Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF KYM LEE-ANNE PEAKE

I, Kym Lee-Anne Peake, Secretary, Department of Health and Human Services, of 50 Lonsdale Street, Melbourne in the state of Victoria, say as follows:

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

2 I make this statement to the Royal Commission into Victoria's Mental Health System (**Royal Commission**) in my capacity as Secretary of the Department. The views in this statement are my views and not necessarily the views of the Victorian Government.

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

Background and qualifications

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

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

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

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

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

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

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

Scope of statement

7 This is the second witness statement I have made to the Royal Commission. Throughout this document, I refer to my witness statement of 24 July 2019 as my 'previous statement to the Royal Commission'.[1] This statement should be read together with my previous statement to the Royal Commission and both statements form my evidence to the Royal Commission.

8 I have been requested by the Royal Commission to provide evidence focused on partnerships between the Commonwealth and state and territory governments, as well as other topics relevant to the inquiry. The information I provide in this statement responds to specific questions posed by the Royal Commission by letter dated 15 May 2020.

9 I note that the Royal Commission will also hear evidence from other witnesses from the Department, with Mr Terry Symonds, Deputy Secretary; Dr Neil Coventry, Chief Psychiatrist; Mr Robert Fiske, Chief Executive Officer of the Victorian Health and Human Services Building Authority; and Associate Professor Simon Stafrace, Chief Adviser, Mental Health Reform Victoria providing written witness statements.

10 This statement should be read together with the above witness statements, the Victorian Government's submission to the Royal Commission, and other information provided to the Royal Commission by the Department.

11 I have structured this statement in four parts:

a. Part A focuses on opportunities to strengthen Commonwealth and State collaboration to deliver a stepped model of care, outlining:

   i. pre-conditions for an effective stepped care model of mental health;

   ii. the respective roles and responsibilities for the missing middle;

   iii. leveraging the current review of the intergovernmental architecture; and

   iv. leveraging a potential national partnership agreement to achieve better integration of planning, commissioning and development of services and workforces at a regional level.

b. Part B focuses on system governance of Victoria's mental health system, including reflections on:

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

i. integrated and distributed commissioning functions;

ii. quality improvement functions;

iii. safeguarding responsibilities;

iv. monitoring implementation and managing change; and

v. supporting meaningful engagement with people with a lived experience of mental illness.

c. Part C addresses questions raised by the Royal Commission about supports for specific cohorts and in specific service settings, including:

i. people at risk of suicide;

ii. people in the justice system and with complex needs; and

iii. people with housing insecurity.

d. Part D addresses specific topics relevant to enabling and embedding a stepped system of care, including:

i. future trends;

ii. managing change with a multi-disciplinary workforce;

iii. digital mental health;

iv. research and innovation;

v. regulation and safeguarding; and

vi. mental health facility design.

PART A: STRENGTHENING COMMONWEALTH AND STATE COLLABORATION TO DELIVER A STEPPED MODEL OF CARE IN MENTAL HEALTH

Pre-conditions for an effective stepped care model of mental health

12 The Department aspires to advance the health and wellbeing of all Victorians and for them to live a life they have reason to value. The World Health Organisation defines health as a state of complete physical, mental and social well-being and not merely the

absence of disease or infirmity. The WHO states that there is no health without mental health.[2]

13 Mental health should be understood as a state of well-being in which an individual realises his or her own abilities, can cope with stresses of life, work productively and make a community contribution. In this sense, mental health care and support is more than disease management, it spans the whole journey from prevention to post-event support. The Royal Commission's interim report (**interim report**) identified gaps in meeting current levels of need for mental health care. Addressing these gaps requires actions to both enhance the performance of current services and to change the underlying system of mental health care and support.

14 To deliver this, it will be necessary to prioritise the lived experience of service users and their families. The view from this lens is essential to both describing and advancing how a successful system should operate – including protecting and promoting human rights.

15 It will also be essential to fully incorporate the expertise of mental health professionals – focusing on best practice care (education, interventions and supports) across the spectrum of need, coupled with engaging with the non-clinical, social determinants of mental health.

16 The Royal Commission has heard about the benefits of moving to a stepped care model of service delivery.

17 For stepped care to be successful, I believe that all actors in the system need to work together to:

a. **promote the general wellbeing of all Victorians** – including by maximising protective factors for everyone and building a broader network of professions who can create the conditions for wellbeing, be potential spokespeople to destigmatise mental ill health, and be early responders to identify and refer people on to more specialist workers where mental ill health is emerging;

b. **remove barriers within and between services** that address mental health, physical health and social needs (i.e. focusing on the whole person, not just their illness);

c. **ensure the right capabilities are in the right areas** – clinicians are skilled in their area of stepped care services and facilitate access to the service that will

[2]Promoting mental health: concepts, emerging evidence, practice : summary report / a report from the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and the University of Melbourne.

best meet an individual's needs at the time; and system managers and commissioners are skilled in their area of health care governance;

d. **recognise the impact of trauma, experiences and identities** on people's wellness and their ability to engage with services – in the delivery of all aspects of prevention, assessment, treatment and recovery;

e. **make it easier to get help earlier** – by meeting needs in a cohesive, local and culturally safe way; and

f. **strengthen safety and recovery** – by providing access to care in the community in the least restrictive environment possible, while supporting a person's connections to family, culture, social supports, work, education and community.

18 In turn, this will require governments to strengthen the following system enablers:

a. **dynamic and responsive national governance**, focused on strategic issues of reform;

b. **durable funding** across the spectrum of care;

c. **laws that embed a rights-based approach** to mental ill-health;

d. **a planning regime** which provides demand-driven access to care and support across the continuum of need;

e. **commissioning processes and governance** at a strategic and operational level that enable better integration of mental, physical and social care;

f. **data collection and linkage** to provide insights on whole of system mental health outcomes, costs and incentives;

g. **research and evaluation** of interventions, programs and models of care and systems to translate evidence into practice; and

h. **effective safeguarding arrangements** with clear responsibilities for setting mental health quality standards, protecting individual consumer rights, and ensuring practitioners and organisations are delivering safe and ethical care.

Roles and responsibilities for the missing middle

19 The Royal Commission has heard evidence about the impacts of historic underfunding and a lack of coordination where primary and acute mental health services meet. Gaps in access to mental health care services make it difficult for people to receive coordinated

and equitable mental health support, resulting in missed opportunities for early intervention, and people falling through the gaps. Others are left without adequate support following an acute episode, which impedes recovery and increases the likelihood of crisis presentations.

Strengthening the delivery of primary mental health care

20 Starting with lower intensity services, responsibility sits with the Commonwealth to strengthen primary care to better support people with low to moderate illness acuity.

21 As the Royal Commission has heard, primary care is often the first point of contact for people accessing support for their mental health. However, not all primary care practitioners have the knowledge or skills needed to identify, assess and support people with mental ill-health or connect them with supports that are appropriate to meet their needs.

22 Better equipping primary care practitioners to fill this role, for example by using state-funded secondary consultation and in-reach models, could strengthen the ability of the primary care system to manage patients with less acute mental health issues.

23 Building on this, access to psychological therapy is another key element of the stepped model, with evidence showing that this type of intervention can be effective for those experiencing moderate mental illness.

24 However, the level of support provided under the Commonwealth's Better Access Initiative is not always adequate for these people, many of whom would benefit from an increase in the number of face-to-face sessions available under the cap. In addition, access issues can mean people in rural and regional areas face real barriers to receiving the support they need. [3]

25 I note that, in response to the COVID-19 pandemic, the Commonwealth Government temporarily expanded the Better Access Initiative to provide an additional 10 Medicare subsidised psychological therapy sessions for people who have used their initial 10 sessions and are in areas subject to restrictions due to the COVID-19 pandemic. Consideration could be given by the Commonwealth to funding more than 10 visits per year for other cohorts of people whose needs are not met by the current 10 sessions.

Improving access and quality of digital mental health care

26 Also as part of its response to the pandemic, the Commonwealth Government introduced new temporary Medicare Benefits Schedule (**MBS**) telehealth items to allow people to

[3] Productivity Commission, *Mental Health* (Draft report, October 2019) vol 1. 256.

access mental health services in their homes. This includes new items for mental health providers to use to deliver psychological services. Both the temporary telehealth items and the expanded Better Access Initiative are currently only available until 31 March 2021.

27 It is likely the more broadscale use of such technologies will become a mainstay in our health and mental health systems after the pandemic has passed. There is an opportunity for a discussion at a national level about the development of guidance to inform the sector and consumers about the safe and effective use of such service delivery platforms.

28 The Commonwealth Government's new 'Head to Health' online platform is designed to assist consumers and practitioners to find digital mental health services from a range of mental health organisations.

29 Addressing these gaps by expanding access to virtual and in-person psychological support would enable more people to actively manage their mental illness, instead of being left without help until their illness gets worse.

Enhancing access to care and refining service models in the specialist system

30 The State has responsibility for the specialist mental health system, which could play a stronger role for people whose illness is too complex to be treated by primary care services alone.

31 A mix of evidence-informed, community-based treatment options are needed to meet the needs of people who, with more intensive clinical support, could avoid an emergency presentation or admission to acute care. This mix is also needed to provide enhanced access to care for those who require additional support to assist their recovery following an acute episode of illness.

32 We also know that for some people – particularly those with enduring or episodic mental health needs – their treatment journey will see them move between primary care and the specialist mental health system as their needs change and evolve. This characteristic of mental illness is why the stepped care model is the nationally agreed approach – it supports people throughout their illness as their needs change over time.

33 For these consumers, clear entry points and strong pathways between primary and specialist services would help to prevent the need to re-tell their story or navigate themselves towards the service that meets their needs.

34 For example, introducing facilitated referrals and care coordination for consumers with the most complex needs would mean that people would be linked in with the broad range of services they need to support their recovery.

35 Joint work between public health services, specialists and Primary Health Networks (**PHNs**) on a regional basis is required to articulate these pathways and support greater engagement between primary care practitioners and specialist metal health services at a local level.

Mechanisms and structures to strengthen Commonwealth and State collaboration

Opportunities to strengthen national co-operation from the current review of intergovernmental architecture

36 Prior to the pandemic, an intergovernmental architecture operated beneath the Council of Australian Governments (**COAG**).

37 The COAG Health Council (**CHC**) led interjurisdictional cooperation on mental health policy, funding and service and workforce development.

38 CHC was supported by the Australian Health Ministers Advisory Committee (**AHMAC**), which comprised heads of Commonwealth and state government departments. AHMAC in turn was supported by four Principal Committees and a series of sub-groups categorised as either Standing Committees, Expert Reference Panels or Project Reference Groups. The work program of CHC and AHMAC covered responsibilities that arose from legislation, multi-lateral agreements, national priorities and requirements of the former COAG.

39 One of the four principal committees was the Mental Health Principal Committee. Time limited working groups and standing committees led delivery of priorities in the Fifth National Mental Health Plan. The intergovernmental structures relevant to mental health are summarised at **Attachment KP-1**.

National reviews in mental health

40 Outside of the formal COAG intergovernmental structures and processes, a number of Commonwealth-initiated reviews into suicide prevention and mental health service delivery are due to report this year, including:

a. the *Productivity Commission inquiry into Mental Health*, due to be tabled in the Commonwealth Parliament in November 2020;

b. *A review by the National Suicide Prevention Advisor* on actions to improve whole-of-government coordination and delivery of suicide prevention activities, due to report to the Prime Minister by December 2020; and

c. *Vision 2030,* commissioned by the National Mental Health Commission to inform national directions for mental health and wellbeing – including future policy and investment decisions of the Commonwealth Government, and the future development of a 6th national mental health plan for agreement between Commonwealth and state governments.

Commonwealth and State funding arrangements

41 The Australian Constitution does not strictly divide responsibilities between the Commonwealth and states, with respect to health care responsibilities. Australia's federated system of government enables jurisdictions to innovate and tailor policy and service responses to their differing contexts and needs, while coming together to learn from one another, benchmark performance, and seek consistency when there is value in this. This is discussed further below.

42 Our federated arrangements, while providing benefits and flexibility, can also create risks of fragmentation, duplication and gaps in service provision.

43 Effective intergovernmental structures and processes are critical to achieving the co-operation necessary to manage complex and interdependent service systems. Indeed, some of the most important areas of policy and service delivery reform, including mental health, sit precisely where intergovernmental cooperation and engagement is most crucial.

44 During the pandemic, the intergovernmental architecture was largely suspended, with the Council of Australian Governments replaced by National Cabinet – which has mainly focused on setting strategic directions for the crisis response to COVID-19 and co-operating on Australia's health, social and economic recovery.

45 On 29 May 2020, the Prime Minister announced an agreement by National Cabinet to review and reset the structure and work programs of COAG Councils and Ministerial forums.[4] The review focuses on more clearly defining the strategic priorities of the COAG Councils and Ministerial forums and improving their decision-making.

COAG structures and mechanisms

[4] Prime Minister, Update following national cabinet meeting (Media Release 29 May 2020) <https://www.pm.gov.au/media/update-following-national-cabinet-meeting>.

46 Prior to the pandemic, the financial and governance arrangements for intergovernmental co-operation largely operated under the stewardship of COAG.

47 In July 2009, COAG endorsed a new Intergovernmental Agreement on Federal Financial Relations, which included, among other things, a new *National Healthcare Agreement*, coming into effect in July 2009.

48 This agreement provided the broad national health policy and funding framework and was visionary in terms of setting out how the Australian healthcare system could be better joined up. For example, the agreement clearly set out:

a. the objectives, expected outcomes and outputs to be achieved under the agreement;

b. the role and responsibilities of each jurisdiction;

c. the policy and reform directions that would be undertaken to work towards the intended outcomes;

d. performance indicators to inform the community on how governments were progressing towards achieving the stated objectives, outcomes and outputs; and

e. performance benchmarks that provided an indication of the standard of service expected or the level of improvement expected in service delivery over a specified period.[5]

49 The performance of all governments in achieving these mutually agreed outcomes and benchmarks was to be monitored and assessed by the COAG Reform Council, which was an innovative approach at the time.[6]

50 Building on this, the introduction of the National Health and Hospitals Network Agreement in 2010 and the subsequent National Health Reform Agreement (**NHRA**) in 2011 represented a major shift in intergovernmental relations[7] – being the first time hospital funding arrangements were mutually agreed and set out for the longer-term.

51 The NHRA was historic in the way it provided a mechanism to encourage state and Commonwealth cooperation. The Commonwealth sharing direct responsibility for hospital funding provided an incentive to develop policies that could mitigate activity growth, such

[5] Department of Health and Human Services (Vic), *National Healthcare Agreement: Hospital Circular 18/09* (2009).
[6] Steering Committee for the Review of Government Service Provision, *National Healthcare Agreement: National Agreement performance information 2008-09* (2009).
[7] Anne-Marie Boxall, *The Changing Demands on Australia's Health Policymakers: A Case Study on Intergovernmental Relations in Health over 40 years* <https://www.anzsog.edu.au/preview-documents/research-output/5360-the-changing-demands-on-australia-s-health-policymakers-a-case-study-on-intergovernmental-relations-in-health-over-40-years/file>.

as improving the delivery of primary care and supporting the more efficient use of funding.[8]

52 Since this time, the negotiation of NHRAs has provided a platform for governments to leverage opportunities around progressing funding and system reform, with the current NHRA endorsed by governments earlier this year.

53 The latest five-year agreement was finalised on 29 May 2020 and includes commitments to progress six long term reforms:

a. empowering people through health literacy;

b. prevention and wellbeing;

c. paying for value and outcomes;

d. joint planning and funding at a local level;

e. enhanced health data; and

f. nationally cohesive health technology assessment.[9]

54 While mental health is a part of the NHRA and encompassed within these priorities, the Commonwealth has foreshadowed that it intends to develop a specific separate National Mental Health National Partnership Agreement (**NPA**) to give more detail to priorities and investment in suicide prevention and mental health service delivery. This NPA would be informed by the findings and recommendations of the federal reviews identified above, and the Royal Commission into Victoria's Mental Health System.

55 It will be important that any future funding arrangements articulated through the proposed NPA provide sustained and durable funding for long term mental health reform. Priorities could include:

a. a pathway from a time limited national partnership agreement to an enduring funding agreement (such as the NHRA);

b. more explicit detail on processes and mechanisms to deliver greater flexibility in the application of NHRA funding for mental health care delivered through public health services; and

[8] Commonwealth of Australia, *Final report: Hospital funding cuts: the perfect storm. The demolition of Federal-State health relations 2014–2016* (2016).
[9] Department of Health (Cth), *2020-2025 National Health Reform Agreement (NHRA)* (Web Page) <https://www.health.gov.au/initiatives-and-programs/2020-25-national-health-reform-agreement-nhra>.

c. state-specific agreements to ensure that data sharing supports reform directions and patient care, and that there is a regional-level approach to pooling of funds that works in the context of each state's service delivery arrangements.

