that
47 information and aggregate that information. I note in the

1 Child and Youth Mental Health Audit that we undertook an
2 analysis of three years worth of data across five health
3 services, and my team advised me that this was the first
4 time that that data had actually been analysed. And, of
5 course, I wondered to myself, why would that be the case?
6 This data has been available.
7
8 And while individual health services may have it
9 within their own power to analyse their data, they don't
10 have it within their power to join their data together and
11 take a system view, and so again, accountability for that
12 system performance must sit with the Department in terms of
13 its oversight role.
14
15 Q. Can I ask you about the debate that you mentioned, the
16 ongoing one between the Auditors-General and the
17 Department. I think you've expressed the Auditors-General
18 position generally. As you understand it, and the
19 Department will speak for themselves later today, but just
20 historically what has been the division point in the debate
21 between Auditors-General and the Department?
22 A. Well, quite simply, a disagreement about this need to
23 oversight system performance. It really goes to a devolved
24 service delivery model and what is the proper role of the
25 Department in that. I might say that this is not just a
26 feature in my experience of mental health or human services
27 in health generally, it's a feature more broadly of
28 government where the centre is less inclined to want to
29 take responsibility for the delivery of services.
30
31 Q. In relation to the question of performance
32 measurement, in your statement you said:
33
34 "The Department's mental health KPIs do not
35 assess whether consumers are accessing
36 appropriate mental health services or track
37 the performance of their 10-year plan in
38 terms of access Victorians have to mental
39 health services."
40
41 That wraps up two concepts: the first is related to
42 KPIs, can you tell the Commissioners what you mean by that?
43 A. What KPIs are, or what we mean by --
44
45 Q. No, what you mean by your conclusion that the mental
46 health KPIs do not assess whether consumers are accessing
47 appropriate services?

1 A. Well, basically when we looked at the suite of KPIs,
2 we couldn't find ones that spoke to that. The predominant
3 objective of the Access Audit was to evaluate access.
4
5 Q. Access, yes.
6 A. And obviously in the mental health plan, when we read
7 through it, it was made clear that there was a major issue
8 in terms of access because of the growth in demand, and so,
9 we would expect in any performance indicator framework
10 given that this was specified as one of the major
11 challenges for the system, that you would want to have a
12 good suite of indicators that spoke to access, so it was
13 the absence of indicators.
14
15 Q. In your assessment, what kind of performance
16 indicators would be capable of better assessing access?
17 A. In the report we referred to some other indicators
18 that could speak to access, and we're particularly
19 interested in the data that may and should be being
20 captured by triage services about the people that are
21 denied access. So, to me, that is a prime indicator and
22 something that I would be interested in understanding more,
23 particularly to understand the unmet demand.
24
25 Q. You also say in your report that getting the right
26 performance indicators is only really half of the story.
27 The other one is what you measure, and you've said that, if
28 performance indicators are to be used to drive strategy and
29 evaluate the effectiveness of planned actions, they must
30 have targets against which progress can be measured: can
31 you elaborate on that?
32 A. Indeed. Yes, and my concern here is, and we go back
33 to systematic issues, we can see through the mental health
34 plan that we've been working on outcome measures and
35 outcome indicators now for a number of years, but not
36 informed by any overarching government policy or strategy
37 in relation to an outcomes framework.
38
39 Most recently we are aware through the Department of
40 Premier and Cabinet that an outcomes framework document has
41 been published.
42
43 My concern, looking at both the outcomes that were
44 expressed in the mental health plan and the outcomes that
45 are now being expressed more recently in the strategic plan
46 of the Department and its new outcomes measures framework,
47 and in the government's document about the outcomes

1 framework more broadly, there is very little, if any,
2 reference to targets. So, we are concerned, or I am
3 concerned, that in the absence of targets it would be
4 difficult to discern a range of matters.
5
6 First and foremost, what is the performance gap? What
7 is it that we're actually trying to achieve? So we can
8 have an outcome measure, we can have an output measure, but
9 if we're not saying to ourselves, what do we want to
10 achieve, and in what timeframes such that you could express
11 a target as a three-year target or as a 10-year target, or
12 in fact both, you could express a target on a final
13 outcome, for example the government in its suicide
14 prevention strategy has articulated a 10-year target of
15 reducing suicide by half.
16
17 So, it is not as though targets have not been
18 expressed, but the frameworks that are being promulgated
19 and the outcomes documents that I have seen seem to avoid
20 targets. So, how will the outcomes framework be something
21 that organises a response that allows us to make funding
22 decisions in the absence of a target?
23
24 So that's my primary concern. I think in any outcomes
25 measurement framework, you need obviously to express the
26 outcome you desire but, if you don't actually tie a target
27 to it, I think you're missing a key part of the
28 accountability equation.
29
30 Q. What, in your view, are the characteristics of useful
31 targets?
32 A. Well, the characteristics of useful targets first and
33 foremost stem from the characteristics of useful
34 indicators. In Victoria, of course, we've had an output
35 based budgetary framework for a number of years, but that
36 has focused on service outputs: time, cost, quantity and
37 quality, and have had targets expressed in them, but I must
38 say some of those actually speak a bit more to outcomes to
39 me than they do to outputs.
40
41 Q. Can you give an example?
42 A. I could actually refer to the Budget Paper 3 which has
43 the mental health outcomes expressed - or output statement
44 expressed in it, if I could find that.
45
46 Under a quality measure in BP 3 - this is from the
47 2019/2020 service delivery statements on p.208 - one of the

1 quality measures is new client index. Now, that new client
2 index has actually been described in the outcomes framework
3 that's been promulgated by the Department.
4
5 So, first and foremost, I'm seeing, we're developing
6 an outcomes framework here, we haven't really gone back and
7 thought about the outputs framework and the interaction
8 between the two. And so, there's probably some
9 rationalisation required and maybe the Secretary of
10 Treasury and Finance could speak to how the new outcomes
11 framework is being integrated and coordinated with the
12 outputs budgetary framework. But that outputs framework
13 has long had targets.
14
15 When we come to outcomes, in my experience people
16 don't like expressing targets for outcomes because outcomes
17 typically take a long time to emerge, and they'll emerge in
18 a longer timeframe than normal political cycles, so you can
19 understand a natural reluctance to express an outcome,
20 because you can't necessarily demonstrate improvement.
21 Sometimes the actions that you take now may take, three,
22 four, five, seven years to actually show an impact, which
23 shouldn't be a reason for not expressing the target, and
24 I've mentioned the suicide target. But what we should try
25 to do when we're defining a good target is to define a good
26 measure.
27
28 In New Zealand, not more recently with their wellbeing
29 budget but the performance measurement framework that
30 preceded that, they had most success in defining
31 intermediate outcomes, and the idea of an intermediate
32 outcome, or part of one of the ideas of an intermediate
33 outcome, is that the time between the action and the effect
34 is less.
35
36 And so, for example, access to mental health services
37 is a good intermediate outcome. If I can get those people
38 who access mental health services up from the 1.1, 1.3,
39 1.5 per cent, whatever the figure is, to 3 per cent, which
40 is the estimate in the population of people that require
41 access, that is an intermediate outcome.
42
43 I can express that, I can express a clear target in
44 relation to that intermediate outcome and I can tie back
45 actions that we're taking to move that rate up to
46 3 per cent. So, yes, a target to me should be quite
47 specific, clear, measurable, but I think it's best

1 expressed in this new framework as intermediate outcome
2 targets rather than final outcome targets.
3
4 In fact, you could mount an argument that you
5 shouldn't have a final outcome target per se, because it is
6 so uncontrollable, there are so many confounding or
7 conflating variables that you can't really mobilise around
8 that target.
9
10 Q. If that example is an intermediate outcome in your
11 hypothetical world, what would be the ultimate outcome by
12 reference to that intermediate outcome?
13 A. Well, I think the ultimate outcomes are expressed in
14 the framework at the moment: the improved mental health of
15 the Victorian population and the reduction in the suicide
16 rate. You will see those also referred to in the report on
17 government service delivery outputs framework. So I think
18 there's not much debate about the long-term final outcomes
19 we're trying to achieve, but let's make sure we're really
20 clear on what the intermediate outcomes are and link those
21 to the outputs.
22
23 Q. And in your view they should be linked to the outputs
24 including for the purposes of Budget Paper 3?
25 A. I'm trying to discern how the outcomes framework as
26 it's currently designed - and I haven't audited this yet so
27 this is my observation based on what I've read - I'm
28 struggling to understand how it will feed into the
29 budgetary process.
30
31 Again, if I reflect on the New Zealand experience with
32 their 10 key result areas, absolutely focused on
33 intermediate outcomes, and funding was directed towards
34 achieving those. We were all - well, not all of us, but
35 Jacinda Ardern was here last week talking about the new
36 wellbeing budget which seems, again from a distance, to try
37 and enshrine the idea of tying the budgetary process to the
38 outcome.
39
40 People will have different views, and governments will
41 have different views, about whether we need an outcomes
42 budget framework or an output budget framework. I'm not
43 barracking for either one: you know, is it still
44 appropriate to fund outputs to, say, the services that are
45 delivered and have your funding directed toward the
46 delivery of outputs; but, in making those decisions about
47 which outputs are provided, the design of the output, the

1 quality of the output, you can be driven by considerations
2 of the outcomes you're trying to achieve and the
3 priorities.
4
5 Now, that's the other thing in my estimation that's
6 presently missing, that the Department has done good work
7 in this outcomes space and the mental health plan is
8 articulating outcomes, and these more recent strategic
9 plans and strategies are articulating that, but I don't
10 have a sense yet of any top-down strategic prioritisation
11 by the government. So, it's good to articulate outcomes
12 down at an individual agency level, but where do they fit
13 in terms of the government's overall priorities? And that
14 also seems to me to be missing from the current outcomes
15 framework.
16
17 Q. I see. And, it's the Department's role to articulate
18 that framework including the links between outputs
19 particularly?
20 A. Well, I think it's more than the Department's role; I
21 think it's the public sector's role to advise the
22 government on the appropriate design of an outcomes
23 framework, and if the words that we read in the outcomes
24 framework are to be given effect, that it's going to
25 mobilise resources, that it's going to help drive actions,
26 there must be some linkage then into the budgetary process.
27 So, I think it's incumbent on the public sector generally
28 to advise government about the appropriate design of this
29 framework.
30
31 Q. Can I just ask you a question about targets finally.
32 Ms Peake will give some evidence later today about targets,
33 and she'll say this:
34
35 "There are important limitations in the use
36 of targets, especially for complex service
37 systems. These include risks that numeric
38 targets [among other things]: prioritise
39 actions that are more easily
40 measurable ... change peoples' behaviour,
41 with perverse results; narrow a reform
42 focus, inhibiting system level
43 integration ... are set to the wrong
44 driver ... [and] reduce flexibility to
45 changing evidence or contexts ..."
46
47 Do you have any observations on that evidence?

1 A. My first observation is that the risks that are
2 articulated there are within the control of the agency and
3 within the control of the government.
4
5 So, simply saying that there are risks attendant upon
6 setting targets is not a reason not to set targets. If
7 we've named the risk, we manage the risk. Yes, and we have
8 seen measures, more importantly, than targets that can
9 create perverse behaviours.
10
11 So, it's in the design of the measure and the setting
12 of the target that is what is important, but again, I
13 wouldn't argue that's a reason not to set the target,
14 because the benefits of setting targets which really are
15 supposed to drive action, drive strategy, track progress,
16 in my estimation far outweigh the risks associated with
17 setting targets.
18
19 MS NICHOLS: Thank you, Mr Greaves. Chair, do the
20 Commissioners have any questions?
21
22 CHAIR: Q. I might start then. Thank you very much,
23 Mr Greaves, for your overview and for your submission and
24 attached information.
25
26 When we look at this issue about accountability within
27 the public sector for service delivery design,
28 implementation and the like, the way that you've described
29 it, given you have a whole-of-government view, can you
30 assist the Commission by identifying where you've seen good
31 practice that you would alert us to and where you think the
32 accountability frameworks are operating well.
33
34 MS NICHOLS: Chair, could you speak closer to the
35 microphone?
36
37 CHAIR: Do you want me to repeat the whole lot?
38
39 THE WITNESS: No, no, I got that, Chair.
40
41 CHAIR: Q. So, really where there are examples of best
42 practice, you use New Zealand, but closer to home in the
43 Victorian public service, for example, or elsewhere in
44 Australia?
45 A. I mean, I use New Zealand because it's the most recent
46 and obvious example. I'm not sure that I can point to
47 better practice. Given what I've said about the current

1 limitations of the outputs framework and the nascent
2 outcomes framework in Victoria, I don't think there's areas
3 that I could really point to that would speak to this being
4 done well.
5
6 One of the features of the New Zealand framework that
7 I'm attracted to, and there was actually an evaluation done
8 of this, a report on it, talked about "blind
9 accountability".
10
11 What that related to was that, we spend a lot of time
12 trying to - or get very vexed about trying to attribute
13 actions to outcomes, and the point of the New Zealand
14 framework was that, don't get caught up in attribution, and
15 yes, it's going to be unfair, but where you have issues
16 that are cross-government, basically the important thing is
17 to get collective responsibility and accountability for an
18 outcome and get the resources mobilised to deliver on that
19 outcome, and whether or not your organisation contributes
20 5 per cent of the outcome or 95 per cent of the outcome is
21 actually irrelevant at the end of the day.
22
23 So, there's unfairness in it, but the evaluations in
24 New Zealand suggested that nevertheless it worked, and that
25 they could point to improvements in those areas that they
26 focused on, those 10 key result areas.
27
28 So, to me, that is still a model of better practice.
29 Now, we have here the Victorian Secretary's Board, and we
30 have conversations now about 1 VPS, and we are moving to
31 bring together our administrative datasets, aggregate them
32 and analyse them, so I think they are all pointers in the
33 right direction, but I still see missing from this
34 overarching, top-down prioritisation of outcomes.
35
36 Q. Can I also go back to the fact that, obviously the
37 Commission's had the opportunity to read both of the
38 reports that you've recently tabled in relation to mental
39 health. In both of those reports you make a number of
40 recommendations for change that you think need to occur in
41 the short term as well as over the longer term.
42
43 What role will you have in following up in terms of
44 where action is at on those recommendations, and are you
45 already engaged in dialogue about that?
46 A. We're engaged in dialogue to this extent: the practice
47 of my office now is to annually write to every agency that

1 we make recommendations to and ask them to update us on how
2 they are going implementing those recommendations.
3
4 I propose this year in fact to make that report
5 public, so we'll be writing to all agencies, including DHHS
6 and those involved in those two audits, we'll be asking
7 them to tell us what they've done, what action they've
8 taken, whether they continue to accept the recommendation,
9 or whether or not our recommendations have been overtaken,
10 for example, by the Royal Commission, with a view to making
11 that a public document.
12
13 Q. Given the nature and extent of some of the concerns
14 you expressed in both of those reports, both about the
15 access and the overarching system around child and
16 adolescent mental health, do you have a sense of what's a
17 realistic timeframe whereby you would like to see
18 improvements across those service systems addressing the
19 issues you've highlighted?
20 A. To answer the question, what is a realistic timeframe,
21 it really needs to consider what is the funding available
22 and the priorities of the government. So, I don't think
23 it's for me to try and second-guess where the government
24 may want to put its funding against all its other
25 priorities, and so, it's probably not appropriate to
26 speculate what would be an appropriate timeframe. Clearly,
27 those who aren't getting access would like access now.
28 Now, that's not achievable given what we understand to be
29 the limitations in terms of infrastructure, funding and
30 staffing.
31
32 To what extent the government mobilises resources to
33 address the infrastructure deficit, the workforce strategy
34 being implemented and the funding of the services, will
35 then impact on how long it actually takes to address it.
36
37 Q. Can I confirm from that, your expectation, though, is
38 that the Department would have a plan that it would put to
39 government about how it thinks it should address your
40 concerns?
41 A. Absolutely. We think the Department should always
42 have a plan because it's already been informed over a
43 number of years about the problems in this. So, yes. Most
44 recently, our report's raised it again. We would expect
45 that there would be a plan which would be timed and
46 resourced, I guess, is the more important matter.
47

1 CHAIR: Thank you.
2
3 MS NICHOLS: May Mr Greaves be excused?
4
5 CHAIR: Yes, thank you very much for your witness
6 statement and evidence today, Mr Greaves.
7
8 <**THE WITNESS WITHDREW**
9
10 MS COGHLAN: The next witness to be called is Felicity
11 Topp, and I call her now.
12
13 <**FELICITY ANNE TOPP, affirmed and examined: [10.40am]**
14
15 MS COGHLAN: Q. Thank you, Ms Topp. You've made a
16 statement to the Commission?
17 A. That's correct.
18
19 Q. I tender that statement. [WIT.0002.0021.0001] You are
20 the Chief Executive Officer of Peninsula Health?
21 A. That's correct.
22
23 Q. And you have the following qualifications: a Diploma
24 of Applied Science in Nursing?
25 A. Yes.
26
27 Q. A Critical Care Nursing Certificate?
28 A. Yes.
29
30 Q. A Bachelor of Nursing?
31 A. Yes.
32
33 Q. A Graduate Diploma in Health Counselling?
34 A. Yes.
35
36 Q. A Master of Public Health?
37 A. Yes.
38
39 Q. And a Vincent Fairfax Fellowship in Ethical
40 Leadership?
41 A. That's correct.
42
43 Q. You started your career as an intensive care nurse?
44 A. Yes.
45
46 Q. You have 34 years of experience in the public health
47 system to date?

1 A. That's right.
2
3 Q. You have been in management and leadership roles for
4 approximately 50 per cent of that time?
5 A. That's correct.
6
7 Q. Being since 2001?
8 A. That's right, so I've worked mainly in operational
9 roles in my leadership experience, and I've been in a Chief
10 Executive role for the last 18 months.
11
12 Q. Can I just ask you about that in terms of, you say in
13 your statement that your experience with the mental health
14 system has been with two public health services. You've
15 just mentioned your current role; what about before that?
16 A. So, interestingly, I've had the experience across the
17 whole health system in that time, but my exposure to mental
18 health has been quite limited. I had a three-month
19 secondment to Barwon Health back in 2017 to assist them
20 through a significant period of change, and I was given the
21 opportunity to take on an executive leadership role for the
22 mental health service over that three-month period. And
23 now as a Chief Executive Officer, we've got a large mental
24 health service down on the Peninsula.
25
26 Q. How long did you say you'd been the CEO of Peninsula?
27 A. Just on 18 months.
28
29 Q. But you do come to that role with extensive experience
30 in health generally?
31 A. Absolutely, yes.
32
33 Q. Can I just ask you some questions about the operations
34 of Peninsula Health, we won't spend much time on this, but
35 just to get an idea of the services. Firstly, just in
36 relation to delivery of public health care services and the
37 catchment, just address that issue?
38 A. So, we provide health care services across the
39 continuum of care; I kind of describe it as birth to end of
40 life. We have 850 square kilometres along the Peninsula,
41 from Carrum, Langwarrin, all the way down to Portsea and
42 then across to Hastings. The service has 6,000 employees,
43 800 volunteers, and like I said, we provide a continuum of
44 care. We've got aged care services, mental health
45 services, acute services, community services.
46
47 Q. Can I just direct your attention to the mental health

1 services, and can you just broadly summarise what they are?
2 A. So, we have an acute inpatient unit and a high
3 dependency unit, aged care inpatient unit, psychogeriatric
4 service. We have a number of community mental health
5 services. We have some specialist services and residential
6 services.
7
8 Q. Could I ask you about a particular aspect of your
9 statement where you say this:
10
11 "Until March 2019 mental health services at
12 Peninsula Health were overseen by a Chief
13 Operating Officer."
14
15 But things have changed since that time?
16 A. That's right.
17
18 Q. Can you just detail what that change is?
19 A. Yep. So, late last year the Chief Operating Officer
20 who was overseeing our mental health system as an executive
21 leader resigned, so we had the opportunity to reconsider
22 the executive portfolios within the organisation.
23
24 During my first eight months at Peninsula Health, I
25 had identified that there were perhaps some significant
26 issues in our mental health service, so there were some
27 leadership issues, some quality issues, so we made the
28 decision to align our Mental Health Program to our
29 Executive Director of Nursing, Midwifery and Allied Health
30 who has extensive mental health experience. So, we made
31 that change and that executive has been leading the program
32 since February this year.
33
34 Q. What's been the benefit of that?
35 A. Well, it's been a terrific support to me, because
36 again, I don't have that huge experience in mental health.
37 It has really allowed us to spend a lot of time with our
38 staff, understanding their current issues that they're
39 experiencing, listening to them in trying to understand
40 what changes we could make within the service that would
41 support them in delivering the care that they want to
42 deliver.
43
44 We've also spent a lot of time integrating our
45 organisational clinical governance framework into the
46 mental health system, and really concentrating on bringing
47 our mental health team into the rest of the organisation.

