Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF ROBYN KRUK AO

I, Robyn Kruk AO, say as follows:

Background

1 My background is in the public service, including positions as director-general of state agencies including the New South Wales Department of Premier and Cabinet, New South Wales Health and NSW Parks and Wildlife. I was the Secretary of the Department of the Environment, Water, Heritage and the Arts, and I subsequently established and worked as the inaugural CEO/Commissioner of the National Mental Health Commission. I retired from full time work in the public sector in 2014.

2 I have held various non-executive positions on state government boards and statutory bodies including the NSW Clinical Excellence Commission, Agency for Clinical Innovation and NSW Ambulance. I was also a Commissioner on the NSW Independent Planning Commission.

3 I currently hold the following positions:

(a) board member of the National Disability Insurance Agency;

(b) interim chair of Mental Health Australia;

(c) board member of the Australian and New Zealand School of Government;

(d) chair of Food Standards Australia New Zealand;

(e) Chair Emerita, Reforming States Group, USA, Milbank Memorial Fund, a philanthropically endowed operating fund that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience; and

(f) independent international adviser to the China Council for International Cooperation on Environment and Development.

4 Attached to this statement and marked 'RK-1' is a list of references for the Royal Commission to consider and that I refer to throughout my statement.

5 I am giving evidence in my personal capacity and not on behalf of any organisations with which I am associated.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

Future trends

The trends or changes

6 There are well documented trends that will profoundly increase the community's need for mental health services in the future. These include crises such as the recent bushfires and coronavirus, climate change, technology and the impact of disadvantage and substance abuse. The impact of disasters have immediate, mid and long term implications for mental health service delivery. Research has shown that following the Victorian Black Saturday bushfires a significant minority of people in the high-affected communities reported persistent PTSD, depression, and psychological distress and recommended the use of health and complementary services, community-based initiatives, and family and other informal supports, to target these persistent problems.[1]

(a) Many people face social disadvantage that can make them more likely to have a mental health issue and less likely to be able to access mental health support services. Disadvantage starts before birth and accumulates throughout life.[2][3] The mental health of people is affected by the social, economic, and physical environments in which they live. Many risk factors for mental illness are associated with social inequalities. Implementing strategies to address the social determinants of mental health will improve the living conditions of people across the life stages, and reduce risks of the mental health issues associated with social inequalities.[4]

(b) The increasing use and attachment to technology have been shown to increase conflict with others, ADHD, and depression in younger populations. Reduced social interactions resulting from increased technological use and dependence on social media for communication have also been linked to poorer mental health outcomes.[5]

(c) At the same time, technology can also provide solutions that improve access to services that otherwise would be impossible as we are seeing in the current COVID-19 pandemic.

(d) There is strong evidence for e-mental health interventions that deliver components of psychological therapies through teleconference/telephone, video conference and/or internet-based apps without a one-to-one relationship with a clinician. The use of digital technology and interventions within an integrated

[1] https://journals.sagepub.com/doi/pdf/10.1177/0004867414534476.
[2] World Health Organization and Calouste Gulbenkian Foundation. Social determinants of mental health. Geneva, World Health Organization, 2014.
[3] https://www.acoss.org.au/wp-content/uploads/2019/04/PC-Mental-Health-Inquiry.pdf.
[4] Mental Health Australia, Submission in response to the Productivity Commission Inquiry into mental health, April 2019
[5] Scott, D.A., Valley, B. & Simecka, B.A. Mental Health Concerns in the Digital Age. *Int J Ment Health Addiction* **15,** 604–613 (2017). https://doi.org/10.1007/s11469-016-9684-0.

framework can supplement traditional face to face services adding considerable flexibility and capacity to the mental health sector at a more affordable cost than building the workforce can achieve alone.[6]

(e) Substance abuse is a major cause of mental illness.[7] The National Institute on Drug Abuse (**NIDA**) reports that about half of the people who experience a mental illness will also experience a substance use disorder at some point in their lives and vice versa. The National Mental Health Commission Review reported that 20 per cent of people with a mental illness use alcohol excessively or have a drug addiction. They also reported that there is a strong service silo approach in response to the needs of people who experience both substance misuse and mental illness.

