Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF BILL BUCKINGHAM

I, Bill Buckingham, Director of Buckingham Consulting Pty Ltd, a private consulting firm based in Melbourne, Victoria, say as follows:

1 I make this statement in my personal capacity and not on behalf of any government department or agency or any other organisation with whom I have worked. The opinions set out in this statement are my own personal opinions.

2 At the time of providing this statement, I am contracted to the Australian Government Department of Health as Technical Advisor on mental health. Contractual obligations with the Commonwealth require that I do not use or release any confidential information and I have adhered to this in this statement. Any information I present below is publicly available or derivable from publicly available data.

3 I make this statement on the basis of my own knowledge and experience, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true and correct.

Background – Qualifications and experience

4 The table below provides a summary of my qualifications and experience.

1972	Bachelor of Science (Honours), Monash University
1977	Diploma of Clinical Psychology, Latrobe University
1976	Psychologist, Gresswell Alcohol and Drug Rehabilitation Centre, Victoria
1976-82	Senior Clinical Psychologist, Mont Park Psychiatric Hospital, Victoria
May 1982 – Jan 1990	Chief Psychologist, Victorian Health Commission (later renamed Health Department of Victoria)
Feb 1990 – Feb 1991	Principal Advisor, Policy and Planning, Office of Psychiatric Services, Health Department of Victoria
1991-1993	Manager, Service Planning, Office of Psychiatric Services, Health Department of Victoria
1993 -	Independent consultant, Director of Buckingham and Associates Pty Ltd (transitioned to Buckingham Consulting Pty Ltd in 2017)

5 I have 45 years of experience in the mental health field, commencing in 1976 as a clinical psychologist in the Victorian mental health services and progressing to Chief Psychologist within the central administration of the Victorian Health Department between 1982 and 1990. For my final three years of employment with that Department, I managed the unit responsible for state-wide planning and reform design of the public mental health system,

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

a period that laid the foundations for the widespread structural reforms implemented by Victoria over the following decade.

6 Since mid-1993, I have worked exclusively as an independent consultant in mental health policy and planning areas through my private consulting firm. Over that period I have worked extensively with the Commonwealth Department of Health, and also undertaken consultancy assignments for the New Zealand Ministry of Health and the health portfolios of all Australian state and territory jurisdictions. Since 2006, I have been working primarily as the Commonwealth Department of Health's mental health Technical Advisor.

7 My consulting work in Australia has been focused on the design and implementation of broad ranging reforms progressed under the National Mental Health Strategy. Work of possible interest to the Royal Commission includes:

(a) **Monitoring of national reform progress** – I designed and authored the original series of semi-annual National Mental Health Reports established to track the progress of governments from the inception of the National Mental Health Strategy in 1993, with 12 reports published through to 2013.[1] I also designed and coordinated the data analysis and authored all five annual performance reports published to track progress of the COAG National Action Plan on Mental Health 2006-2011.[2]

(b) **National mental health information strategy** – I designed the original parameters for collection and reporting of consistent national data at the outset of the National Mental Health Strategy in 1993 and participated in implementation and development over the next two decades. This included the specifications for state and territory performance reporting via nationally agreed KPIs and collection of consumer outcomes data that is now firmly embedded in all state and territory systems. I worked as the consultant/advisor to the all-jurisdiction Australian Health Ministers' Advisory Council (**AHMAC**) National Mental Health Information Strategy Committee in its early establishment years (1993-94) and subsequently participated in its next 100 meetings as a Commonwealth nominee prior to departing the Committee in late 2018. I authored the first (1997) and second (2005) editions of national mental health information priorities that laid out

[1] The first 11 reports were published between 1994 and 2010. The twelfth and final report was drafted by the University of Melbourne and released in 2013: Australian Government Department of Health, 'National mental health report 2013' <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-report13-toc> [accessed 19 June 2020].

[2] These reports were prepared for COAG annually and were made available via the COAG Health Council website. Archived copies are available online via the National Library of Australia's Trove platform.

the agenda for intergovernmental collaboration on data development to support mental health reform.[3]

(c) **National Mental Health Plans** – I have been involved in the development of all five Australian National Mental Health Plans since the first Plan in 1992, with increasing involvement in design and drafting as the series progressed.