Opportunities to strengthen national co-operation from the current review of intergovernmental architecture

56 The final form and overarching operating model of an intergovernmental architecture will be determined by the National Cabinet. Mental health has been identified as a priority for any future arrangements.[10]

57 Through future arrangements, there is an opportunity to improve collaboration on building service capacity and implementing a stepped care system.

58 From time to time, this kind of policy work on regional governance and Commonwealth-state engagement is downplayed as being too distant from service delivery to be able to create real change for consumers. I would argue the opposite: that in reality, many of the most practical difficulties faced by those living with mental illness exist precisely because of the lack of Commonwealth-state focus, engagement and agreement on these matters.

59 While it would not be realistic to anticipate a single implementation plan nationally, or even for each jurisdiction, enablers of a stepped care model could be advanced through leveraging the stronger strategic commissioning approach envisaged in reformed operational arrangements for Ministerial forums.

60 The current structure of AHMAC and principal committees is likely to be replaced by a more streamlined approach to commissioning reform work. Ministers are likely to commission specific pieces or programs of work, with clear priorities, outcomes, deliverables and timeframes. It is also likely that Ministers will draw more strongly on expert advisors (including officials-level expert bodies and panels of external experts). The processes for identifying and commissioning these experts have not been resolved by the new National Cabinet.

61 Through its recommendations, the Royal Commission could inform the scope and sequencing of reform work that cuts across Commonwealth and state responsibilities and is critical to advancing a stepped care model. This would inform national work commissioned by Ministers – for example to agree principle-based approaches to flexible funding models, service models and pathways, planning frameworks and national

[10] Prime Minister, National cabinet (Media Release 23 October 2020) < https://www.pm.gov.au/media/national-cabinet-1>.

priorities for new data sets, performance reporting and regulatory or workforce accreditation reform.

Leveraging a national partnership agreement to achieve better integration of planning, commissioning and development of services and workforces at a regional level

62 Changes in how national policy and investment is managed are necessary, but insufficient to change practice and align service efforts on the ground.

63 This will rely on agreement between governments on:

a. the composition and authority of local governance arrangements for joint planning, design and commissioning of services and service pathways; and

b. flowing funds through these joint commissioning arrangements.

64 The negotiation of a new national partnership agreement (with an associated implementation plan) provides an opportunity and instrument to document initial steps in transitioning to more integrated planning and funding approaches and adopt optimal pathways for people through a stepped care model.

65 Gates for review, performance metrics and reporting, and processes for future bilateral decisions could all be built into the national partnership and implementation plan.

Building on existing work in Victoria

66 Having regard to the matters expressed in the above paragraphs, work has already begun in Victoria to lay a foundation for effective co-commissioning. In July 2018, the Department, Victorian PHNs, and the Victorian PHN Alliance signed a Memorandum of Understanding (**MoU**) to formalise a collaborative working relationship, which includes the co-commissioning of services. This MoU outlines three forms of co-commissioning:

a. Pooled commissioning – where funding from multiple parties is combined to commission services, typically through a single contract. In this context, parties may have direct oversight of their individual investment, but the outputs and outcomes are shared.

b. Aligned or parallel commissioning – where parties agree to use funding to achieve the same outcome but do so in parallel, for examples through separate contracts for each investment, typically representing discrete outputs or components of the commissioned service. In this context, parties maintain direct oversight of their investment, have separate outputs, but share the overall intended outcome.

c. Secondary commissioning – where one party, the primary commissioner, outsources the commissioning, or elements of it, to the other party, the secondary commissioner. The primary commissioner is responsible for the overall intended outcome and the secondary commissioner is responsible for the elements for which they are assigned.[11]

67 There is value in building on this work by progressively trialling and evaluating new co-commissioning arrangements of increasing levels of ambition, with the ultimate aim of pooling funding (rather than simply aligning efforts), which I would view as the optimal approach for seamless and cost-effective care.

68 For example, there is an opportunity for Victoria to work collaboratively with PHNs across the state to conduct joint needs assessments and enter into co-commissioning arrangements to ensure the right mix of mental health services are available across the stepped care pathway.

69 There is also scope to explore opportunities for services to work together at a local level to form multi-disciplinary teams to deliver mental healthcare to consumers with multiple needs. Such arrangements could be established through regional partnerships, with co-location of services and common governance structures. This could include common reporting frameworks and data reports at a regional level to aid regional planning and accountability.

70 In August 2020, the Commonwealth Government announced 15 new mental health 'Head to Help' clinics across metropolitan and regional Victoria. These temporary clinics are designed to provide additional support to Victorians as a result of the restrictions in place due to COVID-19, through delivering multi-disciplinary team support and referrals. The clinics are funded by the Commonwealth, but with joint governance to ensure integration with local services.

71 While temporary, the clinics are a welcome investment, and could provide a platform on which to build further joint efforts, including co-commissioning opportunities for similar approaches, into the future.

72 Lessons learnt from co-commissioning projects that have been trialled in Victoria include:

a. relationship building has taken a considerable amount of time and resources;

b. high quality data is required across care settings, and our data is not yet where it needs to be;

[11] Productivity Commission, *Mental Health* (Draft report, October 2019) vol 2.

c. health services all run different information and communication technology (**ICT**) systems, which are not interoperable, posing barriers to integration;

d. appropriate incentives are required to support services to trial new models; and

e. consideration should be given to mechanisms that can pool or share risk.

PART B: SYSTEM GOVERNANCE

73 In my previous statement to the Royal Commission, I described the components of system governance including stewardship, commissioning, performance management and safeguarding.

74 Separately, Mr Symonds is providing more detailed evidence to the Royal Commission on stewardship and commissioning.

75 I will not seek to duplicate Mr Symonds's evidence on critical components of system governance. In this section I will provide reflections on structural questions on:

a. integrated and stand-alone commissioning functions;

b. quality improvement functions;

c. complaints handling and safeguarding functions;

d. supporting meaningful engagement with people with a lived experience of mental illness; and

e. approaches to monitoring implementation and managing change.

Overarching reflections

76 The experience of the pandemic has reinforced the critical importance of system stewardship and safeguarding. Strategic and regional operational commissioning functions alone are not sufficient to ensure equitable access to services, assure the quality and safety of services, and deliver continuity of care during emergencies and other periods of disruption.

77 I believe the same can be said for the implementation of aged care and National Disability Insurance Scheme (**NDIS**) reforms. It is not enough to overcome information asymmetries (if this can be achieved) and align incentives to the delivery and performance of services. While important to improving the efficiency and value from government investments, planning, funding and performance management processes cannot guarantee sufficient supply of high quality services and that service models and pathways will routinely deliver

the experience and outcomes valued by consumers. Strategic and operational commissioning processes cannot, of themselves, assure workforce engagement and wellbeing, and build a culture of safety, inquiry and continuous improvement.

78 Even where commissioning processes work for the majority of people and the majority of circumstances, it is incumbent on governments to work together to ensure that individuals and cohorts with specific needs, or who live in geographic areas that sit outside the mainstream areas, also receive equitable access to services. System stewardship has a particular focus on the most marginal 10 per cent – those who may miss out in a more market-based commissioning environment. As the pandemic has shown, it is also important to plan for service continuity and availability in unique, unpredictable and infrequent circumstances.

79 Public and mixed markets of services require a strong system steward to articulate shared directions, build sector and workforce capacity, protect equitable access to services and privilege lived experience knowledge.

Comparing integrated and stand-alone commissioning structures

80 To improve the outcomes for people experiencing mental ill-health, and to promote positive mental health for the population as a whole, I believe there is a strong case for maintaining and strengthening the structural connections between health and mental health in approaches to strategic and operational commissioning.

81 While fundamental reform is required to achieve parity and realise the benefits, I think an integrated approach to commissioning can best tackle the determinants of health and wellbeing and provide holistic care for people who experience mental ill-health.

82 I also think there is benefit in streamlining the number of commissioning bodies across health, mental health and social care – especially at a regional operational level – while providing an authorising environment for collaboration and co-commissioning.

83 Some jurisdictions, such as Western Australia, have a separate entity responsible for commissioning mental health service delivery (including planning, resourcing and monitoring mental health service performance).

84 Stand-alone and integrated commissioning structures each have strengths and weaknesses. In my view, an integrated model is the better choice because the strengths of a stand-alone model can be achieved in other ways, but its drawbacks may be hard to overcome.

85 The strength of a stand-alone model is elevating the government's focus on mental health. This is critically important, but there are other good ways to make sure mental health remains front-and-centre of government's agenda. Ambitious improvement targets, robust and independent performance reporting, sufficient dedicated funding, and elevating the voice of consumers can do a lot to raise the prominence of mental health.

86 Community awareness and focus on mental health continues to rise, partly due to the rich combination of experts and advocates we are fortunate to have in Victoria. With the serious mental illness impact of the pandemic, we are sure to see this trend continue. The Royal Commission's own report and recommendations will also go a long way to making sure that mental health receives the attention it deserves in coming years and decades.

87 Establishing a separate entity outside of the core department structure risks disconnecting the mental health portfolio from the incidental intelligence and collaboration that occurs through participating in whole of government decision-making forums on strategic priorities and directions.

88 A substantial drawback of a stand-alone commissioner would be the practical impact on the efficiency and effectiveness of day-to-day system management. Over time, separate commissioners could have divergent commissioning settings or offer services mixed messages and duplicative processes. Even with the best of intentions, there is a rigidity that comes from separate commissioners; they are likely to miss opportunities to pool funding, to work together to manage demand, and to share resources, lessons and evidence.

89 As I described in my previous statement to the Royal Commission, we have started to see benefits emerge from our efforts to structurally integrate mental health into the wider health functions of the Department, particularly in relation to accessing expertise on funding models, business case development, and demand modelling.

90 The far more important risk is creating barriers to integration of care. Separating health and mental health commissioning would make it more difficult to have a holistic approach to healthcare, creating barriers to the development of integrated, evidence-based interventions that consider the whole person and respond to their full range of needs.

91 This is particularly important because we know that health outcomes for people living with mental illness are worse than for the general population, including increased rates of chronic health conditions and a considerably shorter life expectancy.

92 Addressing the poor physical health of people living with mental illness is a national priority, with Victoria among those who have committed to action under the National

Mental Health Commission (**NMHC**) Equally Well framework. It is my view that efforts to reform mental health system governance must be progressed in a way that allows Victoria to deliver on this aim.

93 The Department's response to the COVID-19 pandemic offers some recent examples of how integrated structures, and integrated commissioning, can lead to an approach that looks at the whole system and designs responses for the whole person.

94 The breadth of the Department's commissioning remit was crucial in our support for residents of public housing through the COVID-19 pandemic. After the initial acute emergency response phase in nine public housing towers in North Melbourne and Flemington wound down, the Department commissioned a comprehensive public health response that supported all public housing low and high rise communities across Melbourne through the Stage 4 restriction period.

95 This pro-active 'tenant-centric' model was implemented in partnership with the resident communities to provide an integrated response to the residents that brought together: specialist mental health outreach and mental health first aid; primary care from community health; alcohol and drug outreach services; infection prevention and control from hospitals; ambulance transport and site management; housing officers; and community development workers.

96 All these services were necessary to meet the urgent needs of these communities. Being a single commissioner that works with and understands all of these services intimately was invaluable. While this was an extremely complex crisis response, the benefits apply to longer-term reform too.

97 Geographic clusters of health services were set up to respond to the pandemic. They worked together to boost intensive care capacity across the system, share surge workforce, balance caseloads, support private sector residential aged care, and stand up local public health units, among other crucial aspects of the pandemic response.

98 We are now consulting on how to sustain and build on the remarkable collaboration we've seen across the system. We intend to make the clusters permanent and, as an integrated commissioner, this would provide the foundations for cross-sector collaboration to deal with multi-morbidity, dual diagnosis and the underlying social determinants of health. It is an opportunity to build a governance structure that helps acute care, primary care, mental health and social care all work together – the vision that the Royal Commission outlined in its interim report.

99 The scale, robust clinical governance and management strength of health services and stronger partnerships forged through the clusters have been critical to maintaining service delivery during the pandemic.

Quality improvement functions

100 While the safety of mental health care is paramount, safety is not the same as quality. It is only one of the six domains of quality defined by the US Institute of Medicine.[12] Quality health care is safe, effective, person-centred, timely, efficient, and equitable. In my experience, healthcare providers, funders, and regulators too often focus on safety, typically through compliance surveillance, missing opportunities for improvements in care that matter to both clients and staff.

101 While important, compliance and regulation can result in providers only focusing on those functions, rather than equally prioritising ongoing, forward looking quality improvement measures. This can result in stagnation, if such matters are not being progressed at the same time as compliance and performance management functions are being deployed.

102 Further, in a heavily regulated environment, unless innovation is given support and space, new ideas may not be considered or attempted, for fear that they fall outside the existing supervision structures.

103 This is not to say that safety is not important. It is. But regulating for safety alone doesn't work. As Dr Berwick, of the Institute of Healthcare Improvement (Cambridge, Massachusetts), puts it "more and more ravenous inspection and control" has impeded the delivery of "fundamentally better care, better health, and lower cost". [13] This is as true in mental health as it is in other areas of healthcare. It is long overdue that we do better.

104 That path – the road to better care, better health and lower cost – is through dedicated, purposeful, goal oriented, relentless quality improvement. A review of high performing health services in the UK – those with independently assessed high ratings of quality and safety – showed that a common feature of those services was clear, measurable goals for improvement.[14] A clear and visible articulation of how good the service wanted to be, by what methods they would reach that goal, and how they were tracking towards the goal. The methods of improvement are important. All too often healthcare providers embark upon a journey of improvement with no effective methodologies. As social scientist Dixon-Woods summarises "wanting to improve is not the same as knowing how

[12] Institute of Medicine, *Crossing the Quality Chasm: A new Health System for the 21st Century* (2001) Washington, D.C: National Academy Press.
[13] Donald Berwick, Era 3 for medicine and health care (2016) 315(13) *Journal of the American Medical Association*.
[14] The Kings Fund, *Improving quality in the English NHS* (2016) <https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Improving-quality-Kings-Fund-February-2016.pdf>.

to do it".[15] Mental health improvement in Victoria, at a system level, has that legacy; wanting to improve without really knowing how to do it. Rather than trusting in compliance and regulation to deliver system wide quality improvement, we can deliver better outcomes at lower cost, delivering the "triple aim" of better individual care, better population health, and reduced per capita cost of care.[16]

Safer Care Victoria

105 In 2017 Safer Care Victoria was established as the State's lead agency for quality and safety improvement in healthcare, including mental healthcare – a purposeful separation of quality and safety from healthcare regulation. Safer Care Victoria provides deep expertise on partnering with consumers, clinicians, health services and providers, learned colleges and tertiary institutions to make healthcare safer, more effective, and higher quality. In particular, Safer Care Victoria is committed to placing people at the heart of every healthcare interaction. Safer Care Victoria has developed and adopted robust improvement methodologies and tools to drive improvement, track outcomes and experiences, embed best practice and support sustainable improvements in quality and safety. Safer Care's strategic partnership with the Institute of Healthcare Improvement (**IHI**) brings worldwide expertise in improvement methodologies and application, particularly in mental health.

106 In 2018, Safer Care Victoria set up the Mental Health Clinical Network, joining nine pre-existing clinical networks to provide clinical and client leadership in mental health, and to help deliver enduring improvement in mental health at whole-of-system and health service levels. The network is a partnership of people with lived experience, mental health clinicians, health services, and improvement experts.

107 The network aims to:

a. provide strategic direction to the quality and safety of client care and experience;

b. drive best practice through clinical leadership, collaboration and influence;

c. better understand and reduce variation in care and outcomes by providing advice on evidence-based practices and approaches;

d. build workforce capability through clinical education and training; and

[15] Mary Dixon-Woods, How to improve healthcare improvement (2019) 366(15514) *British journal of management*.
[16] Donald Berwick, Thomas Nolan and John Whittington, The triple aim: care, health, and cost (2008) 27(3) *Health Affairs*.

e. share expertise and insights from overseas mental health services through the IHI partnership.

