MS NICHOLS: Good morning, Commissioners. The next witness is Mr Andrew Greaves, the Auditor-General of Victoria. I call him now.

<ANDREW MARK GREAVES, sworn and examined: [10.02am]

MS NICHOLS: Q. Mr Greaves, are you the Auditor-General of Victoria?
A. I am.

Q. Before your appointment in 2016, were you the Auditor-General of Queensland between 2011-2016?
A. I was.

Q. Before that, did you hold various roles in the Victorian Auditor-General's Office?
A. I did.

Q. What did they include?
A. I was the Assistant Auditor-General in charge of the Performance Audit Group more recently, and before that the Assistant Auditor-General in charge of the Financial Audit Group.

Q. Have you had over 30 years' experience in the public sector in external and internal auditing at federal, state and local government levels?
A. I have.

Q. Have you prepared a statement at the Royal Commission's request?
A. I have.

Q. I tender the statement with its attachments. [WIT.0001.0064.0001] Mr Greaves, could you explain briefly, what is the role of the Auditor-General as an independent officer of the Victorian Parliament?
A. The primary role of the Auditor-General is to provide assurance to the Parliament about the efficient and effective operation of the public sector, and in discharging that role I undertake two important functions: my office undertakes financial audits which examine and report on the reliability of financial information that's reported by the public sector, but my office also undertakes performance audits. In that performance audit function we examine variously, either at an entity or program or activity level, the efficiency, economy and
effectiveness of those various activities and the extent of their compliance with laws and regulations.

Q. What's the relationship between the Auditor-General and Parliament?
A. I am an independent officer of the Parliament, and that is set out in the Constitution Act of Victoria. I have a relationship with an oversight committee, which is the Public Accounts and Estimates Committee. In relation to the Public Accounts and Estimates Committee, they oversee both my budget and my annual work and I must consult with that committee on both of those matters.

Q. What's the relationship between the Auditor-General and the executive arm of government?
A. The intent, as described and set out in the Constitution and also in the Audit Act, is that I cannot be directed in the discharge and performance of my duties and functions. The intent there is that, as an independent officer of the Parliament, I am separate from, and independent of, the executive.

Q. The Auditor-General is not permitted to comment on the merits of government policy; is that correct?
A. That's correct. There's actually a legislative provision in the Audit Act itself which precludes me from commenting on or questioning the merits of government policy objectives. I take that as therefore a prohibition generally, whether in a report or in public, on questioning the merits of government policy objectives.

Q. Thank you. Your office has recently published two audit reports in relation to the Mental Health Act and the mental health sector: the first being Access to Mental Health Services published in March 2019, and the second being Child and Youth Mental Health published in June 2019, and those two are annexed to your statement?
A. They are.

Q. Can I ask you about the Access Report first, what was objective of that audit?
A. The primary objective of the Access Report, as the title would suggest, was to understand to what extent those who require it have access to mental health services in Victoria.

Q. What was your overall conclusion, Mr Greaves?
A. I'll now refer, if I may?

Q. I'll direct you to paragraph 21 of your statement, if that assists?
A. That will. The overall conclusion was that the Department of Health and Human Services has done too little to address the imbalance between demand for and supply of mental health services in Victoria.

Q. And in substance, what were your findings in brief?
A. The major findings: a lack of sufficient and appropriate system level planning, investment and monitoring over many years. That the current 10-year mental health plan outlined few actions that demonstrate how the Department would address the demand challenge that the 10-year plan articulates.

That the priority informed areas identified in the plan do not adequately reflect the underlying issue of lack of system capacity and, as a result, the Department has made almost no progress in addressing the supply and demand imbalance.

That there are few measures in the outcomes framework for the plan that directly capture performance against providing access to services or increasing service reach.

That there is sufficient evidence that there are not enough mental health beds in Victoria to meet current or future demand.

That advice from the Department to government, supported by multiple Departmental Commission reviews, clearly articulates the existing funding and infrastructure gaps, but the Department's progress has been slow and the most important elements of change such as funding reform, infrastructure planning, catchment area review, and improved data collection have only just or not yet commenced.

That the Department has made little progress closing the significant gap between Area Mental Health Services costs and the price they are paid by the Department to deliver mental health services.

And also, in addressing historical inequities in funding allocations that do not align to current
populations and demographics.

That the bed day costs of the AMHSs are higher than the price DHHS pays, and they do not receive the necessary funding to meet demand.

That there are shortcomings in the data collection system including lack of functionality and low usability, which often results in duplication of data collection.

That the Department's approach of approximating demand gives rise to a significant risk that, without the inclusion of data from the triage system and unregistered clients, the Department does not adequately capture the extent of mental health illness in the population and the true unmet demand.

That the public mental health services are subject to an input-based funding model which is not sensitive to unmet demand, the needs and complexity of the mental health services client cohort, contemporary population data and all demographic changes.

And that the introduction of activity-based funding in mental health services has been on the agenda in Victoria for over five years and, although some reform has been proposed, without adequate quantum of funding and the staff and infrastructure required to deliver those services, there is a risk that the intended outcomes will not be achieved.

Q. Thank you, Mr Greaves. We'll return to those shortly. Can I now ask you about the Child and Youth Mental Health Report. What was the objective of that audit?
A. The objective of that audit was to determine whether child and adolescent mental health services effectively prevent, support and treat child and youth mental health problems. We focused on clinical mental health services for young people with moderate-to-severe mental health problems.

Q. What did you find overall?
A. Overall, that not all Victorian children and young people with dangerous and debilitating mental health problems received the services that they and their families need.
Q. What were your further findings in substance?
A. In substance the key findings were that specialist
child, adolescent and youth mental health services do not
meet service demand or operate as a coordinated system.
There is no strategic framework to guide and coordinate the
Department or health services that are responsible for
child and youth mental services, CYMHS. Problems with the
CYMHS performance monitoring system created oversight gaps
for the Department, which leaves it unable to address
significant issues that require a system level response.

The Department does not sufficiently understand the
system and the challenges it faces; its lack of
understanding contributes to a climate of uncertainty and
distrust, which inhibits systematic improvement and creates
significant variability and inequity in the care that
children and young people receive.

The Department has predominantly taken a one size fits
all approach to mental health systems' design and
monitoring which does not adequately identify and respond
do the unique needs of children and young people.

Q. Now, Mr Greaves, the recommendations in your report
directly addressed the issues that you found, but you've
said in your statement to the Commission that often issues
of that kind are symptomatic of some deeper causal problem.
You've conducted a root cause analysis of sorts and
identified two factors that you say are systematic and are
worth considering: can you say what they are?
A. The two factors which I see as root cause factors, and
so first order factors, relate to the role of the
Department in a devolved service delivery environment, and
the second one is the performance measurement framework and
systems that are used to monitor and measure performance.

Q. Can you address the role of the Department first and
say why you think that is a first order issue?
A. The reason I came to that conclusion was, not just
looking at this report, but looking at other reports that
we have tabled variously since 2005 that relate to the
Department and also to reports that other people have also
tabled in relation to the Department, such as the Duckett
Review; which point to a longstanding debate, if you like,
about what is the proper role of the Department as the
systems steward, as it is now variously described, or the
system owner, vis-à-vis the service delivery arms which are

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the health services themselves and those that are out in
the community health space.

So we asked ourselves during those two reports that
we've mentioned why certain actions hadn't been taken, why
reviews and reports had continually raised issues, and yet,
there did not seem to be any response to those issues.

And in those reports and in other reports that I
referred to, such as most recently the report we did on the
right of private practice arrangements in public hospitals,
we have often had the response that "it is not our role",
this being the Department, "it is not our role". And
variously when we ask, in terms of that role, the one
factor that in my experience stands out is the monitoring
and oversight of the system.

I know previous Auditors-General have characterised
this as an oversight deficit. And so, we've had a debate,
a longstanding debate between Auditors-General and the
heads of those agencies about, to what extent is it
necessary and appropriate for the centre, the Department,
which effectively sets policy, sets strategy, funds the
system, to then monitor and oversight the system to
understand to what extent strategy is being given effect
to, how well those funds are being used.

But more importantly, in the context of providing full
and frank advice to the government of the day, how well
informed is the Department about present system capability
and present system performance.

And it's not consistent, but variously we've had these
debates over the years about, to what extent should I be
monitoring, I being the Department, to what extent should
we be monitoring, to what extent should we be oversighting?

Quite often we hear, "Well, it's a devolved system",
and in the devolved system we let the managers manage.
It's not appropriate for us to say how they should spend
their money. We don't always see that policy consistently
applied anyway.

But my deeper and perhaps more systematic problem that
I have with this goes to this whole issue of appropriate
accountability: where should the accountability lie for the
outcomes that are being achieved by the system?
And the features that I see specifically that are exhibited in the health and human services system relate to the funding of that system, and in two parts: the operational funding - my reports identified that the amount of funds that are being provided to the health services do not cover the cost of the provision of those services.

The other feature of this system, of course, is that the capital funding is entirely controlled by the Department, that the health services obtain operational funds but capital funding is a separate matter. So, in terms of planning for infrastructure and delivery of infrastructure, accountability should properly rest with the Department in my estimation, and I also wonder how you can properly hold the health service to account, knowing that you haven't fully funded them to deliver the services you've asked them to deliver.

And, while it is appropriate to say that the hospital is the best place to manage access, they are in one sense best placed to manage access because they are the service providers, but in another sense, if they have to effectively rob Peter to pay Paul to actually pay for that, then they're not best placed to manage access, so the system owner must take some accountability and responsibility for that. And so, this to me is a systematic matter that we need to consider in the whole design of the system: where does the accountability sit?

Q. Can I just take you back, Mr Greaves, and ask - and you've been expressing a number of these things in the form of questions: can I ask for your views about where the accountability should sit, or perhaps put a different way, you referred to an oversight deficit before. What should be the characteristics, in your assessment based on your experience, of the oversight and leadership function of the Department in relation to mental health?

A. Well, oversight is predicated on obtaining the performance information you need, the service performance information you need, to understand service performance, and of course to obtain information about the outcomes or the impacts of the delivery of those services.

So, accountability must sheet home to the Department, for establishing appropriate systems, to capture that information and aggregate that information. I note in the
Child and Youth Mental Health Audit that we undertook an
analysis of three years worth of data across five health
services, and my team advised me that this was the first
time that that data had actually been analysed. And, of
course, I wondered to myself, why would that be the case?
This data has been available.

And while individual health services may have it
within their own power to analyse their data, they don't
have it within their power to join their data together and
take a system view, and so again, accountability for that
system performance must sit with the Department in terms of
its oversight role.

Q. Can I ask you about the debate that you mentioned, the
ongoing one between the Auditors-General and the
Department. I think you've expressed the Auditors-General
position generally. As you understand it, and the
Department will speak for themselves later today, but just
historically what has been the division point in the debate
between Auditors-General and the Department?
A. Well, quite simply, a disagreement about this need to
oversight system performance. It really goes to a devolved
service delivery model and what is the proper role of the
Department in that. I might say that this is not just a
feature in my experience of mental health or human services
in health generally, it's a feature more broadly of
government where the centre is less inclined to want to
take responsibility for the delivery of services.

Q. In relation to the question of performance
measurement, in your statement you said:

"The Department's mental health KPIs do not
assess whether consumers are accessing
appropriate mental health services or track
the performance of their 10-year plan in
terms of access Victorians have to mental
health services."

That wraps up two concepts: the first is related to
KPIs, can you tell the Commissioners what you mean by that?
A. What KPIs are, or what we mean by --

Q. No, what you mean by your conclusion that the mental
health KPIs do not assess whether consumers are accessing
appropriate services?
A. Well, basically when we looked at the suite of KPIs, we couldn't find ones that spoke to that. The predominant objective of the Access Audit was to evaluate access.

Q. Access, yes.
A. And obviously in the mental health plan, when we read through it, it was made clear that there was a major issue in terms of access because of the growth in demand, and so, we would expect in any performance indicator framework given that this was specified as one of the major challenges for the system, that you would want to have a good suite of indicators that spoke to access, so it was the absence of indicators.

Q. In your assessment, what kind of performance indicators would be capable of better assessing access?
A. In the report we referred to some other indicators that could speak to access, and we're particularly interested in the data that may and should be being captured by triage services about the people that are denied access. So, to me, that is a prime indicator and something that I would be interested in understanding more, particularly to understand the unmet demand.

Q. You also say in your report that getting the right performance indicators is only really half of the story. The other one is what you measure, and you've said that, if performance indicators are to be used to drive strategy and evaluate the effectiveness of planned actions, they must have targets against which progress can be measured: can you elaborate on that?
A. Indeed. Yes, and my concern here is, and we go back to systematic issues, we can see through the mental health plan that we've been working on outcome measures and outcome indicators now for a number of years, but not informed by any overarching government policy or strategy in relation to an outcomes framework.

Most recently we are aware through the Department of Premier and Cabinet that an outcomes framework document has been published.

My concern, looking at both the outcomes that were expressed in the mental health plan and the outcomes that are now being expressed more recently in the strategic plan of the Department and its new outcomes measures framework, and in the government's document about the outcomes
framework more broadly, there is very little, if any, reference to targets. So, we are concerned, or I am concerned, that in the absence of targets it would be difficult to discern a range of matters.

First and foremost, what is the performance gap? What is it that we're actually trying to achieve? So we can have an outcome measure, we can have an output measure, but if we're not saying to ourselves, what do we want to achieve, and in what timeframes such that you could express a target as a three-year target or as a 10-year target, or in fact both, you could express a target on a final outcome, for example the government in its suicide prevention strategy has articulated a 10-year target of reducing suicide by half.

So, it is not as though targets have not been expressed, but the frameworks that are being promulgated and the outcomes documents that I have seen seem to avoid targets. So, how will the outcomes framework be something that organises a response that allows us to make funding decisions in the absence of a target?

So that's my primary concern. I think in any outcomes measurement framework, you need obviously to express the outcome you desire but, if you don't actually tie a target to it, I think you're missing a key part of the accountability equation.

Q. What, in your view, are the characteristics of useful targets?
A. Well, the characteristics of useful targets first and foremost stem from the characteristics of useful indicators. In Victoria, of course, we've had an output based budgetary framework for a number of years, but that has focused on service outputs: time, cost, quantity and quality, and have had targets expressed in them, but I must say some of those actually speak a bit more to outcomes to me than they do to outputs.

Q. Can you give an example?
A. I could actually refer to the Budget Paper 3 which has the mental health outcomes expressed - or output statement expressed in it, if I could find that.

Under a quality measure in BP 3 - this is from the 2019/2020 service delivery statements on p.208 - one of the
quality measures is new client index. Now, that new client
index has actually been described in the outcomes framework
that's been promulgated by the Department.

So, first and foremost, I'm seeing, we're developing
an outcomes framework here, we haven't really gone back and
thought about the outputs framework and the interaction
between the two. And so, there's probably some
rationalisation required and maybe the Secretary of
Treasury and Finance could speak to how the new outcomes
framework is being integrated and coordinated with the
outputs budgetary framework. But that outputs framework
has long had targets.

When we come to outcomes, in my experience people
don't like expressing targets for outcomes because outcomes
typically take a long time to emerge, and they'll emerge in
a longer timeframe than normal political cycles, so you can
understand a natural reluctance to express an outcome,
because you can't necessarily demonstrate improvement.
Sometimes the actions that you take now may take, three,
four, five, seven years to actually show an impact, which
shouldn't be a reason for not expressing the target, and
I've mentioned the suicide target. But what we should try
to do when we're defining a good target is to define a good
measure.

In New Zealand, not more recently with their wellbeing
budget but the performance measurement framework that
preceded that, they had most success in defining
intermediate outcomes, and the idea of an intermediate
outcome, or part of one of the ideas of an intermediate
outcome, is that the time between the action and the effect
is less.

And so, for example, access to mental health services
is a good intermediate outcome. If I can get those people
who access mental health services up from the 1.1, 1.3,
1.5 per cent, whatever the figure is, to 3 per cent, which
is the estimate in the population of people that require
access, that is an intermediate outcome.

I can express that, I can express a clear target in
relation to that intermediate outcome and I can tie back
actions that we're taking to move that rate up to
3 per cent. So, yes, a target to me should be quite
specific, clear, measurable, but I think it's best
expressed in this new framework as intermediate outcome targets rather than final outcome targets.

In fact, you could mount an argument that you shouldn't have a final outcome target per se, because it is so uncontrollable, there are so many confounding or conflating variables that you can't really mobilise around that target.

Q. If that example is an intermediate outcome in your hypothetical world, what would be the ultimate outcome by reference to that intermediate outcome?
A. Well, I think the ultimate outcomes are expressed in the framework at the moment: the improved mental health of the Victorian population and the reduction in the suicide rate. You will see those also referred to in the report on government service delivery outputs framework. So I think there's not much debate about the long-term final outcomes we're trying to achieve, but let's make sure we're really clear on what the intermediate outcomes are and link those to the outputs.

Q. And in your view they should be linked to the outputs including for the purposes of Budget Paper 3?
A. I'm trying to discern how the outcomes framework as it's currently designed - and I haven't audited this yet so this is my observation based on what I've read - I'm struggling to understand how it will feed into the budgetary process.

Again, if I reflect on the New Zealand experience with their 10 key result areas, absolutely focused on intermediate outcomes, and funding was directed towards achieving those. We were all - well, not all of us, but Jacinda Ardern was here last week talking about the new wellbeing budget which seems, again from a distance, to try and enshrine the idea of tying the budgetary process to the outcome.

People will have different views, and governments will have different views, about whether we need an outcomes budget framework or an output budget framework. I'm not barracking for either one: you know, is it still appropriate to fund outputs to, say, the services that are delivered and have your funding directed toward the delivery of outputs; but, in making those decisions about which outputs are provided, the design of the output, the
quality of the output, you can be driven by considerations of the outcomes you're trying to achieve and the priorities.

Now, that's the other thing in my estimation that's presently missing, that the Department has done good work in this outcomes space and the mental health plan is articulating outcomes, and these more recent strategic plans and strategies are articulating that, but I don't have a sense yet of any top-down strategic prioritisation by the government. So, it's good to articulate outcomes down at an individual agency level, but where do they fit in terms of the government's overall priorities? And that also seems to me to be missing from the current outcomes framework.

Q. I see. And, it's the Department's role to articulate that framework including the links between outputs particularly?
A. Well, I think it's more than the Department's role; I think it's the public sector's role to advise the government on the appropriate design of an outcomes framework, and if the words that we read in the outcomes framework are to be given effect, that it's going to mobilise resources, that it's going to help drive actions, there must be some linkage then into the budgetary process. So, I think it's incumbent on the public sector generally to advise government about the appropriate design of this framework.

Q. Can I just ask you a question about targets finally. Ms Peake will give some evidence later today about targets, and she'll say this:

"There are important limitations in the use of targets, especially for complex service systems. These include risks that numeric targets [among other things]: prioritise actions that are more easily measurable ... change peoples' behaviour, with perverse results; narrow a reform focus, inhibiting system level integration ... are set to the wrong driver ... [and] reduce flexibility to changing evidence or contexts ..."

Do you have any observations on that evidence?
A. My first observation is that the risks that are articulated there are within the control of the agency and within the control of the government.