1
2 Q. Can I just ask you about that; that one of your
3 observations when you first began was that mental health
4 didn't have that attention.
5 A. Look, I don't really know whether it didn't have that
6 attention, because I wasn't there, so it's kind of hard for
7 me to know. I think the executive who was leading the
8 mental health service before I arrived absolutely gave the
9 service considerable attention; had a fairly heavy
10 portfolio, so what we've done is, we have decreased the
11 portfolio a little bit so more time from an executive can
12 be given to the mental health service.
13
14 So, yes, I think that structural change has made a big
15 difference, but there's also been some other things that
16 Peninsula Health has done to engage the mental health
17 service closer in with the whole health service.
18
19 They undertook, and this is before I arrived, so I'll
20 take no credit for it, but they undertook a process of
21 reviewing the access for mental health services and access
22 across the whole acute service, especially from our
23 Emergency Department point of view, and they created a
24 system of huddles. So, each unit will have an early
25 morning meeting at 8 o'clock to find out what's happening
26 in their area in 24-hours and looking forward to that day,
27 identifying issues of quality, staffing, any lost time to
28 injuries or staff issues that might have occurred; any
29 patients that are requiring extra support, et cetera, and
30 all that information comes up to an executive huddle where
31 all the Directors and the executive meet for 15 minutes
32 every day and we work through, unit by unit, what's
33 happening.
34
35 I go to those meetings whenever I can, and in
36 15 minutes I can get an understanding of what's happening
37 in the organisation.
38
39 Now, we act on issues at that time as we hear issues,
40 and I think what's been good from a mental health service
41 point of view, is that every day they're engaged in the
42 whole organisation discussion about issues and concerns
43 that they have, and I think that's really exposed the whole
44 organisation into understanding our mental health service
45 much better.
46
47 Q. Alright, I'll come to ask you a bit more about that

1 understanding, but can I just take you back to ask you
2 about the Statement of Priorities, Peninsula's strategic
3 plan and annual business plan. I'll ask you to say a
4 little bit about each of those, but just in relation to the
5 Statement of Priorities, you've said how long you've been
6 the CEO of Peninsula, but you have extensive experience
7 otherwise in relation to the preparation of the Statement
8 of Priorities?
9 A. I'll take you through the experience and the process
10 of this year's Statement of Priorities, which is the same
11 process that I followed at Barwon.
12
13 So, we of course have our strategic plan, our
14 five-year strategic plan which is set and developed by the
15 Board, executive and the whole organisation. We run an
16 annual business plan that is aligned to the strategic
17 objectives of our strategic plan, and we work that up
18 before we receive the guidelines from the Department of
19 Health on the Statement of Priorities.
20
21 The Statement of Priorities are the government's
22 priorities that align to their strategy, and we are very
23 easily able to accommodate actions against government
24 Statement of Priorities through our business plan process,
25 so we're not so dissimilar in being able to complete those
26 Statement of Priorities.
27
28 One of the questions that you have asked is about
29 whether mental health is featured in the Statement of
30 Priorities. Through the process of just undertaking our
31 own business objectives for the year, our own business plan
32 would have a number of actions related to mental health,
33 and the mental health team have their business plan.
34
35 So therefore, if there are broad objectives within the
36 Statement of Priorities regarding diversity, Aboriginal
37 Health, occupational violence, then we would be including
38 mental health objectives within those statements.
39
40 Q. So, the drivers or I guess the framework for you to
41 include mental health objectives through the Statement of
42 Priorities is through those other processes that you have?
43 A. Yes.
44
45 Q. What about in terms of the extent to which, in your
46 experience, the Department of Health and Human Services has
47 prioritised mental health in the Statement of Priorities?

1 A. This year they have got a set objective on mental
2 health access in the Statement of Priorities. My
3 experience, and from memory, that would be the first time
4 I've seen specific objectives in the Statement of
5 Priorities for mental health.
6
7 Q. In your view, is the inclusion of specific objectives
8 about mental health within the Statement of Priorities an
9 effective way of achieving improvement in mental health
10 service s?
11 A. In the absence of anything else, of course it would
12 be. If an organisation has a strategic plan and has a
13 business plan process, and is prioritising services of
14 which mental health services are a very big service at
15 Peninsula Health, then perhaps the Statement of Priorities
16 are not so much a driver, but in the absence of any of
17 those documents, then yes, the Statement of Priorities are
18 important.
19
20 And, the Statement of Priorities are the key document
21 that the Chair of the Board signs off with the Minister for
22 Health, so from a Board perspective they are always very
23 keen to see what the objectives are in the Statement of
24 Priorities.
25
26 Q. In terms of the Statement of Priorities and the idea
27 that - I'll take you to a portion of your statement, this
28 is at paragraph 28. You say that in your experience the
29 SOP, or the Statement of Priorities reporting framework,
30 focuses on acute physical health care and has not
31 adequately addressed mental health care. So, that's your
32 view?
33 A. Yes, that's right.
34
35 Q. And so, the way that Peninsula Health deals with it is
36 to have a good strategic plan and the annual business plan
37 to ensure that mental health is appropriately prioritised?
38 A. And supported.
39
40 Q. And supported?
41 A. That's right.
42
43 Q. You talked about the strategic plan and the annual
44 business plan: are you aware of whether those things were
45 in place prior to you becoming the CEO?
46 A. There were some annual quality and safety plans
47 developed by the directorates, and they were reported up to

1 the Board; the detail of those, I'm not completely clear
2 on.
3
4 Q. So, did you drive the change towards the strategic
5 plan - perhaps you and others - and this annual business
6 plan?
7 A. Yeah, so I've changed the process a little bit. So,
8 we've always had a strategic plan and we've just completed
9 a new strategic plan. So, yes, so I brought in a new
10 framework of bringing in the strategic objectives and the
11 business objectives aligned for an annual plan and aligning
12 those to the Statement of Priorities. So, I've just
13 completed that now for this year, and that plan, so the
14 business plan and the Statement of Priorities, are going to
15 the August Board meeting.
16
17 Q. And so, from your perspective, what drove that change?
18 A. Because I'd seen it work elsewhere. So, probably back
19 at Royal Melbourne Hospital actually, at Melbourne Health
20 when I was there, there was a process of developing
21 comprehensive business plans. I felt - and like to use
22 them, I suppose, from a Directorate level for me and the
23 team.
24
25 And then, when I had the opportunity to go to Barwon
26 Health, we shamelessly took Western Health's framework,
27 which had evolved somewhat since we used it at Melbourne,
28 and then I've just taken that same framework to Peninsula.
29 Modified it a little bit.
30
31 Q. Can I just ask you now about prioritisation by the
32 Board. You say in your statement, and this is at
33 paragraph 33:
34
35 "I believe that the Board of a health
36 service can, at any time, ask the executive
37 management to prioritise mental health
38 services as with any service."
39
40 So, there's the capacity to do so. How readily does
41 it happen and what are the impediments?
42 A. So, I think boards can ask executive questions at any
43 time, and they often do. I think Boards do rely on
44 executive management to give them adequate information and
45 coherent information to advise them on what's happening in
46 the health service. If they don't get that information,
47 they won't know.

1
2 So, you have a Statement of Priorities and the reports
3 that you get from the Department of Health: if that's all
4 that's going up to board, then that's all they would get to
5 see. That's not what's happening at Peninsula Health.
6 We've got a number of reports from various groups within
7 the organisation that go up to the Board level for
8 discussion.
9
10 The other observation that I have is that, we do spend
11 a bit of time educating boards on clinical governance and
12 their roles and responsibilities, but to my knowledge I
13 have not seen ever mental health services used as an
14 example of educating boards about what their
15 responsibilities are within the mental health services.
16
17 We might talk about this a little bit more later but,
18 I have found mental health services quite complex to
19 understand. So, I don't completely understand what it is
20 that we are trying to achieve within our mental health
21 service. I kind of get acute health, I get subacute
22 health, I get aged health, I've had those experiences, and
23 those models of care are fairly consistent across the
24 sector.
25
26 But just in my two experiences between Barwon and
27 Peninsula, the two different programs are quite different
28 and, therefore, navigating that as an executive - and even
29 some of the staff are unable to articulate what the models
30 of care are - makes it then quite difficult to be able to
31 educate and support a Board in understanding what the
32 requirements are for us to be providing safe quality care
33 in our mental health services.
34
35 Q. And so, you've had the two experiences that you've
36 described at Barwon and then your current role, but you
37 don't see that problem, about there not being a clear model
38 of care, as a product of the fact that you haven't had
39 extensive experience in the area? So, the fact that you
40 don't understand it is not because of the time that you
41 haven't had to get across it, it's because it's hard to
42 understand?
43 A. It is hard to understand. Well, it's hard to have the
44 people who are working in the system to describe it to you.
45
46 Q. Can you provide an example?
47 A. Okay. So, if I was to speak to a group of mental

1 health clinicians, and if I ask them to, say, explain to me
2 what the model of care is from going through the Emergency
3 Department to acute unit, back out in the community, and
4 what a consumer should expect through that process. I
5 would get different points of view. And, I get different
6 points of view from the same clinicians working in the same
7 area.
8
9 So it's hard to a get an understanding, at my level,
10 of exactly what the models of care are in each of the
11 components of the services that we provide. And when I say
12 "models of care", it is down to numbers of patients, how
13 long patients stay, the treatment and support those clients
14 get, what the staffing numbers are, so how many staff do we
15 need to provide that care?
16
17 And this is the process that we've just gone through
18 to try and develop the budgets, because we need to do all
19 of that to then say, okay, well, does the budget match?
20 So, what are those staffing models, what are we trying to
21 achieve, what are the outcome measures we're trying to
22 achieve, what are the performance indicators, okay, and
23 then what staff do we need to achieve all that? Then, have
24 we got the environment to do that in, have we got the
25 physical infrastructure to do that? So, yeah, that's the
26 process that we've just worked through.
27
28 Q. I just want to ask you about that in greater detail
29 when we get to it. If we can just stick for the moment
30 with prioritisation by the Board, I just want to ask you
31 this question: what factors do you see that would influence
32 the level of attention given by the Board to mental health
33 services? In particular, does it need a champion?
34 A. Does it need a champion? I think, in the lack of good
35 information and good outcome measures, yes, it needs
36 somebody who - it helps having somebody who knows what
37 happens in the mental health service, and that can be an
38 executive as well as a Board member. Because it is so
39 complex, it is helpful to have somebody at a senior level
40 who does understand mental health services.
41
42 Q. One of the things you mention in your statement is
43 that the KPIs aren't enough to understand the deliverables
44 or performance outcomes for mental health?
45 A. Not at all.
46
47 Q. And that a large amount of data that is collected at

1 various levels that is not provided to the Board?
2 A. That's right. Well, not at Peninsula Health at this
3 point in time. So, we have the Statement of Priorities'
4 KPIs presented to the Board, we also report occupational
5 violence information, serious incidents will go up to the
6 Board. We also take any internal/external reviews of
7 services, we would take up to the Board, so that's what we
8 provide in mental health.
9
10 But I am aware of a large amount of data that our
11 teams collect, but that data at this point in time is not
12 being analysed and is not reported up to the executive or
13 the Board, but we are in the process of just reviewing all
14 of that.
15
16 We've had an external clinical governance review to
17 help advise us on what would be some good outcome measures
18 and indicators that would give myself and the Board
19 reassurance that we are providing safe, personal, effective
20 and connected care for all our clients coming into the
21 health service.
22
23 Q. And that is an initiative led by Peninsula Health and
24 not driven at all by the Department of Health and Human
25 Services?
26 A. No, that's us.
27
28 Q. Can I then move on to ask you about oversight by the
29 Executive Leadership Team. You may have already covered a
30 little bit of this, but as the CEO, what kinds of regular
31 performance and activity information about mental health
32 services do you receive?
33 A. So, look, I pretty well much receive the same level of
34 reporting that at this stage goes to the Board, and so,
35 that's why I'm pursuing to get a little bit more
36 information through this clinical governance review.
37
38 Q. So, you've recognised that you need more information?
39 A. That's right.
40
41 Q. And that things that you want to know about, there's
42 no information about them?
43 A. Can't get them. No, that's right. And, look, I have
44 to say that a lot of the measures that are being currently
45 collected are very much process and performance measures.
46 And we have similar constraints in our acute health
47 services, although I think the physical health services

1 have evolved much further than mental health.
2
3 I think one of the things that we really do want to
4 concentrate on now, across all our services, is to have
5 outcome measures that are not only meaningful to us
6 providing the service, but to the consumers who are
7 receiving the service, and there are not very good outcome
8 measures for physical health or mental health on that
9 experience. So, I'm looking forward to doing that piece of
10 work, but it does need to be done.
11
12 Q. You've just touched on there, I guess, some of the
13 parallels with physical health and mental health. There is
14 more comprehensive data monitoring in relation to physical
15 health?
16 A. Yes.
17
18 Q. One of the things you refer to in your statement is a
19 comprehensive dashboard monitoring of a number of
20 performance metrics?
21 A. That's right.
22
23 Q. And that is something that you would also seek to do
24 in mental health?
25 A. That's right.
26
27 Q. But there needs to be more, in your view?
28 A. That's right. So, I think physical health have
29 evolved their reporting frameworks to a much greater extent
30 to what I'm seeing in mental health. Now, there might be
31 other mental health services that are far more advanced
32 than the two services that I've had experience with.
33
34 But certainly physical health, KPIs, dashboards and
35 processes are very similar and you can benchmark. So, I
36 can look at an ED performance dashboard at any one of the
37 hospitals and get it, understand it, and you can almost
38 feel it because you understand it, and same with waiting
39 lists and outpatients.
40
41 But I don't get any comparative data really - there's
42 a little bit on the Statement of Priority KPIs which are
43 limited for mental health - but there's no other KPI or
44 benchmarking that happens across the mental health service.
45
46 So, you know, our community care unit: I've got a
47 staffing profile, but there's no comparison about the types

1 of clients, number of clients, how long they stay, what the
2 outcomes are coming from those areas within our mental
3 health service.
4
5 Q. Can I next ask you about funding and prioritisation,
6 and ask you this question: how does Peninsula Health's
7 mental health activity and performance results impact on
8 funding quantum or activity forecasts or targets in
9 subsequent years?
10 A. So, let me just go through the process, okay, because
11 I think that's kind of easier to explain. So, we started
12 our budget process back in March for the whole organisation
13 and we run the same process across all services. So, we
14 essentially give people a starting budget and that's
15 usually based on what we know or think we're going to get
16 through discussions with government. Within the starting
17 process there will be some productivity savings, we'll know
18 that there will be some grants that start and finish, so we
19 have a starting point.
20
21 Each service builds the budget up from, you know,
22 bottom-up and top-down, and that bottom-up is working
23 through what I was discussing before, what's the model of
24 care? So in our acute unit, how many staff do you need,
25 AM, PM, night duty, how many staff have you got? Okay,
26 that's your EFT, all the other bits and pieces you add -
27 that's your budget.
28
29 When you get government's budget, you try and match
30 that up and that's probably the most difficult part because
31 it's very difficult to match what's actually happening in a
32 service and the budget received. So that's the process
33 that we're working through at the moment.
34
35 All the money coming in for mental health stays within
36 mental health. So, I don't take mental health money and
37 say, I'll put that to the outpatient department, so we
38 ringfence the mental health funding, and it's quite a
39 process to try and match the funding coming into the
40 organisation to all the specific programs. And, it doesn't
41 match. Like, the acute services funding does not fully
42 cover the staffing profiles and the costs of running the
43 acute services.
44
45 Q. Can I ask you a bit more about that. You've touched
46 on cross-subsidisation when you said that you don't take
47 money from mental health and put it into acute services,

1 for example, so I guess conceptually one thing is taking
2 money from mental health to put it into physical health.
3
4 So, would you say that there's no cross-subsidisation
5 in that context, if I can just stick with that point?
6 A. I can say there's - no, so I'll work through that a
7 bit. So, we ringfence the funding for mental health
8 services and we try and make that funding balance for those
9 services that we're providing.
10
11 Now, we do receive throughout a year specified grants,
12 and sometimes they come quite late in the year, so it's
13 almost impossible for you to recruit and get the staff and
14 expend those funds. So, you might end up with a surplus of
15 funds in your Mental Health Program that would then hit the
16 bottom line from a reporting framework and then, if the
17 rest of the health service is over budget, then that
18 surplus would offset that overrun.
19
20 So, it's not purposeful "I'm going to use mental
21 health money to cross-subsidise the physical health
22 services", because my responsibility is the whole health
23 service, so you're trying to balance the whole budget, and
24 so, it might on occasion result in that happening.
25
26 I can go into why, and also why it might happen: it's
27 not only the extra funding that we might get coming in
28 through the year, but it has been incredibly difficult to
29 recruit into the positions that we have available in our
30 mental health service. So, we might carry a significant
31 amount of vacant EFT because we're unable to find the
32 qualified staff to work in those programs, and as a result
33 that would then result in a surplus if it doesn't get
34 offset by the overrun that we have in our acute mental
35 health services.
36
37 Q. I'll come back to ask you about that staffing
38 point that you've raised. Just in terms of sticking, I
39 guess, at the moment with the idea of cross-subsidisation,
40 you say in your statement, and now I'm focusing on within
41 the mental health budget, there is cross-subsidisation
42 between our different mental health programs, and can you
43 just elaborate on that?
44 A. Okay. So, working through our acute program, acute
45 and aged program, bed-based services, the EFT required for
46 us to provide a quality and safe service within those areas
47 is greater than the funding we receive for those services.

1
2 The funding that we receive for our community health
3 contact and all the other programs is there. If we are
4 unable to recruit the EFT that we need to run those
5 services, that funding just by nature will offset the
6 overrun that I would have in my acute service.
7
8 And also, you might set a staffing profile in an acute
9 service to manage the client load that you believe that you
10 need to have, but there's always going to be times when you
11 get extremely complex clients entering in those services,
12 and very often we will have to employ additional staff
13 members to manage those more complex clients. And that's
14 often not in budget. I mean, you try and make an allowance
15 for that because you get an understanding on how often that
16 might happen, but yeah, it's essentially unbudgeted from
17 the funding coming in for those bed-based services.
18
19 Now, that same issue happens in physical health, so
20 it's the same: you do a budget on a board, and you think
21 this is the staffing profile I'm going to need. If you get
22 a patient or a client that needs more care and you need to
23 provide a safe environment, both for staff and for clients,
24 then you would put on extra staffing.
25
26 Q. And so, if you could fill the positions that you have
27 available, you wouldn't be able to cross-subsidise in the
28 way you've described and remain in budget?
29 A. That's right.
30
31 Q. So then, there's a disincentive to be filling those
32 positions, is there?
33 A. Is there? There could be. I mean, I suppose at
34 Peninsula Health we've got nowhere to put the additional
35 people at the moment, so we've got a physical
36 infrastructure issue with our community programs at the
37 moment. So, even if we were to recruit to the numbers that
38 we think we need, we don't have anywhere to put them.
39
40 Q. There is difficulty in any event, partly because of
41 the lack of infrastructure, in recruiting people?
42 A. That's right, so that's not very attractive. For
43 example, our Mornington Mental Health Community Team are
44 residing down at Rosebud. Now, it's very hard to recruit
45 qualified mental health clinicians and say, come and work
46 in Rosebud in a building that is less than adequate, and
47 can you look after clients up in Mornington. You know,

1 it's just incredibly difficult for them and very difficult
2 for us to recruit into those vacancies.
3
4 Q. And they're based in Rosebud because there's nowhere
5 else for them to be?
6 A. Yes, that's right, we've been looking at trying to
7 find an appropriate place to house that group.
8
9 Q. Can I take you now to ask you about the scope for you,
10 or another public health service CEO, to be able to
11 advocate to DHHS for higher funding, and can you answer
12 that question in the context of your recent experience?
13 A. So, this is probably my first year of advocating for
14 mental health services from a funding point of view. So,
15 we met, we've done our budgets and we've been in regular
16 contact with the performance branch in the Department who
17 have been working with us on our budgets and targets.
18
19 We had our meeting last week to clarify a few things
20 and to work through those budgets. Perhaps naively, I
21 asked, "When will we talk about the mental health budget?"
22 And I was told that they don't control the mental health
23 budget, the mental health budget is managed by the mental
24 health branch, and that it would be up to me to make
25 contact with the mental health branch to talk to them about
26 the mental health budget.
27
28 So, you know, I was quite surprised. I was shocked
29 actually, and I thought, well, here we are trying to run
30 the whole budget: you know, it would be nice to be able to
31 talk to people about our whole organisation, so I do need
32 to go ahead and talk to the mental health branch about the
33 budget.
34
35 And that has been a problem. I've been the CEO for
36 18 months. The last 12 months I've only had one formal
37 meeting with the mental health branch, and it's been
38 somewhat - or it has surprised me that there hasn't been a
39 lot of detail in those meetings about what's really going
40 on in our mental health service. So, you know, what are
41 the staffing deficits, what are the budget constraints,
42 what are your quality and safety concerns, you know. Yeah,
43 I was a bit surprised.
44
45 Q. How does that contrast with your interactions with the
46 other branch, I don't recall what the name was?
47 A. Yes, the performance and commission branch. They've

1 got a lot more detail. I've met with them four times, so
2 we meet with them quarterly.
3
4 Q. That's four times over the past year?
5 A. Twelve months, yeah. We have very much clear
6 discussion around quality, safety. We talk about how we're
7 going against our Statement of Priority KPIs, we talk about
8 funding, we talk about capital and infrastructure issues,
9 so it is an opportunity to talk about the whole service,
10 but you don't talk about mental health.
11
12 Now, I have requested for mental health to be in those
13 conversations, and the last two meetings I've had a mental
14 health representative at those meetings.
15
16 Q. What have you been met with when you've tried to
17 include it?
18 A. So then, I'm just talking to the one person from the
19 mental health branch. So, the performance team - and I
20 talk about this in my statement too, is that, it's hard -
21 people don't understand what the mental health service is
22 about. It's kind of, even though we're sitting under the
23 one building, and even though in the Department of Health
24 we're sitting under - there's demarc - people just don't
25 seem to understand what the service is about, and those
26 divides make it very difficult for people like me to
27 understand what is required from a Chief Executive who's
28 responsible for delivering mental health services.
29
30 Q. Can I take you now to ask you about systematic
31 underfunding in mental health, and I'm going to read to you
32 a portion of a question we put to you when you were
33 preparing your statement, and this is at the top of
34 page 12:
35
36 "The Commission understands that public
37 health services are not funded for
38 100 per cent of the cost of the services
39 they are expected to deliver (with the
40 expectation that the shortfall will be made
41 up from own-source revenue, including
42 private patient fees), and that the
43 shortfall is larger for some services than
44 others. For example, the Auditor-General
45 found that DHHS meets around 62 per cent of
46 the cost of delivering an acute mental
47 health bed compared to 82 per cent of the

1 cost of delivering an acute general bed."
2
3 We posed the question to you, what are the
4 consequences of a large discrepancy between costs of
5 service delivery and the funding provided for a health
6 service, and you've touched on some of those, but are there
7 others that you'd seek to address at this point?
8 A. I suppose the main areas are - is you're unable to
9 meet demand. Now, I don't know what the demand is in the
10 mental health service, except what's coming through the
11 Emergency Departments, so I have no capability of
12 understanding of what is the unmet demand in the community.
13
14 So, kind of, our demand in the community is managed by
15 the number of resources that we have available. So, if you
16 don't have budget to recruit two EFT to provide those
17 services, then people miss out on those services. Or, if
18 you don't have budget, then people miss out on those
19 services.
20
21 We would then not be able to achieve performance
22 targets, but there's not a huge number of performance
23 targets in the mental health service, so nobody's really
24 probably watching that.
25
26 And then it's from an infrastructure point of view, so
27 it's difficult to - or our operational budgets don't
28 include capital infrastructure, so it's about negotiating
29 for a capital budget is difficult.
30
31 Q. I'll come back to ask you about the capital investment
32 a bit later as well. In terms of, you mentioned just
33 briefly now in terms of the performance targets, that
34 they're not really measured anyway. I want to ask you
35 specifically about the annual report of Peninsula Health
36 for 2018 and the fact that it reported that it's exceeding
37 KPIs in mental health, I think in every domain. So, that's
38 in relation to KPIs set by the Department?
39 A. M'mm.
40
41 Q. And in your view, do they adequately measure the
42 ability for a service to meet demand?
43 A. No.
44
45 Q. And, what about the ability to adequately measure the
46 extent to which a full range of services are delivered to
47 the community?