(f) The NIDA recommends that treatment for comorbid illnesses should focus on both mental illness and substance use disorders together, rather than one or the other. Yet anecdotal reports indicate that service integration in Australia remains an aspiration rather than a reality with consumers needing to seek support across both service systems.

7 The coronavirus comes on top of a cumulative series of crises at community level, including the recent bushfires. Grief upon grief. The cumulative impact of major events on individuals and communities has the potential to drive further disparities in physical and mental health outcomes. This is outlined in the Australian Council of Social Service "Resilient Community Organisations" project,[8] based on the research report into "Adapting the community sector for climate extremes".[9] Mapping by NSW Council of Social Service on economic disadvantage in NSW based on income showed some of the worst fire affected areas to also be the most economically disadvantaged areas.[10]

8 Communities that have some of the most challenging economic circumstances have been the most affected by bushfires and drought, often in combination. These major economic impacts are likely to increase the prevalence of mental health issues, suicide and social isolation. The need for physical distancing as part of the community response to COVID-19 places further pressures on individuals and communities at a time when their resilience has been most tested. The evidence for negative mental health effects of social isolation is well documented.

[6] Mental Health Australia, Submission in response to the Productivity Commission Inquiry into mental health, April 2019.
[7] Mental Health Australia, Submission in response to the Productivity Commission Inquiry into mental health, April 2019.
[8] https://resilience.acoss.org.au/.
[9] https://www.nccarf.edu.au/content/adapting-community-sector-climate-extremes-extreme-weather-climate-change-community-sector-%E2%80%93.
[10] http://povertyandinequality.acoss.org.au/publication/poverty-in-australia-2020-part-1-overview/.

9 Australia is one of the first countries internationally to review and report the impacts on mental health associated with climate change and the broader environmental footprint.[11]

10 UN Sustainable Development Goals now include mental health metrics: Suicide mortality rate (3.4.2) and Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders (3.5.1).

11 Further targeted research is required to better understand the broader factors that impact specifically on mental health outcomes building on the broader body of knowledge on social determinants of health outcomes.

12 Two key Australian papers on climate change and mental health are:

(a) Hayes K, Blashki G, Wiseman J et al (2018) 'Climate change and mental health: risks, impacts and priority actions,' *International Journal of Mental Health Systems,* 12, 28; and

(b) Fritze JG, Blashki GA, Burke S et al (2008) 'Hope, despair and transformation: Climate change and the promotion of mental health and wellbeing,' *International Journal of Mental Health Systems*, 2, 13.

13 Countries such as the United States have reported the increasing instances of opioid abuse and the related number of so-called 'deaths of despair'. There are worrying indicators of the existence of these problems in Australia. It is likely that there is a lag between what is experienced in the US and Australia and we will face those issues in the future.

14 The Better Access initiative that was part of the Australian Government's contribution to the COAG National Action Plan on Mental Health 2006-2011 has significantly increased access to psychological interventions supported by the MBS and introduced education and training for the mental health workforce. However, the high level of out of pocket costs to users and the MBS provider-driven maldistribution of the workforce to wealthy, more populated areas has further embedded social disadvantage in relation to access to mental health services. Australian research[12] has found that over 40% of people with depression, anxiety and other mental health conditions stated they did not seek healthcare treatment because of the cost.

[11] https://www.blackdoginstitute.org.au/docs/default-source/default-document-library/mental-health-interventions-following-disasters---black-dog-institute---february-2020.pdf?sfvrsn=0.

[12] Callander E, Corscadden, L. & Levesque, J-F. Out-of-pocket healthcare expenditure and chronic disease – do Australians forgo care because of the cost? Australian Journal of Primary Health. 2017(23):15-22; https://www.mentalhealthcommission.gov.au/getmedia/e4c0f6d3-2339-4719-a94d-06c21a73fd5f/NMHC-Submission-to-PC-Draft-report-into-Mental-Health-January-2020.

Preparing and responding to the trends

15 In order to prepare and respond to the future trends identified above, the government must have robust data at a population and individual level to support more integrated or person centred approaches to mental health, rather than episodic approaches. There are a range of assurance and improvement processes and governance mechanisms in the mainstream physical health system that are not currently applied to mental health. This also ties in to how the mental health system is funded, which I discuss below at paragraph 35.