So, simply saying that there are risks attendant upon setting targets is not a reason not to set targets. If we've named the risk, we manage the risk. Yes, and we have seen measures, more importantly, than targets that can create perverse behaviours.

So, it's in the design of the measure and the setting of the target that is what is important, but again, I wouldn't argue that's a reason not to set the target, because the benefits of setting targets which really are supposed to drive action, drive strategy, track progress, in my estimation far outweigh the risks associated with setting targets.

MS NICHOLS: Thank you, Mr Greaves. Chair, do the Commissioners have any questions?

CHAIR: Q. I might start then. Thank you very much, Mr Greaves, for your overview and for your submission and attached information.

When we look at this issue about accountability within the public sector for service delivery design, implementation and the like, the way that you've described it, given you have a whole-of-government view, can you assist the Commission by identifying where you've seen good practice that you would alert us to and where you think the accountability frameworks are operating well.

MS NICHOLS: Chair, could you speak closer to the microphone?

CHAIR: Do you want me to repeat the whole lot?

THE WITNESS: No, no, I got that, Chair.

CHAIR: Q. So, really where there are examples of best practice, you use New Zealand, but closer to home in the Victorian public service, for example, or elsewhere in Australia?

A. I mean, I use New Zealand because it's the most recent and obvious example. I'm not sure that I can point to better practice. Given what I've said about the current
limitations of the outputs framework and the nascent outcomes framework in Victoria, I don't think there's areas that I could really point to that would speak to this being done well.

One of the features of the New Zealand framework that I'm attracted to, and there was actually an evaluation done of this, a report on it, talked about "blind accountability".

What that related to was that, we spend a lot of time trying to - or get very vexed about trying to attribute actions to outcomes, and the point of the New Zealand framework was that, don't get caught up in attribution, and yes, it's going to be unfair, but where you have issues that are cross-government, basically the important thing is to get collective responsibility and accountability for an outcome and get the resources mobilised to deliver on that outcome, and whether or not your organisation contributes 5 per cent of the outcome or 95 per cent of the outcome is actually irrelevant at the end of the day.

So, there's unfairness in it, but the evaluations in New Zealand suggested that nevertheless it worked, and that they could point to improvements in those areas that they focused on, those 10 key result areas.

So, to me, that is still a model of better practice. Now, we have here the Victorian Secretary's Board, and we have conversations now about 1 VPS, and we are moving to bring together our administrative datasets, aggregate them and analyse them, so I think they are all pointers in the right direction, but I still see missing from this overarching, top-down prioritisation of outcomes.

Q. Can I also go back to the fact that, obviously the Commission's had the opportunity to read both of the reports that you've recently tabled in relation to mental health. In both of those reports you make a number of recommendations for change that you think need to occur in the short term as well as over the longer term.

What role will you have in following up in terms of where action is at on those recommendations, and are you already engaged in dialogue about that?

A. We're engaged in dialogue to this extent: the practice of my office now is to annually write to every agency that
we make recommendations to and ask them to update us on how
they are going implementing those recommendations.

I propose this year in fact to make that report
public, so we'll be writing to all agencies, including DHHS
and those involved in those two audits, we'll be asking
them to tell us what they've done, what action they've
taken, whether they continue to accept the recommendation,
or whether or not our recommendations have been overtaken,
for example, by the Royal Commission, with a view to making
that a public document.

Q. Given the nature and extent of some of the concerns
you expressed in both of those reports, both about the
access and the overarching system around child and
adolescent mental health, do you have a sense of what's a
realistic timeframe whereby you would like to see
improvements across those service systems addressing the
issues you've highlighted?
A. To answer the question, what is a realistic timeframe,
it really needs to consider what is the funding available
and the priorities of the government. So, I don't think
it's for me to try and second-guess where the government
may want to put its funding against all its other
priorities, and so, it's probably not appropriate to
speculate what would be an appropriate timeframe. Clearly,
those who aren't getting access would like access now.
Now, that's not achievable given what we understand to be
the limitations in terms of infrastructure, funding and
staffing.

To what extent the government mobilises resources to
address the infrastructure deficit, the workforce strategy
being implemented and the funding of the services, will
then impact on how long it actually takes to address it.

Q. Can I confirm from that, your expectation, though, is
that the Department would have a plan that it would put to
government about how it thinks it should address your
concerns?
A. Absolutely. We think the Department should always
have a plan because it's already been informed over a
number of years about the problems in this. So, yes. Most
recently, our report's raised it again. We would expect
that there would be a plan which would be timed and
resourced, I guess, is the more important matter.
CHAIR: Thank you.

MS NICHOLS: May Mr Greaves be excused?

CHAIR: Yes, thank you very much for your witness statement and evidence today, Mr Greaves.

THE WITNESS WITHDREW

MS COGHLAN: The next witness to be called is Felicity Topp, and I call her now.

FELICITY ANNE TOPP, affirmed and examined: [10.40am]

MS COGHLAN: Q. Thank you, Ms Topp. You've made a statement to the Commission?

A. That's correct.

Q. I tender that statement. [WIT.0002.0021.0001] You are the Chief Executive Officer of Peninsula Health?

A. That's correct.

Q. And you have the following qualifications: a Diploma of Applied Science in Nursing?

A. Yes.

Q. A Critical Care Nursing Certificate?

A. Yes.

Q. A Bachelor of Nursing?

A. Yes.

Q. A Graduate Diploma in Health Counselling?

A. Yes.

Q. A Master of Public Health?

A. Yes.

Q. And a Vincent Fairfax Fellowship in Ethical Leadership?

A. That's correct.

Q. You started your career as an intensive care nurse?

A. Yes.

Q. You have 34 years of experience in the public health system to date?
A. That's right.

Q. You have been in management and leadership roles for approximately 50 per cent of that time?
A. That's correct.

Q. Being since 2001?
A. That's right, so I've worked mainly in operational roles in my leadership experience, and I've been in a Chief Executive role for the last 18 months.

Q. Can I just ask you about that in terms of, you say in your statement that your experience with the mental health system has been with two public health services. You've just mentioned your current role; what about before that?
A. So, interestingly, I've had the experience across the whole health system in that time, but my exposure to mental health has been quite limited. I had a three-month secondment to Barwon Health back in 2017 to assist them through a significant period of change, and I was given the opportunity to take on an executive leadership role for the mental health service over that three-month period. And now as a Chief Executive Officer, we've got a large mental health service down on the Peninsula.

Q. How long did you say you'd been the CEO of Peninsula?
A. Just on 18 months.

Q. But you do come to that role with extensive experience in health generally?
A. Absolutely, yes.

Q. Can I just ask you some questions about the operations of Peninsula Health, we won't spend much time on this, but just to get an idea of the services. Firstly, just in relation to delivery of public health care services and the catchment, just address that issue?
A. So, we provide health care services across the continuum of care; I kind of describe it as birth to end of life. We have 850 square kilometres along the Peninsula, from Carrum, Langwarrin, all the way down to Portsea and then across to Hastings. The service has 6,000 employees, 800 volunteers, and like I said, we provide a continuum of care. We've got aged care services, mental health services, acute services, community services.

Q. Can I just direct your attention to the mental health...
services, and can you just broadly summarise what they are?
A. So, we have an acute inpatient unit and a high
dependency unit, aged care inpatient unit, psychogeriatric
service. We have a number of community mental health
services. We have some specialist services and residential
services.

Q. Could I ask you about a particular aspect of your
statement where you say this:

"Until March 2019 mental health services at
Peninsula Health were overseen by a Chief
Operating Officer."

But things have changed since that time?
A. That's right.

Q. Can you just detail what that change is?
A. Yep. So, late last year the Chief Operating Officer
who was overseeing our mental health system as an executive
leader resigned, so we had the opportunity to reconsider
the executive portfolios within the organisation.

During my first eight months at Peninsula Health, I
had identified that there were perhaps some significant
issues in our mental health service, so there were some
leadership issues, some quality issues, so we made the
decision to align our Mental Health Program to our
Executive Director of Nursing, Midwifery and Allied Health
who has extensive mental health experience. So, we made
that change and that executive has been leading the program
since February this year.

Q. What's been the benefit of that?
A. Well, it's been a terrific support to me, because
again, I don't have that huge experience in mental health.
It has really allowed us to spend a lot of time with our
staff, understanding their current issues that they're
experiencing, listening to them in trying to understand
what changes we could make within the service that would
support them in delivering the care that they want to
deliver.

We've also spent a lot of time integrating our
organisational clinical governance framework into the
mental health system, and really concentrating on bringing
our mental health team into the rest of the organisation.
Q. Can I just ask you about that; that one of your observations when you first began was that mental health didn't have that attention.
A. Look, I don't really know whether it didn't have that attention, because I wasn't there, so it's kind of hard for me to know. I think the executive who was leading the mental health service before I arrived absolutely gave the service considerable attention; had a fairly heavy portfolio, so what we've done is, we have decreased the portfolio a little bit so more time from an executive can be given to the mental health service.

So, yes, I think that structural change has made a big difference, but there's also been some other things that Peninsula Health has done to engage the mental health service closer in with the whole health service.

They undertook, and this is before I arrived, so I'll take no credit for it, but they undertook a process of reviewing the access for mental health services and access across the whole acute service, especially from our Emergency Department point of view, and they created a system of huddles. So, each unit will have an early morning meeting at 8 o'clock to find out what's happening in their area in 24-hours and looking forward to that day, identifying issues of quality, staffing, any lost time to injuries or staff issues that might have occurred; any patients that are requiring extra support, et cetera, and all that information comes up to an executive huddle where all the Directors and the executive meet for 15 minutes every day and we work through, unit by unit, what's happening.

I go to those meetings whenever I can, and in 15 minutes I can get an understanding of what's happening in the organisation.

Now, we act on issues at that time as we hear issues, and I think what's been good from a mental health service point of view, is that every day they're engaged in the whole organisation discussion about issues and concerns that they have, and I think that's really exposed the whole organisation into understanding our mental health service much better.

Q. Alright, I'll come to ask you a bit more about that
understanding, but can I just take you back to ask you about the Statement of Priorities, Peninsula's strategic plan and annual business plan. I'll ask you to say a little bit about each of those, but just in relation to the Statement of Priorities, you've said how long you've been the CEO of Peninsula, but you have extensive experience otherwise in relation to the preparation of the Statement of Priorities?

A. I'll take you through the experience and the process of this year's Statement of Priorities, which is the same process that I followed at Barwon.

So, we of course have our strategic plan, our five-year strategic plan which is set and developed by the Board, executive and the whole organisation. We run an annual business plan that is aligned to the strategic objectives of our strategic plan, and we work that up before we receive the guidelines from the Department of Health on the Statement of Priorities.

The Statement of Priorities are the government's priorities that align to their strategy, and we are very easily able to accommodate actions against government Statement of Priorities through our business plan process, so we're not so dissimilar in being able to complete those Statement of Priorities.

One of the questions that you have asked is about whether mental health is featured in the Statement of Priorities. Through the process of just undertaking our own business objectives for the year, our own business plan would have a number of actions related to mental health, and the mental health team have their business plan.

So therefore, if there are broad objectives within the Statement of Priorities regarding diversity, Aboriginal Health, occupational violence, then we would be including mental health objectives within those statements.

Q. So, the drivers or I guess the framework for you to include mental health objectives through the Statement of Priorities is through those other processes that you have?

A. Yes.

Q. What about in terms of the extent to which, in your experience, the Department of Health and Human Services has prioritised mental health in the Statement of Priorities?
A. This year they have got a set objective on mental health access in the Statement of Priorities. My experience, and from memory, that would be the first time I've seen specific objectives in the Statement of Priorities for mental health.

Q. In your view, is the inclusion of specific objectives about mental health within the Statement of Priorities an effective way of achieving improvement in mental health services?
A. In the absence of anything else, of course it would be. If an organisation has a strategic plan and has a business plan process, and is prioritising services of which mental health services are a very big service at Peninsula Health, then perhaps the Statement of Priorities are not so much a driver, but in the absence of any of those documents, then yes, the Statement of Priorities are important.

And, the Statement of Priorities are the key document that the Chair of the Board signs off with the Minister for Health, so from a Board perspective they are always very keen to see what the objectives are in the Statement of Priorities.

Q. In terms of the Statement of Priorities and the idea that - I'll take you to a portion of your statement, this is at paragraph 28. You say that in your experience the SOP, or the Statement of Priorities reporting framework, focuses on acute physical health care and has not adequately addressed mental health care. So, that's your view?
A. Yes, that's right.

Q. And so, the way that Peninsula Health deals with it is to have a good strategic plan and the annual business plan to ensure that mental health is appropriately prioritised?
A. And supported.

Q. And supported?
A. That's right.

Q. You talked about the strategic plan and the annual business plan: are you aware of whether those things were in place prior to you becoming the CEO?
A. There were some annual quality and safety plans developed by the directorates, and they were reported up to
the Board; the detail of those, I'm not completely clear on.

Q. So, did you drive the change towards the strategic plan - perhaps you and others - and this annual business plan?
A. Yeah, so I've changed the process a little bit. So, we've always had a strategic plan and we've just completed a new strategic plan. So, yes, so I brought in a new framework of bringing in the strategic objectives and the business objectives aligned for an annual plan and aligning those to the Statement of Priorities. So, I've just completed that now for this year, and that plan, so the business plan and the Statement of Priorities, are going to the August Board meeting.

Q. And so, from your perspective, what drove that change?
A. Because I'd seen it work elsewhere. So, probably back at Royal Melbourne Hospital actually, at Melbourne Health when I was there, there was a process of developing comprehensive business plans. I felt - and like to use them, I suppose, from a Directorate level for me and the team.

And then, when I had the opportunity to go to Barwon Health, we shamelessly took Western Health's framework, which had evolved somewhat since we used it at Melbourne, and then I've just taken that same framework to Peninsula. Modified it a little bit.

Q. Can I just ask you now about prioritisation by the Board. You say in your statement, and this is at paragraph 33:

"I believe that the Board of a health service can, at any time, ask the executive management to prioritise mental health services as with any service."

So, there's the capacity to do so. How readily does it happen and what are the impediments?
A. So, I think boards can ask executive questions at any time, and they often do. I think Boards do rely on executive management to give them adequate information and coherent information to advise them on what's happening in the health service. If they don't get that information, they won't know.
So, you have a Statement of Priorities and the reports that you get from the Department of Health: if that's all that's going up to board, then that's all they would get to see. That's not what's happening at Peninsula Health. We've got a number of reports from various groups within the organisation that go up to the Board level for discussion.

The other observation that I have is that, we do spend a bit of time educating boards on clinical governance and their roles and responsibilities, but to my knowledge I have not seen ever mental health services used as an example of educating boards about what their responsibilities are within the mental health services.

We might talk about this a little bit more later but, I have found mental health services quite complex to understand. So, I don't completely understand what it is that we are trying to achieve within our mental health service. I kind of get acute health, I get subacute health, I get aged health, I've had those experiences, and those models of care are fairly consistent across the sector.

But just in my two experiences between Barwon and Peninsula, the two different programs are quite different and, therefore, navigating that as an executive - and even some of the staff are unable to articulate what the models of care are - makes it then quite difficult to be able to educate and support a Board in understanding what the requirements are for us to be providing safe quality care in our mental health services.

Q. And so, you've had the two experiences that you've described at Barwon and then your current role, but you don't see that problem, about there not being a clear model of care, as a product of the fact that you haven't had extensive experience in the area? So, the fact that you don't understand it is not because of the time that you haven't had to get across it, it's because it's hard to understand?
A. It is hard to understand. Well, it's hard to have the people who are working in the system to describe it to you.

Q. Can you provide an example?
A. Okay. So, if I was to speak to a group of mental
health clinicians, and if I ask them to, say, explain to me what the model of care is from going through the Emergency Department to acute unit, back out in the community, and what a consumer should expect through that process. I would get different points of view. And, I get different points of view from the same clinicians working in the same area.

So it's hard to get an understanding, at my level, of exactly what the models of care are in each of the components of the services that we provide. And when I say "models of care", it is down to numbers of patients, how long patients stay, the treatment and support those clients get, what the staffing numbers are, so how many staff do we need to provide that care?

And this is the process that we've just gone through to try and develop the budgets, because we need to do all of that to then say, okay, well, does the budget match? So, what are those staffing models, what are we trying to achieve, what are the outcome measures we're trying to achieve, what are the performance indicators, okay, and then what staff do we need to achieve all that? Then, have we got the environment to do that in, have we got the physical infrastructure to do that? So, yeah, that's the process that we've just worked through.

Q. I just want to ask you about that in greater detail when we get to it. If we can just stick for the moment with prioritisation by the Board, I just want to ask you this question: what factors do you see that would influence the level of attention given by the Board to mental health services? In particular, does it need a champion?

A. Does it need a champion? I think, in the lack of good information and good outcome measures, yes, it needs somebody who - it helps having somebody who knows what happens in the mental health service, and that can be an executive as well as a Board member. Because it is so complex, it is helpful to have somebody at a senior level who does understand mental health services.

Q. One of the things you mention in your statement is that the KPIs aren't enough to understand the deliverables or performance outcomes for mental health?

A. Not at all.

Q. And that a large amount of data that is collected at
various levels that is not provided to the Board?
A. That's right. Well, not at Peninsula Health at this point in time. So, we have the Statement of Priorities' KPIs presented to the Board, we also report occupational violence information, serious incidents will go up to the Board. We also take any internal/external reviews of services, we would take up to the Board, so that's what we provide in mental health.

But I am aware of a large amount of data that our teams collect, but that data at this point in time is not being analysed and is not reported up to the executive or the Board, but we are in the process of just reviewing all of that.

We've had an external clinical governance review to help advise us on what would be some good outcome measures and indicators that would give myself and the Board reassurance that we are providing safe, personal, effective and connected care for all our clients coming into the health service.

Q. And that is an initiative led by Peninsula Health and not driven at all by the Department of Health and Human Services?
A. No, that's us.

Q. Can I then move on to ask you about oversight by the Executive Leadership Team. You may have already covered a little bit of this, but as the CEO, what kinds of regular performance and activity information about mental health services do you receive?
A. So, look, I pretty well much receive the same level of reporting that at this stage goes to the Board, and so, that's why I'm pursuing to get a little bit more information through this clinical governance review.

Q. So, you've recognised that you need more information?
A. That's right.

Q. And that things that you want to know about, there's no information about them?
A. Can't get them. No, that's right. And, look, I have to say that a lot of the measures that are being currently collected are very much process and performance measures. And we have similar constraints in our acute health services, although I think the physical health services
have evolved much further than mental health.

I think one of the things that we really do want to concentrate on now, across all our services, is to have outcome measures that are not only meaningful to us providing the service, but to the consumers who are receiving the service, and there are not very good outcome measures for physical health or mental health on that experience. So, I'm looking forward to doing that piece of work, but it does need to be done.

Q. You've just touched on there, I guess, some of the parallels with physical health and mental health. There is more comprehensive data monitoring in relation to physical health?
A. Yes.

Q. One of the things you refer to in your statement is a comprehensive dashboard monitoring of a number of performance metrics?
A. That's right.