1 A. No, they don't monitor that.
2
3 Q. Do you have ideas about how those things could be
4 better monitored?
5 A. I think it would be helpful to know or get a sense of
6 who in the community are not getting access to services.
7 So, we have no sight of that. I don't know how many times
8 our clinicians are having to say "no" to people, or I don't
9 know how often they say, "No, look, you're not complex
10 enough." Our staff are often saying they feel as though
11 they're having to discharge people too quickly, so there
12 might be some indicators around those outcome measures.
13 So, when is a good time to discharge somebody from a
14 service?
15
16 In physical health, you have the metrics, oh, they're
17 not in pain, they can get up and walk, they're eating food,
18 they can shower themselves and manage their hygiene needs,
19 so you've kind of got some metrics on how you can feel
20 confident that you're discharging somebody safely back
21 home. But we don't have those same measures, that I'm
22 aware of, in mental health, so maybe we could do some
23 thinking around that.
24
25 I would like to understand what the unmet demand is
26 and perhaps whether we're appropriately discharging people
27 from our service. Then it would be useful also to know how
28 we're going and how we can compare ourselves to other
29 services; so, are there best practice models in the system
30 that we're unaware of, but I don't have any sight of that
31 either.
32
33 Q. Can I just ask you about funding growth in the past
34 three years, just take you to that topic. One of the
35 things that you've mentioned in your statement is that
36 there has been funding growth in the past three years?
37 A. Absolutely.
38
39 Q. You haven't looked back further in terms of how that
40 compares to the previous 10?
41 A. No, that was very difficult for me to do in the
42 timeframe.
43
44 Q. But you would say nonetheless, even with this funding
45 growth in recent times, funding is insufficient for
46 Peninsula Health to effectively provide the mental health
47 services to meet the growing demand?

1 A. So, the additional funding that we've received in the
2 last three years have been for specific programs of work,
3 and so, they're very discrete pieces of funding. For
4 example, $3.3 million this year, or last year going into
5 this year for a Crisis Hub in our Emergency Department.
6 So, they're very specific pieces of work that we will do in
7 developing a model of care and a budget, and recruit into
8 that new funding. So, that's where the majority have
9 funding over the last three years that I could ascertain
10 have been for the mental health services.
11
12 Q. Can I ask you then about capital investment or capital
13 funding. One of the things you mention in your statement
14 is that it's in mental health particularly difficult to
15 attain. Can you just elaborate on that?
16 A. So, again, this is from my limited experience of two
17 health services, and I think what I can see is that the
18 investment for big capital - so, this is some building
19 capital - relies on a good service plan, master plan and
20 assessment of your facilities, and are often aligned to
21 obvious indicators that are not being met: so Emergency
22 Departments, theatres, acute beds.
23
24 We've been really fortunate at Peninsula Health: just
25 in the last 12 months we've received $560 million to build
26 a new Frankston Hospital, and now acute and aged mental
27 health services have been included in that.
28
29 I think, once we get beyond that acute system, it's
30 difficult: I don't think it's understood what people are
31 doing in the community and where they're doing their work
32 in the community. I mean, I must admit, I was quite
33 surprised, both at Barwon and at Peninsula when I toured to
34 see where our community services were working from, and
35 they're not great places, they're not in a great space at
36 all; they're certainly not in an environment that would
37 allow them to feel comfortably able to provide appropriate
38 and effective care to the people that they're trying to
39 offer care to. It's always makeshift.
40
41 The Barwon acute facility was very poorly designed,
42 and one of the things that I did in that three months was
43 work with that team on some redevelopment plans, but I'm
44 not too sure whether that actually progressed. They were
45 having to staff - their staffing model to manage that
46 environment was very inefficient, but they needed to have
47 much more additional staff because of the poor environment.

1
2 Q. Just to touch on one of the issues you raised in your
3 answer: so you're talking about the lack of understanding
4 of what community services need. Is that from a
5 Departmental level, is that what you're referring to?
6 A. Yes, and probably from my level too. You know, until
7 you go out there and actually see where they're working and
8 how they're trying to work, yeah, I was surprised.
9
10 Q. The final area I want to ask you about is the key
11 constraints or pressures that may hamper the implementation
12 of mental health reforms or service improvements. There's
13 two in your statement that you address in particular, I'll
14 ask you about them individually.
15
16 The first is the lack of consistent and coherent
17 statewide model of care, and then insufficient integration
18 of mental health services. So, if we can start with the
19 lack of consistent and coherent statewide model of care:
20 you've talked about the model of care in the context of
21 Peninsula Health, but there's a broader picture?
22 A. Yes. So to me, I don't think we do things in the same
23 way in each mental health service; well, it's not clear to
24 me that we've got the same models.
25
26 Even in our own service, the experience of a client
27 coming in to our Emergency Department and working through
28 our service could be very different for each individual
29 person that comes into our service. I'm not clear that the
30 people that are coming into Peninsula Health are receiving
31 the same standard and the same level of best practice care
32 and mental health services: I've got no way of seeing that,
33 I've got no way of measuring that.
34
35 I kind of think, if somebody comes through in the
36 Emergency Department with a physical health concern, I've
37 kind of got an understanding that a similar pathway for
38 physical health would be followed regardless of whether
39 they came to Peninsula Health, Monash, The Alfred,
40 Melbourne, it would be fairly similar. But I don't have
41 that confidence that we've got a similar process or model
42 in our mental health services.
43
44 Now, it could be my lack of understanding, but it's
45 not clear to me. It's not clear whether we're running a
46 residential program the same across the state; it's unclear
47 to me about how we're running our community programs and

1 whether we're providing the same models of care and support
2 in the community. I have no oversight of that.
3
4 So when it comes to talking about mental health
5 services, if you don't understand it and have a language
6 for it, then it's hard to describe to new staff members,
7 it's hard to describe to Board members, and I cannot
8 understand or see how a community member would be able to
9 navigate their way through the system. I have been in the
10 system for a long time, I can navigate my way through the
11 physical health system; I don't think I'd be able to
12 navigate my way through the mental health service.
13
14 Q. And so why is it important that there's consistency in
15 the models of care across services or between services?
16 A. I think it would be helpful, both in educating people
17 about mental health services and making them more
18 accessible to people, and I also think it would help from a
19 benchmarking and service provision. So both by trying to
20 measure quality and outputs, outcome measures, and also
21 some effectiveness measures to see whether the money we're
22 investing in our mental health services is being
23 effectively used.
24
25 Q. Can I ask you then about what you say is insufficient
26 integration of mental health services?
27 A. That's internally too, so again, the Barwon experience
28 and Peninsula experience. The acute mental health
29 services, for example, are sitting on the same land mass,
30 you know, are just there.
31
32 It feels to me like there is - I say it's a fear, and
33 I don't know whether it's kind of a fear that I've had -
34 but there's kind of a lack of confidence of being involved
35 with the mental health team, because of that lack of
36 knowledge, that lack of understanding and that lack of -
37 it's kind of like mental health service business. And so,
38 I've had to work hard at being able to get in there and
39 understand it, and that hasn't been easy.
40
41 And so, part of what we're trying to do at Peninsula
42 Health is to have them better integrated into our whole
43 service, so everybody understands what our mental health
44 service is about, and to feel comfortable to be in there
45 and working with them. We've really engaged our mental
46 health team, we've got some great expertise, our clinicians
47 have got some fantastic knowledge, so we've been using our

1 mental health team to come in and educate and support some
2 of our other teams on how to manage difficult clients,
3 dementia, behavioural concerns, et cetera, but it has been
4 something that I've had to actively do. I've never been
5 encouraged, in all my roles as an Operational Director, to
6 actively participate with mental health.
7
8 Q. Thank you, Ms Topp. Are there any matters you'd like
9 to cover that we haven't addressed?
10 A. No, I think we've just about covered it all, thank
11 you.
12
13 MS COGHLAN: Chair, do the Commissioners have any
14 questions?
15
16 COMMISSIONER COCKRAM: Q. Ms Topp, you've mentioned
17 about capital infrastructure particularly for community
18 services. Can you just explain to the Commission how
19 community services are predominantly funded through the
20 block grant?
21 A. Through the community contact hours. I don't know a
22 lot about the block grant, Alex. I know that we get a
23 block grant, but I think we get some amount of money to
24 support some infrastructure. So, they've given us some
25 money to rent an area in Frankston, but the issue is, is
26 that, we've had to rent not a purpose-built space for our
27 community teams. So, we've kind of got not a great
28 building that they're working out of, and it's certainly
29 not purpose-built for them to provide community services.
30
31 Q. Just then to continue on with what you just mentioned,
32 is that, you have been supported by the Department for
33 covering the rental where Peninsula doesn't specifically
34 own the infrastructure that exists?
35 A. That's right.
36
37 COMMISSIONER COCKRAM: Thank you.
38
39 CHAIR: Q. I just have a few issues that I'd like to
40 raise. The first of them goes to, in your statement you
41 gave a very useful analysis of the fact that the Statement
42 of Priorities govern what's of interest and attention to
43 your Board and also to senior management, and you stated
44 that they are largely focused on physical health, access
45 and quality.
46
47 Can you just give us by way of comparison, what would

1 go to the Board regularly for attention around physical
2 health and then I'd like to come back to the issue of
3 mental health?
4 A. Some of the physical quality indicators that we would
5 report would be staph aureus blood infections, falls,
6 pressure areas, any serious incidents that happen within
7 the physical health services. I said "pressure areas",
8 yeah.
9
10 Q. When you say "pressure areas", what does that mean?
11 A. So, pressure areas are areas where a patient may have
12 had a graze or been in a bed for a long period of time and
13 they get a pressure sore.
14
15 Q. So they're indications of concerns about quality of
16 care?
17 A. Yeah, quality of care.
18
19 Q. And you'd report those sort of things to your Board on
20 a regular basis in the dashboard reporting?
21 A. That's right.
22
23 Q. What gets reported, if anything, to your Board on a
24 regular basis about comparable events in mental health?
25 A. None. So, not on a regular basis. If there was a
26 serious incident, through our ISR reporting, we would
27 report, but there are no similar quality measures at the
28 moment going up the Board regarding - in our Peninsula
29 Health service.
30
31 Q. I think you've explained in part why that's the case
32 and the complexity and the lack of performance metrics that
33 you think are helpful to drive that level of
34 accountability.
35
36 But also in your witness statement you gave us a very
37 helpful description of the range of mental health services
38 that are provided by Peninsula Health, both in acute and
39 residential settings and also in community settings, and
40 it's quite an extensive list of services that are provided.
41
42 I guess it's about the visibility, you said, on
43 community mental health is also very limited to the Board
44 and senior management, notwithstanding the extensive nature
45 of those services that are provided?
46 A. That's exactly right. So, you really have to go out
47 and ask the questions about the services that you provide,

1 and I've certainly spent the last 12 months going out and
2 visiting all those services so I can understand the service
3 that they're providing and the environment that they're
4 providing that service in.
5
6 Q. By way of comparison, you did say that the physical
7 health indicators and reporting framework's quite
8 sophisticated, been established over a long period of time,
9 and you engage in quite robust dialogue with the Department
10 about your performance. For how long has that sort of
11 robust process, in your view, been in place in physical
12 health?
13 A. A long time.
14
15 Q. Decades?
16 A. Yes. Oh, 15 years, and they've certainly evolved. In
17 particular, the quality measures have evolved.
18
19 Q. I think that's illustrative, in your view, of the fact
20 that there's a long way to go in mental health until it has
21 comparable reporting?
22 A. That's right.
23
24 CHAIR: Thank you very much.
25
26 **<THE WITNESS WITHDREW**
27
28 MS COGHLAN: Thank you, Chair. It is early, but is now a
29 convenient time to break for lunch, given that the next
30 witness will be attending at 1.30, and that's Jennifer
31 Williams?
32
33 CHAIR: Thank you very much. Yes, we'll adjourn.
34
35 **LUNCHEON ADJOURNMENT**
36
37 **UPON RESUMING AFTER LUNCH**
38
39 MS COGHLAN: The next witness to be called is Jennifer
40 Williams, and I call her now.
41
42 **<JENNIFER JUNE WILLIAMS, affirmed and examined: [1.33pm]**
43
44 MS COGHLAN: Q. Thank you Ms Williams. You've provided
45 a statement to the Commission?
46 A. I have.
47

1 Q. I tender that statement. [WIT.0002.0020.0001] You are
2 the Chair of Northern Health?
3 A. I am.
4
5 Q. Can you just outline for the Commissioners, firstly,
6 just what your qualifications are?
7 A. I've got a Bachelor of Economics and a Master of
8 Science and I'm a Fellow of the Institute of Company
9 Directors.
10
11 Q. You've had the role of Chair of Northern Health
12 since July 2015?
13 A. Correct.
14
15 Q. What about your current, other board appointments?
16 A. I'm also the chair of Yooralla, and I'm on a number of
17 other boards: I'm on the Barwon Health Board, the
18 InfoXchange Board, the Independent Hospital Pricing
19 Authority, the Medical Research Advisory Board, I'm Chair
20 of the Alfred Full-Time Medical Staff Trust, and I am just
21 in the process of completing assistance to the South
22 Australian Government with the development of a mental
23 health plan as a panel member.
24
25 Q. Prior to those board appointments that you've just
26 described, you've had over 20 years of experience in the
27 health sector?
28 A. That's correct. I have, prior to my board
29 appointments which is just over three years ago, that I
30 have moved to just do boards, I was the Chief Executive at
31 the Red Cross Blood Service for seven years, the Chief
32 Executive at Alfred Health for five years, and the Chief
33 Executive of Austin Health for seven years prior to that,
34 and before that I was with the Department.
35
36 Q. And in fact, for 13 years, you had experience working
37 in the State Government of Victoria?
38 A. I did, yes, that's correct.
39
40 Q. Just detail, just briefly, what those roles were?
41 A. The final role I had was director, which is the deputy
42 secretary level within the Department, they were the titles
43 used at the time. I was the Director of Aged Community and
44 Mental Health and, prior to that, I was the Director of
45 Psychiatric Services, and before that I was not in the
46 health area, I was at the Department of Treasury and
47 Finance, and worked in the area of information systems, and

1 prior to that I was with the Ministry of Housing again, in
2 the area of information systems.
3
4 Q. Can I just ask you now to focus on providing some more
5 detail in relation to the professional roles that you've
6 had in the mental health system in Victoria. Can I ask you
7 to start with Barwon Health and your role as a board member
8 there, at paragraph 15 of your statement.
9 A. Yes. I was initially appointed as a delegate to the
10 Board at Barwon Health, they were having some financial
11 issues at the time, and the office of ministerial delegate
12 is often used to assist the health service to get out of
13 issues which are problematic. So, I started as a
14 ministerial delegate there and then I was appointed to the
15 board of Barwon Health, so subsequent to that I have been a
16 board member at Barwon Health and have continued to be so.
17
18 Q. Can I then also just ask you more specifically about
19 your time as Director of Psychiatric Services with the
20 Department of Health and Community Services that you've
21 mentioned, and just go into a bit more detail about your
22 responsibilities in that role?
23 A. Yes. As Director of Psychiatric Services, I was
24 responsible for the mental health system for the state and
25 moving into that role initially the mental health services
26 were run by the state: so all the employees of mental
27 health reported to the Department, the accountability
28 structure, governance went back to the Department, not to
29 health services, and part of my role there as running
30 mental health services was to bring about the mainstreaming
31 of mental health and the de-institutionalisation and the
32 establishment of community-based services.
33
34 Q. Can I take you to that topic now, paragraph 44. Just
35 drawing on the experience that you've had, can you address
36 the key factors that drove de-institutionalisation at the
37 time?
38 A. Yes. There were a number of things that really caused
39 a significant concern about what was happening with mental
40 health services. Just prior to my arrival there had been
41 the disclosure of abuses of people with mental illness at
42 institutions, so Lakeside was an example of that. There
43 were also abuses of disabled people that were uncovered
44 during that time. So, there was an intent by the
45 government, the Minister and the Director-General of the
46 Department to change the model of care for mental health
47 and to adopt a de-institutionalisation model by moving the

1 services from being directly run by the Department to being
2 mainstreamed and run by the public hospitals, and to at the
3 same time as relocating beds from the institution, to
4 establish community-based services that were also run by
5 the mainstream hospitals where the services would be moved
6 to.
7
8 So, I was responsible for developing of policies and
9 the strategies to bring about those changes to seek the
10 funding to enable the funding of the services, which
11 included significant capital funds because new facilities
12 needed to be built in the acute hospitals, in the subacute
13 hospitals, in residential care and the establishment of
14 community clinics and the associated services like crisis
15 teams, Mobile Support and Treatment teams for them to
16 operate in the community, as well as the establishment of
17 services run by the NGOs for psychosocial rehab.
18
19 Q. You talked about one of the driving forces was what
20 was being uncovered that was occurring within institutions,
21 but there were two other things going on at that time,
22 perhaps in the broader social setting, which was that there
23 was a real focus on homelessness, and there was also highly
24 publicised events where there'd been police shootings.
25 Could you address those two areas?
26 A. Yes, that made the problem much more acute and was
27 very much in the public air. So, Brian Burdekin had done a
28 very significant review of homelessness and that was
29 getting a lot of coverage in the media and a lot of
30 interest and attention politically, and that was uncovering
31 that a very significant number of people that were homeless
32 had a mental illness, many of which had never received
33 treatment and that were unable to access treatment. So,
34 that was certainly an impetus to drive the reforms in
35 mental health.
36
37 And just a short time after the Burdekin reports were
38 released, there were a very unfortunate series, not just
39 one or two, but a series of police shootings where the
40 police were put in situations of danger and the only
41 measures that they felt they could respond by was by using
42 firearms, and there were both shootings that resulted in
43 death as well as other injuries to people with mental
44 illness, and of course, that received enormous attention
45 and concern in my area, in my Department and with the
46 Minister, about what we could do to try and educate and
47 train police in using other strategies to try and deal with

1 people that were very agitated where police intervention
2 was obviously a safe thing to do, but to give them other
3 options as well as to train them in aspects of what mental
4 illness meant and developing strategies along with the
5 police force about how they would deal with those
6 situations.
7
8 Q. You have then just gone on to describe the wave of
9 reform and the things that were implemented. That was
10 supported by the national mental health plan which had
11 similar goals?
12 A. Yes. Sorry?
13
14 Q. That was supported by the national mental health plan
15 which had similar goals?
16 A. That is correct, so there are now five mental health
17 plans and this was the first of those. So, Victoria, as
18 with every other jurisdiction, needed to respond to that
19 national plan, how was Victoria going to respond that
20 national plan and how was it going to implement the goals
21 and the vision that were outlined in that plan.
22
23 So, that was the blueprint that really drove the
24 direction of the reform package in the area that I was
25 responsible for, we developed it, and we developed this
26 document called the framework for mental health services in
27 Victoria, that reflected those goals and identified how we
28 would achieve those and what we would implement to achieve
29 the goals of that first plan.
30
31 Q. Can I just ask you about your observations in how the
32 government made the implementation of significant reforms
33 to mental health services a key priority at that time?
34 A. Yes, I think the circumstances of the issues
35 identified in the institutions, the police shootings, the
36 Burdekin report, those things certainly made mental health
37 very visible and that it needed something done to it.
38
39 But we also had a secretary of the Department who was
40 very determined to improve the plight of people with mental
41 illness. He himself had a disability and he was very
42 adamant that things needed to be changed and we needed
43 quality services that protected the rights of people with a
44 mental illness in that they needed quality services. So a
45 Director-General who was very supportive, and a Minister
46 who was also very receptive and supported the mental health
47 reforms.