16 Collecting and using integrated data sets on the instances of mental illness is complex because of the need to apply and understand the impacts of the various social determinants of mental health. The data that exists on mental health is a pivotal foundation that needs to be significantly enhanced to fully understand and address gaps/inequities while also ensuring that interventions are most likely to improve outcomes. In order to receive early warning signs about mental health issues at a population level and to make meaningful assessments of what does and does not work, there must be a strong basis in data.

17 The other critical factor in preparing and responding to these future trends is to have a comprehensive planning framework and commitment to consistency in shaping that framework. Having such a framework will help determine and track where there may be gaps in the mental health system and where there might be opportunities to take advantage of the link between mental health and the social determinants of health more broadly. The broader mainstream health services have invested in a planning framework which is not at the same stage of maturity in the area of mental health. These planning frameworks are also a necessary precursor to provide insights to the tertiary and vocational training sectors to shape the capability of the future mental health workforce and to ensure it is fit for purpose. Without such a framework the sector is more likely to be remain reliant on legacy models of care and service delivery models.

18 It is also important that the impact of severe crises on communities is given priority for consideration in any future planning and capacity building.

System management

19 Mental health services in most jurisdictions are state wide services that are funded and outsourced to non-government providers or directly delivered by local health districts under the broader accountability of the health system manager. Delivery of mental health services is in most instances delegated to local health districts with the responsibility for the broader system planning and resource allocation remaining with the health system manager. Accountabilities for both roles need to be considered in

tandem to ensure that roles and responsibilities are clear, fit for purpose and support an integrated approach to care for people experiencing mental ill health.

20 The health system manager also has responsibility to ensure effective interaction with the Commonwealth health funders through COAG structures and provide input into broader national policy and planning and health workforce matters through national health plans and partnership agreements.

21 The state system manager of mental health services must be accountable for macro planning, reviewing capacity and allocation of resources on a state-wide or system-wide basis and applying that analysis into the capital and operational budgets for mental health services. If it is not clear that it is the state health system manager's responsibility to also undertake broad state-wide planning for mental health services, then the planning ends up being undertaken at a very local level at mental health service sites which in nearly all instances is unsustainable. If these functions are not clearly the responsibility of the state health system manager, there will also be a disconnect in the capital works response which has the potential to drive further disconnect between mental health services and physical health services and increase disparities in the access to mental health services.

22 In Victoria, as is the case in most administrations, the performance agreements for local health districts are traditionally heavily weighted to health system procedures rather than specific mental health system outcomes. There is less transparency and oversight about the system's ability to assess whether mental health services are provided in the most equitable, cost effective and impactful manner. It is highly important that the state health system manager's key performance metrics drive integration and improvement in both physical and mental health outcomes given the persistently large gap in longevity experienced by people with mental ill health.

23 The Milbank Memorial Fund Report, Integrating Primary Care into Behavioural Health Settings: What Works for Individuals with Serious Mental interesting provides evidence and practitioner insights into this area.[13]

24 In the last few years most of the states and territories have strengthened their engagement with people with lived experience and their carers. However, as outlined in the Productivity Commission's Interim Report, more needs to be done to embed the focus on consumers and carers as key players in mental health policies, planning and reviews. In the absence of integrated data bases and information systems between the acute and primary health sectors, the voice of consumers is even more critical in

[13] https://www.milbank.org/wp-content/uploads/2016/04/Integrating-Primary-Care-Report.pdf.

identifying gaps in delivery models and identifying how to make significant and sustained improvements in mental health outcomes.

25 The Western Australian government adopted a significantly different approach to driving reforms in mental health through a legislatively established Mental Health Commission empowered and funded to strengthen the consumer and carer voice and proactively rebalance the service system to include more community based and early intervention and prevention initiatives. They have quarantined a certain amount of WA Department of Health funding and have directed it to the Western Australian Mental Health Commission with the explicit responsibility to undertake some of the rebalancing of the mental health system. The model has had real benefits in creating policies that are person-centred and increasing the connectivity between other social care and health services and supported efforts to improve the integration with primary care services through the Primary Health Networks. It has enhanced focus on the quality of the services received, access to safe housing and the need to facilitate the establishment of the step up and step down services. The success can be attributed to the Commission having a broadly based accountability that includes recognition of the social determinants and dedicated funding.