Q. And that is something that you would also seek to do in mental health?
A. That's right.

Q. But there needs to be more, in your view?
A. That's right. So, I think physical health have evolved their reporting frameworks to a much greater extent to what I'm seeing in mental health. Now, there might be other mental health services that are far more advanced than the two services that I've had experience with.

But certainly physical health, KPIs, dashboards and processes are very similar and you can benchmark. So, I can look at an ED performance dashboard at any one of the hospitals and get it, understand it, and you can almost feel it because you understand it, and same with waiting lists and outpatients.

But I don't get any comparative data really - there's a little bit on the Statement of Priority KPIs which are limited for mental health - but there's no other KPI or benchmarking that happens across the mental health service.

So, you know, our community care unit: I've got a staffing profile, but there's no comparison about the types
of clients, number of clients, how long they stay, what the outcomes are coming from those areas within our mental health service.

Q. Can I next ask you about funding and prioritisation, and ask you this question: how does Peninsula Health's mental health activity and performance results impact on funding quantum or activity forecasts or targets in subsequent years?
A. So, let me just go through the process, okay, because I think that's kind of easier to explain. So, we started our budget process back in March for the whole organisation and we run the same process across all services. So, we essentially give people a starting budget and that's usually based on what we know or think we're going to get through discussions with government. Within the starting process there will be some productivity savings, we'll know that there will be some grants that start and finish, so we have a starting point.

Each service builds the budget up from, you know, bottom-up and top-down, and that bottom-up is working through what I was discussing before, what's the model of care? So in our acute unit, how many staff do you need, AM, PM, night duty, how many staff have you got? Okay, that's your EFT, all the other bits and pieces you add - that's your budget.

When you get government's budget, you try and match that up and that's probably the most difficult part because it's very difficult to match what's actually happening in a service and the budget received. So that's the process that we're working through at the moment.

All the money coming in for mental health stays within mental health. So, I don't take mental health money and say, I'll put that to the outpatient department, so we ringfence the mental health funding, and it's quite a process to try and match the funding coming into the organisation to all the specific programs. And, it doesn't match. Like, the acute services funding does not fully cover the staffing profiles and the costs of running the acute services.

Q. Can I ask you a bit more about that. You've touched on cross-subsidisation when you said that you don't take money from mental health and put it into acute services,
for example, so I guess conceptually one thing is taking 
money from mental health to put it into physical health.

So, would you say that there's no cross-subsidisation 
in that context, if I can just stick with that point?
A. I can say there's—no, so I'll work through that a 
bit. So, we ringfence the funding for mental health 
services and we try and make that funding balance for those 
services that we're providing.

Now, we do receive throughout a year specified grants, 
and sometimes they come quite late in the year, so it's 
almost impossible for you to recruit and get the staff and 
expend those funds. So, you might end up with a surplus of 
funds in your Mental Health Program that would then hit the 
bottom line from a reporting framework and then, if the 
rest of the health service is over budget, then that 
surplus would offset that overrun.

So, it's not purposeful "I'm going to use mental 
health money to cross-subsidise the physical health 
services", because my responsibility is the whole health 
service, so you're trying to balance the whole budget, and 
so, it might on occasion result in that happening.

I can go into why, and also why it might happen: it's 
not only the extra funding that we might get coming in 
through the year, but it has been incredibly difficult to 
recruit into the positions that we have available in our 
mental health service. So, we might carry a significant 
amount of vacant EFT because we're unable to find the 
qualified staff to work in those programs, and as a result 
that would then result in a surplus if it doesn't get 
offset by the overrun that we have in our acute mental 
health services.

Q. I'll come back to ask you about that staffing 
point that you've raised. Just in terms of sticking, I 
guess, at the moment with the idea of cross-subsidisation, 
you say in your statement, and now I'm focusing on within 
the mental health budget, there is cross-subsidisation 
between our different mental health programs, and can you 
just elaborate on that?
A. Okay. So, working through our acute program, acute 
and aged program, bed-based services, the EFT required for 
us to provide a quality and safe service within those areas 
is greater than the funding we receive for those services.
The funding that we receive for our community health contact and all the other programs is there. If we are unable to recruit the EFT that we need to run those services, that funding just by nature will offset the overrun that I would have in my acute service.

And also, you might set a staffing profile in an acute service to manage the client load that you believe that you need to have, but there's always going to be times when you get extremely complex clients entering in those services, and very often we will have to employ additional staff members to manage those more complex clients. And that's often not in budget. I mean, you try and make an allowance for that because you get an understanding on how often that might happen, but yeah, it's essentially unbudgeted from the funding coming in for those bed-based services.

Now, that same issue happens in physical health, so it's the same: you do a budget on a board, and you think this is the staffing profile I'm going to need. If you get a patient or a client that needs more care and you need to provide a safe environment, both for staff and for clients, then you would put on extra staffing.

Q. And so, if you could fill the positions that you have available, you wouldn't be able to cross-subsidise in the way you've described and remain in budget?
A. That's right.

Q. So then, there's a disincentive to be filling those positions, is there?
A. Is there? There could be. I mean, I suppose at Peninsula Health we've got nowhere to put the additional people at the moment, so we've got a physical infrastructure issue with our community programs at the moment. So, even if we were to recruit to the numbers that we think we need, we don't have anywhere to put them.

Q. There is difficulty in any event, partly because of the lack of infrastructure, in recruiting people?
A. That's right, so that's not very attractive. For example, our Mornington Mental Health Community Team are residing down at Rosebud. Now, it's very hard to recruit qualified mental health clinicians and say, come and work in Rosebud in a building that is less than adequate, and can you look after clients up in Mornington. You know,
it's just incredibly difficult for them and very difficult
for us to recruit into those vacancies.

Q. And they're based in Rosebud because there's nowhere
else for them to be?
A. Yes, that's right, we've been looking at trying to
find an appropriate place to house that group.

Q. Can I take you now to ask you about the scope for you,
or another public health service CEO, to be able to
advocate to DHHS for higher funding, and can you answer
that question in the context of your recent experience?
A. So, this is probably my first year of advocating for
mental health services from a funding point of view. So,
we met, we've done our budgets and we've been in regular
contact with the performance branch in the Department who
have been working with us on our budgets and targets.

We had our meeting last week to clarify a few things
and to work through those budgets. Perhaps naively, I
asked, "When will we talk about the mental health budget?"
And I was told that they don't control the mental health
budget, the mental health budget is managed by the mental
health branch, and that it would be up to me to make
contact with the mental health branch to talk to them about
the mental health budget.

So, you know, I was quite surprised. I was shocked
actually, and I thought, well, here we are trying to run
the whole budget: you know, it would be nice to be able to
talk to people about our whole organisation, so I do need
to go ahead and talk to the mental health branch about the
budget.

And that has been a problem. I've been the CEO for
18 months. The last 12 months I've only had one formal
meeting with the mental health branch, and it's been
somewhat - or it has surprised me that there hasn't been a
lot of detail in those meetings about what's really going
on in our mental health service. So, you know, what are
the staffing deficits, what are the budget constraints,
what are your quality and safety concerns, you know. Yeah,
I was a bit surprised.

Q. How does that contrast with your interactions with the
other branch, I don't recall what the name was?
A. Yes, the performance and commission branch. They've
got a lot more detail. I've met with them four times, so we meet with them quarterly.

Q. That's four times over the past year?
A. Twelve months, yeah. We have very much clear discussion around quality, safety. We talk about how we're going against our Statement of Priority KPIs, we talk about funding, we talk about capital and infrastructure issues, so it is an opportunity to talk about the whole service, but you don't talk about mental health.

Now, I have requested for mental health to be in those conversations, and the last two meetings I've had a mental health representative at those meetings.

Q. What have you been met with when you've tried to include it?
A. So then, I'm just talking to the one person from the mental health branch. So, the performance team - and I talk about this in my statement too, is that, it's hard - people don't understand what the mental health service is about. It's kind of, even though we're sitting under the one building, and even though in the Department of Health we're sitting under - there's demarc - people just don't seem to understand what the service is about, and those divides make it very difficult for people like me to understand what is required from a Chief Executive who's responsible for delivering mental health services.

Q. Can I take you now to ask you about systematic underfunding in mental health, and I'm going to read to you a portion of a question we put to you when you were preparing your statement, and this is at the top of page 12:

"The Commission understands that public health services are not funded for 100 per cent of the cost of the services they are expected to deliver (with the expectation that the shortfall will be made up from own-source revenue, including private patient fees), and that the shortfall is larger for some services than others. For example, the Auditor-General found that DHHS meets around 62 per cent of the cost of delivering an acute mental health bed compared to 82 per cent of the
cost of delivering an acute general bed."

We posed the question to you, what are the consequences of a large discrepancy between costs of service delivery and the funding provided for a health service, and you've touched on some of those, but are there others that you'd seek to address at this point?

A. I suppose the main areas are - is you're unable to meet demand. Now, I don't know what the demand is in the mental health service, except what's coming through the Emergency Departments, so I have no capability of understanding of what is the unmet demand in the community.

So, kind of, our demand in the community is managed by the number of resources that we have available. So, if you don't have budget to recruit two EFT to provide those services, then people miss out on those services. Or, if you don't have budget, then people miss out on those services.

We would then not be able to achieve performance targets, but there's not a huge number of performance targets in the mental health service, so nobody's really probably watching that.

And then it's from an infrastructure point of view, so it's difficult to - or our operational budgets don't include capital infrastructure, so it's about negotiating for a capital budget is difficult.

Q. I'll come back to ask you about the capital investment a bit later as well. In terms of, you mentioned just briefly now in terms of the performance targets, that they're not really measured anyway. I want to ask you specifically about the annual report of Peninsula Health for 2018 and the fact that it reported that it's exceeding KPIs in mental health, I think in every domain. So, that's in relation to KPIs set by the Department?

A. M'mm.

Q. And in your view, do they adequately measure the ability for a service to meet demand?

A. No.

Q. And, what about the ability to adequately measure the extent to which a full range of services are delivered to the community?
A. No, they don't monitor that.

Q. Do you have ideas about how those things could be better monitored?
A. I think it would be helpful to know or get a sense of who in the community are not getting access to services. So, we have no sight of that. I don't know how many times our clinicians are having to say "no" to people, or I don't know how often they say, "No, look, you're not complex enough." Our staff are often saying they feel as though they're having to discharge people too quickly, so there might be some indicators around those outcome measures. So, when is a good time to discharge somebody from a service?

In physical health, you have the metrics, oh, they're not in pain, they can get up and walk, they're eating food, they can shower themselves and manage their hygiene needs, so you've kind of got some metrics on how you can feel confident that you're discharging somebody safely back home. But we don't have those same measures, that I'm aware of, in mental health, so maybe we could do some thinking around that.

I would like to understand what the unmet demand is and perhaps whether we're appropriately discharging people from our service. Then it would be useful also to know how we're going and how we can compare ourselves to other services; so, are there best practice models in the system that we're unaware of, but I don't have any sight of that either.

Q. Can I just ask you about funding growth in the past three years, just take you to that topic. One of the things that you've mentioned in your statement is that there has been funding growth in the past three years?
A. Absolutely.

Q. You haven't looked back further in terms of how that compares to the previous 10?
A. No, that was very difficult for me to do in the timeframe.

Q. But you would say nonetheless, even with this funding growth in recent times, funding is insufficient for Peninsula Health to effectively provide the mental health services to meet the growing demand?
A. So, the additional funding that we've received in the last three years have been for specific programs of work, and so, they're very discrete pieces of funding. For example, $3.3 million this year, or last year going into this year for a Crisis Hub in our Emergency Department. So, they're very specific pieces of work that we will do in developing a model of care and a budget, and recruit into that new funding. So, that's where the majority have funding over the last three years that I could ascertain have been for the mental health services.

Q. Can I ask you then about capital investment or capital funding. One of the things you mention in your statement is that it's in mental health particularly difficult to attain. Can you just elaborate on that?

A. So, again, this is from my limited experience of two health services, and I think what I can see is that the investment for big capital - so, this is some building capital - relies on a good service plan, master plan and assessment of your facilities, and are often aligned to obvious indicators that are not being met: so Emergency Departments, theatres, acute beds.

We've been really fortunate at Peninsula Health: just in the last 12 months we've received $560 million to build a new Frankston Hospital, and now acute and aged mental health services have been included in that.

I think, once we get beyond that acute system, it's difficult: I don't think it's understood what people are doing in the community and where they're doing their work in the community. I mean, I must admit, I was quite surprised, both at Barwon and at Peninsula when I toured to see where our community services were working from, and they're not great places, they're not in a great space at all; they're certainly not in an environment that would allow them to feel comfortably able to provide appropriate and effective care to the people that they're trying to offer care to. It's always makeshift.

The Barwon acute facility was very poorly designed, and one of the things that I did in that three months was work with that team on some redevelopment plans, but I'm not too sure whether that actually progressed. They were having to staff - their staffing model to manage that environment was very inefficient, but they needed to have much more additional staff because of the poor environment.
Q. Just to touch on one of the issues you raised in your answer: so you're talking about the lack of understanding of what community services need. Is that from a Departmental level, is that what you're referring to?
A. Yes, and probably from my level too. You know, until you go out there and actually see where they're working and how they're trying to work, yeah, I was surprised.

Q. The final area I want to ask you about is the key constraints or pressures that may hamper the implementation of mental health reforms or service improvements. There's two in your statement that you address in particular, I'll ask you about them individually.

The first is the lack of consistent and coherent statewide model of care, and then insufficient integration of mental health services. So, if we can start with the lack of consistent and coherent statewide model of care: you've talked about the model of care in the context of Peninsula Health, but there's a broader picture?
A. Yes. So to me, I don't think we do things in the same way in each mental health service; well, it's not clear to me that we've got the same models.

Even in our own service, the experience of a client coming in to our Emergency Department and working through our service could be very different for each individual person that comes into our service. I'm not clear that the people that are coming into Peninsula Health are receiving the same standard and the same level of best practice care and mental health services: I've got no way of seeing that, I've got no way of measuring that.

I kind of think, if somebody comes through in the Emergency Department with a physical health concern, I've kind of got an understanding that a similar pathway for physical health would be followed regardless of whether they came to Peninsula Health, Monash, The Alfred, Melbourne, it would be fairly similar. But I don't have that confidence that we've got a similar process or model in our mental health services.

Now, it could be my lack of understanding, but it's not clear to me. It's not clear whether we're running a residential program the same across the state; it's unclear to me about how we're running our community programs and
whether we're providing the same models of care and support in the community. I have no oversight of that.

So when it comes to talking about mental health services, if you don't understand it and have a language for it, then it's hard to describe to new staff members, it's hard to describe to Board members, and I cannot understand or see how a community member would be able to navigate their way through the system. I have been in the system for a long time, I can navigate my way through the physical health system; I don't think I'd be able to navigate my way through the mental health service.

Q. And so why is it important that there's consistency in the models of care across services or between services?
A. I think it would be helpful, both in educating people about mental health services and making them more accessible to people, and I also think it would help from a benchmarking and service provision. So both by trying to measure quality and outputs, outcome measures, and also some effectiveness measures to see whether the money we're investing in our mental health services is being effectively used.

Q. Can I ask you then about what you say is insufficient integration of mental health services?
A. That's internally too, so again, the Barwon experience and Peninsula experience. The acute mental health services, for example, are sitting on the same land mass, you know, are just there.

It feels to me like there is - I say it's a fear, and I don't know whether it's kind of a fear that I've had - but there's kind of a lack of confidence of being involved with the mental health team, because of that lack of knowledge, that lack of understanding and that lack of - it's kind of like mental health service business. And so, I've had to work hard at being able to get in there and understand it, and that hasn't been easy.

And so, part of what we're trying to do at Peninsula Health is to have them better integrated into our whole service, so everybody understands what our mental health service is about, and to feel comfortable to be in there and working with them. We've really engaged our mental health team, we've got some great expertise, our clinicians have got some fantastic knowledge, so we've been using our
mental health team to come in and educate and support some of our other teams on how to manage difficult clients, dementia, behavioural concerns, et cetera, but it has been something that I've had to actively do. I've never been encouraged, in all my roles as an Operational Director, to actively participate with mental health.

Q. Thank you, Ms Topp. Are there any matters you'd like to cover that we haven't addressed?
A. No, I think we've just about covered it all, thank you.

MS COGHLAN: Chair, do the Commissioners have any questions?

COMMISSIONER COCKRAM: Q. Ms Topp, you've mentioned about capital infrastructure particularly for community services. Can you just explain to the Commission how community services are predominantly funded through the block grant?
A. Through the community contact hours. I don't know a lot about the block grant, Alex. I know that we get a block grant, but I think we get some amount of money to support some infrastructure. So, they've given us some money to rent an area in Frankston, but the issue is, is that, we've had to rent not a purpose-built space for our community teams. So, we've kind of got not a great building that they're working out of, and it's certainly not purpose-built for them to provide community services.

Q. Just then to continue on with what you just mentioned, is that, you have been supported by the Department for covering the rental where Peninsula doesn't specifically own the infrastructure that exists?
A. That's right.

COMMISSIONER COCKRAM: Thank you.

CHAIR: Q. I just have a few issues that I'd like to raise. The first of them goes to, in your statement you gave a very useful analysis of the fact that the Statement of Priorities govern what's of interest and attention to your Board and also to senior management, and you stated that they are largely focused on physical health, access and quality.

Can you just give us by way of comparison, what would
go to the Board regularly for attention around physical health and then I'd like to come back to the issue of mental health?

A. Some of the physical quality indicators that we would report would be staph aureus blood infections, falls, pressure areas, any serious incidents that happen within the physical health services. I said "pressure areas", yeah.

Q. When you say "pressure areas", what does that mean?
A. So, pressure areas are areas where a patient may have had a graze or been in a bed for a long period of time and they get a pressure sore.

Q. So they're indications of concerns about quality of care?
A. Yeah, quality of care.

Q. And you'd report those sort of things to your Board on a regular basis in the dashboard reporting?
A. That's right.

Q. What gets reported, if anything, to your Board on a regular basis about comparable events in mental health?
A. None. So, not on a regular basis. If there was a serious incident, through our ISR reporting, we would report, but there are no similar quality measures at the moment going up the Board regarding - in our Peninsula Health service.

Q. I think you've explained in part why that's the case and the complexity and the lack of performance metrics that you think are helpful to drive that level of accountability.

But also in your witness statement you gave us a very helpful description of the range of mental health services that are provided by Peninsula Health, both in acute and residential settings and also in community settings, and it's quite an extensive list of services that are provided.

I guess it's about the visibility, you said, on community mental health is also very limited to the Board and senior management, notwithstanding the extensive nature of those services that are provided?
A. That's exactly right. So, you really have to go out and ask the questions about the services that you provide,
and I've certainly spent the last 12 months going out and visiting all those services so I can understand the service that they're providing and the environment that they're providing that service in.

Q. By way of comparison, you did say that the physical health indicators and reporting framework's quite sophisticated, been established over a long period of time, and you engage in quite robust dialogue with the Department about your performance. For how long has that sort of robust process, in your view, been in place in physical health?
A. A long time.

Q. Decades?
A. Yes. Oh, 15 years, and they've certainly evolved. In particular, the quality measures have evolved.

Q. I think that's illustrative, in your view, of the fact that there's a long way to go in mental health until it has comparable reporting?
A. That's right.