I have put in my statement that one of the things which I think was very significant about what the Minister did, and it was Marie Tehan at the time, when she launched our policy framework which was the policy, the blueprint for reform, she took the speech we had prepared for her and took it home and she actually wrote in that speech herself that, as Health Minister, she was prepared to be judged on what she did in the whole health portfolio on what she did in mental health alone. The weight of that commitment certainly sat on my shoulders and the people in the Department that I was working with to know that we had a Minister that was just so thoroughly committed to what we were doing, that she would stand behind us and support what we were doing.

And that was done in a very real way because she was able to deliver funding that we needed to bring about the improvement in services, the addition of services, a very large capital program to address the construction of new facilities, both in hospital and out of hospital.

So, that was obviously supported by the Premier and Cabinet at the time, but I think the issues that we were dealing with in the community and that leadership and that commitment, that absolute dedication to making this work, was very much paramount in the success of what we were able to do.

Q. One of the things you comment on in your statement is that:

> "Where there is a commitment at a senior leadership level, proposals for mental health reform and service improvement are more likely to be presented to Cabinet and the Expenditure Review Committee and are more likely to be successful."

A. Yes, to have a Minister advocate so strongly for this area was vital to the success. The health portfolio is a very complex portfolio with enormous demands across many areas, and mental health had never been a high priority in terms of budget allocation, and I think that's something which hopefully this Royal Commission can contribute to putting it back as a high priority on the political agenda to get that sort of attention.

1
2 Because, it's not just the focus and the support, you
3 need that real support by budget allocation, because the
4 enhancement of services cannot occur without additional
5 budget.
6
7 Q. Do you think the vision and service system that was
8 put in place in the 1990s is still relevant to community
9 needs?
10 A. Yes, well that question does make me go back and think
11 about that question, and I think fundamentally, yes: what
12 we put in place back there is still appropriate, and I
13 think those of us that work in mental health can see that
14 the system is still fundamentally there, but there have
15 been many improvements and enhancements and innovations and
16 new parts of the service system that have been added into
17 the system since then, and a lot better reporting on what's
18 going on within mental health.
19
20 But things like the area based service, the inpatient
21 across child and adolescent, adult, aged, the forensic
22 aspects, the special care needs of other specific groups
23 that have particular needs, those elements are still
24 relevant and are still very much in place today.
25
26 I think what has not happened though is that the
27 development of the system has not kept up with the demand,
28 and hence, the service system which was designed and
29 perhaps served Victoria well for five or so years, needed
30 to be continued to be built upon, expanded and evolved and
31 that has lagged the demand on the system, and hence,
32 Victoria has lapsed back in terms of its leadership in
33 mental health.
34
35 Q. Can I just now change direction and take you to your
36 role as Chair of Northern Health, paragraph 9. Can I start
37 by asking you about the arrangements under which Melbourne
38 Health provides clinical mental health services to
39 Northern?
40 A. Yes. So, Northern Health does not run mental health
41 services for the catchment that it serves, the broad
42 catchment that it serves. Some 20 years ago Melbourne
43 Health took responsibility for delivering the mental health
44 services for the catchment that Northern Health covers as
45 well as the catchment that Western Health covers as well as
46 Melbourne Health's own catchment, so it's responsible for
47 those three different services and the mental health

1 services that they deliver.
2
3 And, it is Northern's view that this is a model that
4 worked well for many years, but for many years now it has
5 been a model that has needed to be changed and that
6 Northern Health should take responsibility for the mental
7 health services that serve its catchment, and that the
8 staff that are working in those services that are currently
9 employed by Melbourne Health should be moved to Northern
10 Health and that the management and the Board of Northern
11 Health would take direct accountability for the mental
12 health services for its own population.
13
14 I would draw an analogy with other outsourced services
15 to say that the mental health arrangements are quite
16 different from Northern Health simply purchasing mental
17 health services from Melbourne Health. It is not that
18 arrangement, so we purchase radiology services, we purchase
19 food, we purchase cleaning services, we have contracts, but
20 the Board is still accountable for the delivery of food and
21 radiology and cleaning services.
22
23 In mental health the Board is not accountable or
24 responsible for the mental health services that are
25 provided, it is the Melbourne Health Board that is
26 responsible for that. So, we would very much like to see
27 that transition from Melbourne Health to Northern Health.
28 There have been some discussions over some years for that
29 to occur, but there has been little progress in getting
30 about that transfer.
31
32 Q. Could you just address some of the perhaps unintended
33 consequences of that arrangement?
34 A. Yes. There is almost no visibility of how funds are
35 allocated, what the gaps might be, and what the issues are
36 in mental health services because this is not information
37 that comes either to the management or the Board of
38 Northern Health, so we are pretty well blind to that.
39
40 But it is very difficult to disentangle mental health
41 from the other services that you provide within a hospital
42 as large and complex as Northern Health and its various
43 sites. So, the best example would be talking about mental
44 health patients that present to an Emergency Department,
45 which is the responsibility of Northern Health, but when
46 those patients present, we do not have access to the mental
47 health records of that patient if they had been receiving

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1 previous treatment, so we are not able to get information
2 about previous treatment for those patients.
3
4 We're also reliant on Melbourne Health coming to
5 assess and determine if those patients that might need
6 admission to a mental health bed, that we are dependent on
7 Melbourne Health doing that. Northern Health can't do
8 that. The length of stay for mental health patients in the
9 Northern Health Emergency Department is very
10 unsatisfactory, there are extremely long waiting times for
11 patients in the Northern Health Emergency Departments.
12
13 Until only a couple of years ago we were getting no
14 information at all about the performance of mental health,
15 and we now do get a small number of indicators which only
16 relate to the performance within the Emergency Department
17 of the services, and that looks at the waiting time for
18 mental health patients, and so, there are three indicators
19 that the Board now gets routinely but it is only restricted
20 to the Emergency Department part of the mental health
21 services. We don't get any information about the
22 performance of mental health outside that.
23
24 Recently it came to the Board's attention that we were
25 concerned that patients were being restrained for excessive
26 periods of time in the Emergency Department. I was
27 obviously concerned about that and we asked if it was
28 possible to get information about numbers and duration and
29 how that might compare to other health services about
30 restraint in the Emergency Department, the implication
31 being that patients were being retrained because we didn't
32 have the appropriate facilities within the Emergency
33 Department for these patients. So, we now get some very
34 limited information on the restraint in the Emergency
35 Department but we don't have other information such as
36 seclusion rates or re-admission rates, the normal sort of
37 indicators that other boards and other management teams
38 would get about the mental health services that run within
39 their facilities.
40
41 Q. Can I perhaps draw on some of your previous experience
42 then in asking the next phase of questions. This is on the
43 topic of prioritisation, paragraph 16. In thinking about
44 your past roles in particular, can you describe the extent
45 to which you've seen the prioritisation of mental health
46 within the overall work of hospitals and services?
47 A. Yes. So, at Northern Health, we do not put in

1 submissions for additional funding for mental health
2 because, as I've just explained, we're not responsible for
3 that. But at other health services where I have worked,
4 Barwon Health currently, The Alfred and the Austin where
5 I've been Chief Executive: so at those services you would
6 have regular dialogue with the Department about where you
7 saw there was a need for additional funding or for new
8 services to be funded, and then there's the annual budget
9 process where you can make specific submissions to get
10 additional funding for certain things.
11
12 So, certainly mental health would be considered by
13 management, and by the Board, about what submissions would
14 be made to government to attempt to get additional funding.
15 For larger projects, which might be either operational
16 funding or for larger capital projects, there would be
17 full-blown business cases developed, with fully costed and
18 benefits and risks identified for those sorts of proposals.
19
20 So, that is an annual budget cycle and the mental
21 health part of those budget bids occurs alongside all other
22 budget bids for all other parts of the health system.
23 Within the Department it does get dealt with by a different
24 bit of the Department, but the process if you are sitting
25 within a health service is the same when you're seeking
26 additional funding for surgery or medicine or for mental
27 health.
28
29 Q. Can we just take that a bit further then and address
30 the process that involves DHHS, and specifically if I could
31 ask you about the process for a health service advocating
32 at that level for additional funds?
33 A. Yes. Well, the advocacy to the Department is vital so
34 that the Department understands that the needs and the
35 pressures that you have - because all health services are
36 making submissions to the Department and there's obviously
37 prioritisation that has to occur to identify who is most in
38 need, because there are limits to the budget to be able to
39 address all of the demands that come to them.
40
41 To support discussions with the Department, there are
42 often discussions with the Minister and the Minister's
43 Office, and also you might involve local Members of
44 Parliament to assist in talking to other Members of
45 Parliament and/or the Minister to give additional support
46 to your budget needs.
47

1 The mental health branch within the Department is the
2 one that would need to support your budget bids for it to
3 get even to the first level of consideration before the
4 Department before those budget bids would even then get a
5 chance of being then presented to the Department of
6 Treasury for consideration in the overall budget.
7
8 Q. You've just raised there that there might be an
9 attempt to engage with local government in terms of trying
10 to attract support and advocacy for your cause?
11 A. Local government less so. I mean, it could be local
12 government, but typically it would be local Members of
13 Parliament I was referring to.
14
15 Q. Sorry.
16 A. At Federal or State level, yes. Because local
17 governments provide some support to people with mental
18 illness, but they wouldn't typically support a budget bid
19 to the State Government for extra resources.
20
21 Q. Just moving on then to your observations: what are the
22 sources of unanticipated or greater than budgeted
23 expenditure within a hospital or health service both within
24 clinical mental health services and generally?
25 A. The sources of?
26
27 Q. The sources of unanticipated --
28 A. Unanticipated costs?
29
30 Q. Yes.
31 A. In mental health, as with other areas, your budget is
32 indexed by increases in labour costs usually that would
33 come out of an EBA agreement, so salaries would be indexed
34 accordingly, and then there is an adjustment for non-salary
35 increases, the health CPI or CPI more generally, and your
36 budget would get adjusted according to that.
37
38 There are usually efficiency dividends that are
39 required each year, therefore savings that also would need
40 to be made. So, while you might have an increase in costs
41 resulting from those two areas, salary and non-salary that
42 I just mentioned, usually there is a gap that the health
43 service usually has to try and fund or fund via reducing
44 its costs to be able to operate within the parameters of
45 the budget that has been provided.
46
47 So there would nearly every year, in my experience,

1 you are required to look for efficiency savings so that you
2 can deliver a balanced budget.
3
4 Q. You mention in your statement that mental health has
5 historically been seen as the poor cousin?
6 A. Yes, it's a term often used in mental health
7 unfortunately, and it's sad that that term does get used,
8 but people use it so commonly I think because they feel
9 mental health misses out, where other areas within health
10 are addressed. So, the so-called sexy areas get funding,
11 but mental health misses out, and that's why I've
12 emphasised in my statement the importance of having such
13 strong support at very high levels right throughout
14 government and the bureaucracy to try and redress, I think,
15 that disadvantage that mental health has had over many,
16 many years.
17
18 Q. Can you then please describe your observations as to
19 the quality, timeliness and depth of the performance and
20 financial information available to the Board in relation to
21 clinical mental health service delivery? Is that something
22 you can comment on particularly in terms of your previous
23 experience?
24 A. Yes. I would say it's equivalent to other clinical
25 areas within a health service. Again, at Northern we don't
26 have that information but at other health services they
27 would have financial information about the Mental Health
28 Program and they would have a series of other indicators to
29 identify trends within the existing health service and
30 comparisons with other health services across a range of
31 metrics.
32
33 There are quite a large robust number of mental health
34 indicators which are published for the State as well as
35 national indicators. So, while a lot of these are not
36 outcome indicators, they are more input measures: like, how
37 many hours of community contacts and things like that,
38 they're not really looking at what are the outcomes of the
39 patient. There are a lot of indicators where health
40 services can compare themselves, and that is done
41 routinely.
42
43 There is also organisations like the Health
44 Roundtable, that's a national organisation that gives
45 information that enables you to compare things across
46 health services, so you can look for where you need to
47 improve the care and give attention to the areas where

1 there is under-performance compared with other areas.
2
3 Q. Does that apply to mental health in comparison?
4 A. And that applies to mental health as well.
5
6 Q. On those sort of broader KPIs that you've identified?
7 A. On those broader KPIs as well, yes.
8
9 Q. And so in your view and experience you would say that
10 you don't think that mental health has suffered from
11 adverse internal prioritisation by boards?
12 A. Not by boards, no, I don't think it does. I think in
13 my experience definitely the boards are focused on mental
14 health just as much as they are on other clinical areas and
15 from time to time boards are very focused on mental health
16 because there are very serious incidents that occur in
17 mental health, and the Board can get quite interested and
18 concerned about those issues.
19
20 I can think of one health service in particular where
21 there were external reviews that showed a series of poor
22 outcomes where the Board established a sub-committee to do
23 a deep dive and to monitor rectification of all of the
24 recommendations that were made from a series of reviews.
25 Sometimes those reviews are by the Chief Psychiatrist,
26 sometimes they're external reviews which might have been
27 commissioned by the health service itself.
28
29 So, no, I don't think boards de-prioritise the
30 importance of mental health, certainly not in my
31 experience.
32
33 Q. Does it depend on the information the Board is
34 provided with?
35 A. Certainly it does, but that goes for everything within
36 governance: if management is not providing the Board the
37 information, then it is not as easy for the Board to
38 identify what are the gaps, what are we not seeing, where
39 do we have an interest? And boards might pick that up
40 themselves, but yes, you are very dependent on management
41 to making sure that they do give that balance and make sure
42 that the mental health issues are presented to the Board as
43 frequently as necessary.
44
45 In things like the quality committees of the Board,
46 that you're not just looking at the acute health and
47 subacute sort of issues, that you're also looking at all of

1 the mental health issues as well, whether it be sentinel
2 events or root cause analysis of incidents, as well as some
3 of the metrics that can identify how you're performing
4 against other health services.
5
6 Q. Can I ask you now about geographic catchments and I am
7 going to ask you whether you consider them to be helpful or
8 unhelpful. You've got some particular experience in the
9 fact that they were developed in the first place?
10 A. Yes, I do. In fact, we established the catchment
11 concept back in the early 90s when we developed the set of
12 reforms, and that was driven because there is a lot of
13 concern that, when mental health patients present to a
14 particular hospital or service, that they would not receive
15 treatment, that they would be seen as too difficult, or the
16 hospital would be too busy, or that they didn't have the
17 capacity to deal with the patient and the patient was left
18 having to go around the system trying to find someone that
19 would assist them.
20
21 And so, for that reason area based mental health were
22 established to ensure that a patient had to be treated by
23 the health service within which they had a responsibility
24 for that catchment area.
25
26 There has been criticism of it, that it removes
27 patient choice, why can't patients drive across town and
28 receive services from another health service, and patients
29 can do that. That doesn't stop patients doing that, but it
30 really was the safety net to ensure that there would always
31 be care for a mentally ill person that needed care and that
32 a hospital cannot reject that care.
33
34 There are certainly difficulties with the boundaries
35 and the defined catchment areas of mental health services,
36 and there are currently certainly problems in child and
37 adolescent and in other areas, I believe, in also in aged
38 psychiatry, that the boundaries don't line up to other
39 catchment areas, and I think a review of those catchment
40 areas to see if some changes could be made to better
41 line some of those catchments.
42
43 Whether you could now just through your contracts with
44 health services ensure that they would be obligated always
45 to treat the mentally ill and therefore do away with the
46 defined, you know, I wouldn't rule that out, but it has
47 been seen as really a safety net for patients rather than

1 something that was put up as a barrier for patients.
2
3 Q. You've talked about the proposal that Northern Health
4 take control of mental health in the future. If that was
5 to be the case, how would you then optimise the governance
6 and accountability for mental health within your health
7 service?
8 A. Yes. Well, firstly we would need to be gazetted as a
9 hospital that could receive mental health patients because
10 we're not currently a gazetted hospital, since we don't do
11 that, so there is a requirement for government to give
12 assistance to that through regulation, I believe; it's not
13 a legislative change that would be needed, so that would be
14 the first step that would need to happen.
15
16 The staff would need to be transferred across: that
17 has happened in other service areas, quite routinely that
18 can be done. Northern Health would need an executive
19 structure to incorporate mental health as a significant
20 clinical program reporting either to the Chief Executive or
21 to the Chief Operating Officer, and there would need to be
22 a transition program developed and negotiated with
23 Melbourne Health to progressively bring the services across
24 to the accountability of Northern Health.
25
26 It obviously would be at least a 12-month period to
27 transition this across, and there would be some issues with
28 some of the services that would be more difficult to
29 transition quickly than others; some that are entirely
30 catchment based are very easy, but there are others like
31 child and adolescent and things like that which would be
32 more complex to transition.
33
34 So, the Board would give a lot of attention to the
35 transition of mental health from Melbourne Health to
36 Northern Health.
37
38 I have raised this with the Chair of the Board at
39 Melbourne Health and the Chief Executive at Northern has
40 had discussions with the Chief Executive at Melbourne and
41 it is supported that this transition occurs, but we've just
42 not yet been able to progress the transition.
43
44 Q. In that sense, is it a bit premature to think about
45 how governance and accountability for mental health might
46 be optimised?
47 A. We would certainly be giving a lot of attention to

1 that, and the Mental Health Program would need to be
2 incorporated within our governance frameworks, our clinical
3 governance frameworks, our audit program and a number of
4 different aspects of the governance of Northern Health
5 where we currently do not have mental health at all.
6
7 Q. Can I ask you this question, really in terms of your
8 observations of what's occurred since the 1990s, so sort of
9 going back to that historical perspective, at paragraph 53.
10
11 Since the 1990s have there been developments either in
12 the service system or in the community generally that
13 should be considered in future reform? And you might
14 address in that activity-based funding but future reform
15 ideas more generally.
16 A. Yes. Mental health has been funded historically
17 mainly through block funding, and there have been attempts
18 to come up with activity based funding models for mental
19 health over many years. You are probably going back
20 15 years the work initially started on that.
21
22 That work has continued and there are now some data
23 collection occurring to move to a somewhat modified funding
24 system that the Independent Hospital Pricing Authority, on
25 which I am on the Board, has been working with the
26 jurisdictions to do it. So, I think Victoria is a willing
27 participant in that, and I think in time that will probably
28 occur with the support of other jurisdictions as well.
29
30 I think, since the 1990s, there have been - I
31 mentioned before, we're now up to the Fifth National Mental
32 Health Plan and there have been multiple State plans as
33 well. What has been missing though is the determination to
34 put these plans into action and for them to have successful
35 implementation.
36
37 So, the goals and the visions within those plans are
38 very worthy, but we have not been able to realise the
39 improvements that those plans have aimed to achieve, and I
40 go again to the fact that budget support for those changes
41 are necessary if mental health is to receive the attention
42 that it does and if we are to start to deliver the sort of
43 quality mental health services that I think that everybody
44 that works in the sector would like to see delivered.
45
46 This goes right across the whole mental health system,
47 and I think when you think about changes to the mental

1 health system, you can't talk about improvements in just
2 one component of it, because all parts of the mental health
3 system are so interrelated, so you could augment the
4 bed-based services, but the community-based services would
5 still be under stress; the NGOs would still be under stress
6 for supported accommodation, et cetera.
7
8 So, there is so much interdependency with the
9 different components of the mental health system that that
10 is why I think the need for a plan that has got very firm
11 commitment at State level, at all levels, followed by the
12 funding, is essential if we are to move mental health out
13 of being the lowest funded and one of the poorest
14 performing in the country, to be the pre-eminent State that
15 is leading in mental health service delivery where I think
16 we'd all like to see it.
17
18 MS COGHLAN: Thank you, Ms Williams. Chair, do the
19 Commissioners have questions?
20
21 CHAIR: Q. I have a number. Thank you very much for
22 your overview today, Ms Williams.
23
24 I guess, trying to understand the particular model
25 that's in place for Northern is unusual in terms of the way
26 it's constructed, so just to make sure I and the other
27 Commissioners understand it.
28
29 We had in the attachment and in the submission from
30 Northern Health that your Emergency Department is one of
31 the busiest, if not the busiest in the State?
32 A. That's correct, Northern Health has more presentations
33 to its Emergency Department than any other hospital in the
34 State, and we have more ambulance arrivals than any other
35 hospital in the State, and we've been the busiest for over
36 a year now and we're growing at the rate of about
37 8 per cent per annum, so again, the highest growth rate per
38 annum and that's because of the population growth in that
39 northern corridor up the Hume Highway.
40
41 Q. Of those, I understand a significant number, many
42 thousands present in any year with mental health issues and
43 a proportion of those patients might need inpatient
44 admission?
45 A. That's correct, yes.
46
47 Q. Can you make sure we understand what happens when your