26 Challenges faced by the WA model relate to a lack of clarity on some key areas including clinical governance and the delineation of roles and responsibilities of the health system manager and the Mental Health Commission. The experience in Western Australia highlights the importance of enshrining the consumer and carer voice in key policy and implementation measures, dedicated funding to rebalance the suite of services and the need for role clarity and accountabilities in governance structures. The role of the health state manager needs to be clarified. WA also needs to ensure sustained levels of quality of safety for healthcare services in the community and acute healthcare settings.

27 National Mental Health Commission reports and jurisdictional audits have highlighted the challenges of quarantining funds dedicated to community health purposes within the broader health budget when the pressures of the acute system may prevail. Irrespective of the governance structures rebalancing to enhance community services requires dedicated funding, clear role delineations, ongoing oversight and public reporting of progress.

Monitoring

28 In order to effectively monitor the performance of mental health services, there must be clear articulation of desired outcomes and accountabilities relating to mental health at each tier of government. Many of the most influential levers impacting upon mental health outcomes lie outside of the health budget and include housing, and social care

supports. A number of jurisdictions have identified mental health outcomes as part of a broader suite of whole of government outcome metrics or whole of government strategy (often identified as Premier's Priorities) to drive more person centred approaches that sit beyond the remit of the health secretary. The most critical being supported housing. Collective impact measures have proved very useful in these areas and may assist in maximising investment outcomes. Having robust data will help in monitoring the effectiveness of governance and delivery structures and allowing system improvements to be addressed.

Lived experience in governance

29 Given the weak links between the acute system and the primary health system, the voice of lived experience is one of the best sources of advice about where things are going wrong. Lived experience voices can provide insight on where the gaps and opportunities are in delivery of the mental health system. From this perspective alone, having the voice of lived experience built into decision making is logical from a first principles basis.

30 I refer to reference 6 below, the National Mental Health Commission submission to the Productivity Commission 2019 Draft Report on Mental Health. The submission provides a great summary on the benefit of building the lived experience voice into the planning and delivery of services from an economic perspective.

31 In other areas of healthcare, there is most often a very good line of sight about what is working and greater transparency about the quality of care received – for example, the number of avoidable quality and safety incidents and patient feedback loops. This transparency is vital in building and maintaining confidence in the service providers and providing ongoing direction as to where improvement is needed. The challenge with mental health services is that there is less transparency and less opportunity for people with mental illness to be asked to provide their views on the quality of a service they are experiencing and whether it is making an impact. That is why it makes sense to embed the lived experience voice in system delivery.

32 There is strong evidence regarding the contribution that the lived experience voice makes to quality of care.[14] Having the lived experience voice embedded in health systems needs to become business as usual, rather than something that exists on the side of the system. To effectively embed the lived experience voice in service planning, there needs to be targeted research on the benefit of lived experience roles and

[14] See p4 NMHC consumer and carer practical guide + reference to WHO paper https://www.mentalhealthcommission.gov.au/getmedia/afef7eba-866f-4775-a386-57645bfb3453/NMHC-Consumer-and-Carer-engagement-a-practical-guide; WHO paper 4 World Health Organization Regional Office for Europe. User empowerment in mental health: A statement by the WHO regional office for Europe. Copenhagen: World Health Organisation; 2010. http://www.euro.who.int/__data/assets/pdf_file/0020/113834/E93430.pdf.

exploration and funding of ongoing roles for people with lived experience in the evaluation and monitoring of services.

State and Commonwealth engagement in national reform

Benefits in state and Commonwealth working together for national reform

33 The benefit of state and Commonwealth governments both being involved in national reform is that it provides a greater opportunity for mental health services to be delivered using a 'whole of life' approach. The levers in the national government relating to the social determinants of mental health such as social welfare, aged care, disability and employment can be accessed, as can the levers in the state system like housing and education services. It is also important that private and non-government entities are involved in the reforms.