(d) **Casemix and activity-based funding for mental health** – together with Shane Solomon, current Chair of the Independent Hospital Pricing Commission, I led the Mental Health Classification and Service Costs Project (**MH-CASC**), a $2.7 million project commissioned by the Australian Government in the mid-1990s to develop a casemix classification for mental health services. This project is known for its ground breaking research and development work and is the most complex project of this type ever undertaken in the mental health field internationally. The results set the direction for information development in the public mental health sector over the next two decades, and led to more than $60 million of bilaterally negotiated Commonwealth information development grants to states and territories, targeted at building information systems and developing skills in the clinical workforce to collect and use information in their day to day practice. Subsequent to MH-CASC, I was the Principal Consultant for the New Zealand replication of the work.

(e) **Commonwealth policy and program development** – as noted, since 2006 my consultancy work has been primarily with the Commonwealth Department of Health. The work has focused on policy and program development in primary mental health care, and most recently, the establishment of reforms progressed through the Primary Health Networks (**PHN**s) established in 2015. This has covered development of PHN funding models, program guidelines, evaluation frameworks, data development and performance reporting. I have also worked extensively with the Commonwealth in the development and implementation of key strategic projects that have national implications, including the National Mental Health Service Planning Framework (**NMHSPF**), the framework for the Initial Assessment and Referral project, guidance on joint Commonwealth-state planning for integrated services, regional and other initiatives driven by the various National Mental Health Plans.

8 Attached to this statement and marked 'BB-1' is a summary of my experience. My consulting work over the past three decades has provided a privileged opportunity to be both a participant and observer of the progress by all Australian governments in reform

[3] Australian Government Department of Health, 'National mental health information priorities 2nd edition' <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-infopri2> [accessed 19 June 2020].

of mental health. This provides the basis for the observations and opinions I have detailed in this statement.

Roles and responsibilities of the state and Commonwealth governments across mental health services

9 There is standard wording which is typically used in public reports to describe the division in roles and responsibilities between the state and Commonwealth governments across mental health services.[4] Those descriptions usually focus on the Commonwealth's traditional role as a funder, not a manager, of health services. They emphasise the Commonwealth's roles as a significant funder of national programs, and in running the Pharmaceutical Benefits Scheme (**PBS**) and the Medicare Benefits Schedule (**MBS**). In contrast, the states are generally described as the system managers, responsible for running specialist public sector mental health services.

10 To understand the relative roles and responsibilities of the state and Commonwealth governments, we need to look beyond these generic public descriptions, and examine the evolution of the Commonwealth-state interface over the past three decades.

Commonwealth-state roles and responsibilities in the 1990s

11 The Commonwealth has had a limited historical role in the mental health system, stemming from the division of responsibility in the Australian Constitution. Until the early 1990s, the Commonwealth's involvement was largely limited to funding general services through the MBS and PBS. While the Commonwealth had little direct involvement in provision of mental health services, it bore a significant financial cost of the impact of mental illness on employment capacity through outlays on disability and related income support payments.

12 The relative roles of the state and Commonwealth governments have changed dramatically over the course of the National Mental Health Strategy which commenced with the endorsement of the first National Mental Health Policy in 1992. At that time, the Commonwealth took on a leadership role through targeted mental health reform grants. That is, the Commonwealth began providing substantial funds to the state and territory governments to help them close the standalone mental health institutions and move away from hospitals towards community-based care.

13 In addition to being essentially a benefactor of these reforms, the Commonwealth also took on a monitoring and reporting role, with the introduction of the National Mental Health

[4] See for example the description of roles and responsibilities at pages 9-10 of Department of Health, 'Fifth National Mental Health and Suicide Prevention Plan' <http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf> [accessed 19 June 2020].