Quality improvement at national, State and health service levels

108 Safer Care Victoria is already leading improvement in acute healthcare at the national and whole of State level. There is now an opportunity to build a similar level of activity in the mental health care space, by delivering widespread training in improvement methods to clients, clinicians, health service executives, and health service boards. This mirrors what is already underway in other areas of healthcare. For example, at a whole of State level Safer Care Victoria has delivered improvement programs to reduce in-hospital delirium, reduce stillbirth, reduce hospital deaths from sepsis and reduce birth trauma. Safer Care Victoria also provides training in quality improvement to clinicians and health service boards, enabling improvement to be led from the top and delivered on the ground.

109 I think that a dedicated unit for Mental Health Improvement should be established within Safer Care Victoria. In partnership with clients and services, the unit would:

a. establish improvement goals for the State and individual health services;

b. publish a regular report on mental health improvement goals;

c. deliver training in improvement methods to clinicians, clients and boards;

d. co-design and implement whole-of-system improvement programs;

e. support services in the design and implementation of local improvement programs; and

f. work with interjurisdictional agencies and through Commonwealth committees to lead improvement in mental healthcare at a national level.

110 Ultimately, the Mental Health Improvement unit would seek to implement a whole of State learning healthcare system for mental health.[17] Embedding research, routine reporting of care, outcome and client experience data, and shared methodologies would be used to drive continuous improvement as a state, delivering on the triple aim.[18] It would be the first such learning health system for mental health in Australia.

Victorian Agency for Health Information

[17] Sarah Greene et al, Implementing the learning health system: from concept to action (2012) 157(3) *Annals of internal medicine* 207-210.
[18] Lynn Etheredge, A rapid-learning health system (2007) 26(2) *Health Affairs* 107-118.

111 The Victorian Agency for Health Information (**VAHI**) has worked to improve mental health reporting, to provide better information to mental health clinicians, health services, policymakers and consumers. The aim is to assist in development of evidence informed policy and improvement in the quality, safety and care of people with mental illness.

112 As noted in previous evidence to the Royal Commission, the main report produced for mental health professionals and health services in the biannual "Mental Health Inspire" report, which provides quality and safety information on a range of metrics covering adult mental health, older people's mental health, and child and youth mental health.

113 There is also a range of public mental health data released quarterly via the Victorian Health Services Performance website,[19] providing consumers with information on 28-day readmission rates for adult mental health services, transfer of adults to a mental health beds within the recommended timeframe, and post-discharge follow-up for adult metal health services.

114 In addition, the Victorian Population Health Survey[20] provides a range of publicly accessible data related to community mental health, including prevalence of anxiety and depression, and level of psychological distress (based on Kessler 120 score), by age, gender, income group and Local Government Area (**LGA**).

115 More recently, VAHI has been producing a weekly "Impact on COVID-19 Mental Health, alcohol and other drug" report, which monitors demand on the operation of mental health services, providing better understanding on the wider impact of mental health and wellbeing at different stages of restrictions and isolation, and informing mental health planning during the pandemic. Metrics include data from emergency department presentations, mental health triage services, clinical mental health care, bed-based clinical mental health care, and community-based care (e.g. Beyond Blue and Lifeline data, eating disorder programs, perinatal emotional health program and clinical reported outcomes etc.).

Oversight of quality and safety

116 Safeguarding human rights, overseeing safety and quality and handling complaints, all play a critical role in the exercise of government's duty of care to people accessing publicly funded and delivered services.

[19] See Victorian Agency for Health Information, *Victorian health services performance- mental health* (Web Page) <https://vahi.vic.gov.au/reports/victorian-health-services-performance/mental-health>.
[20] See Victorian Health Information Surveillance System, *Victorian Population Health Survey Report* (Web Page) <https://vhiss.reporting.dhhs.vic.gov.au/ReportParameter.aspx?ReportID=56&TopicID=1&SubtopicID=17>.

117 The present framework of oversight of the quality and safety of Victoria's public mental health system is complicated and arguably fragmented and duplicative. Dr Neil Coventry, Chief Psychiatrist, has already outlined in his 2019 statement to the Royal Commission the key elements of this framework, including the roles of the Chief Psychiatrist, the Mental Health Complaints Commissioner, and the Mental Health Tribunal. [21]

118 There are other entities that can be considered as part of the same regulatory and quality improvement system in Victoria's public mental health system.

a. The Office of the Public Advocate and the Community Visitors Scheme protect and promote the health, safety, wellbeing and rights of people receiving mental health services at prescribed premises.

b. Safer Care Victoria implements targeted improvement projects, collects data and information on healthcare safety, reviews systemic issues and helps services to prevent future harm.

c. VAHI was established to drive improvement in public and private hospitals and health services through greater access to health performance information to patients, carers, clinicians and health service administrators.

d. Agencies such as the Australian Commission on Safety and Quality in Health Care (**ACSQHC**) and the Australian Health Practitioner Regulation Agency (**AHPRA**) also play a role in regulating safety and quality in the mental health system, through the setting of national quality and safety and clinical care standards, and the regulation of registered health practitioners.

119 While there may be synergies in combining some health and mental health system stewardship functions (e.g. VAHI, ACSQHC, AHPRA), there is a strong argument for separate and bespoke approaches for:

a. Oversight of the quality and safety of the mental health system (incorporating the functions of the present Office of the Chief Psychiatrist and distinct from the clinical improvement function, or learning system, that I have proposed above for Safer Care Victoria). The existence of the *Mental Health Act 2014* means that protections need to remain in place that are specific to this legislation and to treatment provided under this legislation. Accountability for the appropriateness, safety and quality of care should be integrated into a single Mental Health Quality and Safety Office, combining chiefs from the clinical mental health and peer worker professions. This will promote strong safeguards for the provision of

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

treatment and care in public mental health services and allow those responsible for overseeing quality and safety to be independently-minded in their approach to recommending system change and quality improvement, removed from any pressures or conflicts that could arise if they were also responsible for commissioning service delivery and clinical improvement functions.

b. Complaints management (incorporating the functions of the Mental Health Complaints Commissioner). I remain confident that complaints management should be independent and separate from the mental health commissioning function. Consumer and carer feedback indicate a higher degree of confidence in an independent body that can investigate and resolve complaints. This body must continually review and improve its own performance in resolving complaints. The functions of the Office of the Public Advocate and the Community Visitors' Scheme should be absorbed into the Office of the Mental Health Complaints Commissioner.

c. Regulatory oversight of compulsory treatment orders enacted under the *Mental Health Act 2014* (i.e. the Mental Health Tribunal).

120 A potentially effective governance arrangement for a Mental Health Quality and Safety Office, incorporating the functions of the Chief Psychiatrist, could be under the umbrella of an independent Mental Health Commission with responsibility for quality and safety assurance, oversight of implementation of the reform agenda and mental health promotion and prevention. This would place service accountability and safety at the centre of the purpose of the mental health system. Reporting to Parliament on implementation of the recommendations of the Royal Commission, and on the performance (i.e. the activity, quality and safety) of the public mental health system would enhance the role of the Commission in holding the system accountable to the community.

121 The data collected through complaints processes is an important source of evidence to inform policy and practice changes, so there should be robust feedback loops between the Mental Health Quality and Safety Office and the department responsible for advising government on policy and budget decisions, however constructed, without compromising the independence of the relationships.

122 When establishing oversight arrangements, each entity must have a clear role and responsibilities. This will prevent fragmentation, confusion and the duplication of effort. It is also helpful to think about how these functions can best work together to support continuous improvement in service quality, safety and outcomes and to eliminate duplication.

Capabilities and functions to oversee mental health reform

123 Mental health reform is complex and requires a comprehensive system-wide response that crosses portfolios, sectors and tiers of government. Reform also takes considerable time to implement, requiring robust planning and strong leadership to facilitate cultural change and minimise disruption for consumers and the dedicated workforce who care for them.

124 In this section I describe two factors that I consider to be critical in achieving enduring mental health reform:

a. a dedicated and appropriately skilled entity that can lead major change; and

b. an approach to change management.

Skilled and dedicated entity

125 As an outcome of the Royal Commission's interim report, Mental Health Reform Victoria (**MHRV**) was established as a dedicated body with a sole focus on working closely with the Department, the sector and people with a lived experience to implement the Royal Commission's recommendations.

126 Establishing MHRV as an Administrative Office to the Department has enabled a strong connection to be maintained between reform and the day-to-day operations of managing mental health service delivery. The close relationship enables us to use our collective expertise to plan and deliver key recommendations, share learnings, develop leadership capability internally and in the sector, and ensure we align key reform efforts.

127 This shared commitment to working collaboratively to identify practical solutions and overcome roadblocks has proven beneficial during the response to the COVID-19 pandemic. MHRV and the Department have stood-up a joint project team to provide leadership and work with the sector to respond to the current challenges. This approach combines expertise in system stewardship with a focus on how we can learn from the experience and embed improvements during reform.

128 While MHRV is well-placed to implement recommendations focused on the specialist mental health system, I am conscious that the Royal Commission intends to explore the intersections between mental health and other portfolio areas, such as housing and justice. As the Royal Commission turns its mind to broader reforms that cut across other service systems, there is merit in considering what changes may be required to the role and capacity of MHRV to drive reforms in relation to these other portfolios and potential synergies with any new entity responsible for stewardship of the transition to a stepped care model.

Supporting change management

129 There are several important features that I think can help reform managers to effect significant change. In my previous statement to the Royal Commission, I suggested that political authority, broad stakeholder and community support, and early actions that lead to tangible improvements for consumers are critical to sustain momentum when delivering reform.

130 Building on these sentiments, in other parts of this statement I have discussed how working collaboratively with sector partners will be key to ensuring interventions are based on the best available evidence and appropriate for the local context. I also describe the importance of embedding the voice of people with a lived experience into the structures and processes established to drive reform – helping to create an enduring practice that recognises the value consumers, carers and families bring to both policy development and service delivery.

131 Rounding out these reflections, I would suggest that the best way to future-proof good policy is by bringing people with us – so that they understand what is working and what needs to change.

132 To do this, I have found that it is important to inspire a commitment to reform by presenting a compelling vision for the future and anchoring change back to the values that matter for the sector. This vision and an agreement on the direction for change can encourage buy in, help focus collective efforts and keep people engaged in the face of challenges and set-backs.

133 It is also critical to maintain clear and regular communication throughout every step of the change process. Those working in the mental health sector will have a better idea than many about why things need to change, but they may not understand how reform activities fit with their expectations about the future system, which can act as an obstacle for reform.

134 For this reason, it will be important to ensure the sector has visibility over how discrete pieces of work help us to move towards the 'big picture' of reform. Change management studies have found that this continual communication can be a leading factor in determining a transformation's success.

135 Communication should not just go one way – effective change programs need to be grounded in feedback from the people using services about what matters to them. It also needs to take into account advice received from the sector about how things are progressing.

136 To account for this feedback, the approach to implementation must be adaptive. This means that, in any big transformation, there are many opportunities to learn and adapt along the way. I have found that this learning approach can help to manage complex reform, as it enables you to test emerging evidence to build an understanding of what works. It also provides an opportunity to respond to unexpected opportunities and make policy and services adjustments when required.

137 Empowering leadership in the sector to provide input into and help drive change on the ground will be critical here. This helps build ownership and means that stakeholders are more likely to support and even champion the change. It also recognises that we won't succeed in transforming the mental health sector if we do not involve the people who work in those services in conversations about how they could make a difference.

138 It is also important to recognise that change management needs to build a new coalition of support that is broader than the current boundaries of the Victorian 'mental health sector'. In particular, there is a need for the coalition to include those who work in primary and preventative mental health care, and those who work in social care, as well as consumers in these programs. Successful reform requires that all of these elements contribute, as well as the more acute, inpatient based services.

139 It is important to recognise that large scale change takes time, and there will invariably be fluctuations in motivation and frustration throughout the journey. I have found that the power of stories can help here by making the change that has occurred real, tangible and human. Momentum for change can be maintained over time by telling stories of human experience, not just telling the story of data and evidence.

Supporting meaningful engagement with people with a lived experience of mental illness

140 People living with mental illness – including consumers, their families and carers – have unique insights into how mental health services can best meet the needs of the people who use them.

141 It is critical that we have the right structures in place to put people with lived experience at the centre of the design and delivery of mental health services, as well as the research and knowledge translation processes.

142 The Department's *Mental Health Lived Experience Engagement Framework* aims to guide policy makers in actively engaging people with lived experience of our mental health services – shifting from the traditional methods of 'deliver and inform' to better collaborating with consumers and carers through co-design and co-production.[22]

[22] Department of Health and Human Services (Vic), *Mental health lived experience engagement framework* (2019).

143 This framework includes the following principles to inform the way we engage with people with a lived experience of mental illness:

a. Be purposeful – this ensures the roles for consumer and carer participants are defined, helping people to understand what is expected of them and what they should expect of the process.

b. Be prepared – this means engagement should occur early and be informed by an understanding of the historical context that people with lived experience bring.

c. Be genuine – this involves actively seeking input and collaborating with consumers and carers and making a commitment to maintain trust and strengthen these relationships over time.

d. Be inclusive – this values the experiences and opinions of all involved, including those who are harder to reach or are traditionally excluded from the conversation.

e. Communicate regularly – this recognises that communication should occur throughout the engagement process to keep those involved updated and provide feedback on how input has been used.

144 As I touched on in my previous statement to the Royal Commission, the Department has implemented mechanisms to facilitate lived experience engagement in shaping reform activities.

145 However, there are opportunities to ensure that, beyond having a voice, consumers, carers and families are treated as partners in the way services are designed, delivered and evaluated. At both the system and service level, these could include:

a. Strengthening existing participation structures, and creating new opportunities for consumers, families and carers to participate fully in system planning, delivery and monitoring at all levels. This includes providing equal access to information and having real decision-making ability.

b. Supporting greater accountability across the system for lived experience engagement, such as co-designing performance indicators that cover the collection and use of experience of care feedback, lived experience workforce measures, and leadership support for lived experience structures.

c. Supporting greater participation by consumers in their own experience of care, including through tools such as strengths-based individual care plans, self-reported measures of care, and supported decision-making mechanisms, such as advance statements.

d. Ongoing and authentic engagement with current and recent service users, including rigorous processes to use feedback towards improvements in safety and quality, and buy-in at all levels to ensure that improvements are implemented and sustained. Strong consumer and carer advisory groups, robust feedback loops and a commitment to co-designing service improvements would be key to making an impact.

e. Further leadership development and additional career pathways for the lived experience workforce, including by increasing the number, scope and influence of Consumer and Carer/Family Consultants and advisers as experts in embedding lived experience perspective at an organisational level.

146 Some of this work is already underway in response to the recommendations outlined in the Royal Commission's interim report. For example, through the Lived Experience Advisory Group, MHRV is working closely with people with a lived experience to understand how best to engage consumer and carer voices in the design and development of new services and models.

PART C: SUPPORTS FOR SPECIFIC COHORTS

147 In this part, I discuss how improvements can be made to governance and other mechanisms to better support specific cohorts, including:

a. people at risk of suicide;

b. people in the justice system and with complex needs; and

c. people with housing insecurity.

People at risk of suicide

The National Suicide Prevention Strategy

148 One of the actions from the Fifth National Mental Health Plan was to develop a *National Suicide Prevention Strategy* (**the Strategy**) that will strengthen health systems' response to suicide prevention, as a first step towards taking a whole of government approach to prevent suicide.

149 Learning from the international experience, the Strategy will describe the consensus reached by all governments on strategic directions, priorities for change, and actions to strengthen the design of the suicide prevention system. It will also set out areas of focus that the Commonwealth and state and territory governments should prioritise in implementing local suicide prevention efforts.

150 These areas of focus are being developed through extensive research and consultation with governments, the suicide prevention sector and people with a lived experience. They will articulate the highest priorities for action to bring down the suicide rate. For this reason, we can be confident that the strategy will provide a comprehensive picture of the action that needs to be taken in the health system to improve outcomes for people at risk of suicide, as well as their families and communities.

151 Moreover, the Strategy will reaffirm each governments' commitment to implement a systems-based approach to suicide prevention, which involves using multiple evidence-based interventions within a geographic region or to support a priority population.

152 Perhaps most importantly, reaching agreement on priorities will provide an important platform to progress intergovernmental collaboration on areas of shared interest, including opportunities to facilitate an increase in joint planning, commissioning and evaluation of suicide prevention efforts.

153 The National Suicide Prevention Adviser is also currently progressing efforts to drive a whole of government focus in suicide prevention – recognising that, as a whole of society issue, coordinated efforts across government will be needed to achieve change. As we have seen in places such as Scotland and Ireland, embedding accountability across multiple portfolios will be key to making real progress in preventing suicide.