Challenges in state and Commonwealth working together for national reform

34 One of the constraints on systemic reform in mental health relates to the governance structures, which are legacy based and often more transactionally and efficiency focussed. Mental health services are being provided without a strong planning framework to support them or in fact to assess their merits. They are often being provided without having regard to a 'whole of life' or 'whole of person' approach to the provision of mental health services. Often when mental health problems are prominent, the response is to put more acute beds into the health system – which may be not in fact be the most effective response from a personal or budgetary perspective. Instead, governments should be looking at the full suite of services required, many of which are social care and support providers that aim to prevent people getting to a stage where they require an emergency department admission. There has also been variable commitment to involving the consumer and carer voice at the heart of planning.

35 The second constraint is the activity-based funding model for states and territories. This model has served mainstream health quite well. It has made the system more efficient by allowing institutions to compare the cost of treatment between different hospitals and allowing states to more easily compare health outcomes. There is a growing focus on 'better value care' which in part seeks to empower health consumers with greater health literacy about what works and what doesn't. However, the mental health system is years behind the physical health system and is a long way from having a good understanding of what an episode of care actually involves and costs. It has proven difficult and slow to determine a meaningful 'efficient price' for community based mental health services and concerns are consistently raised that current funding models continue to provide perverse incentives for people to be treated in the acute system rather than in a

community setting. There is also less public discussion about the efficacy of various mental health related interventions.

36 The way the activity-based funding model applies to the mental health system means that service providers are paid more for seeing people more often. This can provide a perverse incentive for people to be re-admitted rather than be guided by a more recovery oriented approach that that focuses on patient outcomes and successful transitions between acute and community settings. The second issue with the model is that it is not holistic, instead it focuses on a particular episode of care. This biomedical approach does not take into account the circumstances in which a person is living and their life as a whole. That consequently limits the ability of the system to provide wraparound mental health services.

37 Australia is the only jurisdiction I am aware of internationally that has moved down the path of activity-based funding. Many jurisdictions are progressively moving to a more bundled payment system and a progressively more performance based approach structured on an outcome from a multi-disciplinary team, instead of one clinician. This is particularly relevant when a person has a complex condition requiring them to access a range of support services. This approach also enables a greater integration of physical and behavioural/mental health issues to be addressed.

Ways in which state and Commonwealth governments can work together to effect enduring and systemic reform

38 There needs to be a national partnership agreement at the Commonwealth level that makes it clear what the accountabilities of the Commonwealth and state providers are respectively. Ideally this agreement would also consider the accountabilities of private and non-government entities that are mental health service providers.

39 The second aspect is for the tiers of government to have a clear picture on what they want to achieve and what is considered to be success in the area of mental health. The ability to make effective use mechanisms such as commissioning is dependent on knowing what you want to purchase (and agreeing this between levels of government), and ideally to provide flexibility in the manner which this may be achieved to drive innovation. To align the Commonwealth, state and non-government systems and incentivise people to do things differently, there must be a consistent message in relation to what success actually looks like. And to be able to effectively measure it.

40 The third aspect is having robust data on the whole cost of integrated care. In the absence of data on the cost of integrated care, it is very difficult to meaningfully assess the impact of various mental health interventions at a community level. The Commonwealth and states need to unequivocally commit to sharing key data. Currently,

most Commonwealth funding contributions for mental health go towards the Pharmaceutical Benefits Scheme and the Medicare Benefits Scheme. Data exchange between governments will enable a far more meaningful assessment to be made of the impact and full costs and benefits of mental health interventions irrespective of the funding source.

Regional commissioning

41 In relation to the strengths and limitations of regional mental health planning and commissioning, I refer to reference 1, the KPMG Impact Assessment report on the Maranguka Justice Reinvestment Project. The report is a case study on the town of Bourke in north-west New South Wales, which became the first major pilot site in Australia to implement an Aboriginal-led place-based model of justice reinvestment.

42 The case study shows that a lot of mental health reform does not need to be done through formal commissioning mechanisms. It demonstrates the benefit of looking at community need and restructuring processes with leaders in the community to maximise community input. The project was focussed on reducing the incarceration rates of young Aboriginal people on the basis that contact with the justice system tends to be a significant indicator of future wellbeing. The project also had a profound effect on a number of other areas such as family violence and retention rates in the education system.