1 Emergency Department clinicians assess someone as needing a
2 mental health bed, for example?
3 A. Okay. Well, the Northern Health clinicians can't
4 assess if someone needs a bed or not, we have to call on
5 Melbourne Health to do that. So, if a mental health
6 patient arrives at the Northern Emergency Department, the
7 clinical staff there will make sure the patient is
8 medically stabilised, if it's an overdose patient,
9 obviously they will treat that patient. But, if it's a
10 mental health assessment that's needed, that can only be
11 done by Melbourne Health, so we then call upon Melbourne
12 Health to attend the Emergency Department and to do a
13 mental health assessment of that patient, and then they are
14 the only ones who can make a decision on whether to admit
15 or not.
16
17 We have acute mental health beds on site at Northern
18 that they are responsible for running. Often those beds
19 are full, and Melbourne Health might have to admit a
20 patient from Northern Health to one of the other units
21 within Melbourne or within their own control, Melbourne
22 Health meaning Western Health or Melbourne Health. So,
23 Melbourne Health makes those decisions, not Northern
24 Health.
25
26 So unlike other patients, Northern Health emergency
27 physicians can make the decision to admit a patient to a
28 medical or surgical ward that will expedite the treatment
29 of those patients either to a short stay unit or up to one
30 of the wards to get treatment, but that does not occur with
31 mental health patients at Northern.
32
33 Q. So, if there was, for example, an adverse event in the
34 inpatient unit, i.e. a staff member assaulted by a patient,
35 or vice versa, what visibility would your Board have of
36 that incident?
37 A. We'd have no visibility of any incidents that occur in
38 the mental health units at Northern Health. We have
39 visibility of assaults and other incidents that occur in
40 the Emergency Department and they are often jointly managed
41 with Melbourne Health and Northern Health if there is
42 issues, incidents occurring within the Emergency
43 Department.
44
45 The Northern Health Emergency Department,
46 unfortunately, is also very poorly configured to deal with
47 mental health patients. We don't have a behavioural

1 assessment unit which most hospitals now have, which is an
2 area that is specifically designed for mental health
3 patients within the Emergency Department, so we have to
4 care for our mental health patients in our resuscitation
5 bays where there could be severely unwell, frail old people
6 or young people dealing with, it could be a very
7 psychotically disturbed mental health patient in these
8 bays, so we have also been attempting to get funding for a
9 behavioural assessment unit so that we have better
10 facilities within the Emergency Department to deal with
11 these patients.
12
13 Q. Can I just take it from that, that would also mean you
14 would not have visibility about how the triage arrangements
15 work, the activities of the CATT Team?
16 A. Correct.
17
18 Q. The subacute services and community-based services in
19 your catchment area?
20 A. No, we don't have visibility on that, no.
21
22 Q. On an unrelated matter but goes a little bit in terms
23 of your background. In terms of thinking of a contemporary
24 mental health system and in terms of technology, you did
25 say at the moment you don't have visibility about that
26 client medical record. But in terms of other opportunities
27 for technology and enhancements in mental health, do you
28 have any views about what needs to be done to modernise the
29 mental health system in relation to technology?
30 A. Not specifically in relation to technology. Access to
31 the medical record is a very easy thing. There is a
32 statewide mental health IT system that's been in place for
33 many, many years. It's just that, because we're not a
34 provider, we don't have access to that system, so not in
35 terms of technology.
36
37 I think the enhancements to mental health, the service
38 delivery system, is more about trying to augment the sort
39 of core elements of the mental health system, such as the
40 inpatient beds and the community teams to have extended
41 services. So, things like the behavioural assessment unit
42 that I mentioned before in the Emergency Department, they
43 didn't exist even five or six years ago and that has been
44 something that's seen as a vast improvement of how we care
45 for people within the Emergency Department.
46
47 Things like urgent care centres, crisis centres which

1 are in the community, certainly in South Australia that's
2 something that they are currently considering, it's been a
3 model that's been developed in the US where they have
4 clinical and non-clinical staff. There's a big peer
5 workforce that are used in these centres where police and
6 ambulance can take people to these centres so that they
7 don't present to an Emergency Department, and they are less
8 like a clinical setting, and these are taking people that
9 don't need to come to an Emergency Department and dealing
10 with them in these centres.
11
12 So, there are developments such as that which I think
13 augment the core service system which are very valuable
14 additions to what we have within our mental health system.
15
16 CHAIR: Thank you, we may follow up and make sure we know
17 where to look to get further information in relation to
18 that. Thank you.
19
20 MS COGHLAN: Thank you, Chair. May this witness be
21 excused?
22
23 CHAIR: Yes, thank you very much Ms Williams for your
24 statement and your evidence today.
25
26 **<THE WITNESS WITHDREW**
27
28 MS COGHLAN: Is now a convenient time for a five minute
29 break?
30
31 CHAIR: Yes, a five minute break.
32
33 **SHORT ADJOURNMENT**
34
35 MS NICHOLS: Commissioners, the next witness is Ms Kym
36 Peake, I call her now.
37
38 **<KYM LEE-ANNE PEAKE, affirmed and examined: [2.22pm]**
39
40 MS NICHOLS: Q. Ms Peake, are you the Secretary of the
41 Department of Health and Human Services?
42 A. I am.
43
44 Q. You've held that role since November 2015?
45 A. That's correct.
46
47 Q. Prior to holding that role, you had a number of senior

1 public service roles, including as Executive Director,
2 Productivity and Inclusion at the Department of Prime
3 Minister and Cabinet?
4 A. Yes.
5
6 Q. Deputy Secretary, Higher Education and Skills Group at
7 the Victorian Department of Education and Training?
8 A. Yes.
9
10 Q. Lead Deputy Secretary, Strategy and Planning at the
11 Department of Economic Development, Jobs, Transport and
12 Resources?
13 A. That's right.
14
15 Q. And Deputy Secretary, Governance, Policy and
16 Coordination at the Victorian Department of Premier and
17 Cabinet?
18 A. That's right.
19
20 Q. Are you currently the President of the Institute of
21 Public Administration Australia, Victorian branch?
22 A. I am.
23
24 Q. With the help of the VGSO, have you prepared a
25 statement?
26 A. I have?
27
28 Q. I tender the statement. [WIT.0003.0006.1000]
29 Ms Peake, I'd just like to ask you some questions, to start
30 off with, about the current state of the mental health
31 system in Victoria and confirm some things that are in your
32 statement.
33
34 You've said that:
35
36 "Substantial reform is required to improve
37 the experience and outcomes of consumers of
38 mental health services in Victoria. The
39 intended shift to person-centred,
40 rights-based and recovery-oriented service
41 models and practice has not yet been
42 realised."
43
44 That's correct, isn't it?
45 A. That is correct, and I think, if that's okay --
46
47 Q. Go ahead.

A. I think the Premier and the Minister for Mental Health, in announcing the Royal Commission, have really powerfully identified that we have a system that is not meeting the needs of consumers and is not meeting the aspirations of the dedicated staff who support those consumers, and I think the evidence that has been led to the Royal Commission by incredibly brave people telling their stories really underscores how critical an opportunity this Royal Commission is for us to do better in the future.

Q. Thank you, Ms Peake. Can I just have you elaborate on that. I'll just put to you what's in your statement to make it efficient. You say this at paragraph 67 and following:

> "Melbourne's rapid demographic changes have placed particular pressure on services in growth corridors.
>
> "This pressure within public mental health services is creating a vicious cycle. A lack of community-based care is increasing emergency presentations and driving a need for more inpatient services - diverting resources from the community where care could have been provided sooner and more cost-effectively. Pressure on inpatient units is also driving shorter stays for typical patients. Earlier discharge is in turn putting more pressure on community mental health services, resulting in a 'revolving door' of readmissions to hospital.
>
> "While average lengths of stay in acute inpatient units are decreasing, there remain a significant number of long-stay patients in acute inpatient units who are not discharged due to a lack of stable housing or suitable sub-acute and non-acute bed-based alternatives.
>
> "For people whose offending is related to an underlying mental illness, a gap in the availability of treatment also risks people entering and becoming entrenched in the

1 justice system.
2
3 "There are also treatment gaps for children
4 and young people, which mirror the gaps
5 seen in the broader mental health system."
6
7 Does that encapsulate one of the core problems within
8 the mental health system?
9 A. I think it does, yes.
10
11 Q. Recently, the Chief Psychiatrist, who I note is here
12 today, gave evidence in these terms:
13
14 "In response to high demand, mental health
15 service providers focus on the most acute
16 and severely unwell consumers. Consumers
17 may receive less treatment and treatment
18 later in an episode of illness often
19 resulting in increased severity of
20 symptoms. This compromises the principles
21 of Section 11 [of the Mental Health] Act ."
22
23 Now, you don't disagree with that, do you?
24 A. I do not.
25
26 Q.
27 "This increases the likelihood of the need
28 for compulsory treatment. The numbers of
29 consumers being treated compulsorily
30 restricts the capacity of services to
31 accommodate individuals who seek treatment
32 voluntarily."
33
34 You don't disagree with that either, do you?
35 A. I do not.
36
37 Q. Finally, the Chief Psychiatrist also gave evidence in
38 these terms:
39
40 "Access to intensive treatment and support
41 may only be available later in an episode
42 of illness and discharge is more likely to
43 occur before the therapeutic benefit of the
44 admission has been realised.
45 Community-based services are then required
46 to provide treatment to consumers in acute
47 stages of illness."

1
2 You agree with that?
3 A. I do.
4
5 Q. Finally:
6
7 "Community-based services have insufficient
8 resources to provide the intensive
9 treatment and support required for
10 consumers who are very unwell. Their
11 resources do not allow them to provide
12 evidence-based psychological interventions
13 which assist with longer-term recovery.
14 These consumers are therefore more likely
15 to experience slower recovery or a relapse
16 of very acute symptoms."
17
18 You don't disagree with that, do you?
19 A. I do not.
20
21 Q. Thank you. In the submissions filed by the Victorian
22 Government, the government has pointed to five gaps in the
23 system which I just want to take you to very briefly. Can
24 we have the slide from the submissions, please?
25 [RES.0002.0005.0001]
26
27 Ms Peake, just take a moment to have a look at that.
28 That's a page from the Victorian Government's submissions.
29 Are you familiar with that page?
30 A. I am, yes.
31
32 Q. You will see there that the gaps are identified. The
33 first, second and third run across the top, they are the
34 early engagement gap, the missing middle treatment gap, and
35 the severe mental illness treatment gap. Down the bottom
36 is the child and young people treatment gap. You've said
37 quite a bit about those in your witness statement that I
38 don't think we need to elaborate on. That, if I may say
39 so, is consistent with the evidence we've heard in this
40 Commission: would you agree with that proposition?
41 A. I would.
42
43 Q. Would you also agree that the gaps in treatment run
44 right across the spectrum of people in Victoria who would
45 be seeking or would otherwise require treatment for mental
46 ill-health?
47 A. I would.

1
2 Q. Can I ask you now about the box down the bottom which
3 goes to the gaps in the foundation of the mental health
4 system, and those are named as: "Governance, Funding
5 Mechanisms, Data and Systems, Workforce and
6 Infrastructure." The slide can be taken down now, thank
7 you.
8
9 In your statement and in the Victorian Government
10 submissions, those factors are described as critical
11 enablers for the system. Can you say why they're described
12 in those terms?
13 A. Yes. I think in any complex system the ways by which
14 the policy funding and information settings are applied
15 really influence how care is delivered, the capacity of
16 services to be able to meet need, and the way in which a
17 system can continue to evolve and improve as evidence
18 develops, but also as population shifts and the environment
19 within which those services are delivered changes.
20
21 Q. It is not possible to have a properly functioning
22 system without each of those mechanisms itself properly
23 functioning, is it?
24 A. I think that's right, and there will always be, I
25 think, the case that each of those type of supporting
26 conditions for a service system will need to evolve; there
27 isn't a perfect moment in any service system I've been
28 involved with where you would say all of those enabling
29 conditions are at an optimum, but they are incredibly
30 important to continue to improve to deliver improved
31 outcomes.
32
33 Q. Thank you. Can I just ask you to confirm the role of
34 the Department, acknowledging that, as you've said in your
35 statement, there are a number of other entities in the
36 system that also play a role, I just want to concentrate on
37 the role of the Department, if I may.
38
39 You say this in your statement, under the heading,
40 "The stewardship role of government", that:
41
42 "Making progress in improving the lives of
43 people facing complex social issues
44 requires government to assume a duty of
45 care and stewardship of the services
46 designed to support them. How government
47 exercises this role needs to be consistent

1 with the values-based principles
2 established for the whole reform."
3
4 A. That's correct.
5
6 Q. And that really, in some senses, encapsulates the role
7 of government in which the Department plays a part. Is
8 that right?
9 A. That's right, and I think that really what I tried to
10 capture in the expression of stewardship and a duty of
11 care, is that, we don't simply have a purchaser/provider
12 relationship with the entities that are co-producing
13 outcomes for people who have mental illness, for their
14 families, for carers and for the staff involved; that we
15 have a responsibility and a very significant role in
16 working with consumer groups and with the providers of
17 service to look at what are the best evidence and data to
18 improve the models of care, then to link that work on the
19 design of models of care to the funding models that support
20 those models of care to be delivered, through to
21 understanding what sort of measures will enable us to
22 understand the impact of those service models, but also
23 that those service models are being appropriately
24 delivered, right the way through then to the feedback loops
25 that enable us to build new evidence and the cycle
26 continues.
27
28 Q. Can I just, perhaps try and encapsulate what you've
29 just said by reference to your statement. You say that:
30
31 "The Department fully accepts our
32 responsibilities to perform a number of
33 critical functions."
34
35 And to summarise them, they are the provisioning of
36 service and infrastructure planning which involves
37 assessing need, comparing current services to need, then
38 identifying gaps that might be priorities for investment?
39 A. That's correct.
40
41 Q. Service model design and development, which involves
42 drawing together leading evidence to design service models
43 that can meet the needs of identified consumers?
44 A. In conjunction, as I mentioned, with the people who
45 have the expertise to inform that work.
46
47 Q. Yes:

1
2 "Resourcing involves the procurement or
3 funding of services, drawing on careful
4 design and specification of service models
5 that would meet need, and consideration of
6 how these would be provided. Funding
7 models, prices and incentives are all
8 considerations for resourcing."
9
10 A. That's right, and I think there are those two parts
11 that you've identified there: there is the case that we
12 make to government for a level of funding, and then within
13 that available appropriation, it's the funding mechanisms
14 that optimise how that funding can be used.
15
16 Q.
17 "Performance monitoring is the means by
18 which a commissioner [meaning the service
19 commissioner of the Department] evaluates
20 whether funded services meet identified
21 need (including in specifications like
22 quality). In modern public sector
23 commissioning, performance monitoring is
24 usually connected to improvement so that
25 service systems do better over time."
26
27 I think I've covered those. Does that well
28 encapsulate the role of the Department?
29 A. It does.
30
31 Q. We heard some evidence, some time ago now, from
32 Assistant Commissioner, Glenn Weir, and he said this to
33 say:
34
35 "I think everyone's worked really hard and
36 nobly in our own particular areas to do the
37 best we can, but there's no high level
38 coordination or leadership about a lot of
39 these services being provided, and not only
40 how that service operates for the
41 particular silo, but how it works in
42 integrating with all the others.
43
44 "So, I think as an outcome, from a
45 health-driven perspective to provide clear
46 and concise direction around what is trying
47 to be achieved to help people experiencing

1 mental health and to prevent people who
2 might be at the risk of falling into the
3 harm space to be done, that's really quite
4 clear: to provide high level, joined up,
5 coordinated and integrated approaches to
6 what we're all doing for a common purpose,
7 to reduce any barriers that might exist
8 between agencies, even between intra
9 agency, I think that is absolutely vital.
10 But if we keep doing the same thing and
11 expect a different outcome, I don't think
12 that's realistic."
13
14 Would you accept, Ms Peake, that a critical challenge
15 for the Department is to provide leadership at a systems
16 level?
17 A. I would, but I would make two reflections.
18
19 Q. Yes.
20 A. I would say that in my mind there are two levels of
21 governance that are really important to delivering what
22 that witness was really pointing to. The first, as you
23 reflect, is really at the system level, and I call that
24 institutional level of governance, and it is about the role
25 that the Department plays in conjunction with the Ministry
26 in providing that clarity of purpose, sense of direction
27 and providing the mechanisms across government to really
28 join up effort.
29
30 Secondly, there is then a service level governance,
31 which is about how that then translates on the ground into
32 better connected services, particularly for people who have
33 multiple or complex needs, and that doesn't happen simply
34 by there being appropriate policy settings and strong
35 collaboration across the Ministries that are involved in
36 setting up the system settings. It is critical that that
37 cascades down into the institutions and agencies that are
38 involved directly in the delivery of services and are
39 really best placed to understand the differing needs of
40 differing communities across the state.
41
42 Q. And it's the system leader's role, is it not, to
43 understand how those values and objectives are understood
44 and cascading down throughout the entire system?
45 A. It is.
46
47 Q. Can I turn now to a different topic, and I want to ask

1 you about planning in order to meet demand. For the
2 purposes of these and a number of my questions I'm going to
3 ask you to put on a somewhat historical lens, acknowledging
4 that you did not occupy the office you now hold for the
5 whole period, but we want to understand why it is some of
6 the conditions we discussed before have arisen in
7 order that they don't arise in the future.
8
9 The evidence you acknowledged earlier points to a very
10 considerable and concerning gap between supply and demand
11 in the mental health system: do you agree with that?
12 A. I would just say before we go through this series of
13 questions, that I will give answers as fully as I can,
14 recognising that there may be public interest immunity
15 matters that come into scope, but I absolutely will
16 endeavour to give you as much information as I can.
17
18 Q. Yes, Ms Peake, as your counsel and I have discussed I
19 think the way we'll deal with this is, I'll ask you a
20 question and you endeavour to answer the question as far as
21 you can. If you have any public interest immunity claim,
22 just say so, and then we will take that off-line and we'll
23 go to the next question. Is that satisfactory?
24 A. It is, and sorry, if you wouldn't mind repeating the
25 first question?
26
27 Q. No problem. The evidence we discussed a moment ago
28 points to very considerable and concerning gaps between
29 supply and demand in the mental health system: do you agree
30 with that?
31 A. I would, and as we go through I would say that the
32 questions of supply are obviously influenced by resourcing
33 decisions by government.
34
35 Q. Of course.
36 A. And so, there will be some limits on what I can
37 reflect on there. I would also say that the ability of the
38 system to respond to demand has, in Victoria, been
39 profoundly affected by the rapid population growth, and I
40 think we've heard from witnesses in the last day and a half
41 the particular impacts that that has had in growth
42 corridors of the state, and not only in sheer numbers, but
43 also in changing demographics in those areas as well.
44
45 Q. With that said, I would like to focus on the
46 capabilities within the Department over time to engage with
47 that fact.