154 While the Strategy will reaffirm a commitment to working towards this whole-of-government approach – and signals that Australia's next national prevention strategy (to be released in 2024) will encompass all relevant portfolios and be endorsed by First Ministers – the National Suicide Prevention Adviser's final report (due December 2020) will provide direction for how we drive this agenda forward.

155 At the national level, work is also progressing to develop a mental health and wellbeing strategy for children and young people to guide Commonwealth investment and provide a framework for preventing mental illness and reducing its impact on children and young people, their families and the community.

Victorian initiatives

156 To progress the actions outlined in the Strategy, each jurisdiction is responsible for implementing their own state-based suicide prevention frameworks.

157 In Victoria, the *Victorian Suicide Prevention Framework 2016-25* (the Framework) is the primary mechanism for driving current and emerging priorities for suicide prevention across the Victorian Government.[23]

158 The Strategy includes a specific focus on ensuring the implementation of community-driven and culturally appropriate responses to support Aboriginal and Torres Strait Islander people at risk of suicide. This recognises that suicide prevention approaches are more effective when they are community led, and reflect the social, cultural, socio-economic and spiritual needs of communities.

159 In addition, in response to the Commission for Children and Young People's 2019 'Lost, Not Forgotten' report, the Department agreed to develop and implement a suicide prevention strategy for children known to Child Protection that incorporates any relevant findings and recommendations made by the Royal Commission. While planning work has begun, the development of this strategy will come following the delivery of the Royal Commission's final report.

160 Looking ahead, specific responses are likely to be required for young people, older persons, health care workers and people whose income or employment has been affected by the pandemic.

Current State and Commonwealth government suicide prevention partnerships

161 The Victorian and Commonwealth governments collaborate in the provision of aftercare services to people following a suicide attempt. Victoria also works with PHNs to co-commission the delivery of place-based suicide prevention trials.

162 These arrangements provide useful insights into some of the challenges and successes of working collaboratively – and in the case of the place-based trials, working with non-government and community partners – to deliver local suicide prevention initiatives.

<u>Aftercare support</u>

163 Since 2017–18, the Victorian Government has delivered the Hospital Outreach Post-suicidal Engagement (**HOPE**) initiative, which operates at hospital sites to link people in with flexible clinical and non-clinical support following a suicide attempt or intentional self-harm. In its interim report, the Royal Commission recommended that this initiative be expanded state-wide. This recommendation is currently being implemented.

164 An independent evaluation of the initial six sites found that HOPE is generating positive results for a high-risk cohort that was previously only receiving limited direct support.

[23] Department of Health and Human Services (Vic), *Victorian suicide prevention framework 2016-25* (2016).

People engaged in the program reported feeling supported, and the evaluation indicated that participants had improved recovery outcomes and greater access to community-based supports that met their individual circumstances.[24]

165 Recognising the benefit that aftercare and assertive outreach has on consumers, the Victorian Government has been working with the Commonwealth to expand the availability of support to a greater number of Victorians. In June 2019, Victoria entered into a Bilateral Agreement with the Commonwealth. Under this Agreement, the Commonwealth will match Victorian investment in HOPE with four Way Back Support services. This agreement expands suicide aftercare to 16 sites across Victoria.

166 The challenge with this arrangement is that the HOPE and Way Back Service are underpinned by different models – while HOPE incorporates a clinical element of care, the Way Back Service is a purely psychosocial model. This means that people receive a different service depending on where they are in the State.

167 The emerging evidence on aftercare support suggests that integration of psychosocial, peer and therapeutic support provides greater benefit in terms of an individual's quality of life and motivation, as well as observable changes in suicidal behaviour.

168 In meeting the Royal Commission's recommendation to expand HOPE and strengthen program fidelity, Victoria and the Commonwealth will need to work together to agree on how best to deliver this combination of clinical and psychosocial support at all sites.

Place-based suicide prevention trials

169 Place-based suicide prevention trials are supporting local communities to work together to identify what is needed to prevent suicide, foster individual and community resilience and wellbeing, and strengthen approaches to suicide prevention. The trials support responses to be tailored to the needs and capacity of the local area.

170 The strengths of these trials is that they bring together different parts of the community, including people with lived experience of suicidal behaviour, community agencies, the Aboriginal community-controlled sector, schools, businesses, local councils, transport, police, health services, ambulance services and others to identify what is needed to prevent suicide and to find solutions that will work for the local community.

171 To date, the trials have established more than 300 local partnerships across the 12 trial sites, building an improved system to prevent suicide in a diverse range of local communities, and the collective impact of co-commissioning these place-based

[24] *Royal Commission into Victoria's Mental Health System* (Interim Report, November 2019).

responses has helped to improve suicide prevention systems in the targeted local communities.

172 Specifically, the collaborative relationships developed with PHNs have achieved outcomes that otherwise may not have been possible. For example, this relationship has supported the sharing of real-time local suicide data, which has helped to enhance responses in hotspot areas and ensure activities are tailored to local circumstances.

173 This place-based approach represents a new way of working together, requiring strong collaboration across multiple sectors. One of the key learnings to date is that it takes a significant amount of time and effort to build trusting relationships with stakeholder groups, including with people who may not be obvious candidates for involvement, and groups who may not have historically worked closely together.

174 Going forward, a priority of this initiative will be to continue improving cooperation between partners, as well as continuing to forge relationships with priority cohorts, such as Aboriginal and Torres Strait Islander and LGBTIQ+ communities, to ensure they are well linked into local suicide prevention efforts.

Benefits and risks of establishing a stand-alone entity for suicide prevention

175 The Commission requested that I consider the benefits and risks of entities with a single objective focus, using suicide prevention as an example.

176 Despite concerted efforts and considerable investment, successive governments have not been able to make sustained improvements to the suicide rate – both in Victoria and across the country.

177 Prevention typically requires interventions across a wide range of government services as well as broader efforts to engage with communities and change social norms. Prevention can lose in trade-offs against tertiary interventions, which have an impact that is often more certain and always more immediate.

178 For these reasons, there is a long tradition of establishing prevention agencies that are at arms-length from government and ministries which aim to bring many parties to the table and act as public champions for prevention. In Victoria, VicHealth is an early example and the most recent addition is the family violence prevention agency Respect Victoria, which was recommended by another Royal Commission.

179 This model could work for suicide prevention. As I outlined in my previous statement to the Royal Commission, establishing the Transport Accident Commission, which was able

to galvanise key partners and had an ongoing interest in reform, has been critical in reducing the road toll.[25]

180 Like transport accidents, suicide prevention will be a long term, deliberate and incremental process of improvement, building on data and evidence of success. It is therefore important that any future governance arrangements privilege this ongoing task, and ensure that there is sufficient analytical, evidence-driven and data informed capability pointed towards it.

181 I suggest that the Royal Commission also considers the option of a Commissioner for Suicide Prevention. This model can work well and has been established in other important areas, such as for Senior Victorians, Gender and Sexuality, Aboriginal Children and Human Rights, to name a few.

182 It is arguably more important to have a very high profile person with convening and influence power than to establish a new agency. A new parliamentary secretary or assistant minister may be an alternate with similar benefits.

183 There is not strong evidence to make this a clear-cut decision, but on balance I believe a substantial change in governance and prominence is needed for suicide prevention. I support the establishment of an independent body or Commissioner to champion this agenda. I anticipate the Royal Commission to make broader recommendations on governance and note that any model will need to work within the broader structure of system governance the Royal Commission recommends.

184 If the Royal Commission does not recommend significant changes to the institutions and policy approaches applicable in the field of suicide prevention, the Department will work to continue improving how we build resilience (especially for young people), while deepening the evidence base on risk factors for particular groups and target responses accordingly.

People in the justice system with complex needs

185 People's mental health outcomes are dependent on the conditions into which they are born, grow, live, work and age. These conditions also often result in people engaging with our social care systems – for housing, family services, alcohol and aged care– before they engage with clinical mental health services.

[25] Kym Peake, Witness Statement to the Royal Commission into Victoria's Mental Health System (2019) 177.

186 As the Chief Psychiatrist highlighted in his 2019 witness statement, Victoria's imprisonment rate is increasing – growing by 81 per cent between 2008 and 2018, from 4,224 to 7,666.[26]

187 There continues to be an over representation of people with a mental illness entering custodial services, with Aboriginal people in custody experiencing higher rates of diagnosed mental illness, dependence disorders and substance use than non-Aboriginal people in custody.[27] Aboriginal young people in Youth Justice also have higher rates of suicidal ideation, cognitive difficulties and offending under the influence of alcohol and/or drugs.

188 The interface between the mental health system and the justice system often simultaneously involves a much broader range of health and social care services – reflecting co-occurring trauma, poverty and intergenerational disadvantage.

189 The Department is working with the Department of Justice and Community Safety (**DJCS**) on a number of priorities to support children, young people and adults who engage with multiple services across each portfolio.

190 This includes reforms aimed at:

a. decriminalising public drunkenness;

b. improving early intervention, assessment and community-based support for children and young people;

c. strengthening joint police and mental health clinical responses to improve immediate responses to people with mental illness;

d. improving transition planning and continuity of care – especially for people with complex dual disability and mental health diagnoses (recognising continuing challenges in the pricing of NDIS services to people in the justice system who require accommodation and an integrated model of care and support); and

e. co-ordinating planning and access to services for serious offenders with a mental illness through a Serious Offenders Multi Agency Panel.

[26] Neil Coventry, Witness Statement to the Royal Commission into Victoria's Mental Health System (2019) 107.
[27] Emma Cassar, Witness Statement to the Royal Commission into Victoria's Health System (2020); Peta McCammon, Witness Statement to the Royal Commission into Victoria's Health System (2020).

Forensic mental health

191 Prisoners, people on remand and those in youth justice custodial facilities have the same rights to availability, access and quality of mental health care as the general population.

192 The Department and DJCS share responsibilities for adult mental health services with:

a. the Department having responsibility for the delivery of care for people engaged with the justice system in the community;

b. Justice Health, within DJCS, leading the planning, commissioning, performance, and quality and safety of health services for people in Victoria's prisons. This includes the delivery of forensic mental health services in custodial settings;[28] and

c. the Department and Forensicare managing secure forensic mental health services.

193 The departments work closely together on planning for future capacity across these forensic services, and on how to improve transitions and continuity of care. Key service gaps include:

a. forensic youth mental health services, and non-secure therapeutic residential treatment options;

b. community-based forensic mental health programs and in reach models to support people transitioning out of custodial settings;

c. secure forensic beds;

d. accommodation for people with a dual disability and for high risk violent offenders and male sex offenders; and

e. specialist services for people subject to an order under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (**CMIA**).

194 There would be benefit in greater integration of justice and broader mental health systems for the purposes of:

[28] Department of Justice and Community Safety (Vic), *Justice Health* (Web Page 2020) <https://www.corrections.vic.gov.au/justice-health>.

a. sharing personal information to improve the quality and continuity of care between community and custodial settings, especially for people with low-to-moderate acuity conditions;

b. improving linkage between public mental health client records and criminal justice data to inform service development, investment cases and measurement of system outcomes for people engaged with the justice system;

c. building and translating evidence into practice; and

d. quality and safety oversight.

195 As the Royal Commission would be aware, under Victoria's *Mental Health Act 2014*, the role of the Chief Psychiatrist is to provide clinical leadership and expert advice to mental health services, and promote continuous improvement in quality and safety, among other things.

196 There is merit in considering whether the Chief Psychiatrist's role and functions should be extended to include the oversight of forensic mental health services, making these services party to the same standards, guidelines, monitoring, reporting requirements and processes for escalation and review as in the general mental health system.

'Common clients' initiative

197 The Department and DJCS commenced work earlier this year on a new approach to service delivery for clients of multiple government services and reduce their contact with the justice system.

198 The joint project aims to break down system barriers between justice and social services and strengthen the way the two departments work together.

199 The departments have made a joint commitment to:

a. embed a recognition of the impacts of trauma on mental health and wellbeing in new service responses, irrespective of whether someone has a formal diagnosis of mental illness;

b. link data and evidence to provide new insights on how to improve prevention, early intervention and diversion along therapeutic pathways;

c. combine clinical interventions with strategies to build informal networks of support – especially for people transitioning from the justice system and or in families who have intergenerational experiences with justice and social service systems; and

d. privilege cultural safety, identity and self-determination.

200 The Departments are working towards an integrated service model, starting with common foundational features that clients will experience no matter where or how they enter the service system. It will also involve developing better connected pathways, evidence-based interventions and stronger transitions across service systems.

201 At a practice level, this means supporting staff across both departments to work more collaboratively with each other and with clients and their families. At a system level, it means linking up existing reforms across government to build service capacity and capability.

202 Among other things, the departments are working together to develop shared case management practices, create guidance and learning and development opportunities that support information sharing and collaboration across workforces, develop shared accountability for client outcomes, and move towards more outcomes-focused and flexible funding – all with a view to ensure that people get help earlier, irrespective of who funds a particular program or service.

203 In February 2020, four local area-based governance committees were established in Brimbank-Melton, Southern Melbourne, Goulburn and Central Highlands. These committees are co-chaired by the Department and DJCS, and as they mature, will include membership from the Department of Education and Training (**DET**), Victoria Police and the funded sector.

204 The role of the committees is to provide strategic oversight of each area's needs, align area-based implementation of key reform initiatives, address system-wide gaps through integrated service delivery models, and support cross-sector workforce collaboration. Consideration is being given to how these committees could support broader COVID-19 social recovery planning and implementation.

205 These local governance structures are in place to ensure reform remains client-focused and to manage workforce commitment and sector buy in. Local governance is also designed to create a strong authorising environment in which local executives have the flexibility and autonomy to respond directly to local priorities and challenges.

206 A Deputy Secretary-level Steering Group is also in place with membership from the Department, DJCS, DET and the Department of Premier and Cabinet (**DPC**) to oversee social recovery from the COVID-19 pandemic, and to ensure alignment across reform initiatives, including common clients, monitor implementation and support oversight by government.

Challenges of this approach

207 This project is the largest joint initiative to date between the Department, DJCS and the sector, and is not without its challenges. It involves breaking down system barriers to create a new way of working together, so that people get the help they need to improve their lives earlier, instead of ending up in crisis services or the justice system.

208 Like many other parts of society, COVID-19 has impacted the operations of this project. However, the integrated governance arrangements that have been established have proved valuable in supporting departments to work together and allowing areas to respond quickly to vulnerable families in the crisis.

Care for consumers with challenging behaviours

209 The common clients project complements longer standing initiatives to care for consumers with challenging behaviours.

210 We know that the complexity of consumers presenting to mental health services in Victoria is increasing, driven by factors like changing patterns of alcohol and drug use and higher rates of crisis presentations.

211 An absence of appropriate service models and fit-for-purpose facilities means that more challenging consumers – including those with high aggression or behavioural problems – are mixing with vulnerable people in emergency departments and inpatient units, where staff do not always have access to appropriate physical space to support their needs.

212 This increases the risk of occupational violence and reduces the service's capacity to deliver therapeutic treatment that aids recovery. It has also led to challenges in attracting and retaining a skilled workforce.

213 Recognising this risk, the Department has implemented initiatives to address physical aggression and violence in emergency departments and mental health inpatient units, such as establishing mental health and alcohol and other drug (**AOD**) hubs in emergency departments, infrastructure improvements to two Secure Extended Care Units (**SECU**), and implementing the Safewards program in inpatient units to improve safety for both staff and consumers by teaching staff to identify, avoid and respond to 'triggers' of conflict.

214 Despite these efforts, we need to do more to ensure we are funding and implementing programs that will support people within this cohort to receive appropriate treatment. Further, we will continue to have workforce attraction and retention issues within the specialist mental health system.

215 In the past, Victoria's forensic mental health services played a role in supporting non-forensic patients who had a serious mental illness and were a danger to their carers or community. However, I am not convinced that this pathway is the most advantageous approach.

216 Instead of establishing a single service response for consumers who present a high risk to interpersonal safety, greater thought needs to be given to how we can create models that cater for the different risk profiles and needs of consumers – in acute, extended care and community settings.

217 This will require consideration of the most appropriate entry-points, physical infrastructure and specialist expertise required for the initial assessment, triage and treatment of these consumers.

The Multiple and Complex Needs Initiative

218 In 2004, the Multiple and Complex Needs Initiative (**MACNI**) was introduced to provide time-limited and flexible interventions to people aged 16 years or over who are living with a combination of mental illness, substance dependency, intellectual impairment or acquired brain injury, and who pose a risk to themselves or others.