43 There are also examples of commissioning that demonstrate the merits of a regionalised approach. I refer to reference 4, the Mental Health Australia Submission on Intergovernmental Arrangements in response to the Productivity Commission Inquiry into Mental Health. The submission contains a case study on a whole of system strategy that was developed in Greater Manchester in the United Kingdom in 2016. Essentially, the structure created a dispersed model of leadership that reflected the accountability arrangements and responsibilities that existed at a local and national level. The structure enabled shared decision-making, democratic accountability and voice, genuine co-production and the joint delivery of services.

44 In the last few years, Mental Health Australia has been working with Primary Health Networks (**PHN**) to improve commissioning of regional mental health services. Providing PHNs with this responsibility is a good instrument to form the basis of joint planning between Commonwealth, state and local government entities. A very positive change has been to provide PHNs with the responsibility to undertake regional assessment of mental health needs. This will be a valuable foundation upon which to build cooperative planning and service delivery with the state health services and the primary care sector to support more holistic person centric approaches. This can be found at *Report of the*

PHN Advisory Panel on Mental Health (2018)[15] p7-8 which outlines previously identified challenges and opportunities to improve mental health service delivery in partnership with the PHNs.

Learnings from other examples and existing efforts

45 Many jurisdictions have made submissions to the Productivity Commission Inquiry into mental health on the potential benefits of progressing a regional commissioning approach.[16] Queensland and Western Australia have made commitments to progress regional commissioning models in partnership with the Commonwealth government and the Aboriginal Community Controlled Health Organisations. Most recently in Western Australia this has focussed on the Kimberley region. Anecdotally, while there is a strong commitment to progress these initiatives, it is understood that progress has been challenged by a range of issues including data related matters but more significantly, the absence of practised funding models that enable risk sharing arrangements/benefits to be articulated and effectively measured. These are detailed in the WA Sustainable Health Review.[17]

46 A number of jurisdictions including New South Wales and Victoria are understood to have made promising progress in the use of social impact bonds and other means of purchasing or procuring more holistic and outcome focussed services from non-government providers. In NSW these have included work with the NSW Government and The Benevolent Society in seeking to reduce out of home care and Silverchain in the provision of wraparound end of life services. Many jurisdictions including Western Australia are utilising collective impact approaches to address disconnects and fragmentation in human care service as part of efforts to reduce suicide rates.

47 Most Australian states have outcome measures and targets that are used to drive the integration of state services. It is understood the national government is favourable to considering similar approaches but currently does not have a similar agreed set of outcome measures across their own program areas. There is stronger evidence of integration around state delivered services than in large Commonwealth programs.

48 A number of US states have similarly taken a far more localised, regional approach. They have used bundle payments for outcomes and provision of incentives for improvements in outcomes rather than paying for a level of activity, which is the way that we pay in our system at the moment.

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[15] https://www1.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/Report-of-the-PHN-Advisory-Panel-on-Mental-Health.pdf.

[16] https://www.pc.gov.au/__data/assets/pdf_file/0015/244131/sub551-mental-health.pdf pp19-20; https://www.pc.gov.au/__data/assets/pdf_file/0003/250266/sub692-mental-health.pdf pp 4-6.

[17] https://ww2.health.wa.gov.au/~/media/Files/Corporate/Reports%20and%20publications/Holman%20review/a-promising-future-wa-aboriginal-health-programs.pdf.

Public health approaches

49 In order for Victoria's future mental health system to have an effective public health approach, all tiers of government must jointly determine what the desired outcome is, who is accountable for specific responsibilities at Commonwealth and state levels and what data is necessary to assess whether the approach is having the desired outcome. This reinforces the point I made above at paragraphs 38-40.

50 Australia has one of the most successful public health interventions in reducing smoking rates. It is a great example of a suite of policy levers being utilised at the federal level in relation to controls on tax and exports, and at state level in relation to workplace and venue restrictions and restrictions at point of sale. The success was driven by the fact that there was agreement at the Commonwealth and state level about the desirability of reducing smoking rates. And a long term commitment to jointly progress. The other important aspect is that the data on smoking rates is very well articulated to show the impact of different interventions. For example, if you increase the tax on cigarettes to $30, you can assess what impact that has on the reduction in smoking.