Report series in 1994. As mentioned above, I authored the first 11 of those reports, which continued to be published until 2013 and became the key tool for monitoring the performance of each of the Australian states and territories. For at least the first 10 years, these reports helped keep governments to task, and accountable for their stated objectives.[5]

The Commonwealth's increased investment in mental health since the 2000s

14 Commencing in the late 1990s and early 2000s, governments became increasingly aware of the major gap between the community need for mental health care and the availability of services. The first national population survey of mental health was undertaken in 1997 and found that 18% of adults met the criteria for a diagnosis of mental illness.[6] This finding was replicated in a second survey in 2007, which found a prevalence of 20%.[7] But state-run specialist mental health services - the 'bedrock' of all mental health services in Australia - were only treating around 1.6% of the population in 2007-08.[8] The mental health population surveys suggested that only one of three of those with a diagnosable mental illness received any form of health care for their mental health problems.[9]

15 The Commonwealth Government sought to fill the apparently vast gap in primary care by starting to develop population-level mental health promotion and prevention programs. The Commonwealth became the new kid on the block, entering the mental health service delivery market with a set of brand new initiatives. This marked the beginning of an era of demonstration projects in the area of mental health. While encouraging innovation on a scale not seen previously, most of these projects were time limited with no commitment to ongoing funding.

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[5] For a summary of the first 10 years, see Whiteford HA and Buckingham WJ, Ten years of mental health service reform in Australia: are we getting it right? *Medical Journal of Australia*, 2005, 182 (8): 396-400. Available at <https://www.mja.com.au/journal/2005/182/8/ten-years-mental-health-service-reform-australia-are-we-getting-it-right> [accessed 19 June 2020].

[6] The first mental health survey of the Australian population was undertaken by the Australian Bureau of Statistics in 1997. Australian Bureau of Statistic, '4326.0 - Mental <Health and Wellbeing: Profile of Adults, Australia, 1997' <https://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/D5A0AC778746378FCA2574EA00122887?opendocument> [accessed 19 June 2020].

[7] Department of Health, 'The Mental health of Australians 2: report on the 2007 national survey of mental health and wellbeing' <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-mhaust2> [accessed 19 June 2020], see page xii.

[8] Australian Institute of Health and Welfare, 'Key Performance Indicators for Australian Public Mental Health Services' <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-indicators/key-performance-indicators-for-australian-public-mental-health-services> [accessed 1 July 2020], see file titled Key Performance Indicators for Australian Public Mental Health Services, Table KPI.8.2, Proportion of population receiving clinical mental health care.

[9] Ibid, page xiii.

16 The Commonwealth role in funding mental health service delivery expanded substantially with the advent of the *COAG National Action Plan on Mental Health 2006-2011*. That Plan marked the first time that COAG-level agreement had been reached on mental health, and at the time was the largest mutual investment in new programs for mental health. It was driven by the period of high profile incidents, crises and community concern reported by the national media in the period preceding. These have been a feature that emerges in the media around every five years, where there is scandal, public outcry, increased expectations and rightful demands by people for a better deal.

17 The expansion of Commonwealth-funded mental health programs continued with the 2011 Federal Budget and later in 2015 with the Government Response to the National Mental Health Commission Review of Programs.[10]

18 Some of the changes introduced by the Commonwealth during this period were within its traditional domain. Most significantly, in 2006, psychologists and selected other non-medical professional groups were added to the MBS as providers of Medicare-subsidised mental health care, through a program known as *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule - Better Access* for short. Previously, psychiatrists were the only mental health specific item in the MBS. The explicit objective of the initiative was to address the gap between prevalence and services. The program has been wildly successful in achieving its objective, lifting treatment rates. Analysis published on data up to 2011 (five years in to the program) suggested that treatment rates for those with diagnosable mental illness increased from 37% to 46%, with *Better Access* being the driver of growth.[11] Since then, *Better Access* has continued to expand the overall coverage by the MBS system, with the national total number of people accessing the MBS for mental health care increasing from 1.5 million in 2010-11 to more than 2.7 million in 2018-19, amounting to 75% growth.[12] This compares to approximately 445,000 people seen by state and territory mental health services.[13]

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[10] Department of Health, 'Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services' <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-review-response> [accessed 19 June 2020].