219 MACNI aims to provide a platform for people with complex multi-agency needs to access therapeutic treatment and engage with multiple services over the long-term – moving away from crisis responses to a focus on addressing a person's needs and individual goals. This is achieved through coordinating supports to help clients maintain stable housing, health and safety, and support increased social connectedness.

Outcomes

220 MACNI is a voluntary program with more than 240 current clients who use it to link in to supports and services. In some instances, we have seen drastic reductions in the number of times an individual presents to emergency departments in crisis, and a greater capacity to avoid engagement with the criminal justice system. This provides a good indication of the critical role that the coordination of services plays in facilitating better support for people with complex needs.

Potential enhancements

221 Opportunities for enhancement include:

a. lowering the age for the initiative, to better meet the needs of young people under the age of 16 who would benefit from the coordination and intensity of support available through MACNI;

b. adapting governance arrangements to incorporate state-wide escalation processes to better coordinate support in cases where local services are not able to cater for an individual's needs;

c. incorporating assertive outreach to engage with hard-to-reach or disengaged clients, drawing on our knowledge about the value of establishing trusted relationships and the need for sustained effort to maintain contact and engagement; and

d. expanding diagnostic criteria to people with diagnosis such as borderline personality disorder where the personal and community risk is extreme.

222 The Department has undertaken recent work on the design policy, processes and services to enhance support and improve outcomes for:

a. people subject to CMIA proceedings supervision orders; and

b. adults with complex needs – including people with co-occurring needs relating to mental health, substance abuse or cognitive impairment – who pose an unacceptable risk of causing serious harm to other persons.

223 Outside of this work, the Department is monitoring the impact that the NDIS is having on MACNI clients. Currently, the Department has stepped in to provide intensive support to people who are having difficulties navigating the NDIS or experiencing challenges with their planning. Intended as a temporary measure to support the transition to the scheme, some stronger linkages with the NDIS will be required to deliver coordinated care to these clients in the long term.

Future governance arrangements to support coordination

224 As we move forward with the common clients project, the intent is to extend area-based strategic and operational governance state-wide, beyond the initial four demonstration sites and priority cohorts.

225 This would see Victoria's social and justice service systems being underpinned by an integrated service model, providing all Victorians experiencing vulnerability with better connected pathways, interventions and transitions across health, social and justice services.

226 Essential to achieving this will be to remove system barriers that impede cross-departmental coordination, specifically by addressing funding and commissioning, reporting and information sharing barriers. Further, coordination could be enhanced by better data-sharing arrangements and robust joint evaluation and impact measures.

227 Joined-up system governance is a key enabler of this service reform. In practice, a move towards state-wide area-based governance would require structures to be established in each of the Department's 17 service delivery areas, with dedicated arrangements in place to support strategic directions, operational service delivery and client-facing practice.

228 These arrangements would see groups come together as a system to discuss issues and develop solutions across the breadth of justice and social services, including child and family services, family violence, homelessness and housing, alcohol and other drugs and mental health.

Housing for people living with severe mental illness

229 Stable, appropriate and affordable housing is critical to the health, wellbeing, and social and economic security of every Victorian. It is also a critical component of successful treatment and recovery for people with severe mental illness, including those with associated psychiatric disability.

230 State and Commonwealth Governments have joint responsibility for the policy settings, funding and, in some cases, provision of housing and homelessness services for eligible low-income Victorians, including people living with mental illness. A list of relevant housing and supports is outlined in **Attachment KP-2**.

231 Despite the availability of these supports, we know that many people living with mental illness face barriers in accessing or maintaining stable accommodation, with an estimated 20 per cent of registered clients of the clinical mental health system not having stable housing in 2018-19.[29]

232 In reality, this unmet demand for housing supports could be even greater if we consider people not captured in these statistics, such as those living with an undiagnosed mental illness or living in other arrangements that meet their immediate needs (such as living with family) but do not offer the psychosocial support required to enable them to thrive.

233 This lack of access to appropriate, stable and affordable housing makes it very difficult for people with a severe mental illness to manage their health issues, benefit from treatment, and move towards recovery and participation in the social and economic life of the community. This also has flow on effects across other parts of the system, driving avoidable emergency department presentations and high cost acute mental health inpatient services.

[29] Department of Health and Human Services (Vic), *2018-19 Mental Health Services Annual Report* (2019) 79.

234 For some people living with severe and persistent mental illness, a lack of access to appropriate housing and mental health supports can result in them spending prolonged periods in specialist mental health services or other settings that are not appropriate for their needs. In other instances, these people can experience 'iterative' long-term homelessness, cycling between sleeping rough and moving through transitional housing and other sub-standard accommodation.

235 There are several drivers behind this unmet demand for housing among people living with a severe mental illness. For example:

a. **Demand for homelessness services –**

i. The problem of homelessness across Victoria has been growing. On Census night in 2016 there were 24,817 people experiencing homelessness in Victoria, representing a 43 per cent increase since the 2006 Census. This includes people sleeping rough, staying in boarding houses, couch surfing and living in severely overcrowded dwellings.[30]

ii. Around one in three (31 per cent) of those accessing homelessness services identify as having a mental illness. Mental health is often co-occurring with other characteristics such as experiencing family violence (42 per cent of those identifying as having a mental illness) and drug and alcohol use (20 per cent of those identifying as having a mental illness).[31]

b. **Affordability of private housing –**

i. A significant number of people with a severe mental illness rely on government payments as their main source of income (particularly the Disability Support Pension), as well as Commonwealth Rental Assistance (**CRA**).

ii. However, there is a large shortage of affordable private rental properties for people on low incomes. [32]

iii. Commonwealth support through CRA payments have also failed to keep pace with the real cost of renting. In the last 15 years, CRA has grown by around 75 per cent, while actual rents paid have increased by around 175 per cent.[33] This has widened the gap between the cost of renting and

[30] Department of Health and Human Services (Vic), *Homelessness in Victoria* (2020).
[31] Department of Health and Human Services (Vic), *Homelessness in Victoria* (2020).
[32] Anglicare Australia, *Rental Affordability Snapshot - National Report/ April 2019* (2019).
[33] Productivity Commission, *Vulnerable Private Renters: Evidence and Options* (2019).

the ability to afford private rental for Victorians with mental illness on the Disability Support Pension.

c. **Availability of social housing –**

i. Victoria currently has the lowest proportion of social housing in Australia, at 3.0 per cent of all dwellings compared to the national average of 4.2 per cent. As a comparison, New South Wales sits at 4.8 per cent, Queensland at 3.4 per cent and South Australia at 5.9 per cent.

ii. In March 2020, there were a total of 44,703 households on the Victorian Housing Register. Over 50 per cent of these were 'priority' applicants in urgent need of housing.

iii. There are 23,800 households currently registered for priority assistance and around 25 per cent of those registered experience mental illness.

iv. During 2018-19, there were only 4,780 new social housing allocations made. This represents one fifth of the over 23,800 households in urgent need of housing.

v. While people with a mental illness are able to be categorised as having a priority housing need through the existing guidelines, competing pressures to prioritise housing for other high-risk groups can mean they need to wait longer to access the limited stock of social housing.

d. **Availability of long-term supported accommodation –**

i. Many people living with a severe and persistent mental illness who would require intensive mental health and tenancy support to live in the community would likely be eligible for funding through the NDIS.[34]

ii. This could include Specialist Disability Accommodation (**SDA**) funding, which is intended to provide a specialist housing solution for people with very high support needs, and/or Supported Independent Living (**SIL**) packages, which provides assistance with daily tasks to help people live as independently as possible.

iii. However, there are very low levels of SDA funded for NDIS participants with a primary psychosocial disability in Victoria. Even where participants do receive funding, the maturing market means there are shortages in

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

available properties. Combined with this, Victorian participants have relatively low levels of funding committed to SIL packages.

iv. This is creating a significant housing gap for NDIS participants with a severe mental illness and associated psychosocial disability. More broadly, while the Department funds some permanent supportive housing initiatives for people who have experienced long-term homelessness, these are not sufficient to meet demand.

v. Supported Residential Services (**SRS**) are privately operated businesses providing accommodation to Victorians who require day to day support. 47 per cent of residents present with some form of mental illness or psychiatric disability, and of these, just over half (53 per cent) have a psychotic disorder.[35] The lack of alternative supported accommodation options, including through the NDIS, results in SRS accommodation being the only option available for some Victorians with mental illness and significant support needs. The Department is aware that the submission by the Office of the Public Advocate to the Royal Commission has raised concerns about the appropriateness of the SRS model in providing sufficient support and ensuring the safety of residents with mental illness.[36] Growth in the supply of SDA and SIL services would likely assist some residents to relocate to more appropriate accommodation settings.

e. **Access to Commonwealth income support –**

i. The complexity of the Australian Government's income support payments is also a driver of housing insecurity and instability for Victorians with mental illness.

ii. The policy settings and approach to administrative requirements currently in place increases the likelihood that Victorians with mental illness will not meet the requirements to access payments. Victorians with episodic conditions can find it challenging to access the Disability Support Pension. Complex requirements to attend appointments and adhere to activity requirements can be challenging for those with mental illness, and can reinforce housing insecurity if they lead to a cessation of income

[35] Department of Health and Human Services (Vic), *2018 Supported Residential Services Census* (2018).
[36] Office of the Public Advocate, Submission to the Royal Commission into Victoria's Mental Health System (2019).

support payments, which in turn places housing security at risk through not receiving income.

iii. Approximately 10 per cent of adults presenting to Victorian homelessness services (which accounts for more than 10,000 presentations annually) now report having no income from any source. In many cases this is because payments have ceased from the Australian Government income support system.

iv. Safe, stable and appropriate housing requires Victorians with mental illness to receive income support payments in many cases. Challenges in the ability to access, and then maintain, a basic level of income support poses a challenge to meeting the housing needs of Victorians with mental illness.

236 The COVID-19 emergency has brought to the surface significant challenges in the supported and temporary housing options available for those experiencing housing and related social distress. Many options for people in these circumstances involve shared facilities, over-crowding and imperfect health and hygiene measures, and hence have required very active management to prevent COVID-19 transmission.

237 The over representation of Victorians with mental illness in these settings highlights the importance of addressing these issues to improve the mental health of Victorians and improve opportunities for recovery through safe, stable and appropriate accommodation.

238 Unsuitable or unavailable housing for Victorians with mental illness creates demand for a variety of other accommodation services, supports and settings. Between outright homelessness, on one hand, and stable long term accommodation, on the other, sit rooming houses, SRS, a variety of specific-purpose mental illness facilities, SDA, overcrowded private housing, unregistered/illegal rooming houses and other facilities. There is significant work to do across this spectrum with a number of unresolved policy, regulatory, funding and Commonwealth-State issues.

239 The impacts of this unmet need for housing results in Victorians with mental illness experiencing high rates of rough sleeping. Almost half of Victorians experiencing chronic rough sleeping in 2019-20 had previously had a mental health acute admission and two in three had mental health community contacts over the 10 years prior. Similarly, 500 Victorians are discharged from mental health services directly into homelessness each year.[37]

[37] Department of Health and Human Services (Vic), *Homelessness in Victoria* (2020).

240 Expanding access to housing initiatives that are augmented with psychosocial supports has the potential to greatly improve outcomes for people living with a severe and persistent mental illness.

241 In addition, given that the cost of supporting someone in hospital or a residential mental health setting is far greater than private rental or social housing, there is a strong economic argument for improving access to integrated housing and mental health responses.

242 Addressing these issues will require considerable investment from both state and Commonwealth governments. Enhancing the availability of social housing is one key part of this, providing support to people where the private market does not offer safe, stable and affordable housing. Additional investment is also required in housing strategies that provide wrap around support to enable people living with a severe mental illness to maintain stable tenancy and support recovery.

243 Many people in need of social housing have some form of mental illness, from mild anxiety to severe psychotic disorders. The social housing system therefore interacts with mental health supports in many different ways, across a wide range of different personal circumstances.

244 An effective social housing system supporting mental health reform includes:

a. **Growth in housing supply**. A sufficient number of social housing and supported accommodation dwellings are needed to meet demand from people with mental illness.

b. **Capability development.** Greater capability and mental health expertise are required within the housing system, including to provide effective tenancy support to those with complex behaviours resulting from mental illness.

c. **Cross portfolio and integrated services**. Housing responses need to respond to the multi-factor disadvantage experienced by many applicants for social housing – for example, interaction with the corrections system, mental illness and intellectual disability.

d. **Tenure neutral approaches**. Housing setting or tenure should not be a defining characteristic of how supports are provided. A system of mental health supports needs to be provided to those in need wherever they live, including in social housing.

e. **Transitions to the right level of support.** Transition paths are needed in and out of more intensive and purpose-specific supported accommodation. This should enable those whose psychosocial support needs to move to higher support settings (including those moving from home with family and from under-supported SRS settings) and then back into independent living where possible.

245 The high level of unmet demand in social housing represents a significant challenge. Given the high level of mental illness prevalent amongst the highest priority group of applicants (those experiencing rough sleeping), those allocated social housing in Victoria include a high rate of Victorians with mental illness. 'Ring-fencing' or segregating social housing stock for the use of those living with mental illness is expected to be less effective compared with providing mental health supports across housing types, and ensuring sufficient supported accommodation is available for those with the most significant support needs.

246 Finally, I am concerned that the NDIS has failed to stimulate adequate investment in SDA for Victorian participants with severe behavioural issues associated with their mental illness and other co-existing conditions (such as Autism, intellectual disability and acquired brain injury).

247 To address this, there could be benefit in:

a. considering how creative partnerships with private or philanthropic investors could help provide purpose built accommodation for this cohort while the NDIS funded housing market matures; and

b. further work between the National Disability Insurance Agency (**NDIA**) and the State Government to better understand the eligibility criteria for SDA as they apply to those living with mental illness. This should review the tightly held and inflexible eligibility criteria that gate-keep NDIS funding for SDA for people with psychosocial disability. Further effort is required to better ensure that those who in reality have significant disability and require accommodation support actually receive the support they need.

PART D: ENABLING AND EMBEDDING A STEPPED SYSTEM OF CARE

Future trends

248 While the full impact of the pandemic is still unknown, the unprecedented social and economic consequences of COVID-19 are likely to compound disadvantage for vulnerable Victorians and increase demands on Victoria's mental health system in the short and longer term.

249 We know from the evidence that exposure to challenging social, economic, and environmental circumstances can place individuals at an increased risk of many common mental disorders.[38]

250 We also know from past emergencies that mental health impacts cast a shadow that trails thosethose emergencies by weeks, months or even years. For example, research focused on the long-term psychological impact of the Black Saturday bushfires indicated that groups of people from affected communities reported persistent post-traumatic stress disorder, depression and psychological distress several years after the event.[39]

251 New cohorts, including young people and older Victorians are at higher risk of entering the mental health system as a result of financial and housing instability, loss of social connection and unemployment. Health care workers are also at higher risk of post-traumatic stress in the months and years to come.

252 Alongside the long tail of impacts from the pandemic, over the coming decades, there are a range of trends that are likely to drive the need for additional mental health services for members of the community. This includes factors such as:

a. the ongoing threat of bushfires relating to our longer and hotter bushfire seasons, impacting largely on regional and rural communities;

b. other climate-related events which are likely to have a general impact on the community, including immediate risks to safety and impacts on businesses and livelihoods, as well as presenting particular risks to areas and families in a more direct way – for example, the impact of drought on farming communities;

c. the changing complexity of presentations, including due to alcohol and other drug use, the presence of co-morbidities and the effects of social and economic disadvantage; and

d. the needs of Victoria's culturally diverse communities, which are continuing to grow (at the 2016 Census, 49.1 per cent of Victorians were born overseas or had at least one parent born overseas, up from 46.6 per cent in 2011), including the impacts of trauma and dislocation on refugees and asylum seekers. [40]

253 As such, it will be important that the mental health system is able to adapt to these emerging pressures so that it continues to meet community needs into the future.

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[38] World Health Organisation, *Social determinants of mental health* (2014).
[39] Richard Bryant et al, 'Psychological outcomes following the Victorian Black Saturday bushfires' (2014) 48(7) *Australian & New Zealand Journal of Psychiatry* 634-643.
[40] Department of Premier and Cabinet (Vic), *Victorian Government Report in Multicultural Affairs 2017-18* (2018).

254 There are a number of things that will be important in helping us to prepare for and respond to these trends. These include:

a. access to good data that can alert us to increasing and unmet demand at the system level, as well as potential risk factors at the population level, such as levels of psychological distress;

b. a robust planning framework to guide service, workforce and infrastructure investment over the long team, supported by adaptive planning processes that account for new evidence and emerging models of practice; and

c. an ability to apply our analysis of population and service developments to inform capital investment decisions for government.