CHAIR: Thank you very much.

<THE WITNESS WITHDREW

MS COGHLAN: Thank you, Chair. It is early, but is now a convenient time to break for lunch, given that the next witness will be attending at 1.30, and that's Jennifer Williams?

CHAIR: Thank you very much. Yes, we'll adjourn.

LUNCHEON ADJOURNMENT

UPON RESUMING AFTER LUNCH

MS COGHLAN: The next witness to be called is Jennifer Williams, and I call her now.

<JENNIFER JUNE WILLIAMS, affirmed and examined: [1.33pm]

MS COGHLAN: Q. Thank you Ms Williams. You've provided a statement to the Commission?
A. I have.
Q. I tender that statement. [WIT.0002.0020.0001] You are the Chair of Northern Health?
A. I am.

Q. Can you just outline for the Commissioners, firstly, just what your qualifications are?
A. I've got a Bachelor of Economics and a Master of Science and I'm a Fellow of the Institute of Company Directors.

Q. You've had the role of Chair of Northern Health since July 2015?
A. Correct.

Q. What about your current, other board appointments?
A. I'm also the chair of Yooralla, and I'm on a number of other boards: I'm on the Barwon Health Board, the InfoXchange Board, the Independent Hospital Pricing Authority, the Medical Research Advisory Board, I'm Chair of the Alfred Full-Time Medical Staff Trust, and I am just in the process of completing assistance to the South Australian Government with the development of a mental health plan as a panel member.

Q. Prior to those board appointments that you've just described, you've had over 20 years of experience in the health sector?
A. That's correct. I have, prior to my board appointments which is just over three years ago, that I have moved to just do boards, I was the Chief Executive at the Red Cross Blood Service for seven years, the Chief Executive at Alfred Health for five years, and the Chief Executive of Austin Health for seven years prior to that, and before that I was with the Department.

Q. And in fact, for 13 years, you had experience working in the State Government of Victoria?
A. I did, yes, that's correct.

Q. Just detail, just briefly, what those roles were?
A. The final role I had was director, which is the deputy secretary level within the Department, they were the titles used at the time. I was the Director of Aged Community and Mental Health and, prior to that, I was the Director of Psychiatric Services, and before that I was not in the health area, I was at the Department of Treasury and Finance, and worked in the area of information systems, and
prior to that I was with the Ministry of Housing again, in
the area of information systems.

Q. Can I just ask you now to focus on providing some more
detail in relation to the professional roles that you've
had in the mental health system in Victoria. Can I ask you
to start with Barwon Health and your role as a board member
there, at paragraph 15 of your statement.
A. Yes. I was initially appointed as a delegate to the
Board at Barwon Health, they were having some financial
issues at the time, and the office of ministerial delegate
is often used to assist the health service to get out of
issues which are problematic. So, I started as a
ministerial delegate there and then I was appointed to the
board of Barwon Health, so subsequent to that I have been a
board member at Barwon Health and have continued to be so.

Q. Can I then also just ask you more specifically about
your time as Director of Psychiatric Services with the
Department of Health and Community Services that you've
mentioned, and just go into a bit more detail about your
responsibilities in that role?
A. Yes. As Director of Psychiatric Services, I was
responsible for the mental health system for the state and
moving into that role initially the mental health services
were run by the state: so all the employees of mental
health reported to the Department, the accountability
structure, governance went back to the Department, not to
health services, and part of my role there as running
mental health services was to bring about the mainstreaming
of mental health and the de-institutionalisation and the
establishment of community-based services.

Q. Can I take you to that topic now, paragraph 44. Just
drawing on the experience that you've had, can you address
the key factors that drove de-institutionalisation at the
time?
A. Yes. There were a number of things that really caused
a significant concern about what was happening with mental
health services. Just prior to my arrival there had been
the disclosure of abuses of people with mental illness at
institutions, so Lakeside was an example of that. There
were also abuses of disabled people that were uncovered
during that time. So, there was an intent by the
government, the Minister and the Director-General of the
Department to change the model of care for mental health
and to adopt a de-institutionalisation model by moving the
services from being directly run by the Department to being
mainstreamed and run by the public hospitals, and to at the
same time as relocating beds from the institution, to
establish community-based services that were also run by
the mainstream hospitals where the services would be moved
to.

So, I was responsible for developing of policies and
the strategies to bring about those changes to seek the
funding to enable the funding of the services, which
included significant capital funds because new facilities
needed to be built in the acute hospitals, in the subacute
hospitals, in residential care and the establishment of
community clinics and the associated services like crisis
teams, Mobile Support and Treatment teams for them to
operate in the community, as well as the establishment of
services run by the NGOs for psychosocial rehab.

Q. You talked about one of the driving forces was what
was being uncovered that was occurring within institutions,
but there were two other things going on at that time,
perhaps in the broader social setting, which was that there
was a real focus on homelessness, and there was also highly
publicised events where there'd been police shootings.
Could you address those two areas?
A. Yes, that made the problem much more acute and was
very much in the public air. So, Brian Burdekin had done a
very significant review of homelessness and that was
getting a lot of coverage in the media and a lot of
interest and attention politically, and that was uncovering
that a very significant number of people that were homeless
had a mental illness, many of which had never received
treatment and that were unable to access treatment. So,
that was certainly an impetus to drive the reforms in
mental health.

And just a short time after the Burdekin reports were
released, there were a very unfortunate series, not just
one or two, but a series of police shootings where the
police were put in situations of danger and the only
measures that they felt they could respond by was by using
firearms, and there were both shootings that resulted in
death as well as other injuries to people with mental
illness, and of course, that received enormous attention
and concern in my area, in my Department and with the
Minister, about what we could do to try and educate and
train police in using other strategies to try and deal with
people that were very agitated where police intervention was obviously a safe thing to do, but to give them other options as well as to train them in aspects of what mental illness meant and developing strategies along with the police force about how they would deal with those situations.

Q. You have then just gone on to describe the wave of reform and the things that were implemented. That was supported by the national mental health plan which had similar goals?
A. Yes. Sorry?

Q. That was supported by the national mental health plan which had similar goals?
A. That is correct, so there are now five mental health plans and this was the first of those. So, Victoria, as with every other jurisdiction, needed to respond to that national plan, how was Victoria going to respond that national plan and how was it going to implement the goals and the vision that were outlined in that plan.

So, that was the blueprint that really drove the direction of the reform package in the area that I was responsible for, we developed it, and we developed this document called the framework for mental health services in Victoria, that reflected those goals and identified how we would achieve those and what we would implement to achieve the goals of that first plan.

Q. Can I just ask you about your observations in how the government made the implementation of significant reforms to mental health services a key priority at that time?
A. Yes, I think the circumstances of the issues identified in the institutions, the police shootings, the Burdekin report, those things certainly made mental health very visible and that it needed something done to it.

But we also had a secretary of the Department who was very determined to improve the plight of people with mental illness. He himself had a disability and he was very adamant that things needed to be changed and we needed quality services that protected the rights of people with a mental illness in that they needed quality services. So a Director-General who was very supportive, and a Minister who was also very receptive and supported the mental health reforms.
I have put in my statement that one of the things which I think was very significant about what the Minister did, and it was Marie Tehan at the time, when she launched our policy framework which was the policy, the blueprint for reform, she took the speech we had prepared for her and took it home and she actually wrote in that speech herself that, as Health Minister, she was prepared to be judged on what she did in the whole health portfolio on what she did in mental health alone. The weight of that commitment certainly sat on my shoulders and the people in the Department that I was working with to know that we had a Minister that was just so thoroughly committed to what we were doing, that she would stand behind us and support what we were doing.

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

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

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

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

A. Yes, to have a Minister advocate so strongly for this area was vital to the success. The health portfolio is a very complex portfolio with enormous demands across many areas, and mental health had never been a high priority in terms of budget allocation, and I think that's something which hopefully this Royal Commission can contribute to putting it back as a high priority on the political agenda to get that sort of attention.
Because, it's not just the focus and the support, you need that real support by budget allocation, because the enhancement of services cannot occur without additional budget.

Q. Do you think the vision and service system that was put in place in the 1990s is still relevant to community needs?
A. Yes, well that question does make me go back and think about that question, and I think fundamentally, yes: what we put in place back there is still appropriate, and I think those of us that work in mental health can see that the system is still fundamentally there, but there have been many improvements and enhancements and innovations and new parts of the service system that have been added into the system since then, and a lot better reporting on what's going on within mental health.

But things like the area based service, the inpatient across child and adolescent, adult, aged, the forensic aspects, the special care needs of other specific groups that have particular needs, those elements are still relevant and are still very much in place today.

I think what has not happened though is that the development of the system has not kept up with the demand, and hence, the service system which was designed and perhaps served Victoria well for five or so years, needed to be continued to be built upon, expanded and evolved and that has lagged the demand on the system, and hence, Victoria has lapsed back in terms of its leadership in mental health.

Q. Can I just now change direction and take you to your role as Chair of Northern Health, paragraph 9. Can I start by asking you about the arrangements under which Melbourne Health provides clinical mental health services to Northern?
A. Yes. So, Northern Health does not run mental health services for the catchment that it serves, the broad catchment that it serves. Some 20 years ago Melbourne Health took responsibility for delivering the mental health services for the catchment that Northern Health covers as well as the catchment that Western Health covers as well as Melbourne Health's own catchment, so it's responsible for those three different services and the mental health
services that they deliver.

And, it is Northern's view that this is a model that worked well for many years, but for many years now it has been a model that has needed to be changed and that Northern Health should take responsibility for the mental health services that serve its catchment, and that the staff that are working in those services that are currently employed by Melbourne Health should be moved to Northern Health and that the management and the Board of Northern Health would take direct accountability for the mental health services for its own population.

I would draw an analogy with other outsourced services to say that the mental health arrangements are quite different from Northern Health simply purchasing mental health services from Melbourne Health. It is not that arrangement, so we purchase radiology services, we purchase food, we purchase cleaning services, we have contracts, but the Board is still accountable for the delivery of food and radiology and cleaning services.

In mental health the Board is not accountable or responsible for the mental health services that are provided, it is the Melbourne Health Board that is responsible for that. So, we would very much like to see that transition from Melbourne Health to Northern Health. There have been some discussions over some years for that to occur, but there has been little progress in getting about that transfer.

Q. Could you just address some of the perhaps unintended consequences of that arrangement?
A. Yes. There is almost no visibility of how funds are allocated, what the gaps might be, and what the issues are in mental health services because this is not information that comes either to the management or the Board of Northern Health, so we are pretty well blind to that.

But it is very difficult to disentangle mental health from the other services that you provide within a hospital as large and complex as Northern Health and its various sites. So, the best example would be talking about mental health patients that present to an Emergency Department, which is the responsibility of Northern Health, but when those patients present, we do not have access to the mental health records of that patient if they had been receiving
previous treatment, so we are not able to get information about previous treatment for those patients.

We're also reliant on Melbourne Health coming to assess and determine if those patients that might need admission to a mental health bed, that we are dependent on Melbourne Health doing that. Northern Health can't do that. The length of stay for mental health patients in the Northern Health Emergency Department is very unsatisfactory, there are extremely long waiting times for patients in the Northern Health Emergency Departments.

Until only a couple of years ago we were getting no information at all about the performance of mental health, and we now do get a small number of indicators which only relate to the performance within the Emergency Department of the services, and that looks at the waiting time for mental health patients, and so, there are three indicators that the Board now gets routinely but it is only restricted to the Emergency Department part of the mental health services. We don't get any information about the performance of mental health outside that.

Recently it came to the Board's attention that we were concerned that patients were being restrained for excessive periods of time in the Emergency Department. I was obviously concerned about that and we asked if it was possible to get information about numbers and duration and how that might compare to other health services about restraint in the Emergency Department, the implication being that patients were being retrained because we didn't have the appropriate facilities within the Emergency Department for these patients. So, now we get some very limited information on the restraint in the Emergency Department but we don't have other information such as seclusion rates or re-admission rates, the normal sort of indicators that other boards and other management teams would get about the mental health services that run within their facilities.

Q. Can I perhaps draw on some of your previous experience then in asking the next phase of questions. This is on the topic of prioritisation, paragraph 16. In thinking about your past roles in particular, can you describe the extent to which you've seen the prioritisation of mental health within the overall work of hospitals and services?
A. Yes. So, at Northern Health, we do not put in
submissions for additional funding for mental health because, as I've just explained, we're not responsible for that. But at other health services where I have worked, Barwon Health currently, The Alfred and the Austin where I've been Chief Executive: so at those services you would have regular dialogue with the Department about where you saw there was a need for additional funding or for new services to be funded, and then there's the annual budget process where you can make specific submissions to get additional funding for certain things.

So, certainly mental health would be considered by management, and by the Board, about what submissions would be made to government to attempt to get additional funding. For larger projects, which might be either operational funding or for larger capital projects, there would be full-blown business cases developed, with fully costed and benefits and risks identified for those sorts of proposals.

So, that is an annual budget cycle and the mental health part of those budget bids occurs alongside all other budget bids for all other parts of the health system. Within the Department it does get dealt with by a different bit of the Department, but the process if you are sitting within a health service is the same when you're seeking additional funding for surgery or medicine or for mental health.

Q. Can we just take that a bit further then and address the process that involves DHHS, and specifically if I could ask you about the process for a health service advocating at that level for additional funds?
A. Yes. Well, the advocacy to the Department is vital so that the Department understands that the needs and the pressures that you have - because all health services are making submissions to the Department and there's obviously prioritisation that has to occur to identify who is most in need, because there are limits to the budget to be able to address all of the demands that come to them.

To support discussions with the Department, there are often discussions with the Minister and the Minister's Office, and also you might involve local Members of Parliament to assist in talking to other Members of Parliament and/or the Minister to give additional support to your budget needs.
The mental health branch within the Department is the one that would need to support your budget bids for it to get even to the first level of consideration before the Department before those budget bids would even then get a chance of being then presented to the Department of Treasury for consideration in the overall budget.

Q. You've just raised there that there might be an attempt to engage with local government in terms of trying to attract support and advocacy for your cause?
A. Local government less so. I mean, it could be local government, but typically it would be local Members of Parliament I was referring to.

Q. Sorry.
A. At Federal or State level, yes. Because local governments provide some support to people with mental illness, but they wouldn't typically support a budget bid to the State Government for extra resources.

Q. Just moving on then to your observations: what are the sources of unanticipated or greater than budgeted expenditure within a hospital or health service both within clinical mental health services and generally?
A. The sources of?

Q. The sources of unanticipated --
A. Unanticipated costs?

Q. Yes.
A. In mental health, as with other areas, your budget is indexed by increases in labour costs usually that would come out of an EBA agreement, so salaries would be indexed accordingly, and then there is an adjustment for non-salary increases, the health CPI or CPI more generally, and your budget would get adjusted according to that.

There are usually efficiency dividends that are required each year, therefore savings that also would need to be made. So, while you might have an increase in costs resulting from those two areas, salary and non-salary that I just mentioned, usually there is a gap that the health service usually has to try and fund or fund via reducing its costs to be able to operate within the parameters of the budget that has been provided.

So there would nearly every year, in my experience,
you are required to look for efficiency savings so that you can deliver a balanced budget.

Q. You mention in your statement that mental health has historically been seen as the poor cousin?
A. Yes, it's a term often used in mental health unfortunately, and it's sad that that term does get used, but people use it so commonly I think because they feel mental health misses out, where other areas within health are addressed. So, the so-called sexy areas get funding, but mental health misses out, and that's why I've emphasised in my statement the importance of having such strong support at very high levels right throughout government and the bureaucracy to try and redress, I think, that disadvantage that mental health has had over many, many years.

Q. Can you then please describe your observations as to the quality, timeliness and depth of the performance and financial information available to the Board in relation to clinical mental health service delivery? Is that something you can comment on particularly in terms of your previous experience?
A. Yes. I would say it's equivalent to other clinical areas within a health service. Again, at Northern we don't have that information but at other health services they would have financial information about the Mental Health Program and they would have a series of other indicators to identify trends within the existing health service and comparisons with other health services across a range of metrics.

There are quite a large robust number of mental health indicators which are published for the State as well as national indicators. So, while a lot of these are not outcome indicators, they are more input measures: like, how many hours of community contacts and things like that, they're not really looking at what are the outcomes of the patient. There are a lot of indicators where health services can compare themselves, and that is done routinely.

There is also organisations like the Health Roundtable, that's a national organisation that gives information that enables you to compare things across health services, so you can look for where you need to improve the care and give attention to the areas where
there is under-performance compared with other areas.

Q. Does that apply to mental health in comparison?
A. And that applies to mental health as well.

Q. On those sort of broader KPIs that you've identified?
A. On those broader KPIs as well, yes.

Q. And so in your view and experience you would say that you don't think that mental health has suffered from adverse internal prioritisation by boards?
A. Not by boards, no, I don't think it does. I think in my experience definitely the boards are focused on mental health just as much as they are on other clinical areas and from time to time boards are very focused on mental health because there are very serious incidents that occur in mental health, and the Board can get quite interested and concerned about those issues.

I can think of one health service in particular where there were external reviews that showed a series of poor outcomes where the Board established a sub-committee to do a deep dive and to monitor rectification of all of the recommendations that were made from a series of reviews. Sometimes those reviews are by the Chief Psychiatrist, sometimes they're external reviews which might have been commissioned by the health service itself.

So, no, I don't think boards de-prioritise the importance of mental health, certainly not in my experience.

Q. Does it depend on the information the Board is provided with?
A. Certainly it does, but that goes for everything within governance: if management is not providing the Board the information, then it is not as easy for the Board to identify what are the gaps, what are we not seeing, where do we have an interest? And boards might pick that up themselves, but yes, you are very dependent on management to making sure that they do give that balance and make sure that the mental health issues are presented to the Board as frequently as necessary.

In things like the quality committees of the Board, that you're not just looking at the acute health and subacute sort of issues, that you're also looking at all of
the mental health issues as well, whether it be sentinel
events or root cause analysis of incidents, as well as some
of the metrics that can identify how you're performing
against other health services.

Q. Can I ask you now about geographic catchments and I am
going to ask you whether you consider them to be helpful or
unhelpful. You've got some particular experience in the
fact that they were developed in the first place?
A. Yes, I do. In fact, we established the catchment
concept back in the early 90s when we developed the set of
reforms, and that was driven because there is a lot of
concern that, when mental health patients present to a
particular hospital or service, that they would not receive
treatment, that they would be seen as too difficult, or the
hospital would be too busy, or that they didn't have the
capacity to deal with the patient and the patient was left
having to go around the system trying to find someone that
would assist them.

And so, for that reason area based mental health were
established to ensure that a patient had to be treated by
the health service within which they had a responsibility
for that catchment area.

There has been criticism of it, that it removes
patient choice, why can't patients drive across town and
receive services from another health service, and patients
can do that. That doesn't stop patients doing that, but it
really was the safety net to ensure that there would always
be care for a mentally ill person that needed care and that
a hospital cannot reject that care.

There are certainly difficulties with the boundaries
and the defined catchment areas of mental health services,
and there are currently certainly problems in child and
adolescent and in other areas, I believe, in also in aged
psychiatry, that the boundaries don't line up to other
catchment areas, and I think a review of those catchment
areas to see if some changes could be made to better
line some of those catchments.