51 Obesity is a significant public health issues that has proven resistant to policy intervention. A number of jurisdictions including New Zealand, Western Australia and NSW have made promising inroads to child obesity rates. In WA, the government has agreed to make childhood obesity the target of a whole of government approach – there by driving greater alignment between state and local government and cooperation between key government agencies such as education and health. In NSW, the Premier has adopted ambitious targets to constrain growth in childhood obesity with these targets included as a key metric for chief executives. Again, progress is being made. Focus at this level has facilitated significant engagement at the community level – with approaches determined at the local level in partnership with families and communities.

52 Childhood obesity can be likened to mental health in relation to the fact that it is a difficult measure to change with successful outcomes beyond the reach of any one funding body. It touches on so many aspects and areas of government. It requires involvement at the community level, in education systems and in local government. It requires CEOs of health entities and other key agencies to be accountable for improving outcomes, which can create quite different partnerships at community level and create better alignment across that activity, whether it be through philanthropic efforts, local government work or perhaps a sporting body.

53 The other key learning garnered about embedding prevention and promotion approaches in government programs relates to public reporting. Including public reporting in performance agreements is significant and can drive changes in behaviour at a local government level. For example, in relation to childhood obesity the township

of Wellington came to an agreement to lose one tonne of weight. That was driven by the fact that the health system put a real focus on childhood obesity and the response was driven at a community level and through schools. Similarly, in relation to mental health the ability to make a significant impact is predicated on involvement and alignment of all tiers of government, across all providers.

Research

Fundamental principles guiding public investment in mental health research

54 As mentioned above at paragraph 32, mental health research must take the lived experience voice into account, as it will show where a number of gaps are in the system. The lived experience voice is vital in evaluating how effective various forms of intervention are from a qualitative and quantitative perspective. It is important to ensure that research is aligned with the desired outcomes the system is working towards achieving.

55 Secondly, research must include evaluations and a commitment to make the results of program evaluations publicly available.

56 The third and most critical factor is to ensure that any research is structured around the recipients of mental health services.

57 The final aspect is the ability to communicate the research so that the evidence is translated into practice. In mental health, there are quite different degrees of evidence around different components of care. There needs to be a focus on the areas along the continuum that are least understood. There also needs to be a focus on proactively driving change across the health system, because some of the challenges are as much cultural as they are structural.

Strengthening the role of mental health research and evaluation in policy and reform

58 Others are better able to comment on this area. The National Mental Health Commission is understood to be developing a mental health research strategy in consultation with consumers and carers. I am not familiar with its current status.[18]

The mental health workforce

59 Having an effective system-level workforce strategy relates to the hierarchical approach I outlined above at paragraphs 38-40. That is, systems need to have a clear idea of the

[18] https://www.mentalhealthcommission.gov.au/Mental-health-Reform/National-Mental-Health-Research-Strategy.

outcomes they are seeking to promote, ideally an agreed or accepted planning framework, and data to support the benefits of pursuing various models of care and then determine the capabilities of the workforce that will be required to meet these challenges. There must also be clear accountability on which parts of the system will be major leaders in facilitating change.

60 Secondly, the mental health workforce needs to be reviewed against the backdrop of growing demands for the disability and aged care workforce. Although it is important to consider what the training and background of the future mental health workforce should be, issues of supply and demand must be considered first. Preliminary analysis suggests that the growing demand for aged care/disability services will far outweigh the available supply pipelines. The areas are in potential competition. The national government needs to play a key role given its responsibilities for the funding of the tertiary sector and its key responsibilities in the aged care and disability sectors – that includes consideration of workforce related matters.

61 Thirdly, the system should consider a far more integrated approach in relation to the delivery of services across the larger funding streams of mental health, aged care and disability. One of the things that was demonstrated in the Western Australian Sustainable Health Review is that most families are actually dealing with at least two of those delivery systems at one point in time. In that regard, the focus of the programs should be on individual families' needs, which is potentially a more efficient way of providing services, particularly in more remote communities.