255 Further information on how the Department has been enhancing our ability in this respect can be found in my previous statement to the Royal Commission.

Managing change with multi-disciplinary workforces

256 There are cultural and system barriers to growing the multi-disciplinary workforces necessary for a community-based, stepped care system of mental health care and support. These include training, career and appetite for risk.

257 I think that to deliver transformative reform of the mental health workforce, we will need to:

a. address structural and cultural barriers that have created difficulties in recruiting and retaining skilled mental health clinicians and hindered the growth of lived experience workforces;

b. think more deeply about the composition of the workforce, and whether we have the right mix of skills and capabilities to support the needs of people living with a mental illness;

c. ensure regulatory, educational and system settings allow and encourage the workforce to enact new skills, work to top of scope, have innovation in role and be supported by cultures of learning and wellbeing;

d. ensure that workforces in the universal and wider social services sectors receive the supports they need to identify, assist and refer people to appropriate mental health treatment and support; and

e. deliver significant workforce expansion in a way that avoids placing pressure on workforces in other social service systems.

258 There are several practical mechanisms that could help to ensure workforces are prepared for, involved in and supported through this period of significant change.

259 Reflecting on the experience with family violence reform, the development of a 10 year industry plan has been a useful way to describe what we want the workforce to be doing, and what capabilities, organisational support, and training infrastructure is needed to build and maintain the workforce over the long term.

260 The *'Building from Strength'* plan establishes a long-term vision for the workforces that prevent and respond to family violence, and outlines the actions that will build the foundations of the system, strengthen the specialist workforce and deliver a largescale capability build in family violence prevention and response across other sectors.[41]

261 Adaptive implementation is a useful approach that enables you to build on what works, incorporate emerging evidence and respond to unanticipated changes in the broader system. With this in mind, a series of three-year Rolling Action Plans are being progressively released that will that work towards achieving the long-term vision of the Plan.

262 The First Rolling Action Plan 2019-2022 ('S*trengthening the Foundations'*) includes initiatives that lay the foundations for building supported, valued, skilled and diverse workforces and a responsive system that encompasses a range of sectors whose workforces intersect with family violence. For example, it includes actions that will build workforce capability, enhance training architecture, support the recruitment and retention of specialist workforces, and strengthen leadership in the specialist sectors.[42]

263 While the Royal Commission's interim report includes several valuable recommendations to strengthen the mental health workforce, there could be benefit in considering the merits of an industry plan, such as that which I have described above.

264 The intent of the Royal Commission's interim report is clear that a future mental health system must place people at the forefront, be recovery oriented, trauma informed and based on the best evidence. This requires a workforce that is not just bolstered in supply of multi-disciplinary professionals – including people with lived experience – but is organised around these principles and integrated practice. Significant practice change

[41] Family Safety Victoria, *Building from Strength: 10-year industry plan for family violence prevention and response* (2017).

requires new standards and guidelines around integrated care and culturally responsive new models of care. A workforce capable of responding to future mental health needs will need to work in multidisciplinary teams and have a culture of inquiry, safety and continuous improvement.

265 In a future system, the Victorian Collaborative Centre for Mental Health and Wellbeing will provide a center of gravity for workforce development and practice improvement through its responsibilities for disseminating knowledge and research.

266 Early and enduring engagement with the workforce – including peaks and other professional bodies – is critical during any significant change.

267 For example, when implementing family violence reforms, the government established the Industry Taskforce to guide the development of the industry plan. This comprises representatives from a range of sectors including:

a. family violence and sexual assault services;

b. primary prevention organisations;

c. community services;

d. justice, health and education and training sectors; and

e. peak bodies, professional associations, unions and education and training providers.

268 The Taskforce was supported by dedicated working groups, which were involved in developing work over the longer term. These formal governance structures had strong sector buy in, and in my view, were a helpful way to target engagement with the sector and support the co-design of workforce models and development opportunities.

269 To help implement a significant workforce change agenda, it can also be useful to empower peak bodies to play a leadership role in supporting the sector through the change process, including people with lived experience. These change leaders can be useful in helping to inform practice change, as well as providing advice on how tools and training can be tailored to the needs of the workforce. Critical to successful systems transformation will be the alignment and shared understanding of all stakeholders.

270 Implementing change of this scale requires careful consideration of the sequencing of reform. Often, the awareness and literacy across broader sectors can be much lower than in the specialist system. For this reason, a useful policy logic can be to build the foundations within the specialist workforces early on, before supporting and embedding

practice change across the rest of the system – including in mainstream and universal services.

271 In the family violence context, embedding family violence expertise in key mental health and alcohol and drugs services was a useful way to create culture change, organisational awareness and skill uplift in relation to the prevention of and response to family violence. Similarly, these positions were a helpful source of information on how to target improvements at the local level.

Digital mental health

Factors affecting the adoption of digital technologies in mental health

272 Digital technologies are becoming increasingly important to identifying, diagnosing, treating and supporting mental health conditions. By digital technologies, I am referring to any type of technology that facilitates engagement in or the delivery and coordination of care.

273 Some of these technologies, such as telehealth, videoconferencing and websites, are already well embedded into both health and mental health service delivery. They have a strong evidence base behind them, and are well understood and implemented by government funded services.

274 However, governments are lagging when it comes to implementing newer technologies (sometimes referred to as 'disruptive' technologies), such as webchat, smartphone apps, wearable devices, sensors and artificial intelligence tools. These kinds of emerging technologies hold promise for improved care, including empowering consumers to take a more active role in managing their own care, but the evidence base is still emerging, and there are risks for government in investing public money in unproven tools.

275 As the Royal Commission has heard, there is a further disparity between the adoption of innovative approaches to technology between general health and other areas, such as mental health.

276 This disparity persists even when we look at more established technologies such as the expansion of telehealth and the use of electronic medical records. I think this is most likely because the transition to digital health platforms has occurred in a more structured way in the acute health sector, as a result of the 'lack of parity' between acute care delivered in hospitals and mental health that I referred to in my previous statement to the Royal Commission.

277 This compares to mental health conditions, which can be enduring in nature and may see people being managed across multiple services and sectors over the course of their lifetime. Where services are required to support and manage complex conditions, the adoption of digital health technologies is more difficult.

278 The Fifth National Mental Health and Suicide Prevention Plan (**Fifth Plan**) acknowledged that this is an area where we need to improve – committing to developing a National Digital Mental Health Framework to guide the creation of new digital service delivery platforms to improve coordination and enhance the quality of care.[43]

279 However, over recent months we have seen the adoption of digital technologies in mental health quickly starting to change. In response to the COVID-19 pandemic, the mental health sector and its dedicated workforce have rapidly innovated to reconfigure services and use technology in new ways to support people and shift care from hospital wards to home and community settings.

280 In the primary care system, as I mentioned earlier in my statement, new MBS items have been introduced temporarily to enable a wider range of mental health consultations to be delivered by telehealth. This move has been well received among industry bodies and enabled the extensive take-up of telehealth in GP and private practice settings.

281 In the specialist system, mental health services have transitioned wherever possible from acute inpatient care to community settings, and the trend towards videoconferencing for the delivery of mental health interventions has seen rapidly increased uptake by the mental health workforce and consumers, including for triage, screening, assessment and aspects of community-based treatment.

282 To illustrate the significance of the change, in April 2019 area mental health services in Victoria delivered 346 contacts via teleconference. By April 2020 this had increased to more than 10,000 contacts.[44]

283 This change has also supported innovative new ways of working, such as the delivery of online clinics, the provision of virtual sub-acute care as an alternative to sub-acute bed-based services, and the increased use of teleconferencing to support deliberations by the Mental Health Tribunal.

284 The momentum generated by the COVID-19 pandemic has supported a rapid scaling-up of established, evidence based technologies, and as we move into a recovery stage, there is an opportunity to build on this – ensuring that effective service delivery innovations are

[43] Department of Health (Cth), *Fifth National Mental Health and Suicide Prevention Plan* (2017).
[44] Internal departmental data extracted from CMI/ODS, 2020.

retained, and that lessons learnt are used to inform enduring improvements in how services and supports are accessed by and delivered to the Victorian community.

285 In doing so, we need to also build in strategies for government to leverage private sector innovation in using emerging technologies to improve mental health outcomes. This can be done most effectively by testing new approaches and assessing their impact in partnership with consumers, academics and the private sector. Consumer participation and co-design should be central to these processes. The evidence generated can then guide government investment in larger-scale implementation of technologies that we know will have the most impact on improving outcomes.

Driving and incentivising digital technologies in mental health service delivery

286 Under the Department's 'Digitising Health Strategy', health services have been working to lift their ICT resilience – ensuring they have access to the technology and bandwidth they need to support the delivery of care using digital technologies.

287 However, the Department's recent experiences with COVID-19 tells us that improvements will be required to enable to continue uptake of digital interventions for the provision of both clinical and psychosocial support. It has become clear that mental health programs in health services need to build more remote and flexible working capacity, as well as needing access to new and contemporary ICT infrastructure.

288 For example, while we have made significant inroads into Electronic Medical Records (**EMR**) implementation across the State, there is further investment required to ensure EMRs support the specific needs of mental health care. Mental health care services, in adopting a recovery model of care, require specific mental health modules to support recovery-oriented mental health care practices and provide the data used to identify and evaluate quality improvement initiatives.

289 Access to contemporary ICT is also an issue for consumers. Funded mental health services are reporting that some consumers are not able to access telehealth because cost barriers prevent them from purchasing a smart device, while for some consumers and service providers, poor connectivity can be a barrier.

290 In response to COVID-19, the Department has been rolling out mobile phones and data plans for vulnerable and high-risk clients of public clinical mental health services and AOD services, so they can remain engaged with treatment and support services during the coronavirus pandemic and subsequent recovery period.

291 The Department has also negotiated the purchase of additional call volumes to support phone-based service provision and has provided equipment and IT grants to State funded community mental health providers to support them to offer their services remotely.

292 To continue to drive the take-up of digital technologies, the workforce also needs to be supported to adapt to these new ways of working through access to appropriate guidance and training focused on the delivery of high quality and safe care – including advice on when digital service provision is most suitable.

293 In line with the commitment made in the Fifth Plan, the Australian Commission on Safety and Quality in Healthcare is leading work to develop National Safety and Quality Digital Mental Health Standards in collaboration with consumers, carers, clinicians, service providers and technical experts.

294 These standards aim to support safety and quality assurance for people accessing digital mental health services and provide best practice guidance for service providers and developers. Once developed, they will provide useful guidance on how best to support the shift towards emerging digital mental health approaches – including in relation to clinical governance, partnering with consumers to support service design, and delivering evidence-based and safe models of care.[45]

295 However, with implementation likely to be voluntary (at least initially), these standards will need to be complemented by local mechanisms to ensure appropriate quality assurance frameworks are in place to facilitate the shift towards digital health solutions.

Research and innovation

296 I note the Royal Commission's interim report recommendation to establish a new Collaborative Centre for Mental Health and Wellbeing (**Collaborative Centre**), which will be charged with creating the infrastructure needed to support alignment across multiple research streams, conducting interdisciplinary research, disseminating knowledge and driving exemplary practice across the sector embedded in direct service delivery.

297 The Collaborative Centre will be central in fostering a culture of innovation, helping to support the ongoing improvement of mental health services over time.

298 The Collaborative Centre's work will need to be guided by robust and transparent principles to help target investment, including:

[45] Australian Commission on Safety and Quality in Healthcare, *National Safety and Quality Digital Mental Health Standards - Consultation* Draft (2020).

a. prioritising knowledge translation to improve practice;

b. recognising operational infrastructure costs in research grants;

c. placing the participation of people with a lived experience of mental illness at the centre of research and knowledge translation, including through informing research priorities, shaping research methods, helping to interpret findings, and contributing to the evaluation and dissemination of knowledge;

d. supporting person-centred research that recognises consumers as people with full lives and places an ultimate focus on improving outcomes for Victorians;

e. actively encouraging collaboration between government, other funding bodies, research entities, clinical academics, service providers, practitioners and those with a lived experience of mental health issues;

f. preferencing research that is locally relevant, readily translatable and scalable;

g. investing in research that has the ability to change community attitudes towards mental health and mental illness; and

h. developing new knowledge across the spectrum of prevention, detection and management of mental health conditions to support recovery.

Connecting knowledge to policy development

299 Complex problems are not typically amenable to 'set and forget' policy responses. Instead, they require careful monitoring and regular adaptations, including changes over time as community trends and needs change, and the evidence on best-practice approaches evolves.

300 Generating a robust evidence base and using this to continually inform policy and practice will therefore be key to ensuring Victoria's future mental health system continues to evolve and improve outcomes for consumers and carers. Continuous learning requires a willingness to test new ideas, an understanding about what does and does not work, an ability to disseminate feedback and share best practice, and an ongoing focus on system performance.[46]

301 In addition to conducting research and translating this into practice, in which the Collaborative Centre will play a leading role, evaluating existing interventions and adopting an adaptive implementation approach are also important practices that support

[46] New Zealand Productivity Commission, *More effective social services* (2015).

policy decisions to be better connected to knowledge and enable an environment of continuous learning.

Adaptive implementation

302 As I discussed in my previous statement to the Royal Commission, when it comes to complex service delivery reform, I have found that taking an adaptive approach to design and implementation can assist in testing new approaches before bringing them to scale.

303 Even when you have a solid understanding of the evidence, the reality is that unexpected opportunities can emerge as technologies and evidence evolve and new service models and ways of working are tested. Invariably some reform ideas do not deliver the anticipated impact.

304 Building adaptation and learning into the implementation process can help to create an environment that supports calculated risk-tasking by enabling policy and service adjustments to be made more quickly. This approach can also enable improvements in service design as the evidence builds about what is effective.

305 Adaptive methodologies in government involve being:

a. flexible – by focusing on outcomes, being willing to experiment with service delivery models and measuring performance;

b. experimental – by undertaking demonstration projects to test what works, allowing experience to influence implementation, learning from mistakes and moving to scale progressively;

c. facilitative – by working with others (including providers) rather than in isolation when developing policies and programs;

d. agile – by creating stages that allow programs to be modified on the basis of ongoing monitoring and evaluation, learning continuously by doing, sharing information about good practice, mistakes and near misses to inform program design.[47]

306 The key is to do things at the right speed, sequencing efforts in a way that allows you to learn quickly, implement programs with fidelity to models, and make incremental improvements consistently across services that can maximise outcomes.

[47] Australian Public Service Commission, *Learning from failure: why large government policy initiatives have gone so badly wrong in the past and how the chances of success in the future can be improved* (2015).

307 The NDIS demonstrates how adaptive learning approaches can be used when delivering large-scale reform. The former chair of the NDIA, Bruce Bonyhady, has described how the NDIA implemented a "learn-build-learn-build" approach to improve the NDIS design, which involved implementing service improvements every six months based on the emerging evidence.[48]

308 We should learn valuable lessons from this approach – and other major reform processes that have delivered full-scale programs that are able to respond quickly and flexibly to emerging problems – in thinking about how a reimagined mental health system can be set up to succeed, remain consistent across all services and contemporary to needs.

Evaluation

309 A system that learns and improves over time needs to have a strong grasp of the evidence on what is working, and what is not. This is important because, without adequately evaluating existing policies and programs, it is impossible make decisions about scaling up successful interventions or winding down initiatives that are not meeting their intended purpose.

310 Evaluations are a valuable way to understand if activities are being implemented as intended, and to determine the overall impact of a policy or program. This information can be used for a range of purposes, such as:

a. improving and informing policy, providing an evidence base to develop future options and alternatives;

b. driving service or system improvement, resulting in changes to existing or future programs and policies; and

c. supporting and determining budget priorities, identifying cost efficiencies and resource allocation options.[49]

311 To best support continuous improvement, evaluations should be designed in a way that provides practical evidence about how policies, services and programs can be enhanced to deliver better outcomes for the community. This is best facilitated when program evaluation is funded as a specific element of program implementation.[50]

312 Once evidence has been developed that could improve practice, this should be shared widely to inform improvements in other services, sectors and jurisdictions.

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[48] National Disability Insurance Agency, *NDIS powers towards 9000 plans: Latest quarterly report* (2014).
[49] Centre for Evaluation and Research: Department of Health and Human Services, *Evaluation guide* (2017).
[50] Productivity Commission, *Mental Health* (Draft report, October 2019) vol 2.