Whether you could now just through your contracts with
health services ensure that they would be obligated always
to treat the mentally ill and therefore do away with the
defined, you know, I wouldn't rule that out, but it has
been seen as really a safety net for patients rather than
something that was put up as a barrier for patients.

Q. You've talked about the proposal that Northern Health take control of mental health in the future. If that was to be the case, how would you then optimise the governance and accountability for mental health within your health service?

A. Yes. Well, firstly we would need to be gazetted as a hospital that could receive mental health patients because we're not currently a gazetted hospital, since we don't do that, so there is a requirement for government to give assistance to that through regulation, I believe; it's not a legislative change that would be needed, so that would be the first step that would need to happen.

The staff would need to be transferred across: that has happened in other service areas, quite routinely that can be done. Northern Health would need an executive structure to incorporate mental health as a significant clinical program reporting either to the Chief Executive or to the Chief Operating Officer, and there would need to be a transition program developed and negotiated with Melbourne Health to progressively bring the services across to the accountability of Northern Health.

It obviously would be at least a 12-month period to transition this across, and there would be some issues with some of the services that would be more difficult to transition quickly than others; some that are entirely catchment based are very easy, but there are others like child and adolescent and things like that which would be more complex to transition.

So, the Board would give a lot of attention to the transition of mental health from Melbourne Health to Northern Health.

I have raised this with the Chair of the Board at Melbourne Health and the Chief Executive at Northern has had discussions with the Chief Executive at Melbourne and it is supported that this transition occurs, but we've just not yet been able to progress the transition.

Q. In that sense, is it a bit premature to think about how governance and accountability for mental health might be optimised?

A. We would certainly be giving a lot of attention to
that, and the Mental Health Program would need to be incorporated within our governance frameworks, our clinical governance frameworks, our audit program and a number of different aspects of the governance of Northern Health where we currently do not have mental health at all.

Q. Can I ask you this question, really in terms of your observations of what's occurred since the 1990s, so sort of going back to that historical perspective, at paragraph 53.

Since the 1990s have there been developments either in the service system or in the community generally that should be considered in future reform? And you might address in that activity-based funding but future reform ideas more generally.

A. Yes. Mental health has been funded historically mainly through block funding, and there have been attempts to come up with activity based funding models for mental health over many years. You are probably going back 15 years the work initially started on that.

That work has continued and there are now some data collection occurring to move to a somewhat modified funding system that the Independent Hospital Pricing Authority, on which I am on the Board, has been working with the jurisdictions to do it. So, I think Victoria is a willing participant in that, and I think in time that will probably occur with the support of other jurisdictions as well.

I think, since the 1990s, there have been - I mentioned before, we're now up to the Fifth National Mental Health Plan and there have been multiple State plans as well. What has been missing though is the determination to put these plans into action and for them to have successful implementation.

So, the goals and the visions within those plans are very worthy, but we have not been able to realise the improvements that those plans have aimed to achieve, and I go again to the fact that budget support for those changes are necessary if mental health is to receive the attention that it does and if we are to start to deliver the sort of quality mental health services that I think that everybody that works in the sector would like to see delivered.

This goes right across the whole mental health system, and I think when you think about changes to the mental health system...
health system, you can't talk about improvements in just one component of it, because all parts of the mental health system are so interrelated, so you could augment the bed-based services, but the community-based services would still be under stress; the NGOs would still be under stress for supported accommodation, et cetera.

So, there is so much interdependency with the different components of the mental health system that that is why I think the need for a plan that has got very firm commitment at State level, at all levels, followed by the funding, is essential if we are to move mental health out of being the lowest funded and one of the poorest performing in the country, to be the pre-eminent State that is leading in mental health service delivery where I think we'd all like to see it.

MS COGLIAN: Thank you, Ms Williams. Chair, do the Commissioners have questions?

CHAIR: Q. I have a number. Thank you very much for your overview today, Ms Williams.

I guess, trying to understand the particular model that's in place for Northern is unusual in terms of the way it's constructed, so just to make sure I and the other Commissioners understand it.

We had in the attachment and in the submission from Northern Health that your Emergency Department is one of the busiest, if not the busiest in the State?

A. That's correct, Northern Health has more presentations to its Emergency Department than any other hospital in the State, and we have more ambulance arrivals than any other hospital in the State, and we've been the busiest for over a year now and we're growing at the rate of about 8 per cent per annum, so again, the highest growth rate per annum and that's because of the population growth in that northern corridor up the Hume Highway.

Q. Of those, I understand a significant number, many thousands present in any year with mental health issues and a proportion of those patients might need inpatient admission?

A. That's correct, yes.

Q. Can you make sure we understand what happens when your
Emergency Department clinicians assess someone as needing a mental health bed, for example?
A. Okay. Well, the Northern Health clinicians can't assess if someone needs a bed or not, we have to call on Melbourne Health to do that. So, if a mental health patient arrives at the Northern Emergency Department, the clinical staff there will make sure the patient is medically stabilised, if it's an overdose patient, obviously they will treat that patient. But, if it's a mental health assessment that's needed, that can only be done by Melbourne Health, so we then call upon Melbourne Health to attend the Emergency Department and to do a mental health assessment of that patient, and then they are the only ones who can make a decision on whether to admit or not.

We have acute mental health beds on site at Northern that they are responsible for running. Often those beds are full, and Melbourne Health might have to admit a patient from Northern Health to one of the other units within Melbourne or within their own control, Melbourne Health meaning Western Health or Melbourne Health. So, Melbourne Health makes those decisions, not Northern Health.

So unlike other patients, Northern Health emergency physicians can make the decision to admit a patient to a medical or surgical ward that will expedite the treatment of those patients either to a short stay unit or up to one of the wards to get treatment, but that does not occur with mental health patients at Northern.

Q. So, if there was, for example, an adverse event in the inpatient unit, i.e. a staff member assaulted by a patient, or vice versa, what visibility would your Board have of that incident?
A. We'd have no visibility of any incidents that occur in the mental health units at Northern Health. We have visibility of assaults and other incidents that occur in the Emergency Department and they are often jointly managed with Melbourne Health and Northern Health if there is issues, incidents occurring within the Emergency Department.

The Northern Health Emergency Department, unfortunately, is also very poorly configured to deal with mental health patients. We don't have a behavioural
assessment unit which most hospitals now have, which is an
area that is specifically designed for mental health
patients within the Emergency Department, so we have to
care for our mental health patients in our resuscitation
bays where there could be severely unwell, frail old people
or young people dealing with, it could be a very
psychotically disturbed mental health patient in these
bays, so we have also been attempting to get funding for a
behavioural assessment unit so that we have better
facilities within the Emergency Department to deal with
these patients.

Q. Can I just take it from that, that would also mean you
would not have visibility about how the triage arrangements
work, the activities of the CATT Team?
A. Correct.

Q. The subacute services and community-based services in
your catchment area?
A. No, we don't have visibility on that, no.

Q. On an unrelated matter but goes a little bit in terms
of your background. In terms of thinking of a contemporary
mental health system and in terms of technology, you did
say at the moment you don't have visibility about that
client medical record. But in terms of other opportunities
for technology and enhancements in mental health, do you
have any views about what needs to be done to modernise the
mental health system in relation to technology?
A. Not specifically in relation to technology. Access to
the medical record is a very easy thing. There is a
statewide mental health IT system that's been in place for
many, many years. It's just that, because we're not a
provider, we don't have access to that system, so not in
terms of technology.

I think the enhancements to mental health, the service
delivery system, is more about trying to augment the sort
of core elements of the mental health system, such as the
inpatient beds and the community teams to have extended
services. So, things like the behavioural assessment unit
that I mentioned before in the Emergency Department, they
didn't exist even five or six years ago and that has been
something that's seen as a vast improvement of how we care
for people within the Emergency Department.

Things like urgent care centres, crisis centres which
are in the community, certainly in South Australia that's something that they are currently considering, it's been a model that's been developed in the US where they have clinical and non-clinical staff. There's a big peer workforce that are used in these centres where police and ambulance can take people to these centres so that they don't present to an Emergency Department, and they are less like a clinical setting, and these are taking people that don't need to come to an Emergency Department and dealing with them in these centres.

So, there are developments such as that which I think augment the core service system which are very valuable additions to what we have within our mental health system.

CHAIR: Thank you, we may follow up and make sure we know where to look to get further information in relation to that. Thank you.

MS COGHLAN: Thank you, Chair. May this witness be excused?

CHAIR: Yes, thank you very much Ms Williams for your statement and your evidence today.

THE WITNESS WITHDREW

MS COGHLAN: Is now a convenient time for a five minute break?

CHAIR: Yes, a five minute break.

SHORT ADJOURNMENT

MS NICHOLS: Commissioners, the next witness is Ms Kym Peake, I call her now.

KYM LEE-ANNE PEAKE, affirmed and examined: [2.22pm]

MS NICHOLS: Q. Ms Peake, are you the Secretary of the Department of Health and Human Services?
A. I am.

Q. You've held that role since November 2015?
A. That's correct.

Q. Prior to holding that role, you had a number of senior
public service roles, including as Executive Director, Productivity and Inclusion at the Department of Prime Minister and Cabinet?
A. Yes.

Q. Deputy Secretary, Higher Education and Skills Group at the Victorian Department of Education and Training?
A. Yes.

Q. Lead Deputy Secretary, Strategy and Planning at the Department of Economic Development, Jobs, Transport and Resources?
A. That's right.

Q. And Deputy Secretary, Governance, Policy and Coordination at the Victorian Department of Premier and Cabinet?
A. That's right.

Q. Are you currently the President of the Institute of Public Administration Australia, Victorian branch?
A. I am.

Q. With the help of the VGSO, have you prepared a statement?
A. I have?

Q. I tender the statement. [WIT.0003.0006.1000]
Ms Peake, I'd just like to ask you some questions, to start off with, about the current state of the mental health system in Victoria and confirm some things that are in your statement.

You've said that:

"Substantial reform is required to improve the experience and outcomes of consumers of mental health services in Victoria. The intended shift to person-centred, rights-based and recovery-oriented service models and practice has not yet been realised."

That's correct, isn't it?
A. That is correct, and I think, if that's okay --

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

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

"Melbourne's rapid demographic changes have placed particular pressure on services in growth corridors.

"This pressure within public mental health services is creating a vicious cycle. A lack of community-based care is increasing emergency presentations and driving a need for more inpatient services - diverting resources from the community where care could have been provided sooner and more cost-effectively. Pressure on inpatient units is also driving shorter stays for typical patients. Earlier discharge is in turn putting more pressure on community mental health services, resulting in a 'revolving door' of readmissions to hospital.

"While average lengths of stay in acute inpatient units are decreasing, there remain a significant number of long-stay patients in acute inpatient units who are not discharged due to a lack of stable housing or suitable sub-acute and non-acute bed-based alternatives.

"For people whose offending is related to an underlying mental illness, a gap in the availability of treatment also risks people entering and becoming entrenched in the
There are also treatment gaps for children and young people, which mirror the gaps seen in the broader mental health system."

Does that encapsulate one of the core problems within the mental health system?

A. I think it does, yes.

Q. Recently, the Chief Psychiatrist, who I note is here today, gave evidence in these terms:

"In response to high demand, mental health service providers focus on the most acute and severely unwell consumers. Consumers may receive less treatment and treatment later in an episode of illness often resulting in increased severity of symptoms. This compromises the principles of Section 11 [of the Mental Health] Act."

Now, you don't disagree with that, do you?

A. I do not.

Q. "This increases the likelihood of the need for compulsory treatment. The numbers of consumers being treated compulsorily restricts the capacity of services to accommodate individuals who seek treatment voluntarily."

You don't disagree with that either, do you?

A. I do not.

Q. Finally, the Chief Psychiatrist also gave evidence in these terms:

"Access to intensive treatment and support may only be available later in an episode of illness and discharge is more likely to occur before the therapeutic benefit of the admission has been realised. Community-based services are then required to provide treatment to consumers in acute stages of illness."
You agree with that?
A. I do.

Q. Finally:

"Community-based services have insufficient resources to provide the intensive treatment and support required for consumers who are very unwell. Their resources do not allow them to provide evidence-based psychological interventions which assist with longer-term recovery. These consumers are therefore more likely to experience slower recovery or a relapse of very acute symptoms."

You don't disagree with that, do you?
A. I do not.

Q. Thank you. In the submissions filed by the Victorian Government, the government has pointed to five gaps in the system which I just want to take you to very briefly. Can we have the slide from the submissions, please?

Ms Peake, just take a moment to have a look at that. That's a page from the Victorian Government's submissions. Are you familiar with that page?
A. I am, yes.

Q. You will see there that the gaps are identified. The first, second and third run across the top, they are the early engagement gap, the missing middle treatment gap, and the severe mental illness treatment gap. Down the bottom is the child and young people treatment gap. You've said quite a bit about those in your witness statement that I don't think we need to elaborate on. That, if I may say so, is consistent with the evidence we've heard in this Commission: would you agree with that proposition?
A. I would.

Q. Would you also agree that the gaps in treatment run right across the spectrum of people in Victoria who would be seeking or would otherwise require treatment for mental ill-health?
A. I would.
Q. Can I ask you now about the box down the bottom which
goes to the gaps in the foundation of the mental health
system, and those are named as: "Governance, Funding
Mechanisms, Data and Systems, Workforce and
Infrastructure." The slide can be taken down now, thank
you.

In your statement and in the Victorian Government
submissions, those factors are described as critical
enablers for the system. Can you say why they're described
in those terms?
A. Yes. I think in any complex system the ways by which
the policy funding and information settings are applied
really influence how care is delivered, the capacity of
services to be able to meet need, and the way in which a
system can continue to evolve and improve as evidence
develops, but also as population shifts and the environment
within which those services are delivered changes.

Q. It is not possible to have a properly functioning
system without each of those mechanisms itself properly
functioning, is it?
A. I think that's right, and there will always be, I
think, the case that each of those type of supporting
conditions for a service system will need to evolve; there
isn't a perfect moment in any service system I've been
involved with where you would say all of those enabling
conditions are at an optimum, but they are incredibly
important to continue to improve to deliver improved
outcomes.

Q. Thank you. Can I just ask you to confirm the role of
the Department, acknowledging that, as you've said in your
statement, there are a number of other entities in the
system that also play a role, I just want to concentrate on
the role of the Department, if I may.

You say this in your statement, under the heading,
"The stewardship role of government", that:

"Making progress in improving the lives of
people facing complex social issues
requires government to assume a duty of
care and stewardship of the services
designed to support them. How government
exercises this role needs to be consistent
with the values-based principles
established for the whole reform."

A. That's correct.

Q. And that really, in some senses, encapsulates the role
of government in which the Department plays a part. Is
that right?
A. That's right, and I think that really what I tried to
capture in the expression of stewardship and a duty of
care, is that, we don't simply have a purchaser/provider
relationship with the entities that are co-producing
outcomes for people who have mental illness, for their
families, for carers and for the staff involved; that we
have a responsibility and a very significant role in
working with consumer groups and with the providers of
service to look at what are the best evidence and data to
improve the models of care, then to link that work on the
design of models of care to the funding models that support
those models of care to be delivered, through to
understanding what sort of measures will enable us to
understand the impact of those service models, but also
that those service models are being appropriately
delivered, right the way through then to the feedback loops
that enable us to build new evidence and the cycle
continues.

Q. Can I just, perhaps try and encapsulate what you've
just said by reference to your statement. You say that:

"The Department fully accepts our
responsibilities to perform a number of
critical functions."

And to summarise them, they are the provisioning of
service and infrastructure planning which involves
assessing need, comparing current services to need, then
identifying gaps that might be priorities for investment?
A. That's correct.

Q. Service model design and development, which involves
drawing together leading evidence to design service models
that can meet the needs of identified consumers?
A. In conjunction, as I mentioned, with the people who
have the expertise to inform that work.

Q. Yes:
"Resourcing involves the procurement or funding of services, drawing on careful design and specification of service models that would meet need, and consideration of how these would be provided. Funding models, prices and incentives are all considerations for resourcing."

A. That's right, and I think there are those two parts that you've identified there: there is the case that we make to government for a level of funding, and then within that available appropriation, it's the funding mechanisms that optimise how that funding can be used.

Q. "Performance monitoring is the means by which a commissioner [meaning the service commissioner of the Department] evaluates whether funded services meet identified need (including in specifications like quality). In modern public sector commissioning, performance monitoring is usually connected to improvement so that service systems do better over time."

I think I've covered those. Does that well encapsulate the role of the Department?

A. It does.

Q. We heard some evidence, some time ago now, from Assistant Commissioner, Glenn Weir, and he said this to say:

"I think everyone's worked really hard and nobly in our own particular areas to do the best we can, but there's no high level coordination or leadership about a lot of these services being provided, and not only how that service operates for the particular silo, but how it works in integrating with all the others.

"So, I think as an outcome, from a health-driven perspective to provide clear and concise direction around what is trying to be achieved to help people experiencing
mental health and to prevent people who might be at the risk of falling into the harm space to be done, that's really quite clear: to provide high level, joined up, coordinated and integrated approaches to what we're all doing for a common purpose, to reduce any barriers that might exist between agencies, even between intra agency, I think that is absolutely vital. But if we keep doing the same thing and expect a different outcome, I don't think that's realistic."

Would you accept, Ms Peake, that a critical challenge for the Department is to provide leadership at a systems level?
A. I would, but I would make two reflections.
Q. Yes.
A. I would say that in my mind there are two levels of governance that are really important to delivering what that witness was really pointing to. The first, as you reflect, is really at the system level, and I call that institutional level of governance, and it is about the role that the Department plays in conjunction with the Ministry in providing that clarity of purpose, sense of direction and providing the mechanisms across government to really join up effort.

Secondly, there is then a service level governance, which is about how that then translates on the ground into better connected services, particularly for people who have multiple or complex needs, and that doesn't happen simply by there being appropriate policy settings and strong collaboration across the Ministries that are involved in setting up the system settings. It is critical that that cascades down into the institutions and agencies that are involved directly in the delivery of services and are really best placed to understand the differing needs of differing communities across the state.

Q. And it's the system leader's role, is it not, to understand how those values and objectives are understood and cascading down throughout the entire system?
A. It is.
Q. Can I turn now to a different topic, and I want to ask
you about planning in order to meet demand. For the
purposes of these and a number of my questions I'm going to
ask you to put on a somewhat historical lens, acknowledging
that you did not occupy the office you now hold for the
whole period, but we want to understand why it is some of
the conditions we discussed before have arisen in
order that they don't arise in the future.

The evidence you acknowledged earlier points to a very
considerable and concerning gap between supply and demand
in the mental health system: do you agree with that?
A. I would just say before we go through this series of
questions, that I will give answers as fully as I can,
recognising that there may be public interest immunity
matters that come into scope, but I absolutely will
endeavour to give you as much information as I can.

Q. Yes, Ms Peake, as your counsel and I have discussed I
think the way we'll deal with this is, I'll ask you a
question and you endeavour to answer the question as far as
you can. If you have any public interest immunity claim,
just say so, and then we will take that off-line and we'll
go to the next question. Is that satisfactory?
A. It is, and sorry, if you wouldn't mind repeating the
first question?