1
2 As the Auditor-General observed in his Access Report,
3 of which you have had notice, the Department's 10-Year Plan
4 for 2009-2019, so the previous iteration of the plan,
5 forecasts the imminent gap in meeting demand. Are you
6 familiar with that report?
7 A. With that plan, I am, yes.
8
9 Q. I would just like to turn to it, if I may. Can the
10 document please be shown, it's entitled, "Because mental
11 health matters". You don't need to turn to it, Ms Peake,
12 but I think it's referenced in paragraph 50 of your
13 statement. The document will appear on the screen in just
14 a moment. [DHHS.0002.0003.1073]
15
16 Before we turn to that document, can I just put this
17 to you. The Auditor-General said at p.10 of his Access
18 Report:
19
20 "As system manager, DHHS has a
21 responsibility to ensure service access by
22 supporting the foundations of the system:
23 funding, capital infrastructure and service
24 distribution, and understanding demand and
25 system performance to guide proper
26 investment."
27
28 Do you accept that as an accurate description?
29 A. I do, and as we work through this, how we build that
30 picture, again, I think engages both level of governance:
31 so, the system level governance and the sorts of
32 information systems that we have in part and need to
33 continue to develop, but alongside that the rich local
34 information that I think very positively has been a
35 commitment through the Fifth National Mental Health Plan
36 for stronger collaboration between Primary Health Networks
37 and our health services to really pull together local
38 information about need, which then will cascade up to give
39 us a richer - another source of rich information.
40
41 Q. I'll certainly give you an opportunity, Ms Peake, to
42 talk a bit later on about the good work that's going on
43 now, but we might just go back in time a little bit, if we
44 may.
45
46 Commissioners, this document has hopefully appeared on
47 your screens. Can we go to internal page 7, please. Just

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1 to clarify, Ms Peake, you were not in the Department at the
2 time this document came out?
3 A. I was not.
4
5 Q. But it's one you're reasonably familiar with, I take
6 it?
7 A. I am.
8
9 Q. Just for context, about two-thirds of the way down the
10 page, you will see the words, "And yet". Can you see,
11 nearing the top of the page:
12
13 "And yet, as Part One of this document
14 argues, it is time for a shift in our
15 thinking on mental health. This means
16 looking at the mental health needs of the
17 whole of our population, at the social
18 determinants of mental health and mental
19 illness. It means considering mental
20 health and mental illness as everyone's
21 business."
22
23 Now, that's just a bit of context. But we are doing
24 the very same thing right now, aren't we?
25 A. That's right. This is very consistent with the
26 philosophy behind the stepped care model that is described
27 as a positive direction forward in the whole-of-government
28 submission.
29
30 Q. Can we have internal page 9, please. You will see,
31 under the heading:
32
33 "Secondly, it [this is the plan] covers
34 programs and services that respond to
35 people experiencing the spectrum of mental
36 health conditions."
37
38 I won't read out the whole text, but you will see that
39 that plan is focused on covering the whole spectrum, and
40 that includes, does it not, the spectrum of people depicted
41 in the graph that we displayed at the outset in the
42 Victorian Government Solicitor's report?
43 A. That's right, and I think the - sorry to leap ahead -
44 but the practical consideration in that is the different
45 role that the state will play in different parts of the
46 system where some - your earlier description of our system
47 manager and steward role is much more direct, and where

1 we're talking about the work that is funded and regulated
2 by the Commonwealth Government, it is still incredibly
3 important that we are active partners and that that local
4 and regional planning is brought to bear, but the levers
5 that we have to influence that are more indirect.
6
7 Q. But both this plan and current circumstances,
8 including the Victorian Government submission, recognise
9 that the mental health system has to engage with the entire
10 spectrum?
11 A. That's right.
12
13 Q. And we've still got very significant gaps right across
14 the entire spectrum?
15 A. That is absolutely right.
16
17 Q. Can we have internal page 13, please.
18 A. I might just add, as we're moving to that, that for me
19 one of the opportunities of being the Chair of the
20 principal committee that brings together Commonwealth and
21 state senior officials responsible for mental health is
22 absolutely to make those connections, to look across the
23 whole system.
24
25 Q. Thank you, Ms Peake. Just while we're here we might
26 go two-thirds of the way down the page. You will see the
27 text, the third dot point now from the bottom:
28
29 "Renew our Suicide Prevention Plan, *Next*
30 *Steps: Victoria's suicide prevention action*
31 *plan*, using the new national framework to
32 strengthen our ability to identify and
33 respond to risk factors and emerging trends
34 in suicidal behaviour and suicide
35 prevention."
36
37 I don't want to get into any great detail about
38 suicide, but are you familiar with whether the plan being
39 introduced at that stage at Victoria's level was
40 substantially different to the plan that's recently or more
41 relatively recently been rolled out?
42 A. I'm not aware of the compatibility of those two, I'm
43 sorry.
44
45 Q. Thank you. Can we have internal page 14, please. You
46 will see halfway down the page, under, "Reform area 3", the
47 first dot point:

1
2 "Create more accessible information, advice
3 and referral services that can assist
4 people with a broad spectrum of mental
5 health problems, including a 24/7 call
6 line for the general public."
7
8 Now, I'm not assuming you know about this, but do you
9 happen to know anything about that?
10 A. Look, only that I know that there was, subsequent to
11 this strategy, a change in government and a change in
12 direction on some of the detail of this plan, and I know
13 that - I'm sure that we'll get to - there continue to be
14 significant challenges around triage in this state.
15
16 Q. Thank you, Ms Peake. Can we look at internal page 23,
17 please. You will see under the heading, "Population based
18 planning" the words:
19
20 "Planning services on the basis of the
21 needs of, and impacts on, the whole
22 community (and defined subgroups), and
23 across the spectrum of severity. This
24 approach will help ensure that the effort
25 is invested where the greatest benefits can
26 be realised, while maintaining a clear
27 focus on those with the most intense and
28 urgent needs for support ."
29
30 You would accept, wouldn't you, that that's the goal
31 that we have today, among others?
32 A. That is correct.
33
34 Q. Can I ask for internal page 24, please. Under the
35 heading, "The mental health outcomes framework" the
36 document reads:
37
38 "In line with national health performance
39 frameworks the proposed mental health
40 outcomes framework will provide the basis
41 for a set of agreed mental health
42 indicators ...
43
44 Population surveys and other data will be
45 used to assess achievement over time of
46 agreed population outcomes, such as
47 reductions in prevalence of mental health

1 problems, level of disability associated
2 with mental health problems and associated
3 economic and social impacts."
4
5 Q. This outcomes framework, is that really the kind of
6 outcomes framework that you are now looking to implement?
7 A. It is, and I'm happy to speak now or if you prefer
8 till the end.
9
10 Q. We'll go to it at the end. But in substance, it is
11 still reasonably aspirational at this point?
12 A. That's right, aspirational, narrative description of
13 outcomes with key performance indicators, or performance
14 indicators that enable us to look at all parts of the
15 system that need to contribute to improvement.
16
17 Q. We'll go to the substance of it a bit later, but my
18 point is rather this: that way back in 2009 the objective
19 to implement an outcomes framework was present. I accept
20 that you weren't there at that time, but we're still
21 endeavouring to do that; is that right?
22 A. I would caveat that in saying that the outcomes
23 framework that was put in place with the 10-Year Plan that
24 was released a couple of years ago does have a range of
25 measures that are now populated. There are still some that
26 have not been, but they have a range of indicators that
27 have been populated and are publicly released on an annual
28 basis.
29
30 Q. Can we go to internal page 29, please. Here you will
31 see the predictions that the Auditor-General referred to in
32 his Access Report. Under the heading, "Drivers for
33 change", it's said:
34
35 "An estimated 19 per cent of the population
36 is affected by a mental health problem in
37 any 12-month period ...", and so on.
38
39 Underneath the box:
40
41 "In reality, by 2019 these numbers are
42 likely going to be higher given a range of
43 factors including the ageing of the
44 population."
45
46 There's some further information, and it's then said:
47

1 "Action is needed, not only to address the
2 current needs of the Victorian population
3 but to plan for the projected numbers of
4 people likely to be seeking help for mental
5 health problems in 10 years' time. Not
6 everyone with a mental illness seeks a
7 mental health service, however those people
8 who actively seek a service, too many do
9 not receive help due to factors including
10 complexity of needs, cost of accessing
11 private services, or the lack of public or
12 private services in their locality."
13
14 What I'd like to suggest, Ms Peake, is that, the need
15 to understand the demand pressures caused by population
16 growth was understood back in 2009?
17 A. Yeah, I think that's absolutely right, and the
18 population projections that were informed, the planning of
19 every Department, so the whole-of-government population
20 projections were wildly exceeded by the rapid growth in the
21 state; that doesn't detract from your point at all.
22
23 Secondly, I think that right around the world - and
24 New Zealand is a great example of this - the other piece of
25 this puzzle is understanding the intersections between
26 other services, whether that's housing, justice services,
27 that also can either ameliorate or exacerbate those
28 pressures
29 Q. We'll come to those a bit later. Only two more
30 references in this document. Can I have internal page 32,
31 please. Under the heading, "Key aspects of the reform
32 challenge", it's said that:
33
34 "Despite progressive growth and many
35 innovations in mental health-related
36 services over the past decade, some
37 significant gaps and imbalances have
38 emerged. As a result, we are missing
39 important opportunities to improve the
40 lives of many Victorians ...
41
42 While strengthening core services remains
43 important, the wide consensus is that just
44 investing in more of the same will not
45 yield the benefits we need to see."
46
47 There's reference to a paper which focuses on a need

1 for emphasis on:
2
3 "The importance of delivering services that
4 are recovery-oriented and are informed by
5 consumers' and carers' perspectives and
6 recognising the need for culture change to
7 one that empowers those who use services."
8
9 Those values discussed there, they're now embodied in
10 the Mental Health Act and they're specifically reflected in
11 section 11; is that right?
12 A. That's correct.
13
14 Q. You are aware, are you not, that the Chief
15 Psychiatrist has given evidence to which I alluded briefly
16 earlier that essentially, because of very significant
17 demand pressures on the system, a number of those
18 principles are being compromised and they're not able to be
19 embodied in the mental health system?
20 A. I think that's right, and I would also reinforce that,
21 in my conversations with the Mental Health Complaints
22 Commissioner, that the same feedback around the impact of
23 capacity, models of care, and access has been on being able
24 to realise those principles.
25
26 Q. Finally, just on page 35, there is the observation
27 that:
28
29 "Demand pressures on specialist public
30 mental health services are considerable.
31 Services have continued to provide quality
32 care and made many adjustments to cope
33 effectively with demand. Yet measures such
34 as the rate of involuntary admissions, bed
35 occupancy levels, and emergency department
36 waits remain a cause for concern."
37
38 It's the case, isn't it, that it may have been a
39 concern at that point but it's now developed to a crisis
40 state?
41 A. Yes, it really is at a much more serious level of both
42 occupancy, and the ability for continuity of care into the
43 community is much more acute now even than then.
44
45 Q. Thank you, Ms Peake. I just want to put something to
46 you that the Auditor-General found, again acknowledging
47 that you haven't been occupying the office for the whole

1 period. The Auditor-General concluded in his Access Report
2 that:
3
4 "The Department has done too little to
5 address the imbalance between demand for
6 and supply of mental health services in
7 Victoria."
8
9 Now, the Department accepted that finding, did it not?
10 A. It did, and again, I would reiterate that implicit in
11 that is both demand and supply, so we accept the finding in
12 the context of our capacity to work within the parameters
13 we operate within.
14
15 Q. Of course. There are many other subjects to discuss,
16 but at a high level, what are your observations about the
17 systematic impediments to DHHS understanding, as a part
18 with others, addressing the gap between supply and demand?
19 I'm asking you for an historical view at this stage?
20 A. Yes, so I would talk to three impediments. The first
21 is that the clear issue around the level of resourcing that
22 is available to the system, and I think there are two
23 reasons for the pressure or the challenge that has been
24 encountered in securing those resources, and I think these
25 are actually common challenges to a lot of social services.
26
27 The first is technical, and it really goes to the
28 points you've just made, the reflections of the
29 Auditor-General around the sophistication of the systems,
30 the analytic systems, to be able to model demand and
31 provide advice to government about social return on
32 investment.
33
34 The second though I think is more cultural. When I
35 reflect, and I just look back at my time as Secretary of
36 Department of Health and Human Services, there really have
37 been four areas that have experienced growth in funding,
38 and they are: funding to support elective surgery and
39 Emergency Department, funding to support mental health
40 actually, funding to support child protection and funding
41 to support family violence.
42
43 I think the common characteristic between those four
44 areas is that there's been strong political leadership,
45 that there's been community acceptability for significant
46 investment to be made in those areas, and there's been the
47 ability by the nature of the investment to show really

1 reasonably quick outcomes or returns which build community
2 trust in a service they value.
3
4 I do think that, where there is significant stigma and
5 discrimination associated with a type of service, that that
6 has the practical effect of discounting the public value
7 that is placed on that service.
8
9 And so, that would be my first reflection, that I
10 think - I will be quick, I promise.
11
12 Q. Yes, we'll return to that question later.
13 A. The funding is a critical one. The second one, and
14 I'm sure we'll return to this so I'll just give a headline,
15 is around the funding mechanisms. We have had an expert
16 view that really elucidates the ways in which the existing
17 block funding model, as you've heard a lot of evidence
18 about, doesn't create the right incentives for the right
19 models of care and continuity of care, and we can talk more
20 about the history of that.
21
22 Then I think the third is that there hasn't been the
23 link between the population level data that we hold
24 translating down or, sorry, gathering up more local
25 information, we haven't had good enough systems for that.
26
27 Q. Thank you, Ms Peake, that's a very convenient summary.
28 Just on that point, without descending to too much
29 granularity, one of the foundation gaps you identify, or
30 the government identifies, and the Auditor-General
31 identified, is data limitations, and I think it's called an
32 undeveloped or unrefined approach to data forecasting in
33 the Victorian Government's submissions.
34
35 Can you say, without being too technical about it,
36 what are the principal limitations on data gathering?
37 A. So, a couple: one is the information systems to enable
38 data that is captured routinely to be conveniently,
39 quickly, easily, aggregated up.
40
41 The second then is that, the methods that we have used
42 in government have tended to take more of a statistical
43 approach to the analysis of that data.
44
45 Q. As opposed to?
46 A. As opposed to really being able to use more
47 sophisticated machine learning techniques to be able to

1 project forward and in different scenarios - it's called
2 micro-simulation, I won't get technical - but to really
3 understand what would be the practical effect of different
4 types of investment on costs and outcomes.
5
6 Q. Is there presently the capability to do that?
7 A. We are developing that capability. We have much
8 better systems to be able to do the machine learning; the
9 micro-simulation, we are in the process of - even though
10 we're in Australia, it's got this deep capability, but
11 we're in the process of building that capability right now.
12
13 Q. Can I just interrogate that answer a little bit
14 because, implicit in it, it may not have been intentional,
15 is the suggestion, I think, that you don't have the data
16 capability because technically it's not available. What
17 I'm really after is, what were the impediments to gathering
18 and analysing the appropriate data?
19 A. That was really the first piece. The gathering was
20 really that we haven't had the information systems on the
21 ground to make it easy to extract that data. I know the
22 Auditor-General talked at some length about the difference
23 between our model of governance of health services where
24 there are individual systems at each health service. There
25 are many benefits to that, and I'm sure we'll talk about
26 that. One of the practical implications is that, with a
27 few exceptions we don't have an easy way of looking in and
28 seeing data across the board, and then there's the
29 technical capability to analyse it.
30
31 Q. But you would accept, wouldn't you, that it's
32 essential to have that capability to gather data from the
33 component parts of the system that has devolved governance?
34 A. And, in order to do that, you either need to have, and
35 there have been efforts to do this, you either need to have
36 compatible systems, and that's really not realistic, or you
37 need to get - the IT market is getting much better at
38 providing solutions where you can have data kind of sucked
39 out and put into a portal - and I am not trying to make
40 excuses for the gaps in our capabilities, but I think there
41 is much more technical ability to, in a cost-effective way,
42 fulfil that requirement of our system management with the
43 developments in the cloud and IT systems going forward.
44
45 Q. There is the suggestion, is there, that the reason
46 there hasn't been proper data gathering and analysis has
47 been simply because of a lack of existing technology?

1 A. No, but in the absence of that technology, there has
2 been a much bigger endeavour, and I have also indicated, I
3 think, it's not only about that sucking up the data, it has
4 been about the analytical capability to make use of that
5 data as well.
6
7 Q. To finish off that point, your evidence is that the
8 Department is --
9 A. On the journey.
10
11 Q. -- gaining capability?
12 A. On the journey.
13
14 Q. And, to put it --
15 A. Sorry, and I should say that I think one of the really
16 important developments in the last couple of years on the
17 back of the Duckett review into quality and safety in the
18 health system has been the creation of the Victorian Health
19 Information Agency which has provided a dedicated
20 capability in the Department for this type of work, working
21 with our performance people to make sure that we've got
22 both the custodianship of data clear, but then the analysis
23 of that data capabilities being lifted.
24
25 Q. Alright, acknowledging that today's not the occasion
26 to focus at great length on data, but you do accept, don't
27 you, that in light of what the Auditor-General has found,
28 and in light of the various statements in your evidence in
29 the Victorian Government's submissions, that having the
30 capacity to gather and properly analyse data is absolutely
31 essential for the system leader?
32 A. It is a critical priority and it is one that is not
33 fully there in the system, absolutely.
34
35 Q. And what you said in your submissions is that the
36 absence of data capacity, if I can just summarise it in
37 that way, has inhibited long-term statewide infrastructure
38 planning: that's correct, isn't it?
39 A. It has, as well as service planning, yes.
40
41 Q. And it's also inhibited outcomes monitoring?
42 A. It has, although I would add, in addition to those
43 core data sources, I think that we have been - between 2010
44 and now, evolving our technical capability about defining
45 the indicators as well.
46
47 Q. Alright, but I think your evidence --

1 A. But it is a critical part of it, yes.
2
3 Q. And your evidence and the Victorian Government's
4 submissions are to the effect that the data problems have
5 inhibited outcomes monitoring?
6 A. Yes.
7
8 Q. And also have inhibited demand predictions for the
9 purposes of managing supply?
10 A. Correct.
11
12 Q. You accept, don't you, I think on behalf of your
13 predecessors, that back in 2009 it must have been
14 understood that this sort of capability would be necessary
15 to have?
16 A. And would be a priority to develop, yes.
17
18 Q. And it now is a priority, I take it?
19 A. And it has - there has been improvements; there's a
20 way to go.
21
22 Q. Alright, we'll leave that topic for now. With that
23 background, can you say, why is it that, at least on the
24 evidence we've heard in this Commission, that Victoria's
25 growth corridors have experienced the highest rates of
26 population growth, are said to have some of the highest
27 rates of mental distress, but also received some of the
28 lowest rates of funding per capita? What factors have led
29 to that outcome?
30 A. So, I think there's really two factors: one is the
31 lead times for the development of infrastructure and
32 creation of bed capacity and adding staff. There have been
33 recent investments in the last couple of years, they will
34 take a while to come online. So, in the meantime where
35 there is extra funding that is provided to us, the way in
36 which we allocate that money takes account of where there
37 is capacity to deliver.
38
39 Q. So, are you saying that --
40 A. It's a bit of a vicious cycle.
41
42 Q. -- it's hard to catch up: if population growth gets
43 away from you, it's quite hard to catch up, is that the
44 gist of it?
45 A. That's right, and to make sure that we make best use
46 of the money right now, that it is dispersed differently
47 between the catchments.

1
2 Q. Does the Department accept that it is a priority among
3 many others, but a priority nonetheless to ensure that the
4 growth corridors are better funded?
5 A. Better funded, and that there is an opportunity to
6 look at what that funding is used for, so the models of
7 care.
8
9 Q. Can I ask you about the framework for strategic
10 planning. Now, the 10-Year Mental Health Plan is the most
11 important strategic document, is it not?
12 A. Unlike the 2009 document, we were very conscious -
13 this was right at the time I started - but we were very
14 conscious of not looking to start/stop strategic direction.
15 In the 10-Year Plan there is a cross-reference back to
16 building on the strategy from 2009. I think there was a
17 very strong view that, to take another three years, which
18 was about the time that strategic plan took to develop,
19 would miss the urgency of getting on with ensuring that
20 there was more capacity put into the system.
21
22 Q. But it is the document that sets out the strategic --
23 A. If I could just finish.
24
25 Q. Oh, sorry.
26 A. So, therefore, it was a clear decision that it would
27 be an important document, but not the only document, that
28 would guide strategic direction and investment in that term
29 of government, and that it would be complemented with some
30 other sub-plans or parallel work on a service and
31 infrastructure plan for the whole of health, including
32 mental health, for example, a Suicide Prevention Plan which
33 was released about a year later; the work that was
34 happening at the time on the Fifth National Mental Health
35 Plan, putting effort into that and the regional planning
36 that came out of - that was reflected as a commitment, all
37 Ministers signed on to from that.
38
39 So, I think it is important to say it was an important
40 document, but it was designed in a slightly more narrow way
41 to enable us as a Department and the government more
42 broadly to get on with the important work of the system.
43
44 Q. So, acknowledging that there are companion pieces,
45 this nevertheless is the place where one looks to find the
46 strategic plan for mental health in Victoria?
47 A. Certainly, it is the place to look for the outcomes.

1 Again, I would say that there are a suite of documents that
2 give you the strategic plan.
3
4 Q. In your statement you've said the plan was a good
5 start to defining outcomes, but that further work is
6 needed. I'll take you very shortly to it, so you can tell
7 us what that work is. But, I think in light of some
8 findings of the Auditor-General, in your statement you've
9 acknowledged that the plan did not outline the optimal
10 level and mix of public mental health services or describe
11 actions required to deliver a comprehensive stepped care
12 model for Victoria?
13 A. That's right, because it was part of a suite of
14 documents that covered different elements of that.
15
16 Q. I see. Do you accept the Auditor-General's finding
17 that, while the 10-Year Plan clearly identified significant
18 service demand and access issues, little within it directly
19 addresses the access issues?
20 A. And again, I think the intent was that that work would
21 be progressed outside of the domain of the plan through the
22 development of a service and infrastructure plan, and
23 through then subsequently some commissioned work that did a
24 much deeper dive on looking at what were the drivers and
25 solutions which is informing continued thinking in the
26 Department.
27
28 Q. We'll go to more present time in a moment, but do you
29 accept the Auditor-General's criticism really of the plan,
30 that it really didn't deal itself with the most pressing
31 issue, which was the access to services issue?
32 A. I would absolutely accept the finding about the scope
33 of the plan. I guess what I am trying to indicate, is
34 that, my perspective coming into the Department at that
35 point was that that wasn't the intent of the plan. The
36 intent of the plan was to provide what over that term of
37 government in particular could be the initial work, the
38 first two waves of reform, to enable there to be a deeper
39 dive into those issues around access and forward solutions,
40 and the third wave of the plan foreshadowed that further
41 work being done, it didn't try and wait for it to be done
42 for the plan to be released.
43
44 Q. Do you accept that, as a system leader going forward,
45 that the strategic vision and documents that reflect that
46 should deal with pressing issues such as access?
47 A. Absolutely, and that the link then to the 10-Year Plan

1 needs to be made very clear, where you have a separate
2 document that provides that sort of guidance to the sector.
3
4 And, with the advent of the Royal Commission I would
5 be extremely optimistic that the findings and
6 recommendations of the Royal Commission will provide us
7 with a lot of that roadmap which may lead to there needing
8 to be some or some significant changes to the overarching
9 plan, but obviously will provide more detailed guidance on
10 those specific issues around access as well.
11
12 Q. Of course, and just one more question on this topic:
13 back in 2015, when that plan was introduced - is that the
14 right date?
15 A. Yes, it was the end of - it was November 2015.
16
17 Q. So at that point a detailed dive on access hadn't
18 occurred. When was the first time that that occurred?
19 A. Yes, so there was a significant piece of work that was
20 undertaken in, I think it was the second half of 2016 into
21 2017.
22
23 Q. Thank you. Can I just ask you some questions about
24 targets. You've given some evidence in your statement that
25 you think there are some difficulties with targets in
26 complex service systems, and that's at paragraph 165 of
27 your statement.
28
29 I think, to be fair, I think you distinguished between
30 targets and aspirational or qualitative expressions of
31 outcome measures.
32 A. That's right.
33
34 Q. The Auditor-General gave some evidence this morning
35 that, reflecting on his analysis of the 10-Year Plan, there
36 ought to be targets in such documents however they exist.
37 His evidence was to this effect: that you have, as system
38 leader, the capacity to mitigate the risks of problems with
39 targets by properly defining them. What do you say about
40 that?
41 A. Yeah, thank you. Because it is a really important
42 question and it's one of very few points of slightly
43 different perspective that, as a system manager, I think
44 that I bring. There is absolutely much in the
45 Auditor-General's report that I welcome and agree with but
46 this is a point of fine difference.
47