Fostering public trust in data collections and infrastructure

313 Collecting and sharing information and data such as clinical records among treating practitioners is best practice, providing clinicians with a full picture of a person's treatment history and enabling consumers to move between services and receive treatment over an extended period in a way that is coordinated.

314 In an area such as mental health, where people can experience enduring mental illness or have episodic mental health needs that sees them move between treating practitioners, access to this type of information is particularly important.

315 Electronic clinical records require strong safeguards, and system stewards need to cultivate a high level of trust in the community that their privacy and data security will be maintained.

316 Gaining public trust will be particularly important when it comes to some of the more vulnerable members of our community. While many high-volume health service users are comfortable with the use of technology to collect and share health information as they see how it will make their journey easier and more integrated, other parts of the community – such as those accessing mental health services, AOD treatment services or justice services – may be more reticent to embrace electronic records. Consumers may also be concerned about how information is stored, shared and used by government.

317 Actively engaging with the public about how their information will be used, communicating the benefits of information sharing, and listening and responding to community concerns can go a long way to build social licence for this type of activity.[51] Similarly, enabling experts outside of government to participate in, and inform the public debate can help to build public confidence in new digital infrastructure.

318 Reflecting on the experience with My Health Record, while there was robust legislation and infrastructure supporting the roll-out of the new system, and considerable support among the sector, a lack of trust among members of the community meant that it was challenging to get off the ground. Reviewing the lessons from this experience, as well as the recent roll-out of the COVIDsafe app, will assist with building public trust around mental health data and systems.

[51] Office of the National Data Commissioner, *Building trust through data sharing principles* (2019).

Incentivising innovation and new approaches to service delivery

319 Providing incentives and flexibility for services to adapt and try new ways of doing things is important to allow service delivery to evolve over time to meet the changing needs of consumers.

320 There are several levers the system steward can use to enable the development and implementation of innovative or contemporary service models. I explore two of these levers – funding approaches and regulatory design – below.

Funding approaches

321 As noted earlier in my statement, responsibility for health funding, including mental health, is shared between levels of government in Australia:

a. Commonwealth government funding responsibilities include the MBS (e.g. primary care and specialist care delivered outside the hospital), Pharmaceutical Benefits Scheme (e.g. medications), PHNs, Aboriginal Community Controlled Health Organisations (**ACCHOs**), some mental health care programs (e.g. Beyond Blue and Headspace), medical research grants and health professional education. The Commonwealth Government also contributes to private health insurance costs through a rebate, which is subsequently spent on inpatient mental health care services.

b. The Commonwealth and state and territory governments share funding responsibility for public hospitals, the NDIS, preventative services, registration and accreditation of health professionals and targeted Aboriginal and Torres Strait Islander health services.

322 Different funding models are applied to different types of services, with fee-for-service payments in primary care (with some modest payment for performance); a mix of activity-based and block funding in hospital care and block funded contracting for community services and organisations to deliver targeted services and programs.

323 Gaps exist in funding and funding incentives for prevention and supports for a joined up mental health stepped care pathway. The Productivity Commission has drawn attention to gaps in funding for navigation platforms and services, care plans and care co-ordinators. Rationing of mental health care is common through restrictions on access to services, co-payments, exclusions from coverage (for private health insurance) and capped budgets.

324 As the Royal Commission has heard, reform success will depend on improvements in how funding mechanisms translate into incentives for the provision of services for particular cohorts and support appropriate and multidisciplinary care.

325 Incentives are currently misaligned, leading to different services being offered and accessed. For example:

a. key Commonwealth funding sources (such as the Medicare Benefits Scheme) are not accessible to many professions who are well placed to provide mental health care (such as allied health practitioners, mental health nurses and peer workers);

b. current funding models do not recognise mental health care provided by professionals who are not typically considered part of the mental health workforce, such as counsellors in schools;

c. payment models (episodic, fee for service and activity-based funding) can act as barriers to collaboration and innovation;

d. sudden changes in program funding and short-term funding cycles impact on workforce development and building and translation of evidence into practice; and

e. consumer demand for mental health care is particularly sensitive to price, especially for specialist care.

326 As the Royal Commission has heard, mental health systems nationally have less clearly identified and reported measurable outcomes from mental health care. There is a need to better identify, measure and articulate the social return on mental health investments.

327 All funding models have their advantages and disadvantages – with trade-offs between complexity and the ability to incentivise access to good quality care. An overview of potential models is provided at **Attachment KP-3**.

328 While there is no clear 'best' funding model for mental health care internationally, there would be benefit in realigning provider incentives to stimulate the transition from hospital-centric services to integrated, stepped systems of care in the community.

329 As the Royal Commission noted in its interim report, increased investment and longer funding cycles will be a critical enabler of reform. Careful design will be required to align funding models with financial incentives, delivery mechanisms, and performance enablers.

330 In my view, funding model reform will need to be iterative, but should be:

a. based on an agreed set of principles, recognising individual jurisdictions should continue to have flexibility to test different approaches for different services and cohorts;

b. aligned with broader health care system directions (including optimising value and incentivising community-based and integrated care);

c. designed to incentivise the efficient delivery of evidence-based care; and

d. deliberate in encouraging and enabling innovation.

331 As the Royal Commission has discussed in its public hearings, this will require investment in data collection and analysis – for example on costs and resource use to calculate prices, on patient characteristics to risk adjust finding, and on outcomes to reward providers for good practice.

Lessons from other funding reform processes

332 One way to drive innovation and incentivise the delivery of contemporary service models is to fund for outcomes. There are different ways that this can be done – with jurisdictions around the world trialling and implementing a range of funding and payment mechanisms that incentivise service providers to deliver the outcomes that matter most to consumers.

333 One approach that is being trialled in Victoria is the Partnerships Addressing Disadvantage (**PAD**) program, which takes a partnership approach to funding innovative new service responses. As David Martine, Secretary of the Department of Treasury and Finance, explained in his 2019 statement to the Royal Commission, this program brings together the public, private and not-for-profit sectors to address complex problems, using an outcomes-based funding model whereby government makes payments upon the achievement of measurable social outcomes.[52]

334 Victoria's first two Social Impact Investment programs, Journey to Social Inclusion (focussing on addressing homelessness) and COMPASS (focused on supporting young people transitioning from out-of-home care), are types of PAD programs, harnessing capital and expertise from all parties for the achievement of agreed outcomes.

335 Both models are accompanied by a robust evaluation that compares outcomes for participants in the program to outcomes for a similar group of non-participating clients, to

[52] David Martine, Witness Statement to the Royal Commission into Victoria's Mental Health System (2019).

understand the comparative impacts of these programs and ensure they have been delivered with fidelity.

336 In addition to supporting a focus on outcomes, partnerships such as this are a valuable way to support innovation, with non-government organisations able to take risks in a way that governments cannot. Working in partnership can therefore enable the testing of ideas before bringing new approaches to scale.

337 From the Department's experience trialling this social impact approach, I would suggest that the characteristics of effective alliances and partnerships include clear expectations for outcomes, the use of evidence-informed practices, shared accountability for measured results, and strong trust and collaboration between all parties.

338 I would also highlight the importance of:

a. empowering all parties through agreed governance and operational arrangements, which re-orientate engagement between government and non-government organisations to promote flexible and innovative approaches;

b. applying a collaborative framework to provide opportunities for all partners to better understand and test the problem, identify what works, what does not work and why; and

c. agreeing desirable outcomes, enabling partners to proactively engage to monitor progress against expected performance indicators and allowing them to adjust activities when required.

339 Building on this, it can also be helpful to think about how innovation funding can be used to support the development of innovative new practices and enable the uptake of new service models across the broader sector.

340 For example, in 2016, the Better Care Victoria (**BCV**) Innovation Fund was established to help the Victorian health sector to identify and embed innovation. Now in its fourth year, the BCV Innovation Fund has supported 37 projects that aim to change the game in terms of improving access to and the quality of healthcare. The fund also supports scaling of successful projects so that innovative practice can be embedded across the health sector. This approach aligns with the advice we are hearing from the sector, which indicates how difficult change management can be when it is not appropriately funded.

<u>Regulatory design</u>

341 Regulatory design is another important lever that can either support or inhibit innovation and the creativity necessary to test new ideas or models of care.

342 The key principles that should guide the development of best practice modern regulatory frameworks include:

a. clear regulatory objectives and functions that are separate from other functions of government and distinct from other roles in the system, such as system planning, advocacy, contract management and service delivery;

b. a focus on regulatory outcomes and outcomes-based requirements;

c. a clear scope, while being sufficiently broad or flexible enough to enable the framework to adapt over time to keep up with changing circumstances;

d. a genuine basis for risk-based regulation to ensure regulators' resources are allocated to regulating according to harm and consequences;

e. being clear and easily understood by business and the community;

f. being efficient, transparent and proportionate to the risk of harm without placing undue burden on communities, organisations, individuals or the broader system; and

g. avoiding duplication of regulatory requirements and supporting the streamlining of regulatory activity where overlapping or similar regulatory regimes exist, including between Commonwealth and state regimes.

343 Good regulatory design balances providing regulated entities with enough flexibility to encourage innovation while still ensuring that the outcomes of the regulation, such as protecting the community or service users, are achieved.

344 In contrast, regulation can inhibit innovation if it creates excessive uncertainty or complexity, is delivered inconsistently, does not account for increasing integrated service delivery, or lacks clarity in the roles and responsibilities for oversight and enforcement.

345 In considering the best regulatory settings to support innovation, I would suggest that outcomes-based regulation (which focuses on the requirement to achieve an outcome) enables more scope to test new models of care than prescriptive rules-based regulatory models (which detail prescriptive rules about what or how something must be done).

346 For example, if the required outcome was that services are provided in a safe, secure and fit-for-purpose environment, regulated entities or individuals would be empowered to determine the most effective and efficient way to achieve the outcome rather than being made to comply with prescriptive rules that may rapidly become outdated or no longer reflect best practice or technological advancements.

347 While not appropriate for all regulated entities or risks, in the right context and through sound design and operationalisation, outcomes-based models can be a good way to help future-proof regulation by enabling regulators, the sector and individuals to more readily respond to changing technology, markets, risks and community expectations and needs.

348 To support the effectiveness of outcome-based regulation, it is important that stated outcomes are not so high level that they are aspirational or not able to be assessed against the evidence. It is also important to consider whether the sector has the maturity and confidence to innovate within an outcomes-based framework. The less mature the sector is, the greater the need for stronger guidelines to supplement standards.

349 Clear guidelines can assist regulated entities and individuals to understand the outcomes being sought and provide parameters and considerations to assist with compliance. This is important because too much uncertainty about what is expected or how to meet the requirements can lead regulated entities and individuals to take a conservative approach as they try to make sense of how to comply.

Continuous modernisation of physical infrastructure design

350 The physical environment in which consumers receive care has a powerful impact on their mental health outcomes. The fabric and condition of our public infrastructure can shape a consumer's experience of treatment – with welcoming environments far more likely to support wellbeing and aid recovery than settings that are perceived as being sterile, uninviting or unsafe.

351 In establishing new services and refitting existing facilities, it will be important that this infrastructure is designed in a way that provides a therapeutic environment and supports the delivery of contemporary models of care.

352 In line with the Australasian Health Facilities Guidelines (**Guidelines**), creating a physical environment that supports recovery orientated mental health will involve:

a. creating a welcoming and supportive space that reduces stress, encourages family and friends to visit and allows consumers to continue, where possible, to undertake activities of daily living and participate in a range of activities;

b. supporting the development of therapeutic relationships and helping consumers to actively participate in their recovery;

c. enabling consumers to maintain meaningful engagement with family and friends;

d. providing space and resources to assist in self-management;

e. having access to spaces that enable holistic management of health; and

f. creating a safe environment that balances the principles of choice with duty of care and safety.[53]

353 Treatments and methods of care frequently change, as do the health needs of the populations served. As the needs of consumers change and models of care advance, it will be important that mental health facilities are able to adapt over time so that they can continue to support high-quality care into the future.

354 It is important for the system manager to have a state-wide view of infrastructure priorities to help to balance investment across the entire system and ensure resourcing is being directed at the areas of greatest need, including considering the investment mix between refurbishments and new builds. To do so, we need to:

a. understand the contemporary evidence about how built environments can support recovery;

b. identify whether any upgrades or refurbishments are required to existing assets to support high-quality care; and

c. collate this information centrally to inform investment decisions relating to service improvements.

355 When it comes to identifying capital upgrades required to support the modernisation of existing facilities, where possible I think it is best to design these as bottom-up processes – that is, drawing on an organisation's local knowledge of their asset conditions, in conjunction with contemporary design methodology. This will lead to better outcomes for services and consumers than using top down processes, such as centrally led audits.

356 Actively integrating mental health service and infrastructure planning with that undertaken for other general health services should also assist service providers in the way they think about and prioritise mental health during conversations about capital investment.

357 In responding to the Royal Commission's interim report the Victorian Health and Human Services Building Authority (**VHHSBA**) has been working with health services to help build acute mental health bed capacity across the North-West and South-West catchments.

[53] Australasian Health Infrastructure Alliance, *Australasian Health Facility Guidelines: Part B - Health Facility Briefing and Planning HPU 131 Mental Health – Overarching Guideline* (2018).

358 Informed by consultation with local health services, area mental health services, and co-design with people who have lived experience, this work has considered:

a. a system-wide view of demand, with modelling undertaken to identify relative gaps in bed supply across catchments and how best to integrate new supply into the existing service system, including emergency departments;

b. common principles for model of care within acute facilities including cohort streaming, improved access to therapeutic space, progressive approaches to de-escalation and restrictive practices; and improved staff experience and safety; and

c. a salutogenic approach to the design of high-amenity built environments that support recovery and perceptions of wellbeing.

359 More broadly, to enable the upkeep of mental health facilities into the future, I think it will be important for organisations to build their capacity to strategically manage their own assets. Health services are already responsible for ongoing maintenance of facilities. This approach is preferred as it prevents any perverse incentives for services to neglect maintenance, which can accelerate the need for major repairs or shorten the operational life of an asset.

360 Since the recent introduction of the Asset Management Accountability Framework (**AMAF**) under the *Financial Management Act 1994*, VHHSBA has been working with health services to educate and build their capacity in this regard, generating a focus on understanding and improving the governance and management of the health asset base.

361 With asset management practices decentralised, the Department does not have the data required at a macro or individual health service level to ensure and assure that all hospitals are maintaining and adequately managing their assets. VHHSBA's work will increase the visibility of asset condition, risk of asset failure and develop strategic investment patterns to minimise long term costs and avert service failures.

Concluding remarks

362 In this statement, I have reflected on opportunities for the Commonwealth and Victorian governments to work together to set the frameworks, systems and processes for a better integrated stepped care model of mental health services.

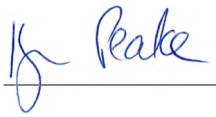
363 I believe this starts with a cultural shift to privilege the lived experience of service users and their families, incorporate the expertise of mental health professionals in defining best

practice care and engage with the non-clinical, social determinants of mental health and wellbeing.

364 Aligning incentives and removing barriers between health, mental health and social care, will be critical to changing the experience and outcomes of people in contact with the mental health system. This will require systematic changes to commissioning, funding models and measurement of outcomes. It will also require cultural and practice change amongst the many professions that help create the conditions for wellbeing and deliver mental health care.

365 It is my hope that these reflections will assist the Royal Commission in forming its final recommendations so that we are able to improve the experience and outcomes for people living with a mental illness, their carers and families both now and into the future.