Q. No problem. The evidence we discussed a moment ago
points to very considerable and concerning gaps between
supply and demand in the mental health system: do you agree
with that?
A. I would, and as we go through I would say that the
questions of supply are obviously influenced by resourcing
decisions by government.

Q. Of course.
A. And so, there will be some limits on what I can
reflect on there. I would also say that the ability of the
system to respond to demand has, in Victoria, been
profoundly affected by the rapid population growth, and I
think we've heard from witnesses in the last day and a half
the particular impacts that that has had in growth
corridors of the state, and not only in sheer numbers, but
also in changing demographics in those areas as well.

Q. With that said, I would like to focus on the
capabilities within the Department over time to engage with
that fact.
As the Auditor-General observed in his Access Report, of which you have had notice, the Department's 10-Year Plan for 2009-2019, so the previous iteration of the plan, forecasts the imminent gap in meeting demand. Are you familiar with that report?
A. With that plan, I am, yes.

Q. I would just like to turn to it, if I may. Can the document please be shown, it's entitled, "Because mental health matters". You don't need to turn to it, Ms Peake, but I think it's referenced in paragraph 50 of your statement. The document will appear on the screen in just a moment. [DHHS.0002.0003.1073]

Before we turn to that document, can I just put this to you. The Auditor-General said at p.10 of his Access Report:

"As system manager, DHHS has a responsibility to ensure service access by supporting the foundations of the system: funding, capital infrastructure and service distribution, and understanding demand and system performance to guide proper investment."

Do you accept that as an accurate description?
A. I do, and as we work through this, how we build that picture, again, I think engages both level of governance: so, the system level governance and the sorts of information systems that we have in part and need to continue to develop, but alongside that the rich local information that I think very positively has been a commitment through the Fifth National Mental Health Plan for stronger collaboration between Primary Health Networks and our health services to really pull together local information about need, which then will cascade up to give us a richer - another source of rich information.

Q. I'll certainly give you an opportunity, Ms Peake, to talk a bit later on about the good work that's going on now, but we might just go back in time a little bit, if we may.

Commissioners, this document has hopefully appeared on your screens. Can we go to internal page 7, please. Just
to clarify, Ms Peake, you were not in the Department at the
time this document came out?
A. I was not.

Q. But it's one you're reasonably familiar with, I take
it?
A. I am.

Q. Just for context, about two-thirds of the way down the
page, you will see the words, "And yet". Can you see,
nearing the top of the page:

"And yet, as Part One of this document
argues, it is time for a shift in our
thinking on mental health. This means
looking at the mental health needs of the
whole of our population, at the social
determinants of mental health and mental
illness. It means considering mental
health and mental illness as everyone's
business."

Now, that's just a bit of context. But we are doing
the very same thing right now, aren't we?
A. That's right. This is very consistent with the
philosophy behind the stepped care model that is described
as a positive direction forward in the whole-of-government
submission.

Q. Can we have internal page 9, please. You will see,
under the heading:

"Secondly, it [this is the plan] covers
programs and services that respond to
people experiencing the spectrum of mental
health conditions."

I won't read out the whole text, but you will see that
that plan is focused on covering the whole spectrum, and
that includes, does it not, the spectrum of people depicted
in the graph that we displayed at the outset in the
Victorian Government Solicitor's report?
A. That's right, and I think the - sorry to leap ahead -
but the practical consideration in that is the different
role that the state will play in different parts of the
system where some - your earlier description of our system
manager and steward role is much more direct, and where
we're talking about the work that is funded and regulated by the Commonwealth Government, it is still incredibly important that we are active partners and that that local and regional planning is brought to bear, but the levers that we have to influence that are more indirect.

Q. But both this plan and current circumstances, including the Victorian Government submission, recognise that the mental health system has to engage with the entire spectrum?
A. That's right.

Q. And we've still got very significant gaps right across the entire spectrum?
A. That is absolutely right.

Q. Can we have internal page 13, please.
A. I might just add, as we're moving to that, that for me one of the opportunities of being the Chair of the principal committee that brings together Commonwealth and state senior officials responsible for mental health is absolutely to make those connections, to look across the whole system.

Q. Thank you, Ms Peake. Just while we're here we might go two-thirds of the way down the page. You will see the text, the third dot point now from the bottom:

"Renew our Suicide Prevention Plan, Next Steps: Victoria's suicide prevention action plan, using the new national framework to strengthen our ability to identify and respond to risk factors and emerging trends in suicidal behaviour and suicide prevention."

I don't want to get into any great detail about suicide, but are you familiar with whether the plan being introduced at that stage at Victoria's level was substantially different to the plan that's recently or more relatively recently been rolled out?
A. I'm not aware of the compatibility of those two, I'm sorry.

Q. Thank you. Can we have internal page 14, please. You will see halfway down the page, under, "Reform area 3", the first dot point:
"Create more accessible information, advice and referral services that can assist people with a broad spectrum of mental health problems, including a 24/7 call line for the general public."

Now, I'm not assuming you know about this, but do you happen to know anything about that?
A. Look, only that I know that there was, subsequent to this strategy, a change in government and a change in direction on some of the detail of this plan, and I know that - I'm sure that we'll get to - there continue to be significant challenges around triage in this state.

Q. Thank you, Ms Peake. Can we look at internal page 23, please. You will see under the heading, "Population based planning" the words:

"Planning services on the basis of the needs of, and impacts on, the whole community (and defined subgroups), and across the spectrum of severity. This approach will help ensure that the effort is invested where the greatest benefits can be realised, while maintaining a clear focus on those with the most intense and urgent needs for support."

You would accept, wouldn't you, that that's the goal that we have today, among others?
A. That is correct.

Q. Can I ask for internal page 24, please. Under the heading, "The mental health outcomes framework" the document reads:

"In line with national health performance frameworks the proposed mental health outcomes framework will provide the basis for a set of agreed mental health indicators ...

Population surveys and other data will be used to assess achievement over time of agreed population outcomes, such as reductions in prevalence of mental health
problems, level of disability associated with mental health problems and associated economic and social impacts."

Q. This outcomes framework, is that really the kind of outcomes framework that you are now looking to implement? A. It is, and I'm happy to speak now or if you prefer till the end.

Q. We'll go to it at the end. But in substance, it is still reasonably aspirational at this point?
A. That's right, aspirational, narrative description of outcomes with key performance indicators, or performance indicators that enable us to look at all parts of the system that need to contribute to improvement.

Q. We'll go to the substance of it a bit later, but my point is rather this: that way back in 2009 the objective to implement an outcomes framework was present. I accept that you weren't there at that time, but we're still endeavouring to do that; is that right?
A. I would caveat that in saying that the outcomes framework that was put in place with the 10-Year Plan that was released a couple of years ago does have a range of measures that are now populated. There are still some that have not been, but they have a range of indicators that have been populated and are publicly released on an annual basis.

Q. Can we go to internal page 29, please. Here you will see the predictions that the Auditor-General referred to in his Access Report. Under the heading, "Drivers for change", it's said:

"An estimated 19 per cent of the population is affected by a mental health problem in any 12-month period ...", and so on.

Underneath the box:

"In reality, by 2019 these numbers are likely going to be higher given a range of factors including the ageing of the population."

There's some further information, and it's then said:
"Action is needed, not only to address the current needs of the Victorian population but to plan for the projected numbers of people likely to be seeking help for mental health problems in 10 years' time. Not everyone with a mental illness seeks a mental health service, however those people who actively seek a service, too many do not receive help due to factors including complexity of needs, cost of accessing private services, or the lack of public or private services in their locality."

What I'd like to suggest, Ms Peake, is that, the need to understand the demand pressures caused by population growth was understood back in 2009?
A. Yeah, I think that's absolutely right, and the population projections that were informed, the planning of every Department, so the whole-of-government population projections were wildly exceeded by the rapid growth in the state; that doesn't detract from your point at all.

Secondly, I think that right around the world - and New Zealand is a great example of this - the other piece of this puzzle is understanding the intersections between other services, whether that's housing, justice services, that also can either ameliorate or exacerbate those pressures
Q. We'll come to those a bit later. Only two more references in this document. Can I have internal page 32, please. Under the heading, "Key aspects of the reform challenge", it's said that:

"Despite progressive growth and many innovations in mental health-related services over the past decade, some significant gaps and imbalances have emerged. As a result, we are missing important opportunities to improve the lives of many Victorians ...

While strengthening core services remains important, the wide consensus is that just investing in more of the same will not yield the benefits we need to see."

There's reference to a paper which focuses on a need...
for emphasis on:

"The importance of delivering services that are recovery-oriented and are informed by consumers' and carers' perspectives and recognising the need for culture change to one that empowers those who use services."

Those values discussed there, they're now embodied in the Mental Health Act and they're specifically reflected in section 11; is that right?

A. That's correct.

Q. You are aware, are you not, that the Chief Psychiatrist has given evidence to which I alluded briefly earlier that essentially, because of very significant demand pressures on the system, a number of those principles are being compromised and they're not able to be embodied in the mental health system?

A. I think that's right, and I would also reinforce that, in my conversations with the Mental Health Complaints Commissioner, that the same feedback around the impact of capacity, models of care, and access has been on being able to realise those principles.

Q. Finally, just on page 35, there is the observation that:

"Demand pressures on specialist public mental health services are considerable. Services have continued to provide quality care and made many adjustments to cope effectively with demand. Yet measures such as the rate of involuntary admissions, bed occupancy levels, and emergency department waits remain a cause for concern."

It's the case, isn't it, that it may have been a concern at that point but it's now developed to a crisis state?

A. Yes, it really is at a much more serious level of both occupancy, and the ability for continuity of care into the community is much more acute now even than then.

Q. Thank you, Ms Peake. I just want to put something to you that the Auditor-General found, again acknowledging that you haven't been occupying the office for the whole
period. The Auditor-General concluded in his Access Report that:

"The Department has done too little to address the imbalance between demand for and supply of mental health services in Victoria."

Now, the Department accepted that finding, did it not?
A. It did, and again, I would reiterate that implicit in that is both demand and supply, so we accept the finding in the context of our capacity to work within the parameters we operate within.

Q. Of course. There are many other subjects to discuss, but at a high level, what are your observations about the systematic impediments to DHHS understanding, as a part with others, addressing the gap between supply and demand? I'm asking you for an historical view at this stage?
A. Yes, so I would talk to three impediments. The first is that the clear issue around the level of resourcing that is available to the system, and I think there are two reasons for the pressure or the challenge that has been encountered in securing those resources, and I think these are actually common challenges to a lot of social services.

The first is technical, and it really goes to the points you've just made, the reflections of the Auditor-General around the sophistication of the systems, the analytic systems, to be able to model demand and provide advice to government about social return on investment.

The second though I think is more cultural. When I reflect, and I just look back at my time as Secretary of Department of Health and Human Services, there really have been four areas that have experienced growth in funding, and they are: funding to support elective surgery and Emergency Department, funding to support mental health actually, funding to support child protection and funding to support family violence.

I think the common characteristic between those four areas is that there's been strong political leadership, that there's been community acceptability for significant investment to be made in those areas, and there's been the ability by the nature of the investment to show really
reasonably quick outcomes or returns which build community
trust in a service they value.

I do think that, where there is significant stigma and
discrimination associated with a type of service, that that
has the practical effect of discounting the public value
that is placed on that service.

And so, that would be my first reflection, that I
think - I will be quick, I promise.

Q. Yes, we'll return to that question later.
A. The funding is a critical one. The second one, and
I'm sure we'll return to this so I'll just give a headline,
is around the funding mechanisms. We have had an expert
view that really elucidates the ways in which the existing
block funding model, as you've heard a lot of evidence
about, doesn't create the right incentives for the right
models of care and continuity of care, and we can talk more
about the history of that.

Then I think the third is that there hasn't been the
link between the population level data that we hold
translating down or, sorry, gathering up more local
information, we haven't had good enough systems for that.

Q. Thank you, Ms Peake, that's a very convenient summary.
Just on that point, without descending to too much
granularity, one of the foundation gaps you identify, or
the government identifies, and the Auditor-General
identified, is data limitations, and I think it's called an
undeveloped or unrefined approach to data forecasting in
the Victorian Government's submissions.

Can you say, without being too technical about it,
what are the principal limitations on data gathering?
A. So, a couple: one is the information systems to enable
data that is captured routinely to be conveniently,
quickly, easily, aggregated up.

The second then is that, the methods that we have used
in government have tended to take more of a statistical
approach to the analysis of that data.

Q. As opposed to?
A. As opposed to really being able to use more
sophisticated machine learning techniques to be able to
project forward and in different scenarios - it's called micro-simulation, I won't get technical - but to really understand what would be the practical effect of different types of investment on costs and outcomes.

Q. Is there presently the capability to do that?
A. We are developing that capability. We have much better systems to be able to do the machine learning; the micro-simulation, we are in the process of - even though we're in Australia, it's got this deep capability, but we're in the process of building that capability right now.

Q. Can I just interrogate that answer a little bit because, implicit in it, it may not have been intentional, is the suggestion, I think, that you don't have the data capability because technically it's not available. What I'm really after is, what were the impediments to gathering and analysing the appropriate data?
A. That was really the first piece. The gathering was really that we haven't had the information systems on the ground to make it easy to extract that data. I know the Auditor-General talked at some length about the difference between our model of governance of health services where there are individual systems at each health service. There are many benefits to that, and I'm sure we'll talk about that. One of the practical implications is that, with a few exceptions we don't have an easy way of looking in and seeing data across the board, and then there's the technical capability to analyse it.

Q. But you would accept, wouldn't you, that it's essential to have that capability to gather data from the component parts of the system that has devolved governance?
A. And, in order to do that, you either need to have, and there have been efforts to do this, you either need to have compatible systems, and that's really not realistic, or you need to get - the IT market is getting much better at providing solutions where you can have data kind of sucked out and put into a portal - and I am not trying to make excuses for the gaps in our capabilities, but I think there is much more technical ability to, in a cost-effective way, fulfil that requirement of our system management with the developments in the cloud and IT systems going forward.

Q. There is the suggestion, is there, that the reason there hasn't been proper data gathering and analysis has been simply because of a lack of existing technology?
A. No, but in the absence of that technology, there has been a much bigger endeavour, and I have also indicated, I think, it's not only about that sucking up the data, it has been about the analytical capability to make use of that data as well.

Q. To finish off that point, your evidence is that the Department is --
A. On the journey.

Q. -- gaining capability?
A. On the journey.

Q. And, to put it --
A. Sorry, and I should say that I think one of the really important developments in the last couple of years on the back of the Duckett review into quality and safety in the health system has been the creation of the Victorian Health Information Agency which has provided a dedicated capability in the Department for this type of work, working with our performance people to make sure that we've got both the custodianship of data clear, but then the analysis of that data capabilities being lifted.

Q. Alright, acknowledging that today's not the occasion to focus at great length on data, but you do accept, don't you, that in light of what the Auditor-General has found, and in light of the various statements in your evidence in the Victorian Government's submissions, that having the capacity to gather and properly analyse data is absolutely essential for the system leader?
A. It is a critical priority and it is one that is not fully there in the system, absolutely.

Q. And what you said in your submissions is that the absence of data capacity, if I can just summarise it in that way, has inhibited long-term statewide infrastructure planning: that's correct, isn't it?
A. It has, as well as service planning, yes.

Q. And it's also inhibited outcomes monitoring?
A. It has, although I would add, in addition to those core data sources, I think that we have been - between 2010 and now, evolving our technical capability about defining the indicators as well.

Q. Alright, but I think your evidence --
A. But it is a critical part of it, yes.

Q. And your evidence and the Victorian Government's submissions are to the effect that the data problems have inhibited outcomes monitoring?
A. Yes.

Q. And also have inhibited demand predictions for the purposes of managing supply?
A. Correct.

Q. You accept, don't you, I think on behalf of your predecessors, that back in 2009 it must have been understood that this sort of capability would be necessary to have?
A. And would be a priority to develop, yes.

Q. And it now is a priority, I take it?
A. And it has - there has been improvements; there's a way to go.

Q. Alright, we'll leave that topic for now. With that background, can you say, why is it that, at least on the evidence we've heard in this Commission, that Victoria's growth corridors have experienced the highest rates of population growth, are said to have some of the highest rates of mental distress, but also received some of the lowest rates of funding per capita? What factors have led to that outcome?
A. So, I think there's really two factors: one is the lead times for the development of infrastructure and creation of bed capacity and adding staff. There have been recent investments in the last couple of years, they will take a while to come online. So, in the meantime where there is extra funding that is provided to us, the way in which we allocate that money takes account of where there is capacity to deliver.

Q. So, are you saying that --
A. It's a bit of a vicious cycle.

Q. -- it's hard to catch up: if population growth gets away from you, it's quite hard to catch up, is that the gist of it?
A. That's right, and to make sure that we make best use of the money right now, that it is dispersed differently between the catchments.
Q. Does the Department accept that it is a priority among many others, but a priority nonetheless to ensure that the growth corridors are better funded?
A. Better funded, and that there is an opportunity to look at what that funding is used for, so the models of care.

Q. Can I ask you about the framework for strategic planning. Now, the 10-Year Mental Health Plan is the most important strategic document, is it not?
A. Unlike the 2009 document, we were very conscious - this was right at the time I started - but we were very conscious of not looking to start/stop strategic direction. In the 10-Year Plan there is a cross-reference back to building on the strategy from 2009. I think there was a very strong view that, to take another three years, which was about the time that strategic plan took to develop, would miss the urgency of getting on with ensuring that there was more capacity put into the system.

Q. But it is the document that sets out the strategic --
A. If I could just finish.

Q. Oh, sorry.
A. So, therefore, it was a clear decision that it would be an important document, but not the only document, that would guide strategic direction and investment in that term of government, and that it would be complemented with some other sub-plans or parallel work on a service and infrastructure plan for the whole of health, including mental health, for example, a Suicide Prevention Plan which was released about a year later; the work that was happening at the time on the Fifth National Mental Health Plan, putting effort into that and the regional planning that came out of - that was reflected as a commitment, all Ministers signed on to from that.

So, I think it is important to say it was an important document, but it was designed in a slightly more narrow way to enable us as a Department and the government more broadly to get on with the important work of the system.

Q. So, acknowledging that there are companion pieces, this nevertheless is the place where one looks to find the strategic plan for mental health in Victoria?
A. Certainly, it is the place to look for the outcomes.
Again, I would say that there are a suite of documents that
give you the strategic plan.

Q. In your statement you've said the plan was a good
start to defining outcomes, but that further work is
needed. I'll take you very shortly to it, so you can tell
us what that work is. But, I think in light of some
findings of the Auditor-General, in your statement you've
acknowledged that the plan did not outline the optimal
level and mix of public mental health services or describe
actions required to deliver a comprehensive stepped care
model for Victoria?
A. That's right, because it was part of a suite of
documents that covered different elements of that.

Q. I see. Do you accept the Auditor-General's finding
that, while the 10-Year Plan clearly identified significant
service demand and access issues, little within it directly
addresses the access issues?
A. And again, I think the intent was that that work would
be progressed outside of the domain of the plan through the
development of a service and infrastructure plan, and
through then subsequently some commissioned work that did a
much deeper dive on looking at what were the drivers and
solutions which is informing continued thinking in the
Department.