62 Fourthly, there is a vast opportunity to provide people with flexible roles in the mental health workforce and to expand existing scopes of practice. An adherence to traditional role delineations and a cultural reluctance to move to a greater utilisation of multidisciplinary teams is less cost effective nor responsive to a more holistic person centred approach. This is particularly so in areas where there is no workforce available other than fly in fly out (**FIFO**) workers. Australia has fallen behind other jurisdictions in relation to the adoption of flexible roles in the mental health workforce. With greater utilisation of telehealth capabilities, payment parity and expanded scopes of practice states in the USA such as New Mexico have been able to expand services in remote communities and expand the utilisation of community health workers under the mental health clinicians and provide services to communities previously beyond the reach of traditional models. This has involved the use of highly skilled clinicians using digital and other internet technologies to provide services through teams at a local level on a range of issues including mental health, alcohol and other drug use (**AOD**) and disability issues. Essentially the care is delivered through a multi-disciplinary setting, rather than having people move between the mental health system and other care systems. A number of those professional roles are not available in Australia.

63 Finally, it is important to build local capacity. Some of the most challenged communities from a mental health perspective do not have ready access to services other than FIFO services. There are a number of organisations at a local level, such as Aboriginal Community Controlled Health Organisations, that are focussed on building capacity in the existing service system. However, there needs to be more institutional support for these arrangements – potentially through regional commissioning measures.

Alcohol and other drugs

64 Mental and substance use disorders account for more years of life lost due to disability than any other disorders (24% of burden) and are second only to cardiovascular disease (**CVD**) and cancer as leading causes of disease burden. The top 10 causes of burden of disease in young Australians (15-24 years) are dominated by mental and substance use disorders[19]. There is a suite of issues that must be addressed in relation to service delivery, training and shifting culture in order for the system to have greater integrated care for people with co-occurring mental illness and AOD.[20] Barriers to accessing services can arise when entry requirements to services precludes addressing either condition. A mental health service may exclude someone who they believe has an AOD issue and an AOD service may exclude someone who is deemed to have a mental illness. It can be difficult to separate the two issues. Poor access to drug and alcohol rehabilitation services only exacerbates this problem.[21]

65 There are cultural issues in a number of health jurisdictions that have seen AOD and mental health in siloed compartments within the health bureaucracy. From my experience in New South Wales Health, it offered considerable benefit having AOD and mental health as an integrated service, based on the co-morbidities. However, the challenges in effective implementation were in many instances cultural and there was a push to keep the services disconnected. In some instances, the focus on mental health excluded consideration of AOD issues. For example, some services that have introduced special pathways into emergency departments for people experiencing psychiatric challenges have rules that do not allow the consideration of people that are experiencing AOD issues at the same time.

66 In order for a future system to deliver more integrated care, there must be an understanding of the patient journey. This will include proper consideration of the

[19] Submission in response to the Productivity Commission Inquiry into mental health APRIL 2019, accessible at https://mhaustralia.org/sites/default/files/docs/mental_health_australia_submission_to_the_productivity_commission_inquir._.pdf , page 17 https://nswmentalhealthcommission.com.au/sites/default/files/assets/File/NSW%20MHC%20Discussion%20document%20on%20comorbidity%20cover%20page.pdf.

[20] Submission in response to the Productivity Commission Inquiry into mental health APRIL 2019, accessible at https://mhaustralia.org/sites/default/files/docs/mental_health_australia_submission_to_the_productivity_commission_inquir._.pdf , page 17.

[21] https://mhaustralia.org/general/mental-health-australias-submission-productivity-commission-inquiry-mental-health.

frequency of co-morbidities and dual disability. This needs to occur both at the level of individual clinicians, but particularly in relation to the models of care provided to people.

67 Taking a bundled payment approach would support structural integration of health services and community services. The system could consider far more joint training and integrated information systems that readily allow practice changes and promote integrated data capture on physical and mental health related issues. A number of states have reported difficulties in their data systems for mental health patients in respect to their compatibility with other electronic medical records within the health system. There is an opportunity and a need to make more proactive use of the national electronic health records to ensure there is one repository of people's health issues to support the delivery of more integrated care.

sign here ►

print name Robyn Kruk

Date 4 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RK-1

This is the attachment marked 'RK-1' referred to in the witness statement of Robyn Kruk dated 4 May 2020.

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1 KPMG, Maranguka Justice Reinvestment Project, Impact Assessment, 27 November 2018.

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8 Integrating Primary Care into Behavioural Health Settings: What Works for Individuals with Serious Mental Illness, Milbank Memorial Fund, 2016.