366 I look forward to continuing to work with the Royal Commission, the Victorian community and most importantly people with a lived experience of mental illness as we seek to improve the mental health system and deliver on the intent of the inquiry.

sign here ► 

print name Kym Peake

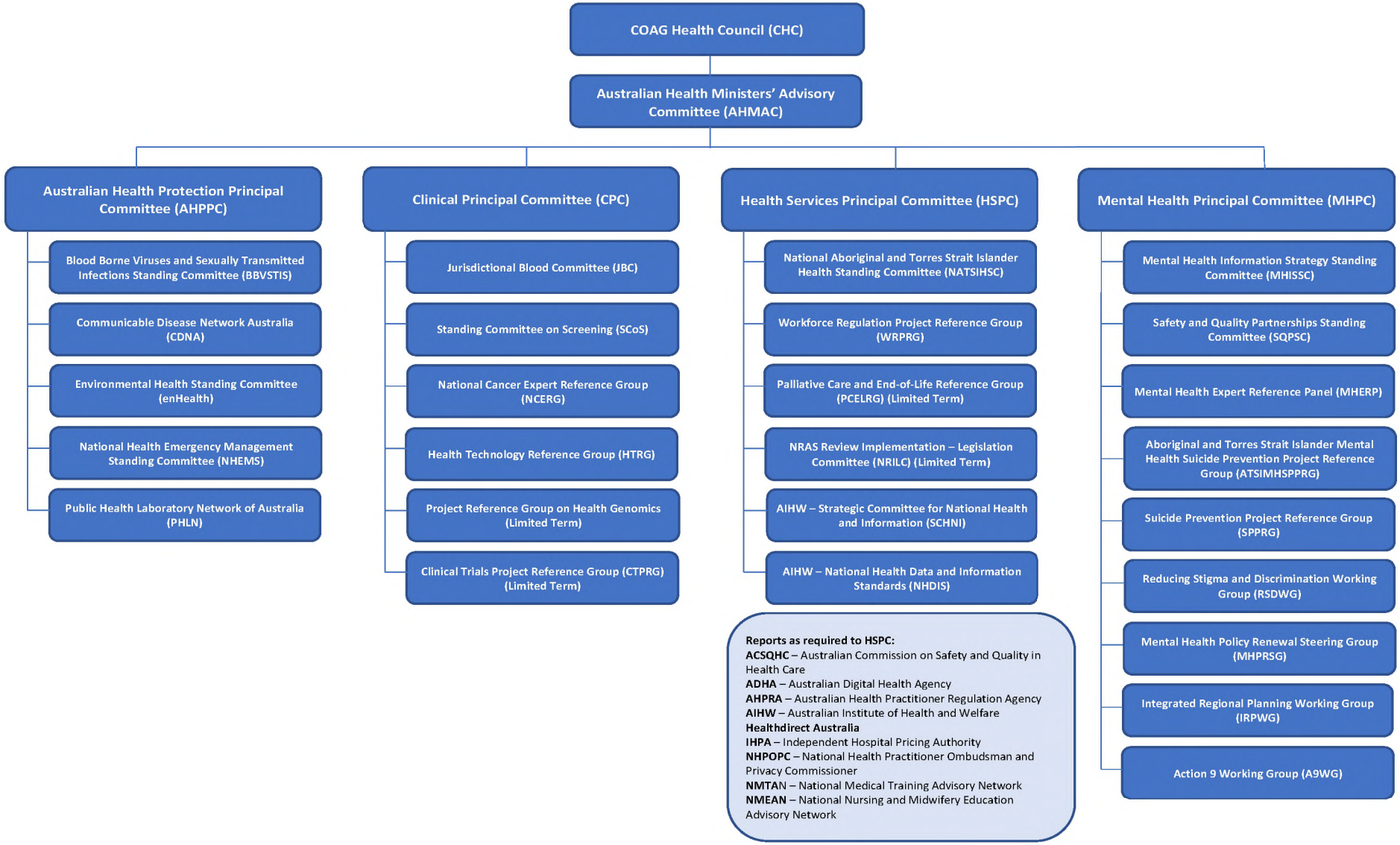
date 4 October 2020

Royal Commission into Victoria's Mental Health System

ATTACHMENT KP-1

This is the attachment marked KP-1 referred to in the witness statement of Kym Peake dated 4 November 2020.

The current structure for the COAG Health Council and the Australian Health Ministers' Advisory Committee is illustrated below. The stated purpose of these structures were to provide forums for continued cooperation on health issues and to advise on strategic issues relating to the co-ordination of health services, including operating as a national forum for planning, information sharing and innovation.


COAG Health Council (CHC)
Australian Health Ministers' Advisory Committee (AHMAC)
Australian Health Protection Principal Committee (AHPPC)
Blood Borne Viruses and Sexually Transmitted Infections Standing Committee (BBVSTIS)
Communicable Disease Network Australia (CDNA)
Environmental Health Standing Committee (enHealth)
National Health Emergency Management Standing Committee (NHEMS)
Public Health Laboratory Network of Australia (PHLN)
Clinical Principal Committee (CPC)
Jurisdictional Blood Committee (JBC)
Standing Committee on Screening (SCoS)
National Cancer Expert Reference Group (NCERG)
Health Technology Reference Group (HTRG)
Project Reference Group on Health Genomics (Limited Term)
Clinical Trials Project Reference Group (CTPRG) (Limited Term)
Health Services Principal Committee (HSPC)
National Aboriginal and Torres Strait Islander Health Standing Committee (NATSIHSC)
Workforce Regulation Project Reference Group (WRPRG)
Palliative Care and End-of-Life Reference Group (PCELRG) (Limited Term)
NRAS Review Implementation – Legislation Committee (NRILC) (Limited Term)
AIHW – Strategic Committee for National Health and Information (SCHNI)
AIHW – National Health Data and Information Standards (NHDIS)
Reports as required to HSPC:
ACSQHC – Australian Commission on Safety and Quality in Health Care
ADHA – Australian Digital Health Agency
AHPRA – Australian Health Practitioner Regulation Agency
AIHW – Australian Institute of Health and Welfare
Healthdirect Australia
IHPA – Independent Hospital Pricing Authority
NHPOPC – National Health Practitioner Ombudsman and Privacy Commissioner
NMTAN – National Medical Training Advisory Network
NMEAN – National Nursing and Midwifery Education Advisory Network
Mental Health Principal Committee (MHPC)
Mental Health Information Strategy Standing Committee (MHISSC)
Safety and Quality Partnerships Standing Committee (SQPSC)
Mental Health Expert Reference Panel (MHERP)
Aboriginal and Torres Strait Islander Mental Health Suicide Prevention Project Reference Group (ATSIMHSPPRG)
Suicide Prevention Project Reference Group (SPPRG)
Reducing Stigma and Discrimination Working Group (RSDWG)
Mental Health Policy Renewal Steering Group (MHPRSG)
Integrated Regional Planning Working Group (IRPWG)
Action 9 Working Group (A9WG)

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ATTACHMENT KP-2

This is the attachment marked KP-2 referred to in the witness statement of Kym Peake dated 4 November 2020.

Policies or strategies of the Victorian Government to improve the supply of housing and supports

1 In Victoria, the overarching strategies in place to improve the supply of affordable housing and deliver other housing supports includes:

a) the *2017 Homes for Victorians Strategy* – this is a whole-of-Victorian Government housing affordability strategy that sets out a path for working in partnership with the Australian Government and local councils, the community social housing sector, and the development and construction industries to support social and affordable housing.

b) the *2020 Aboriginal Housing and Homelessness Framework* – this framework sets out a blueprint to improve Aboriginal housing outcomes within a generation. Initial investment under this framework will support initiatives such as an Aboriginal-specific Private Rental Assistance Program, community engagement activities and exploring future investment in Aboriginal housing. It will also secure the continuation of the award-winning More Than a Landlord program, which provides life coaching and support towards education, employment and maintaining stable housing. The framework is the first self-determined strategic policy direction led and developed by the Victorian Aboriginal community

c) the *2018 Homelessness and Rough Sleeping Action Plan* – this action plan provides the framework for the Victorian Government's long-term response to rough sleeping and homelessness across the state.

2 These strategies are supported by a variety of investments to increase the availability of social housing and deliver other housing and homelessness supports – such as the Social Housing Growth Fund, the Public Housing Renewal Program and investment in the community housing and homelessness sectors.

3 In May 2020 the Victorian Government invested almost $500 million to build and upgrade community and public housing as part of the Building Works package. As part of the package, more than 23,000 social housing dwelling will be upgraded across Victoria.

Existing housing and support in Victoria for people living with mental illness

4 The Department and funded community service organisations provide housing and support to Victorians most in need. These services include long-term housing programs as well as temporary accommodation and homelessness support.

5 There are also specific housing and support programs targeted at people living with mental illness through the public housing, community housing and homelessness sectors, as well as programs that aim to support individuals to maintain private sector housing. These programs are outlined below.

Name	Description
Youth Residential Rehabilitation Services	These services provide psychosocial rehabilitation support to young people aged 16-25 years with a mental health condition, including those with an emerging or existing psychiatric disability, in a residential setting for up to 12 months. The aim of this service is to assist the young person to: better cope with and manage their mental illness and other physical health needs; build practical life skills and confidence for independent living; develop and or maintain meaningful relationships with family and friends; and participate in education, vocational training, employment and other community activities the young person is interested in. There are 17 of these services across Victoria. This service is out of scope for the NDIS.
South Melbourne Community Capacity Building initiative	This new social landlord model integrates tenancy and property management, individual and community development and specialist mental health support services at three public housing estates in Victoria. The mental health component prioritises residents with mental health problems, behaviours of concern and complex needs and assists them to better self-manage their mental illness, connect with local services and sustain their housing.
Barwon Mental Health Housing and Support Initiative	This is a new initiative that will provide transitional housing (up to three months) augmented by tenancy management and psychosocial supports to eight clients experiencing homelessness or high risk of homelessness on discharge from acute mental health inpatient services delivered by Barwon Health.

Name	Description
Homeless Outreach Mental Health Service	This demonstration model provides individualised multidisciplinary supports on an assertive outreach basis to people sleeping rough in the Melbourne CBD who have highly complex needs associated with their mental illness. The initiative is delivered in a partnership with Inner West Area Mental Health Service and Launch Housing and aims to improve the mental health and functional capacity of clients and create pathways to long-term housing.
Wadamba Willum	This service provides holistic, intensive outreach support to 30 Aboriginal and Torres Strait Islander people at any one time who are experiencing homelessness and mental illness. The program employs a trauma-informed approach and engages clients in a strong therapeutic relationship to assist them to reduce the impact of trauma on their daily life, engage in meaningful treatment and create a pathway out of homelessness. The program works with Aboriginal people from the Darebin and Whittlesea LGAs and is delivered through a partnership involving Neami National, the Victorian Aboriginal Health Service, Uniting Care ReGen and Northern Area Mental Health Service.
Joined up Initiative	Select non-government mental health providers have nomination rights over direct tenure housing and transitional housing. This initiative fast tracks clients who are experiencing a severe mental illness, associated psychosocial disability and homelessness to public housing. The client receives housing which is augmented with psychosocial supports (which going forward will be provided by the NDIS or through initiatives such as the state funded Early Intervention Psychosocial Support Response).
Doorways	This housing and recovery program supports people experiencing mental health issues who are at risk of or experiencing homelessness to secure and sustain a home within the private rental market and build their capacity to better self-manage their mental illness and tenancy.
Transition Housing, including mental health pathways	The Mental Health Pathways Initiative is aimed at providing pathways out of homelessness for people with a serious mental illness and complex needs through provision of specialist support packages and allocation of targeted transitional housing stock.

Name	Description
Rough Sleeping Action Plan: Supportive Housing Teams	This initiative provides targeted support to individuals with a history of chronic homelessness and rough sleeping. The supportive housing teams consist of staff with a range of skills and disciplines, including peer support workers, social workers and community mental health nurses. The support provided includes clinical interventions addressing people's mental health needs and emerging issues.
Rough Sleeping Action Plan: Modular Units	The modular units provide multi-disciplinary support to assist residents with histories of recurring homelessness and sleeping rough to achieve housing stability, improved personal wellbeing and social connectedness. Modular based support workers work with supportive housing and assertive outreach teams to complement tenancy and property management services delivered by registered housing services.
Rough Sleeping Action Plan: Assertive Outreach	Assertive outreach teams use persistent, street-based, and person-centred engagement to offer a continuum of integrated support. To be eligible for the services provided by assertive outreach teams, clients must have experienced recent or past episodes of chronic homelessness including sleeping rough, experienced homelessness that is symptomatic of complex needs including mental illness and persistent systems failure and demonstrated links to, or a desire to establish links to, community and services.
Elizabeth Street Common Ground	Common Ground is a permanent supportive housing initiative for people who have experienced long-term homelessness. There are 65 studio apartments and on-going support is provided to improve residents' health, wellbeing and lifestyle. Support workers offer residents 24-hour support to ensure they get the care and support they needed to live better lives.
Supported accommodation services	The Department funds several supported accommodation services through the MHCSS program. They include: **Rooming House Plus –** Sacred Heart Mission is funded to provide on-site psychosocial supports targeted to 29 tenants of the South Melbourne Rooming House who have a mental illness. The initiative also provides general support to the balance of tenants who have a history of homelessness with complex health and social support needs.

Name	Description
	McAuley Community Services for Women – this is a 10-bed women's only Support Accommodation Service for people with a history of homelessness and/or family violence who have mental health and substance misuse issues. **Bethlehem Community** – this is a 10-bed service targeted to single women over 35 years experiencing multiple issues related to homelessness or risk of homelessness including mental illness, substance misuse, brain injury and physical illness. This service is managed by Sacred Heart Mission.
Haven Foundation	In 2019, the Victorian Government allocated funding to the Haven Foundation to build two new housing developments to provide long-term supported accommodation for people with significant and persistent mental ill-health. These new residential developments will be located in the outer Melbourne areas of Whittlesea and Wyndham and build on existing sites in other locations across Victoria. Support for these residents is via the NDIS.
Support for High Risk Tenancies (SfHRT) program	This program offers a central point of coordination, advocacy, brokerage and consultation to public housing care teams. When a consumer presents as acutely unwell or requires psychosocial support, this program can provide an immediate response and referrals to mental health services for earlier and more connected support.
Tenancy Plus program	This program supports social housing tenants to maintain their tenancy. The program is aimed at establishing successful tenancies or intervening when tenancies are at risk. This can include through providing advice, help with legal issues, financial counselling and referrals to other services. Tenancy support services do not specifically target people with poor mental health, but mental ill-health is a common reason for seeking support.

Royal Commission into Victoria's Mental Health System

ATTACHMENT KP-3

This is the attachment marked KP-3 referred to in the witness statement of Kym Peake dated 4 November 2020. It provides an overview of possible funding models.

Model	Examples	Benefits	Drawbacks
Block funding Funding to a service provider without a relationship to outputs, outcomes or population needs, typically based on prior funding levels	Small rural hospitals Aboriginal Community Controlled Health Organisations	Simplicity Flexibility Incentives for efficiency and prevention (savings from reduced cost and demand can be retained) Low administrative burden	Incentive to under-service No incentive for quality Likely to be inequitable (no link to services or health needs) Does not reduce unwarranted clinical variation (no link to cost or outputs) Low transparency for funder Uncertainty (arbitrary changes in funding is possible) Status quo bias
Fee-for-service Funding is based on the type and amount of services delivered	Medicare Benefits Schedule (MBS) payments Activity-based funding for hospitals	Transparency Promotes activity Strong incentive to reduce cost	Incentive to over-service (e.g. low value care, retaining less complex care in high-cost settings) No incentive for quality Difficult to account for cost drivers beyond the control of services (e.g. diseconomies of scale, built form constraints)

			Prices require regular updating based on changes in practice, input costs and clinical evidence Risk of skewing activity towards remunerative treatments and gaming or misreporting (e.g. 'upcoding' to more costly types of care) Some variants (e.g. activity-based funding) are complex and costly to administer
Population based funding Funding based on the health needs of a catchment	Aspects of Primary Health Network funding	Simplicity Flexibility Certainty and stability Low administrative burden Incentives for efficiency and prevention Equitable (if appropriate adjustments are made for factors such as age, ethnicity, and socioeconomic status)	Incentive to under-service Challenges defining populations and accurately calculating needs
Capitated funding Funding for enrolled people based on their anticipated	HealthLinks: Chronic Care	Strong incentives for quality and prevention	Financial risks for providers, especially if risk stratification is not accurate enough, or risk pools are small

health care costs (risk stratified)	Private sector residential aged care	Incentive for efficiency Transparency Promotes continuity of care Reduced incentive to 'cherry pick' low risk patients (if risk stratification is reliable)	Disincentive to treat high-risk patients (if risk stratification is unreliable) Requires independent assessment of needs to address conflicts of interest Can reduce flexibility for patients to move providers Administratively complex with high reporting burden
Pay for performance (PfP) Funding linked to performance measures	GP practice incentives	Focuses effort on measures relevant for funder Compatible with a wide range of funding models	Can create perverse incentives to focus on PfP metrics to the detriment of access, quality or outcomes Unlikely to provide the required resources to improve practice when there is poor performance Measurement and reporting can be complex depending on performance measures
Bundled payments Funding for a series of linked services, such as a pathway of care	Commonwealth Health Care Homes initiative	Incentive for quality Incentive for efficiency Reduces unwarranted clinical variation Promotes integration of care	Financial risks for providers, especially if risk stratification is not accurate enough, or risk pools are small Disincentive to treat high-risk patients Prices require regular updating based on changes in practice, input costs and clinical evidence Administratively complex