Q. We'll go to more present time in a moment, but do you
accept the Auditor-General's criticism really of the plan,
that it really didn't deal itself with the most pressing
issue, which was the access to services issue?
A. I would absolutely accept the finding about the scope
of the plan. I guess what I am trying to indicate, is
that, my perspective coming into the Department at that
point was that that wasn't the intent of the plan. The
intent of the plan was to provide what over that term of
government in particular could be the initial work, the
first two waves of reform, to enable there to be a deeper
dive into those issues around access and forward solutions,
and the third wave of the plan foreshadowed that further
work being done, it didn't try and wait for it to be done
for the plan to be released.

Q. Do you accept that, as a system leader going forward,
that the strategic vision and documents that reflect that
should deal with pressing issues such as access?
A. Absolutely, and that the link then to the 10-Year Plan
needs to be made very clear, where you have a separate
document that provides that sort of guidance to the sector.

And, with the advent of the Royal Commission I would
be extremely optimistic that the findings and
recommendations of the Royal Commission will provide us
with a lot of that roadmap which may lead to there needing
to be some or some significant changes to the overarching
plan, but obviously will provide more detailed guidance on
those specific issues around access as well.

Q. Of course, and just one more question on this topic:
back in 2015, when that plan was introduced – is that the
right date?
A. Yes, it was the end of – it was November 2015.

Q. So at that point a detailed dive on access hadn't
occurred. When was the first time that that occurred?
A. Yes, so there was a significant piece of work that was
undertaken in, I think it was the second half of 2016 into
2017.

Q. Thank you. Can I just ask you some questions about
targets. You've given some evidence in your statement that
you think there are some difficulties with targets in
complex service systems, and that's at paragraph 165 of
your statement.

I think, to be fair, I think you distinguished between
targets and aspirational or qualitative expressions of
outcome measures.
A. That's right.

Q. The Auditor-General gave some evidence this morning
that, reflecting on his analysis of the 10-Year Plan, there
ought to be targets in such documents however they exist.
His evidence was to this effect: that you have, as system
leader, the capacity to mitigate the risks of problems with
targets by properly defining them. What do you say about
that?
A. Yeah, thank you. Because it is a really important
question and it's one of very few points of slightly
different perspective that, as a system manager, I think
that I bring. There is absolutely much in the
Auditor-General's report that I welcome and agree with but
this is a point of fine difference.
From my perspective, I think that it is really important that an outcomes framework provides the means of measuring across the range of parts of the system, so the parts of the stepped care system, the range of interventions that are going to be necessary to achieve improvements.

The great risk with leaping to numeric targets when we don't have the underlying data foundations, is that actually perversely we might further entrench stigma and discrimination - or discrimination; that we might inadvertently lead to there being incentive created to only serve the service, the clients with less complex needs, and that there can perversely be situations that I've absolutely seen in other service systems, where there is over-emphasis on one part of the system at the expense of advancing reform in other parts of the system.

That's really I think been evident in the UK where an over-emphasis on, in fact some access targets, has really resulted in quality and safety issues in the system. I could use the example of how important it is, when we think about sentinel events, that we don't inadvertently create, through a target, a perverse distortion of behaviour not to speak up and report adverse events.

So, there are times when numeric targets are entirely appropriate, but I think numeric targets tend to be more appropriate where the data is robust and well-established, where there is clear attribution between an action and a result, and generally where there is a more straightforward set of actions that need to be taken that involve fewer parties than when we're talking about all of the actors involved in a stepped care model being put in place.

Q. Do you accept the Auditor-General's point though, that there needs to be a means, in an outcomes framework, of measuring the difference between where you are now --
A. Yes.

Q. Sorry, where you were: where you are now and where you're intending to get to?
A. Well, certainly the first two, and I think you might have had some evidence a few days ago from the Road Safety Authority as well around the benefits of having an aspirational target like Towards Zero, and the real criticality of measuring as you go on progress and having a
suite of measures that enable you to do that. So, I think
that is incredibly important, and the Mental Health Annual
Report, is our intent, to be able to make that information
not only internally obvious but publicly reported.

And so, having an aspirational target of where you
want to get to I'm entirely comfortable with. Where I get
uncomfortable is, if it is reduced by this amount to that
amount for only a few of the important outcomes that are
going to drive a systemic complex reform.

Q. But that would speak to having to design your targets
property, wouldn't it?
A. No, because I think that would mean either you have so
many targets that cover all facets of the reform that you
blunt their impact, because actually targets are generally
most powerful when there are few of them that really do
direct effort, and that for me feels to be in conflict with
saying, across a stepped care system there are multiple –
your earlier point about there being multiple parts of the
system involving a broad array of actors that need to be
involved in delivering better service and better outcomes.

Q. Alright, but you're not suggesting, are you, that the
measures in the appendix to the Mental Health Annual Report
can't be improved?
A. Not at all, and I think that's clear and I've made
that point in my witness statement, that one of the – and
in the whole-of-government submission – that based on the
evidence and the analysis, that the Royal Commission does
really welcome that view, that insight on how those
measures can be improved.

We're doing a lot of work right now with education
about how the educational measures can be enhanced and
populated, and so, absolutely it's a work-in-progress.

Q. Just back on the question of access, the
Auditor-General has suggested that measures for wait times
for services and the number of consumers declined or
delayed services due to capacity constraints, and consumer
reported experience of service accessibility would all be
useful measures in relation to access: do you accept that?
A. Yeah, so again, two points very quickly that I would
make: one is that, at the moment I think that we have data
and indicators around access that are spread between too
many different data collections and reporting tools. So,
we have quarterly reporting, we have Statement of Priority reporting, we have the reporting associated with the 10-Year Mental Health Plan which is more outcome-oriented, and we have other sort of episodic reporting that is used.

In turning to 2018/19 we received some funding to complement the outcomes framework with a performance management framework which really goes more to system performance and access issues.

Having said all of that, I do agree that, as we develop that performance management framework, which I think is the right place for these type of access measures, I think the Auditor-General's reflections, particularly in relation to where people have contacted a triage service and then not received a service and then subsequently presented to an Emergency Department and/or been admitted, are really critical information for us to have a better handle on.

Q. Thank you. Just finally on the 10-Year Plan, the Auditor-General said that there was a lack of routine senior level oversight of and reporting against the plan: you accept that finding?
A. One of the things I would reflect, and you may come to this a bit later, about the capabilities that are needed to be developed, but a system process and capability or skill level has been developing that sort of project management capability.

We do have governance structures within the Department. The 10-Year Plan is reported up through to a sub-committee of the Executive Board that I Chair, but certainly I think the reflections of the Auditor-General and the Implementation Monitor for Family Violence have given us pause in the last 12 months to think about both how those governance arrangements are working and also the systems and tools that are necessary, and we are developing an IT platform called Our Impact which will make that reporting more standard and enable there to be more scrutiny.

Q. To the extent you can say, is there any capability the Department needs to develop in relation to personnel in that respect or is it more of an IT issue?
A. I think there is a project management discipline, or capability that is in short supply through the public
service, and there are targeted - you know, there's
targeted work we're doing as a Department but I think there
is more that we need to do to build the skills in how you
break down complex reform into actionable deliverables, as
well as then have the systems to monitor progress.

Q. I just note for completeness, Ms Peake, we won't go to
it in the interests of time, but there are in your witness
statement set out a number of the activities and very
significant resources that have been devoted to undertaking
the activities in the 10-Year Plan; I've been directing my
questions more to the management and implementation and
monitoring of it.

Can I ask you now about a different question, and that
is the issue of trials and what I mean by that is programs
being rolled out on a trial or pilot basis. There has been
a significant amount of evidence in this Commission from a
range of people to the effect that, when good programs are
rolled out as a trial and then their funding becomes
uncertain and their continuity becomes uncertain, a whole
range of problems occur, including that staff who have been
secured and are working well may not be able to be secured;
consumers lose continuity and lose relationships.

Do you accept that one consequence of having too many
pilots is instability in the system.
A. So, what I would say is that I think historically the
pilots have been used not only to trial innovation, but
also to enable there to be partial implementation within
budget capacity. I think that conflation of using trials
for an innovation purpose, versus partial implementation
has created the effect that you describe.

I think as a whole-of-government there has been a lot
of work done in the last couple of years to be really clear
about innovation methodology, what sort of analytics and
performance measurement and evaluation is important, and
what sort of decision-making processes are necessary to
enable there to be a genuine trial of innovation,
evaluation of impact and then approach to scaling. So, I
think again it's something where a historical view versus a
forward-looking approach is a bit different.

Q. And your forward-looking approach is to try and
engender longevity in funding and program continuity; is
that right?
A. Where it is evidence-based and --

Q. Of course.
A. -- and where there is evidence of working. I would never want to be saying that there is no space for genuine innovation and trialling, and also that it is important, if we are going to have more innovation in the system, that it's okay for some things to not work and therefore --

Q. Of course.
A. -- absolutely to call quits on something that hasn't achieved its intended aim.

Q. On the question of catchments, the Victorian Government's submissions state that:

"Misaligned catchment boundaries are preventing people from accessing services."

We've certainly heard evidence to that effect in the Commission, and I'll take you in a moment to your views about catchments briefly, but can I ask you this first: the Auditor-General said in his Access Report in relation to the Department:

"Despite understanding these issues for many years [that's issues about catchments and access] and commissioning work to examine them and make recommendations, the Department did not take action to address them."

Did you accept that finding?
A. And it will come to the later discussion about what we mean by catchments. So, we accepted the finding and I think there are many layers to the geographic boundary versus the operational management within a catchment, and I know the previous witness talked to some of the operational governance issues that are relevant to catchments as well, but there is no question that there is a significant need and opportunity, both through the Royal Commission and potentially in parallel with the Royal Commission, to deal with some of those challenges around catchments without abandoning the concept altogether.

Q. The purpose of my question was really to elicit whether there is any structural or systematic impediment to not being able to implement reform catchment, acknowledging
like most things in mental health it's complex. Just responding to the Auditor-General's finding about the fact that the issue was understood for a long time and not acted on?

A. I think the two things I would say with impediments was, firstly, that there wasn't an effective way for joint work with PHNs or with the primary care system to really bring together the thinking about catchments. And secondly, that the timing of decision-making often got out of sync with the rhythm of an election cycle, for want of better words, and so, opportunities have been missed.

Q. Just picking up on that observation as a general point, the timing of reform measures and their coinciding or not with election cycles: is that a problem that bedevils someone trying to enact reform in a system?

A. So, I wouldn't cast it in the language of "it's a problem". I would say it's a really important factor to take into account in thinking about the sequencing and pace of both advice to government and implementation.

Q. We'll come to those at the end, we'll be asking your views about those things. Can I ask you a bit more about capital infrastructure. You've acknowledged the role of the Department in commissioning system-wide service and infrastructure and planning, and we've dealt with the issue of the data limitations.

There's a relationship drawn in the submissions of the Victorian Government about the limitations on data and being able to engage in commissioning infrastructure for mental health: what's the relationship between the two?

A. Well, it's really the comment that I made earlier, that in the absence of sufficient physical capacity it becomes a challenge to actually then allocate money for services in places that they are needed because there isn't the staff or the physical space.

Q. I see, alright. Separately, the Commission has heard evidence that Victoria has a serious shortage of acute inpatient beds, and one of the lowest bed bases nationally, and also, that many inpatient facilities don't provide appropriate, safe or therapeutic environments. I know it's a very broad question, but what in your view are the key factors that have led to that outcome?

A. So, I think it is important to say that the comparisons nationally are not altogether helpful because
Victoria, right from the start of – or the model that was implemented post de-institutionalisation has really put significant emphasis on the community model which is again recommended through the government, or proposed through the government submission for further investigation.

That was really because there was a strong view that therapeutic settings are more amenable to a community environment, and that is not to discount the importance of having acute inpatient capacity for people who are severely unwell, but their ongoing treatment and recovery and then rehabilitation, I think there is significant evidence that we need to think about those two things differently and that's part of the stepped care model.

So, having said that as a bit of a caveat, I think that it goes back in part to my earlier comment about the way in which funding deliberations are influenced by those three factors of: political leadership, community acceptability and the ability to implement quickly to build confidence in a service the community values.

We have seen in the most recent couple of budgets more investment put in to inpatient beds, and we have a long way to go.

Q. So, is the gist of your answer, that it hasn't, politically speaking, been able to be prioritised in the past?
A. I think that is definitely a part of it, the competing need for there to be also investment in the community sector which is seen as a really critical part of the system, and then comes back again to the lead time in terms of infrastructure constraints.

Q. I see, thank you. Does the Department have a detailed infrastructure plan for mental health services?
A. And this is going to be into a space where I can give you a partial answer.

Q. Go as far as you can.
A. So, we have been doing a lot of work in the last few years with the creation of the Health and Human Services Building Authority to build the analytical base so that we can provide effective advice into the annual budget cycle. That's probably as far as I can go.
Q. So, you can't tell us any more because?
A. So, certainly that --

Q. Just to be clear about why you can't answer any more about that topic?
A. It really does move into a matter of public interest immunity about the extent of the planning.

Q. Alright, we won't pursue that any longer for the time being, but we will note that that question has been asked and you've answered it as far as you can for the moment.

You've mentioned the Victorian Health and Human Services Building Authority in your statement, and you've said that:

"There is an increasing focus on incorporating and prioritising mental health service provision."

What's new about that?
A. Yeah, so one of the things that we have been really doing more of since 2016 is re-integrating mental health responsibilities into the broader health stewardship responsibilities of the Department.

The rationale for that is both that, I do think that mental health should be considered a specialty like any other in the health system, I think that's important, to improve the parity between physical and mental health and to overcome some of the stigma that has impacted on delivery and prioritisation.

And, as part of that, the Building Authority's expertise in infrastructure planning, design, project delivery, is now being leveraged for the putting forward of business cases and the management of delivery of mental health projects, rather than a stand-alone mental health branch having those infrastructure functions themselves.

Q. So you see that as a very positive development?
A. I do. I think we have seen that we've got better capability to build better cases and to then manage projects. The second thing I would say is that it is also leading to more thought being given to new hospital developments to take account of factoring mental health capacity in.
Q. Can I ask you about a different topic now, and that is to return to the subject of overall system level planning, just briefly. In the Victorian Government's submission, it said at 3.5.1, that:

"Responsibility and accountability for quality and safety oversight of the specialist mental health system is distributed across multiple bodies which can create a level of confusion around accountability and may inhibit continuous improvement efforts."

Can you say what that confusion is about and why it is said that it may inhibit continuous improvement efforts?
A. Certainly. So, at the moment there are many avenues for people to - for consumers or family members - to raise a complaint. There's lots of work that is happening to create protocols, information sharing, between the various bodies but it does make for a confused space for people to know where to go to get an issue resolved, so that's the first thing.

The second thing is, I think that, in terms of the point around quality improvement, that there has been multiple bodies that have had a piece of the work around service model development through to practice support. The work that we've been doing in the last 12 months, and really aided by the Chief Psychiatrist and Safer Care Victoria, is to get more clarity around the strengths and contributions of the different parts of the system and leverage the expertise of the Chief Psychiatrist in terms of really deep, deep, clinical knowledge of the system and Safer Care Victoria's methods of working with clinical and consumer communities to develop service models and to build the kind of agreement that they should then be the basis of what is more consistently delivered in the system.

So, I think we are working our way through that, but I would well accept that, for the service providers, that there still seems to be lots of bodies, how do they all fit together.

Q. On the question of models of care, in your statement you have said:
"Following the identification of population-level need, as a commissioner the Department is responsible for providing clarity as to appropriate models of care, with a focus on what funded services are expected to deliver."

There's no ambiguity about that role?
A. Yeah, so, the only thing I would say, and I think we go on to say this later in the statement, is that, in developing those service models it is critically important that there is that clinical and consumer input.

Q. Of course.
A. And secondly, that it is really important that the level of definition leaves sufficient flexibility so that a service model can be tailored to the needs of a local community. So, for example, how a service model is applied to an Aboriginal community, or to a refugee community, will have different elements to it, and so I wouldn't want it to be sort of read as an absolute that it's one size fits all and a level of prescription that is counterproductive.

Q. Certainly. Models of care are rolled out, are they not, in other areas of health?
A. Correct, that's right.

Q. It's correct, isn't it, that in mental health we're lagging behind somewhat in doing this?
A. That's right. So, the mental health clinical network really follows the experience from acute health about the way to do this work, and again I see it as a great benefit of having integrated mental health much more deeply into the health stewardship functions of the Department, that we're able to leverage that capability.

Q. Thank you. On a slightly different topic, the submissions have acknowledged that there's no overarching framework for service planning to address mental health promotion, illness prevention and early intervention in Victoria. I just have one question: do you accept that there should be one?
A. Yes, and again, that it needs to interface with Primary Health Networks who will also have a critical role in that.

Q. Finally, on strategic frameworks, the Auditor-General
found that there was no strategic framework to guide and coordinate the Department or health services that are responsible for children and young persons' mental health services: do you accept that finding?

A. Yes, and I do think it's important to distinguish between children and young people, and I think going forward, and in a lot of these areas the value of the Royal Commission in providing insights about where to go next. I think there are quite different views, particularly in the children's space, about what that framework should entail.

Q. I'm not asking you right now what it should be, because we'd probably be here more than all day, but why was there no strategic framework? Is it the issue you've just alluded to or something different?

A. I think it is a combination of there being deep engagement and different views around what the best framework should be, and I think for young people there has been a kind of bringing together - and I think this is happening - of the sort of psychosocial perspectives and the clinical perspectives. So, it's not so much - in the children's space I think it's a much more contest in the clinical space about what the right model is; in the youth space I think it's more that there's been a maturation about how the different elements could be brought together of a multidisciplinary response.

Q. But there's no disagreement --

A. And it should be there.

Q. -- that despite clinical complexity and differences of views, there should always be a strategic framework?

A. Absolutely. I think it's a really critical priority going forward.

Q. On the question of governance and leadership, you've mentioned in your statement that two events have catalysed a significant shift in the focus and resourcing of the Department's system leadership responsibility since 2015: the first was the events that led to the targeting zero review, or the Duckett report, about hospital safety and quality in October 2016, and the second was the unprecedented surge in asthma and respiratory disease after the thunder storm of November 2016.

With that background, noting that neither of those is in mental health, but you raise them in your statement
anyway because they relate to the Department's leadership capabilities, you've said:

"Both have led to a strengthening of the Department's stewardship responsibilities, with work continuing to strengthen engagement with health CEOs ...", and so on.

The Duckett review found, did it not, that the Department, at least in that context, had inadequate overarching governance and oversight of safety and quality in hospitals, and that one issue giving rise to that was inadequate data?

A. I think it was more than --

Q. Perhaps one?
A. One of the factors was inadequate data yes.

Q. I take it, you've raised that issue in your statement because you reflect on that experience as saying something about the issues with leadership in the Department and you're making the point that, since that time, steps have been taken to improve the Department's stewardship?
A. Yeah, I wouldn't frame it so much as leadership, I would frame it as emphasis and resourcing.