1 From my perspective, I think that it is really
2 important that an outcomes framework provides the means of
3 measuring across the range of parts of the system, so the
4 parts of the stepped care system, the range of
5 interventions that are going to be necessary to achieve
6 improvements.
7
8 The great risk with leaping to numeric targets when we
9 don't have the underlying data foundations, is that
10 actually perversely we might further entrench stigma and
11 discrimination - or discrimination; that we might
12 inadvertently lead to there being incentive created to only
13 serve the service, the clients with less complex needs, and
14 that there can perversely be situations that I've
15 absolutely seen in other service systems, where there is
16 over-emphasis on one part of the system at the expense of
17 advancing reform in other parts of the system.
18
19 That's really I think been evident in the UK where an
20 over-emphasis on, in fact some access targets, has really
21 resulted in quality and safety issues in the system. I
22 could use the example of how important it is, when we think
23 about sentinel events, that we don't inadvertently create,
24 through a target, a perverse distortion of behaviour not to
25 speak up and report adverse events.
26
27 So, there are times when numeric targets are entirely
28 appropriate, but I think numeric targets tend to be more
29 appropriate where the data is robust and well-established,
30 where there is clear attribution between an action and a
31 result, and generally where there is a more straightforward
32 set of actions that need to be taken that involve fewer
33 parties than when we're talking about all of the actors
34 involved in a stepped care model being put in place.
35
36 Q. Do you accept the Auditor-General's point though, that
37 there needs to be a means, in an outcomes framework, of
38 measuring the difference between where you are now --
39 A. Yes.
40
41 Q. Sorry, where you were: where you are now and where
42 you're intending to get to?
43 A. Well, certainly the first two, and I think you might
44 have had some evidence a few days ago from the Road Safety
45 Authority as well around the benefits of having an
46 aspirational target like Towards Zero, and the real
47 criticality of measuring as you go on progress and having a

1 suite of measures that enable you to do that. So, I think
2 that is incredibly important, and the Mental Health Annual
3 Report, is our intent, to be able to make that information
4 not only internally obvious but publicly reported.
5
6 And so, having an aspirational target of where you
7 want to get to I'm entirely comfortable with. Where I get
8 uncomfortable is, if it is reduced by this amount to that
9 amount for only a few of the important outcomes that are
10 going to drive a systemic complex reform.
11
12 Q. But that would speak to having to design your targets
13 property, wouldn't it?
14 A. No, because I think that would mean either you have so
15 many targets that cover all facets of the reform that you
16 blunt their impact, because actually targets are generally
17 most powerful when there are few of them that really do
18 direct effort, and that for me feels to be in conflict with
19 saying, across a stepped care system there are multiple -
20 your earlier point about there being multiple parts of the
21 system involving a broad array of actors that need to be
22 involved in delivering better service and better outcomes.
23
24 Q. Alright, but you're not suggesting, are you, that the
25 measures in the appendix to the Mental Health Annual Report
26 can't be improved?
27 A. Not at all, and I think that's clear and I've made
28 that point in my witness statement, that one of the - and
29 in the whole-of-government submission - that based on the
30 evidence and the analysis, that the Royal Commission does
31 really welcome that view, that insight on how those
32 measures can be improved.
33
34 We're doing a lot of work right now with education
35 about how the educational measures can be enhanced and
36 populated, and so, absolutely it's a work-in-progress.
37
38 Q. Just back on the question of access, the
39 Auditor-General has suggested that measures for wait times
40 for services and the number of consumers declined or
41 delayed services due to capacity constraints, and consumer
42 reported experience of service accessibility would all be
43 useful measures in relation to access: do you accept that?
44 A. Yeah, so again, two points very quickly that I would
45 make: one is that, at the moment I think that we have data
46 and indicators around access that are spread between too
47 many different data collections and reporting tools. So,

1 we have quarterly reporting, we have Statement of Priority
2 reporting, we have the reporting associated with the
3 10-Year Mental Health Plan which is more outcome-oriented,
4 and we have other sort of episodic reporting that is used.
5
6 In turning to 2018/19 we received some funding to
7 complement the outcomes framework with a performance
8 management framework which really goes more to system
9 performance and access issues.
10
11 Having said all of that, I do agree that, as we
12 develop that performance management framework, which I
13 think is the right place for these type of access measures,
14 I think the Auditor-General's reflections, particularly in
15 relation to where people have contacted a triage service
16 and then not received a service and then subsequently
17 presented to an Emergency Department and/or been admitted,
18 are really critical information for us to have a better
19 handle on.
20
21 Q. Thank you. Just finally on the 10-Year Plan, the
22 Auditor-General said that there was a lack of routine
23 senior level oversight of and reporting against the plan:
24 you accept that finding?
25 A. One of the things I would reflect, and you may come to
26 this a bit later, about the capabilities that are needed to
27 be developed, but a system process and capability or skill
28 level has been developing that sort of project management
29 capability.
30
31 We do have governance structures within the
32 Department. The 10-Year Plan is reported up through to a
33 sub-committee of the Executive Board that I Chair, but
34 certainly I think the reflections of the Auditor-General
35 and the Implementation Monitor for Family Violence have
36 given us pause in the last 12 months to think about both
37 how those governance arrangements are working and also the
38 systems and tools that are necessary, and we are developing
39 an IT platform called Our Impact which will make that
40 reporting more standard and enable there to be more
41 scrutiny.
42
43 Q. To the extent you can say, is there any capability the
44 Department needs to develop in relation to personnel in
45 that respect or is it more of an IT issue?
46 A. I think there is a project management discipline, or
47 capability that is in short supply through the public

1 service, and there are targeted - you know, there's
2 targeted work we're doing as a Department but I think there
3 is more that we need to do to build the skills in how you
4 break down complex reform into actionable deliverables, as
5 well as then have the systems to monitor progress.
6
7 Q. I just note for completeness, Ms Peake, we won't go to
8 it in the interests of time, but there are in your witness
9 statement set out a number of the activities and very
10 significant resources that have been devoted to undertaking
11 the activities in the 10-Year Plan; I've been directing my
12 questions more to the management and implementation and
13 monitoring of it.
14
15 Can I ask you now about a different question, and that
16 is the issue of trials and what I mean by that is programs
17 being rolled out on a trial or pilot basis. There has been
18 a significant amount of evidence in this Commission from a
19 range of people to the effect that, when good programs are
20 rolled out as a trial and then their funding becomes
21 uncertain and their continuity becomes uncertain, a whole
22 range of problems occur, including that staff who have been
23 secured and are working well may not be able to be secured;
24 consumers lose continuity and lose relationships.
25
26 Do you accept that one consequence of having too many
27 pilots is instability in the system.
28 A. So, what I would say is that I think historically the
29 pilots have been used not only to trial innovation, but
30 also to enable there to be partial implementation within
31 budget capacity. I think that conflation of using trials
32 for an innovation purpose, versus partial implementation
33 has created the effect that you describe.
34
35 I think as a whole-of-government there has been a lot
36 of work done in the last couple of years to be really clear
37 about innovation methodology, what sort of analytics and
38 performance measurement and evaluation is important, and
39 what sort of decision-making processes are necessary to
40 enable there to be a genuine trial of innovation,
41 evaluation of impact and then approach to scaling. So, I
42 think again it's something where a historical view versus a
43 forward-looking approach is a bit different.
44
45 Q. And your forward-looking approach is to try and
46 engender longevity in funding and program continuity; is
47 that right?

1 A. Where it is evidence-based and --
2
3 Q. Of course.
4 A. -- and where there is evidence of working. I would
5 never want to be saying that there is no space for genuine
6 innovation and trialling, and also that it is important, if
7 we are going to have more innovation in the system, that
8 it's okay for some things to not work and therefore --
9
10 Q. Of course.
11 A. -- absolutely to call quits on something that hasn't
12 achieved its intended aim.
13
14 Q. On the question of catchments, the Victorian
15 Government's submissions state that:
16
17 "Misaligned catchment boundaries are
18 preventing people from accessing services."
19
20 We've certainly heard evidence to that effect in the
21 Commission, and I'll take you in a moment to your views
22 about catchments briefly, but can I ask you this first: the
23 Auditor-General said in his Access Report in relation to
24 the Department:
25
26 "Despite understanding these issues for
27 many years [that's issues about catchments
28 and access] and commissioning work to
29 examine them and make recommendations, the
30 Department did not take action to address
31 them."
32
33 Did you accept that finding?
34 A. And it will come to the later discussion about what we
35 mean by catchments. So, we accepted the finding and I
36 think there are many layers to the geographic boundary
37 versus the operational management within a catchment, and I
38 know the previous witness talked to some of the operational
39 governance issues that are relevant to catchments as well,
40 but there is no question that there is a significant need
41 and opportunity, both through the Royal Commission and
42 potentially in parallel with the Royal Commission, to deal
43 with some of those challenges around catchments without
44 abandoning the concept altogether.
45 Q. The purpose of my question was really to elicit
46 whether there is any structural or systematic impediment to
47 not being able to implement reform catchment, acknowledging

1 like most things in mental health it's complex. Just
2 responding to the Auditor-General's finding about the fact
3 that the issue was understood for a long time and not acted
4 on?
5 A. I think the two things I would say with impediments
6 was, firstly, that there wasn't an effective way for joint
7 work with PHNs or with the primary care system to really
8 bring together the thinking about catchments. And
9 secondly, that the timing of decision-making often got out
10 of synch with the rhythm of an election cycle, for want of
11 better words, and so, opportunities have been missed.
12
13 Q. Just picking up on that observation as a general
14 point, the timing of reform measures and their coinciding
15 or not with election cycles: is that a problem that
16 bedevils someone trying to enact reform in a system?
17 A. So, I wouldn't cast it in the language of "it's a
18 problem". I would say it's a really important factor to
19 take into account in thinking about the sequencing and pace
20 of both advice to government and implementation.
21
22 Q. We'll come to those at the end, we'll be asking your
23 views about those things. Can I ask you a bit more about
24 capital infrastructure. You've acknowledged the role of
25 the Department in commissioning system-wide service and
26 infrastructure and planning, and we've dealt with the issue
27 of the data limitations.
28
29 There's a relationship drawn in the submissions of the
30 Victorian Government about the limitations on data and
31 being able to engage in commissioning infrastructure for
32 mental health: what's the relationship between the two?
33 A. Well, it's really the comment that I made earlier,
34 that in the absence of sufficient physical capacity it
35 becomes a challenge to actually then allocate money for
36 services in places that they are needed because there isn't
37 the staff or the physical space.
38
39 Q. I see, alright. Separately, the Commission has heard
40 evidence that Victoria has a serious shortage of acute
41 inpatient beds, and one of the lowest bed bases nationally,
42 and also, that many inpatient facilities don't provide
43 appropriate, safe or therapeutic environments. I know it's
44 a very broad question, but what in your view are the key
45 factors that have led to that outcome?
46 A. So, I think it is important to say that the
47 comparisons nationally are not altogether helpful because

1 Victoria, right from the start of - or the model that was
2 implemented post de-institutionalisation has really put
3 significant emphasis on the community model which is again
4 recommended through the government, or proposed through the
5 government submission for further investigation.
6
7 That was really because there was a strong view that
8 therapeutic settings are more amenable to a community
9 environment, and that is not to discount the importance of
10 having acute inpatient capacity for people who are severely
11 unwell, but their ongoing treatment and recovery and then
12 rehabilitation, I think there is significant evidence that
13 we need to think about those two things differently and
14 that's part of the stepped care model.
15
16 So, having said that as a bit of a caveat, I think
17 that it goes back in part to my earlier comment about the
18 way in which funding deliberations are influenced by those
19 three factors of: political leadership, community
20 acceptability and the ability to implement quickly to build
21 confidence in a service the community values.
22
23 We have seen in the most recent couple of budgets more
24 investment put in to inpatient beds, and we have a long way
25 to go.
26
27 Q. So, is the gist of your answer, that it hasn't,
28 politically speaking, been able to be prioritised in the
29 past?
30 A. I think that is definitely a part of it, the competing
31 need for there to be also investment in the community
32 sector which is seen as a really critical part of the
33 system, and then comes back again to the lead time in terms
34 of infrastructure constraints.
35
36 Q. I see, thank you. Does the Department have a detailed
37 infrastructure plan for mental health services?
38 A. And this is going to be into a space where I can give
39 you a partial answer.
40
41 Q. Go as far as you can.
42 A. So, we have been doing a lot of work in the last
43 few years with the creation of the Health and Human
44 Services Building Authority to build the analytical base so
45 that we can provide effective advice into the annual budget
46 cycle. That's probably as far as I can go.
47

1 Q. So, you can't tell us any more because?
2 A. So, certainly that --
3
4 Q. Just to be clear about why you can't answer any more
5 about that topic?
6 A. It really does move into a matter of public interest
7 immunity about the extent of the planning.
8
9 Q. Alright, we won't pursue that any longer for the time
10 being, but we will note that that question has been asked
11 and you've answered it as far as you can for the moment.
12
13 You've mentioned the Victorian Health and Human
14 Services Building Authority in your statement, and you've
15 said that:
16
17 "There is an increasing focus on
18 incorporating and prioritising mental
19 health service provision."
20
21 What's new about that?
22 A. Yeah, so one of the things that we have been really
23 doing more of since 2016 is re-integrating mental health
24 responsibilities into the broader health stewardship
25 responsibilities of the Department.
26
27 The rationale for that is both that, I do think that
28 mental health should be considered a specialty like any
29 other in the health system, I think that's important, to
30 improve the parity between physical and mental health and
31 to overcome some of the stigma that has impacted on
32 delivery and prioritisation.
33
34 And, as part of that, the Building Authority's
35 expertise in infrastructure planning, design, project
36 delivery, is now being leveraged for the putting forward of
37 business cases and the management of delivery of mental
38 health projects, rather than a stand-alone mental health
39 branch having those infrastructure functions themselves.
40
41 Q. So you see that as a very positive development?
42 A. I do. I think we have seen that we've got better
43 capability to build better cases and to then manage
44 projects. The second thing I would say is that it is also
45 leading to more thought being given to new hospital
46 developments to take account of factoring mental health
47 capacity in.

1
2 Q. Can I ask you about a different topic now, and that is
3 to return to the subject of overall system level planning,
4 just briefly. In the Victorian Government's submission, it
5 said at 3.5.1, that:
6
7 "Responsibility and accountability for
8 quality and safety oversight of the
9 specialist mental health system is
10 distributed across multiple bodies which
11 can create a level of confusion around
12 accountability and may inhibit continuous
13 improvement efforts."
14
15 Can you say what that confusion is about and why it is
16 said that it may inhibit continuous improvement efforts?
17 A. Certainly. So, at the moment there are many avenues
18 for people to - for consumers or family members - to raise
19 a complaint. There's lots of work that is happening to
20 create protocols, information sharing, between the various
21 bodies but it does make for a confused space for people to
22 know where to go to get an issue resolved, so that's the
23 first thing.
24
25 The second thing is, I think that, in terms of the
26 point around quality improvement, that there has been
27 multiple bodies that have had a piece of the work around
28 service model development through to practice support. The
29 work that we've been doing in the last 12 months, and
30 really aided by the Chief Psychiatrist and Safer Care
31 Victoria, is to get more clarity around the strengths and
32 contributions of the different parts of the system and
33 leverage the expertise of the Chief Psychiatrist in terms
34 of really deep, deep, clinical knowledge of the system and
35 Safer Care Victoria's methods of working with clinical and
36 consumer communities to develop service models and to build
37 the kind of agreement that they should then be the basis of
38 what is more consistently delivered in the system.
39
40 So, I think we are working our way through that, but I
41 would well accept that, for the service providers, that
42 there still seems to be lots of bodies, how do they all fit
43 together.
44
45 Q. On the question of models of care, in your statement
46 you have said:
47

1 "Following the identification of
2 population-level need, as a commissioner
3 the Department is responsible for providing
4 clarity as to appropriate models of care,
5 with a focus on what funded services are
6 expected to deliver."
7
8 There's no ambiguity about that role?
9 A. Yeah, so, the only thing I would say, and I think we
10 go on to say this later in the statement, is that, in
11 developing those service models it is critically important
12 that there is that clinical and consumer input.
13
14 Q. Of course.
15 A. And secondly, that it is really important that the
16 level of definition leaves sufficient flexibility so that a
17 service model can be tailored to the needs of a local
18 community. So, for example, how a service model is applied
19 to an Aboriginal community, or to a refugee community, will
20 have different elements to it, and so I wouldn't want it to
21 be sort of read as an absolute that it's one size fits all
22 and a level of prescription that is counterproductive.
23
24 Q. Certainly. Models of care are rolled out, are they
25 not, in other areas of health?
26 A. Correct, that's right.
27
28 Q. It's correct, isn't it, that in mental health we're
29 lagging behind somewhat in doing this?
30 A. That's right. So, the mental health clinical network
31 really follows the experience from acute health about the
32 way to do this work, and again I see it as a great benefit
33 of having integrated mental health much more deeply into
34 the health stewardship functions of the Department, that
35 we're able to leverage that capability.
36
37 Q. Thank you. On a slightly different topic, the
38 submissions have acknowledged that there's no overarching
39 framework for service planning to address mental health
40 promotion, illness prevention and early intervention in
41 Victoria. I just have one question: do you accept that
42 there should be one?
43 A. Yes, and again, that it needs to interface with
44 Primary Health Networks who will also have a critical role
45 in that.
46
47 Q. Finally, on strategic frameworks, the Auditor-General

1 found that there was no strategic framework to guide and
2 coordinate the Department or health services that are
3 responsible for children and young persons' mental health
4 services: do you accept that finding?
5 A. Yes, and I do think it's important to distinguish
6 between children and young people, and I think going
7 forward, and in a lot of these areas the value of the Royal
8 Commission in providing insights about where to go next. I
9 think there are quite different views, particularly in the
10 children's space, about what that framework should entail.
11
12 Q. I'm not asking you right now what it should be,
13 because we'd probably be here more than all day, but why
14 was there no strategic framework? Is it the issue you've
15 just alluded to or something different?
16 A. I think it is a combination of there being deep
17 engagement and different views around what the best
18 framework should be, and I think for young people there has
19 been a kind of bringing together - and I think this is
20 happening - of the sort of psychosocial perspectives and
21 the clinical perspectives. So, it's not so much - in the
22 children's space I think it's a much more contest in the
23 clinical space about what the right model is; in the youth
24 space I think it's more that there's been a maturation
25 about how the different elements could be brought together
26 of a multidisciplinary response.
27
28 Q. But there's no disagreement --
29 A. And it should be there.
30
31 Q. -- that despite clinical complexity and differences of
32 views, there should always be a strategic framework?
33 A. Absolutely. I think it's a really critical priority
34 going forward.
35
36 Q. On the question of governance and leadership, you've
37 mentioned in your statement that two events have catalysed
38 a significant shift in the focus and resourcing of the
39 Department's system leadership responsibility since 2015:
40 the first was the events that led to the targeting zero
41 review, or the Duckett report, about hospital safety and
42 quality in October 2016, and the second was the
43 unprecedented surge in asthma and respiratory disease after
44 the thunder storm of November 2016.
45
46 With that background, noting that neither of those is
47 in mental health, but you raise them in your statement

1 anyway because they relate to the Department's leadership
2 capabilities, you've said:
3
4 "Both have led to a strengthening of the
5 Department's stewardship responsibilities,
6 with work continuing to strengthen
7 engagement with health CEOs ...", and so
8 on.
9
10 The Duckett review found, did it not, that the Department,
11 at least in that context, had inadequate overarching
12 governance and oversight of safety and quality in
13 hospitals, and that one issue giving rise to that was
14 inadequate data?
15 A. I think it was more than --
16
17 Q. Perhaps one?
18 A. One of the factors was inadequate data yes.
19
20 Q. I take it, you've raised that issue in your statement
21 because you reflect on that experience as saying something
22 about the issues with leadership in the Department and
23 you're making the point that, since that time, steps have
24 been taken to improve the Department's stewardship?
25 A. Yeah, I wouldn't frame it so much as leadership, I
26 would frame it as emphasis and resourcing.
27
28 Q. I see, can you say what you mean by that?
29 A. Absolutely. So, I think that what came out of the
30 Duckett review was the importance of us being more deeply
31 connected with health services about strategic development
32 of the sector.
33
34 That within a devolved model - and this is the second
35 point where the Auditor-General and I have a nuanced
36 difference of view - but in a devolved system of
37 governance, that there is a critical stewardship role for
38 the Department to help bring people together to look at
39 system level issues that can't simply be solved by an
40 individual health service. That in part goes to the data
41 and access to information, but it also goes to model of
42 care development, it goes to facilitating joint solutions,
43 it goes to having the mechanisms for collaboration earlier
44 in policy processes to joint problem solve.
45
46 Q. So your evidence is that, on each of those, the
47 Department has come on a journey since that review --

1 A. And still has a way to --
2
3 Q. -- and are still on that continuum?
4 A. And I think we've heard evidence today about the
5 opportunity for us to go even further in mainstreaming to
6 embed the work on Statements of Priorities and performance
7 discussions in the existing stewardship mechanisms that the
8 health system have and have been maturing - sorry, the
9 health stewardship function has, and mental health is
10 partially in those, but I think has predominantly been in
11 the focus of Emergency Department management rather than
12 those broader aspects of service model development and
13 collaboration.
14
15 Q. There's a number of things you mention in your
16 statement that we don't have time to address in that
17 respect. Can I ask you, I think you mentioned Statements
18 of Priorities just a moment ago. How are mental
19 health-specific KPIs included within health services
20 Statement of Priorities?
21 A. So, there are now seven KPIs that are specifically
22 about mental health that are embedded in the Statement of
23 Priorities. In addition, there are general KPIs that
24 relate in particular to Emergency Department access that
25 also include mental health, and there is a specific
26 objective in this year's Statement of Priorities around
27 working collectively as a system to look at the very issues
28 we've been talking about, about meeting the needs of mental
29 health patients that is more explicit in this year's
30 Statement of Priorities.
31
32 Q. Leaving to one side this year, and I think the
33 preceding two years where there have been changes, for how
34 long had the mental health KPIs remained the same?
35 A. The mental health KPIs, which is a slightly different
36 question to what's in the Statement of Priorities --
37
38 Q. Sorry, in the Statement of Priorities I mean.
39 A. Sorry, my understanding, and this does precede me, my
40 understanding is that they've been evolving since 2014/15.
41
42 Q. So, before that time they were static?
43 A. They were managed separately and, as I understand it -
44 and I can take this on notice and confirm for you the
45 precise trajectory - but my understanding is that there has
46 been an increase of KPIs sort of year-on-year from 2014/15
47 to now.

1
2 Q. And as of 2019, a strategic priority of supporting
3 mental health systems will be included in all Statements of
4 Priority?
5 A. Yes, and that's both for - just to make that crystal
6 clear, I know there was evidence that was discussed in the
7 previous hearing - that is both relevant to health services
8 that are responsible within their catchment, as well as
9 other health services who still need to manage referral
10 pathways, for example.
11
12 Q. How will that be monitored? How does one, as system
13 leader, know whether a service who has that in their
14 Statement of Priorities is supporting the mental health
15 system?
16 A. So we have performance discussions on a quarterly
17 basis with the health services, and that will form part of
18 those discussions.
19
20 Q. If you don't know, just say, but do you know how it
21 will be determined whether or not the service is doing
22 whatever that might mean?
23 A. Yeah, and what - I can't give you the specifics on
24 this one, but what generally happens with anything in a
25 Statement of Priorities is, there is a discussion and
26 evidence that is furnished about how Boards are meeting
27 their expectations under the Statement of Priorities.
28
29 Q. Would it be fair to say that there's probably a way to
30 go in developing an understanding of what is required in
31 order to meet that KPI?
32 A. And also, I think that the link between that and the
33 performance management framework which is being finalised
34 at the moment.
35
36 Q. Thank you, I was just going to ask you about that. My
37 question is, how far away is that from being ready to be
38 implemented?
39 A. Yes. So, the performance management framework was
40 funded in the 2018/19 budget, it's well underway, it's
41 expected to be completed by the end of this year for then
42 formal roll out in the 2020/21 year, and it will be more
43 embedded in the Statement of Priorities from next year.
44
45 Part of the reason for that timing is to line up with
46 the national performance framework which is expected to be
47 completed by early next year.

1
2 Q. Will that include measures of the ability of services
3 to meet demand?
4 A. So, it will have access indicators within it.
5
6 Q. Different from the existing KPIs?
7 A. We are looking at - the conversation earlier about
8 some of the feedback that's come from the Auditor-General,
9 as well as other advice that we had commissioned, is being
10 built into that performance management framework.
11
12 Q. Thank you, Ms Peake. Just some questions about
13 Emergency Department wait times. The Royal Commission's
14 heard evidence that, according to the National Emergency
15 Access Target, the wait time for Emergency Department
16 presentations for the general population is four hours and
17 for mental health population it's eight hours. Can you
18 clarify whether that is correct?
19 A. So, it is not quite correct. So, the four-hour target
20 applies to anyone who presents at an Emergency Department
21 including a mental health patient. Similarly, the 24-hour
22 target applies to everyone in an Emergency Department.
23
24 The eight-hour target is an extra safeguard, if you
25 like, because we know from the data that there are an
26 over-representation of people, with mental health patients
27 who are spending longer, unacceptably long periods of time
28 in Emergency Departments, and so, rather than waiting from
29 four hours to 24, there's another trigger point. It was a
30 pre-existing measure but we've kept it to provide that
31 extra sort of view on the system about what's happening in
32 Emergency Departments.
33
34 Q. So, accepting that you should have as many views as
35 you can on what's happening in Emergency Departments, the
36 rationale for the eight-hour period is an understanding
37 that mental health patients will wait longer in Emergency
38 Department generally?
39 A. No, the data is showing us that they are waiting
40 longer, and so, that we want to have another trigger in the
41 system.
42
43 Q. The evidence is also to this effect: that mental
44 health patients are by far and away the most represented
45 when wait times for movement between Emergency and an
46 inpatient bed exceed 24-hours: do you accept that?
47 A. That is correct.

1
2 Q. The evidence was also that in at least some hospitals,
3 a 24-hour breach in relation to a mental health patient,
4 whilst it's understood is a breach and not acceptable, it
5 would not be subject to the same kind of examination as it
6 would in the case of a general health patient for the
7 reason that there are very few, if any, options available
8 to Emergency Departments to deal with mental health
9 patients?
10 A. That's right. So, it's not a matter of there being
11 less priority or less care, it's that the examination is,
12 sadly, often able to be completed more quickly because the
13 reason is capacity in the system.
14
15 Q. It's really not an acceptable situation, is it?
16 A. It's not, that's right, which comes back to the
17 conversation we had right at the start of this hearing,
18 about the pressures the system is under.
19
20 Q. Just to finish that off, if there is a 24-hour breach
21 for a mental health patient, is that required to be
22 reported to the Department?
23 A. It is immediately to be reported to the Department,
24 and obviously that forms a really important part of the
25 evidence base that flows through into budget considerations
26 as well.
27
28 Q. Is there a different process or policy for
29 investigating 24-hour breaches for mental health and
30 general patients?
31 A. No. The policy is the same, the practical - as we've
32 just indicated, the practical way in which it plays out
33 because of the shortness of the examination that's usually
34 required, means that it looks a bit different in the level
35 of examination that's required, but the policy is the same.
36
37 Q. Yes, so there are really very few, if any, options to
38 ameliorate that situation in the current system?
39 A. And I think that is exactly why - the scope of the
40 mental health Royal Commission - to be looking across the
41 whole stepped care model is so critical, that simply
42 looking at the flow of patients into inpatient is not going
43 to solve the problem of how many people are waiting for
44 unacceptable periods of time in an Emergency Department.
45
46 Q. On the question of funding, in your evidence and in
47 the Victorian Government Solicitor's, it's accepted I think

1 that current funding mechanisms specifically referring to
2 block funding is unresponsive to changes in population and
3 inflexible to needs, funding's been allocated on a
4 historical basis, and it's not adjusted for the wider and
5 disparate needs in the complexity of clients.
6
7 There have been numerous other parts of the evidence
8 dealing with the complexities and problems with the funding
9 model. Why is it that inappropriate funding models have
10 been allowed to persist for such a long period of time?
11 A. And it is equally a very complex, expert, technical
12 exercise to get the alternative right. I think there was
13 some evidence led in Ms Williams' hearing, that the first
14 go at this actually was in the 1990s, where the
15 Commonwealth attempted to design an activity-based funding
16 model. Between 2012 and 2015 the Department did design a
17 model, it got to the point of being shadowed in health
18 services, but the classifications within it were not
19 sufficiently robust, and what we saw was enormous
20 volatility.
21
22 So, shadowing means that it's not actually used to
23 allocate money but you measure for the year what would have
24 happened if it had been in place. And so, when mental
25 health was reintegrated into the broader health branch or
26 division in 2016, one of the opportunities that arose was
27 for the people who are actually responsible for health
28 funding to take much more of a leadership role in relation
29 to looking at activity-based funding, particularly in a way
30 that would enable there to be packages of care along the
31 spectrum, and have been working really closely with the
32 Independent Health Pricing Authority to look at both, how
33 do you classify those phases of care and complexity of
34 patient need within those phases of care, and then what the
35 costing models would be.
36
37 There is enormous work that is going on with consumer
38 and clinical experts to look at how you do define those
39 phases, so that there is stability and predictability in
40 the model with a view to then having a shadow process, and
41 we've been really actively involved in that.
42
43 Again, I would reiterate, the expertise that we have
44 in the health funding team, actually people who design case
45 mix in the first place for the whole country, reside in
46 that unit, so there's deep expertise that wasn't available
47 between 2012 and 2015 when mental health was trying to do

1 it on its own.
2
3 Q. Acknowledging that it is complex and acknowledging
4 that mental health is not the same as general health,
5 nevertheless in general health you've had activity-based
6 funding for a very long period of time, accepting the
7 complexity, are there systemic reasons why the funding
8 models have been allowed to continue for so long?
9 A. I think it is important to say that parts of physical
10 health don't have activity-based funding that have more
11 similar characteristics to mental health. So, more of the
12 outpatient and community-based delivery, more of the notion
13 of what is the approach to thinking about a pathway of
14 care. Similarly we are at pretty early stages in physical
15 health of designing those sort of funding models that are
16 fit for purpose for that as well.
17
18 I think two things: I think the activity-based funding
19 was originally very much designed for a model of care that
20 was about infectious disease and trauma, and that was the
21 priority and so there was a relative priority that was
22 given. As the burden of disease has increasingly shifted
23 to chronic disease, that the very complex technical work
24 has started, including for mental health, about what a
25 variation of an activity-based funding model might look
26 like.
27
28 Q. And --
29 A. I should say, we'll be the first place anywhere in the
30 world, if and when - when - we get this right.
31
32 Q. That sounds good, Ms Peake. So, there's a process of
33 reform in which, just to summarise, a lot of work is
34 happening and the Department and Treasury and others and
35 various experts are considering funding alternatives to
36 block funding, and without going to the detail, am I right
37 in thinking that's not just limited to activity-based
38 funding, but you're considering a range of other options as
39 well?
40 A. Yeah, and for different parts of the key journey,
41 that's correct.
42
43 Q. On funding further, in 2019 to 2022, for that period,
44 there was a very significant increase in the mental health
45 budget compared to 2014/15, it was a 42 per cent increase.
46 Without disclosing information subject to public interest
47 immunity claim, what were the big factors that led to that

1 increase being able to be granted being successful?
2 A. I think it really does go back to our earlier
3 conversation about what are the factors that are important.
4 I think there has been, you know, really strong political
5 leadership, there has been a recognition within the
6 community about the pressure the mental health system is
7 under, and the sorts of investments that have been made
8 have been pretty targeted to be able to provide early
9 results in relation to alleviating some - a little bit - of
10 that pressure.
11
12 It is probably worth saying that, when you look at the
13 rate of growth between 2010/2011 and 2018/19, the rate of
14 growth is pretty comparable between acute health and mental
15 health; the base that we were coming from in mental health
16 has really been the problem about that funding resource.
17 So much more work is needed to get to anywhere near a level
18 of capacity in the system that is needed.
19
20 Q. I just have a few more questions for you, Ms Peake.
21 Commissioners, I won't be too much longer. On this
22 question of prioritisation, you've used the interesting
23 expression in your statement about "lack of parity of
24 esteem of mental health as compared to physical health",
25 and you've said that lack of parity of esteem is:
26
27 "... evident in the social determinants of
28 mental health ... in the treatment gaps
29 evident across our mental health system,
30 and in the fabric of mental health
31 infrastructure, which falls behind general
32 health care environments in terms of
33 contemporary expectations."
34
35 Can I just explore that a little. Do you have a view
36 about where the lack of parity resides, in whose
37 perception?
38 A. Yeah, I think that, certainly coming back to the
39 point around evidence, stigma and discrimination still
40 existing particularly I think for severe mental illness and
41 particularly in relation to psychotic illnesses and
42 personality disorder conditions - which is not to discount
43 stigma in relation to depressive and anxiety disorders
44 either - I think that is absolutely at the heart of this.
45
46 I also think that, by virtue to some extent, even as
47 mainstreaming has occurred, there's still been some

1 separation, not thinking and talking about mental health as
2 a really critical specialty like any other - like cancer,
3 like cardiac - that we haven't helped in building that
4 esteem. And again, I just can't underscore enough how
5 important I think this Royal Commission is to counter some
6 of that.
7
8 Q. Can I just ask you about that stigma. Do you mean to
9 convey that there is a perception amongst those who make
10 decisions about prioritising about what the community
11 thinks, or something different?
12 A. Yeah, so I think, in terms of the community
13 expectation and the community acceptability, if you like,
14 of where priority should be placed.
15
16 Q. Thank you. In relation to a question of how you make
17 reform stick and how you implement it properly, there are a
18 number of things in your statement that we are interested
19 in. One thing you've talked about is having an adaptive
20 approach, and I think you've already covered having the
21 right tempo for reform, the right pace and staging, and the
22 need for careful up-front planning and so on.
23
24 Noting we don't have a lot of time, is there something
25 you want to say to the Commissioners about the question of
26 pace and timing?
27 A. Yeah, look, only that there is this very fine balance
28 between having early progress that maintains momentum for
29 reform and builds that community acceptability and
30 confidence, with seeking to have too many different parts
31 all being implemented at once so that the
32 inter-dependencies can't be well managed, and that the
33 opportunities that may arise as elements of reform unfold
34 that you couldn't have even predicted when you started, the
35 opportunities might be missed.
36
37 And so, my reflection would be, the more that we can
38 frame a reform agenda that has practical, actionable
39 components that can be implemented and then built on, I
40 think that builds the sustainability of the reform.
41
42 Q. You've mentioned strong institutional governance
43 arrangements are necessary, including at ministerial level,
44 Cabinet Committees and Task Forces. Is there anything more
45 specific you want to say about that aspect of it?
46 A. No, I think that's - yeah.
47

1 Q. I thought you would say that. You've also said in
2 your statement that robust system level governance is
3 necessary. I think you've probably said quite a few things
4 about that in your evidence. You mention the desirability
5 of establishing an independent monitoring body to help
6 provide assurance to both government and the community
7 about sector capability and performance.
8
9 A. Yeah, just before I go on to that, just the bit that
10 you just mentioned about the service level governance: I
11 think the other point that I made in there that I would
12 reinforce, is that I do think that there is value in having
13 a strong, stable public institution that is a fulcrum of
14 that service level governance that has an enduring, both
15 connection to the values of the reform ambition, but also
16 has the sort of stability and endurance to be able to keep
17 that momentum happening at the service delivery level, as
18 well as the sort of things that would be put in place at
19 the system level. So ministerial committees and
20 cross-government senior officials structures will get you
21 some way; it's the people, that strong leadership on the
22 ground that really matters.
23
24 I think where I have seen, and I've given some
25 examples in my statement, something new being created, it's
26 quite difficult to form and provide that leadership for
27 significant ongoing reform at the same time.
28
29 Q. So, in order to address that, what kind of structure
30 would you have in mind, can you say?
31 A. And, I think that's something that we need to keep
32 kind of talking about in the next few months.
33
34 Q. Of course.
35 A. But in principle I think that at least the principle
36 of having something in place, that there is an existing
37 institution that has the capability to hit the ground
38 running and will endure is a pretty important ingredient
39 for success.
40
41 Q. Finally, Ms Peake, do you have a view about this
42 issue, and that is, that as we saw at the outset of your
43 evidence by looking at the 2009 report, this is an
44 environment where much is understood, although there is a
45 lot of complexity, and there's been a wealth of reports and
46 recommendations often saying very much the same thing, and
47 we at the same time see a persistence of the very same

1 problems over long periods of time. If you have to
2 identify the key reasons why it is so hard to actually get
3 to where we aspire to in mental health, what are they?
4 A. So, I think absolutely part of it is having that
5 resourcing for change, not only for capacity but actually
6 for change. It is having the authority and accountability
7 for leading the change embedded at that service level. It
8 is having the mechanisms, not only for operational
9 governance, but for that collaborative governance with all
10 parts of the system; I don't think we've had that very
11 effectively in the past. There is some prospect with
12 Primary Health Networks for there to be a mechanism, a
13 stronger mechanism, for that work.
14
15 I think the other thing we haven't done well in the
16 past is, we haven't really engaged the private
17 practitioners in that system level or that service
18 deliverable governance. And I've included an example,
19 which actually was referred to in the 2009 work as well,
20 about the integrated cancer services as a bit of a model,
21 that mightn't be quite right, but there are some learnings
22 from it that I think we could take.
23
24 I think it's the resourcing, it's the political sort
25 of authority that having a Royal Commission gives, and then
26 it's having those right institutional and, in particular,
27 service level governance structures to drive it forward.
28
29 MS NICHOLS: Thank you, Ms Peake. Chair, do the
30 Commissioners have any questions for Ms Peake?
31
32 CHAIR: Q. Thank you, Ms Peake, I have one. We've heard
33 very clearly throughout your evidence today and the
34 evidence of other people who have come before this
35 Commission and in our community consultations and other
36 things, about the daily experience of the demand pressures
37 on the mental health system.
38
39 We've heard about so many of the strains on the
40 community-based services as well as the hospital-based
41 services, and we've also heard about the disparity and
42 availability of services across the state, so a lot of
43 pilots that haven't gone to scale which means that you get
44 a different level of service in one area compared to
45 another.
46
47 And so, when we think about the task ahead, I guess

1 I'm interested: you mentioned lead times, the lead times
2 that are involved in developing a plan, securing the
3 funding, establishing the infrastructure and then getting
4 the workforce to actually be able to staff that, for
5 example.
6
7 Traditionally in mental health, or in health more
8 broadly, what are the lead times that you think we as a
9 Commission need to be conscious of?
10 A. So, and again, I think that having things happening at
11 the same time as the bigger change, having more of a lead
12 time is important to build that belief. So, I think there
13 probably needs to be sort of a year for development and a
14 realistic sort of three to five-year timeframe for phased
15 implementation, but even in that first year trying to take
16 some of the demand pressure out is, I think, really
17 critical for people feeling that they can lift themselves
18 out of the burden of that acute pressure that everybody
19 feels at the moment to engage with what could be different
20 service models and what could make a longer term
21 difference.
22
23 Q. A final thing was also, just to take up the point that
24 you said, and it was specifically in relation to funding
25 models: you talked about the fact that now you are seeking
26 to use the capability, not just in the mental health
27 branch, but in the data analytic and other capability
28 you've got in the health part of the broader portfolio. Is
29 that your intention to do that more, in terms of other
30 aspects of the functioning and designing of mental health
31 and the response to mental health issues?
32 A. It is. I think I mentioned Safer Care Victoria and
33 the work that they do on service model development: there's
34 fantastic work that they've done, for example, in stroke
35 care which has led to clot retrieval services being more
36 standard for the state.
37
38 So they, with the clinical networks, now have a very
39 strong methodology for this work, and they are auspicing a
40 new six-month-old mental health clinical network, so they
41 are a really important capability.
42
43 The other piece that I really haven't mentioned is our
44 system Analytics Unit that is doing a lot of work on
45 linking data from health and human services to really
46 understand what the contribution of all of our services can
47 be to improving wellbeing as well as health and safety

1 outcomes. That unit was given status as a linking
2 authority, national status, about a year ago which means
3 that they are able to also link in Commonwealth data. So,
4 we're at a point with that group where they've linked all
5 of the DHHS data, they've now got education data and
6 justice data, including corrections and police data that
7 they have linked in, with of course appropriate protections
8 around privacy central to that.
9
10 We've done some specific projects with the
11 Commonwealth, particularly in cardiac care to look at
12 variation in care, so that authority or that capability
13 will be, I think, really critical for us in thinking about,
14 not only what we've been focused on today about the mental
15 health system but its interface with other critical
16 services.
17
18 Equally, our strategic policy area is leading the work
19 on engagement with the Commonwealth about interface issues
20 with the NDIS and aged care, and that is an important
21 function and capability that we are using for the mental
22 health interfaces as well.
23
24 And finally, the research and evaluation capability
25 within the Department, which again, I think has got a
26 really important role if we go back to how do we avoid
27 having trials that don't have a proper path to scale.
28
29 Q. Thank you. I think the other issue we just take on
30 notice is that issue of the Commonwealth-state relationship
31 in mental health that appears to be pretty fundamental to
32 the future design --
33 A. Yes, absolutely.
34
35 Q. -- and better leveraging of shared interests, I think.
36 A. If I give a one minute burst. I think the next, so
37 the Sixth National Mental Health Plan, is due to be
38 starting next year and is a significant opportunity for us
39 to think about some of those issues around funding models,
40 data and performance, consistent datasets. So, not only
41 initiatives, but actual fundamentals of a stepped care
42 system.
43
44 There's also work that's going on in suicide
45 prevention, both a health driven plan, but also with the
46 new Suicide Prevention Advisor thinking about the role that
47 all of the other community and service opportunities can

1 bring to bear on suicide prevention, so I think there are
2 some real opportunities to leverage off, and obviously the
3 final one is the work of the Productivity Commission.
4
5 MS NICHOLS: May Ms Peake be excused?
6
7 CHAIR: Yes. Thank you very much for your witness
8 statement and your evidence today, Ms Peake.
9
10 <**THE WITNESS WITHDREW**
11
12 MS NICHOLS: There are no more witnesses today, Chair.
13
14 **AT 4.15PM THE COMMISSION WAS ADJOURNED TO**
15 **FRIDAY, 26 JULY 2019 AT 10.00AM**
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