Q. I see, can you say what you mean by that?
A. Absolutely. So, I think that what came out of the Duckett review was the importance of us being more deeply connected with health services about strategic development of the sector.

That within a devolved model - and this is the second point where the Auditor-General and I have a nuanced difference of view - but in a devolved system of governance, that there is a critical stewardship role for the Department to help bring people together to look at system level issues that can't simply be solved by an individual health service. That in part goes to the data and access to information, but it also goes to model of care development, it goes to facilitating joint solutions, it goes to having the mechanisms for collaboration earlier in policy processes to joint problem solve.

Q. So your evidence is that, on each of those, the Department has come on a journey since that review --
A. And still has a way to --

Q. -- and are still on that continuum?
A. And I think we've heard evidence today about the opportunity for us to go even further in mainstreaming to embed the work on Statements of Priorities and performance discussions in the existing stewardship mechanisms that the health system have and have been maturing - sorry, the health stewardship function has, and mental health is partially in those, but I think has predominantly been in the focus of Emergency Department management rather than those broader aspects of service model development and collaboration.

Q. There's a number of things you mention in your statement that we don't have time to address in that respect. Can I ask you, I think you mentioned Statements of Priorities just a moment ago. How are mental health-specific KPIs included within health services Statement of Priorities?
A. So, there are now seven KPIs that are specifically about mental health that are embedded in the Statement of Priorities. In addition, there are general KPIs that relate in particular to Emergency Department access that also include mental health, and there is a specific objective in this year's Statement of Priorities around working collectively as a system to look at the very issues we've been talking about, about meeting the needs of mental health patients that is more explicit in this year's Statement of Priorities.

Q. Leaving to one side this year, and I think the preceding two years where there have been changes, for how long had the mental health KPIs remained the same?
A. The mental health KPIs, which is a slightly different question to what's in the Statement of Priorities --

Q. Sorry, in the Statement of Priorities I mean.
A. Sorry, my understanding, and this does precede me, my understanding is that they've been evolving since 2014/15.

Q. So, before that time they were static?
A. They were managed separately and, as I understand it - and I can take this on notice and confirm for you the precise trajectory - but my understanding is that there has been an increase of KPIs sort of year-on-year from 2014/15 to now.
Q. And as of 2019, a strategic priority of supporting mental health systems will be included in all Statements of Priority?
A. Yes, and that's both for - just to make that crystal clear, I know there was evidence that was discussed in the previous hearing - that is both relevant to health services that are responsible within their catchment, as well as other health services who still need to manage referral pathways, for example.

Q. How will that be monitored? How does one, as system leader, know whether a service who has that in their Statement of Priorities is supporting the mental health system?
A. So we have performance discussions on a quarterly basis with the health services, and that will form part of those discussions.

Q. If you don't know, just say, but do you know how it will be determined whether or not the service is doing whatever that might mean?
A. Yeah, and what - I can't give you the specifics on this one, but what generally happens with anything in a Statement of Priorities is, there is a discussion and evidence that is furnished about how Boards are meeting their expectations under the Statement of Priorities.

Q. Would it be fair to say that there's probably a way to go in developing an understanding of what is required in order to meet that KPI?
A. And also, I think that the link between that and the performance management framework which is being finalised at the moment.

Q. Thank you, I was just going to ask you about that. My question is, how far away is that from being ready to be implemented?
A. Yes. So, the performance management framework was funded in the 2018/19 budget, it's well underway, it's expected to be completed by the end of this year for then formal roll out in the 2020/21 year, and it will be more embedded in the Statement of Priorities from next year.

Part of the reason for that timing is to line up with the national performance framework which is expected to be completed by early next year.
Q. Will that include measures of the ability of services to meet demand?
A. So, it will have access indicators within it.

Q. Different from the existing KPIs?
A. We are looking at - the conversation earlier about some of the feedback that's come from the Auditor-General, as well as other advice that we had commissioned, is being built into that performance management framework.

Q. Thank you, Ms Peake. Just some questions about Emergency Department wait times. The Royal Commission's heard evidence that, according to the National Emergency Access Target, the wait time for Emergency Department presentations for the general population is four hours and for mental health population it's eight hours. Can you clarify whether that is correct?
A. So, it is not quite correct. So, the four-hour target applies to anyone who presents at an Emergency Department including a mental health patient. Similarly, the 24-hour target applies to everyone in an Emergency Department.

The eight-hour target is an extra safeguard, if you like, because we know from the data that there are an over-representation of people, with mental health patients who are spending longer, unacceptably long periods of time in Emergency Departments, and so, rather than waiting from four hours to 24, there's another trigger point. It was a pre-existing measure but we've kept it to provide that extra sort of view on the system about what's happening in Emergency Departments.

Q. So, accepting that you should have as many views as you can on what's happening in Emergency Departments, the rationale for the eight-hour period is an understanding that mental health patients will wait longer in Emergency Department generally?
A. No, the data is showing us that they are waiting longer, and so, that we want to have another trigger in the system.

Q. The evidence is also to this effect: that mental health patients are by far and away the most represented when wait times for movement between Emergency and an inpatient bed exceed 24-hours: do you accept that?
A. That is correct.
Q. The evidence was also that in at least some hospitals, a 24-hour breach in relation to a mental health patient, whilst it's understood is a breach and not acceptable, it would not be subject to the same kind of examination as it would in the case of a general health patient for the reason that there are very few, if any, options available to Emergency Departments to deal with mental health patients?
A. That's right. So, it's not a matter of there being less priority or less care, it's that the examination is, sadly, often able to be completed more quickly because the reason is capacity in the system.

Q. It's really not an acceptable situation, is it?
A. It's not, that's right, which comes back to the conversation we had right at the start of this hearing, about the pressures the system is under.

Q. Just to finish that off, if there is a 24-hour breach for a mental health patient, is that required to be reported to the Department?
A. It is immediately to be reported to the Department, and obviously that forms a really important part of the evidence base that flows through into budget considerations as well.

Q. Is there a different process or policy for investigating 24-hour breaches for mental health and general patients?
A. No. The policy is the same, the practical - as we've just indicated, the practical way in which it plays out because of the shortness of the examination that's usually required, means that it looks a bit different in the level of examination that's required, but the policy is the same.

Q. Yes, so there are really very few, if any, options to ameliorate that situation in the current system?
A. And I think that is exactly why - the scope of the mental health Royal Commission - to be looking across the whole stepped care model is so critical, that simply looking at the flow of patients into inpatient is not going to solve the problem of how many people are waiting for unacceptable periods of time in an Emergency Department.

Q. On the question of funding, in your evidence and in the Victorian Government Solicitor's, it's accepted I think
that current funding mechanisms specifically referring to block funding is unresponsive to changes in population and inflexible to needs, funding's been allocated on a historical basis, and it's not adjusted for the wider and disparate needs in the complexity of clients.

There have been numerous other parts of the evidence dealing with the complexities and problems with the funding model. Why is it that inappropriate funding models have been allowed to persist for such a long period of time?

A. And it is equally a very complex, expert, technical exercise to get the alternative right. I think there was some evidence led in Ms Williams' hearing, that the first go at this actually was in the 1990s, where the Commonwealth attempted to design an activity-based funding model. Between 2012 and 2015 the Department did design a model, it got to the point of being shadowed in health services, but the classifications within it were not sufficiently robust, and what we saw was enormous volatility.

So, shadowing means that it's not actually used to allocate money but you measure for the year what would have happened if it had been in place. And so, when mental health was reintegrated into the broader health branch or division in 2016, one of the opportunities that arose was for the people who are actually responsible for health funding to take much more of a leadership role in relation to looking at activity-based funding, particularly in a way that would enable there to be packages of care along the spectrum, and have been working really closely with the Independent Health Pricing Authority to look at both, how do you classify those phases of care and complexity of patient need within those phases of care, and then what the costing models would be.

There is enormous work that is going on with consumer and clinical experts to look at how you do define those phases, so that there is stability and predictability in the model with a view to then having a shadow process, and we've been really actively involved in that.

Again, I would reiterate, the expertise that we have in the health funding team, actually people who design case mix in the first place for the whole country, reside in that unit, so there's deep expertise that wasn't available between 2012 and 2015 when mental health was trying to do
it on its own.

Q. Acknowledging that it is complex and acknowledging that mental health is not the same as general health, nevertheless in general health you've had activity-based funding for a very long period of time, accepting the complexity, are there systemic reasons why the funding models have been allowed to continue for so long?
A. I think it is important to say that parts of physical health don't have activity-based funding that have more similar characteristics to mental health. So, more of the outpatient and community-based delivery, more of the notion of what is the approach to thinking about a pathway of care. Similarly we are at pretty early stages in physical health of designing those sort of funding models that are fit for purpose for that as well.

I think two things: I think the activity-based funding was originally very much designed for a model of care that was about infectious disease and trauma, and that was the priority and so there was a relative priority that was given. As the burden of disease has increasingly shifted to chronic disease, that the very complex technical work has started, including for mental health, about what a variation of an activity-based funding model might look like.

Q. And --
A. I should say, we'll be the first place anywhere in the world, if and when - when - we get this right.

Q. That sounds good, Ms Peake. So, there's a process of reform in which, just to summarise, a lot of work is happening and the Department and Treasury and others and various experts are considering funding alternatives to block funding, and without going to the detail, am I right in thinking that's not just limited to activity-based funding, but you're considering a range of other options as well?
A. Yeah, and for different parts of the key journey, that's correct.

Q. On funding further, in 2019 to 2022, for that period, there was a very significant increase in the mental health budget compared to 2014/15, it was a 42 per cent increase. Without disclosing information subject to public interest immunity claim, what were the big factors that led to that
increase being able to be granted being successful?
A. I think it really does go back to our earlier
cornerstone conversation about what are the factors that are important.
I think there has been, you know, really strong political
leadership, there has been a recognition within the
community about the pressure the mental health system is
under, and the sorts of investments that have been made
have been pretty targeted to be able to provide early
results in relation to alleviating some - a little bit - of
that pressure.

It is probably worth saying that, when you look at the
rate of growth between 2010/2011 and 2018/19, the rate of
growth is pretty comparable between acute health and mental
health; the base that we were coming from in mental health
has really been the problem about that funding resource.
So much more work is needed to get to anywhere near a level
of capacity in the system that is needed.

Q. I just have a few more questions for you, Ms Peake.
Commissioners, I won't be too much longer. On this
question of prioritisation, you've used the interesting
expression in your statement about "lack of parity of
esteem of mental health as compared to physical health",
and you've said that lack of parity of esteem is:

"... evident in the social determinants of
mental health ... in the treatment gaps
evident across our mental health system,
and in the fabric of mental health
infrastructure, which falls behind general
health care environments in terms of
contemporary expectations."

Can I just explore that a little. Do you have a view
about where the lack of parity resides, in whose
perception?
A. Yeah, I think that, certainly coming back to the
point around evidence, stigma and discrimination still
existing particularly I think for severe mental illness and
particularly in relation to psychotic illnesses and
personality disorder conditions - which is not to discount
stigma in relation to depressive and anxiety disorders
either - I think that is absolutely at the heart of this.

I also think that, by virtue to some extent, even as
mainstreaming has occurred, there's still been some
separation, not thinking and talking about mental health as a really critical specialty like any other - like cancer, like cardiac - that we haven't helped in building that esteem. And again, I just can't underscore enough how important I think this Royal Commission is to counter some of that.

Q. Can I just ask you about that stigma. Do you mean to convey that there is a perception amongst those who make decisions about prioritising about what the community thinks, or something different?
A. Yeah, so I think, in terms of the community expectation and the community acceptability, if you like, of where priority should be placed.

Q. Thank you. In relation to a question of how you make reform stick and how you implement it properly, there are a number of things in your statement that we are interested in. One thing you've talked about is having an adaptive approach, and I think you've already covered having the right tempo for reform, the right pace and staging, and the need for careful up-front planning and so on.

Noting we don't have a lot of time, is there something you want to say to the Commissioners about the question of pace and timing?
A. Yeah, look, only that there is this very fine balance between having early progress that maintains momentum for reform and builds that community acceptability and confidence, with seeking to have too many different parts all being implemented at once so that the inter-dependencies can't be well managed, and that the opportunities that may arise as elements of reform unfold that you couldn't have even predicted when you started, the opportunities might be missed.

And so, my reflection would be, the more that we can frame a reform agenda that has practical, actionable components that can be implemented and then built on, I think that builds the sustainability of the reform.

Q. You've mentioned strong institutional governance arrangements are necessary, including at ministerial level, Cabinet Committees and Task Forces. Is there anything more specific you want to say about that aspect of it?
A. No, I think that's - yeah.
Q. I thought you would say that. You've also said in your statement that robust system level governance is necessary. I think you've probably said quite a few things about that in your evidence. You mention the desirability of establishing an independent monitoring body to help provide assurance to both government and the community about sector capability and performance.

A. Yeah, just before I go on to that, just the bit that you just mentioned about the service level governance: I think the other point that I made in there that I would reinforce, is that I do think that there is value in having a strong, stable public institution that is a fulcrum of that service level governance that has an enduring, both connection to the values of the reform ambition, but also has the sort of stability and endurance to be able to keep that momentum happening at the service delivery level, as well as the sort of things that would be put in place at the system level. So ministerial committees and cross-government senior officials structures will get you some way; it's the people, that strong leadership on the ground that really matters.

I think where I have seen, and I've given some examples in my statement, something new being created, it's quite difficult to form and provide that leadership for significant ongoing reform at the same time.

Q. So, in order to address that, what kind of structure would you have in mind, can you say?
A. And, I think that's something that we need to keep kind of talking about in the next few months.

Q. Of course.
A. But in principle I think that at least the principle of having something in place, that there is an existing institution that has the capability to hit the ground running and will endure is a pretty important ingredient for success.

Q. Finally, Ms Peake, do you have a view about this issue, and that is, that as we saw at the outset of your evidence by looking at the 2009 report, this is an environment where much is understood, although there is a lot of complexity, and there's been a wealth of reports and recommendations often saying very much the same thing, and we at the same time see a persistence of the very same
problems over long periods of time. If you have to
identify the key reasons why it is so hard to actually get
to where we aspire to in mental health, what are they?
A. So, I think absolutely part of it is having that
resourcing for change, not only for capacity but actually
for change. It is having the authority and accountability
for leading the change embedded at that service level. It
is having the mechanisms, not only for operational
governance, but for that collaborative governance with all
parts of the system; I don't think we've had that very
effectively in the past. There is some prospect with
Primary Health Networks for there to be a mechanism, a
stronger mechanism, for that work.

I think the other thing we haven't done well in the
past is, we haven't really engaged the private
practitioners in that system level or that service
deliverable governance. And I've included an example,
which actually was referred to in the 2009 work as well,
about the integrated cancer services as a bit of a model,
that mightn't be quite right, but there are some learnings
from it that I think we could take.

I think it's the resourcing, it's the political sort
of authority that having a Royal Commission gives, and then
it's having those right institutional and, in particular,
service level governance structures to drive it forward.

MS NICHOLS: Thank you, Ms Peake. Chair, do the
Commissioners have any questions for Ms Peake?

CHAIR: Q. Thank you, Ms Peake, I have one. We've heard
very clearly throughout your evidence today and the
evidence of other people who have come before this
Commission and in our community consultations and other
things, about the daily experience of the demand pressures
on the mental health system.

We've heard about so many of the strains on the
community-based services as well as the hospital-based
services, and we've also heard about the disparity and
availability of services across the state, so a lot of
pilots that haven't gone to scale which means that you get
a different level of service in one area compared to
another.

And so, when we think about the task ahead, I guess
I'm interested: you mentioned lead times, the lead times that are involved in developing a plan, securing the funding, establishing the infrastructure and then getting the workforce to actually be able to staff that, for example.

Traditionally in mental health, or in health more broadly, what are the lead times that you think we as a Commission need to be conscious of?

A. So, and again, I think that having things happening at the same time as the bigger change, having more of a lead time is important to build that belief. So, I think there probably needs to be sort of a year for development and a realistic sort of three to five-year timeframe for phased implementation, but even in that first year trying to take some of the demand pressure out is, I think, really critical for people feeling that they can lift themselves out of the burden of that acute pressure that everybody feels at the moment to engage with what could be different service models and what could make a longer term difference.

Q. A final thing was also, just to take up the point that you said, and it was specifically in relation to funding models: you talked about the fact that now you are seeking to use the capability, not just in the mental health branch, but in the data analytic and other capability you've got in the health part of the broader portfolio. Is that your intention to do that more, in terms of other aspects of the functioning and designing of mental health and the response to mental health issues?

A. It is. I think I mentioned Safer Care Victoria and the work that they do on service model development: there's fantastic work that they've done, for example, in stroke care which has led to clot retrieval services being more standard for the state.

So they, with the clinical networks, now have a very strong methodology for this work, and they are auspicing a new six-month-old mental health clinical network, so they are a really important capability.

The other piece that I really haven't mentioned is our system Analytics Unit that is doing a lot of work on linking data from health and human services to really understand what the contribution of all of our services can be to improving wellbeing as well as health and safety.
outcomes. That unit was given status as a linking
authority, national status, about a year ago which means
that they are able to also link in Commonwealth data. So,
we're at a point with that group where they've linked all
of the DHHS data, they've now got education data and
justice data, including corrections and police data that
they have linked in, with of course appropriate protections
around privacy central to that.

We've done some specific projects with the
Commonwealth, particularly in cardiac care to look at
variation in care, so that authority or that capability
will be, I think, really critical for us in thinking about,
not only what we've been focused on today about the mental
health system but its interface with other critical
services.

Equally, our strategic policy area is leading the work
on engagement with the Commonwealth about interface issues
with the NDIS and aged care, and that is an important
function and capability that we are using for the mental
health interfaces as well.

And finally, the research and evaluation capability
within the Department, which again, I think has got a
really important role if we go back to how do we avoid
having trials that don't have a proper path to scale.

Q. Thank you. I think the other issue we just take on
notice is that issue of the Commonwealth-state relationship
in mental health that appears to be pretty fundamental to
the future design --
A. Yes, absolutely.

Q. -- and better leveraging of shared interests, I think.
A. If I give a one minute burst. I think the next, so
the Sixth National Mental Health Plan, is due to be
starting next year and is a significant opportunity for us
to think about some of those issues around funding models,
data and performance, consistent datasets. So, not only
initiatives, but actual fundamentals of a stepped care
system.

There's also work that's going on in suicide
prevention, both a health driven plan, but also with the
new Suicide Prevention Advisor thinking about the role that
all of the other community and service opportunities can
bring to bear on suicide prevention, so I think there are
some real opportunities to leverage off, and obviously the
final one is the work of the Productivity Commission.

MS NICHOLS: May Ms Peake be excused?

CHAIR: Yes. Thank you very much for your witness
statement and your evidence today, Ms Peake.

THE WITNESS WITHDREW

MS NICHOLS: There are no more witnesses today, Chair.

AT 4.15PM THE COMMISSION WAS ADJOURNED TO
FRIDAY, 26 JULY 2019 AT 10.00AM
accountability [1] - 1711, 1719, 1728
achievable [1] - 1712:28
actual [1] - 1803:41
agreed [1] - 1764:9, 1778:9, 1785:24, 1789:38
act [1] - 1716:39
acted [1] - 1785:3