[11] Whiteford HA, Buckingham WJ et.al. *Estimating treatment rates for mental disorders in Australia*, Australian Health Review, 2014 Feb; 38(1):80-5. Available at <https://www.publish.csiro.au/ah/AH13142> [accessed 21 June 2020].

[12] Australian Institute of Health and Welfare, 'Mental health services | data' <https://www.aihw.gov.au/reports-data/health-welfare-services/mental-health-services/data> [accessed 21 June 2020], see file titled 'Medicare-subsidised mental health-related services 2018-19', Data Table MBS.3.

[13] Productivity Commission, 'Report on Government Services 2020' <https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/health/mental-health-management> [accessed 21 June 2020], see Data Tables, Table 13A.7, Cell O5.

19 A simple statistic highlights the role of the MBS in provision of mental health care in Australia – of those who seek formal health care assistance for a mental health problem, eight out of every ten are seen by service providers funded through the Commonwealth MBS system.[14]

20 In addition to lifting treatment rates through changes to the MBS system, the Commonwealth also began funding and developing services previously the exclusive province of state and territory jurisdictions, such as:

(a) under the COAG Action Plan from 2006:

i. the Personal Helpers and Mentors program (**PHaMs**) – a program to coordinate the care of people with severe and persistent mental illness, funded from 2006 as part of the COAG Action Plan on Mental Health;

ii. the Day to Day Living program – day programs for people with severe and persistent mental illness;

(b) through the 2011 Federal Budget:

i. the Early Youth Psychosis program, funded from 2011, and implemented without any hospitals to back it;

ii. the Partners in Recovery program, also targeted at those with severe and persistent mental illness; and

(c) more recently under Federal Budget initiatives of the current Government – adult community mental health centres, residential centres for people with eating disorders and psychosocial support for those with disability arising from mental illness.

21 All of these were major and welcomed funding interventions to the mental health service system. But all have traditionally been areas of state funded services, and blurred the boundaries of Commonwealth-state relative responsibility. In my opinion, the Commonwealth took these steps in goodwill and out of concern about mental health services being under-resourced. However, they sowed the seeds for the situation we have now – a spaghetti bowl of complexity and confusion about who does what.

Difficulties with the current roles and responsibilities

22 We now have substantial areas of responsibility that are shared between the Commonwealth and state governments. The sharing of responsibilities, and merging of roles, between the Commonwealth and state governments is not being done in a

[14] This statistic is derived from the figures referenced at n 12 and 13 above, i.e. 2.7 million people as a proportion of 3.145 million people (being 2.7 million plus 445,000 people).

deliberate way and is relatively uncoordinated. There are many areas of mental health service delivery where it is essentially a toss of the coin whether a project is funded by the Commonwealth or a state/territory government. Generally, the answer to that question will depend on where you live.

23 As a result, the system is messy and difficult to navigate, not only for clients but also for service providers. It is very difficult for service providers to know who is funding what service, and in turn very easy for governments to try to pass responsibility on to a different level or part of government.

24 The most problematic areas of diffusion include psychosocial care, suicide prevention, youth mental health, early psychosis, social and emotional wellbeing and Indigenous mental health.

25 Part of the reason for the increasing role diffusion is that both state/territory and Commonwealth governments, with goodwill in mind and a desire to do the right thing for communities, take action without communicating with other levels of government. At times there has been a political competition as to which jurisdiction can be credited with having the best signature mental health programs. No government is innocent in this regard, with government Ministers for health or mental health striving to make their mark with game changing 'signature programs'. Future historians attempting to unravel the recent period will puzzle about the many ministerial footprints left in the sedimentary layers created by governments laying one program upon another without due reference to the bigger design issues.

26 The investment in suicide prevention during the last three or so years provides a good example of these issues of competition and duplication. The Commonwealth and all state and territory jurisdictions each made very large, unprecedented investments to fund suicide prevention trials. Each searched for fresh geographical fields to conduct their own trials around new system-level approaches to achieve a reduction in self-harm and suicide in Australia, often finding that the other level of government had planted a flag in the area. There was no collaboration or dialogue between jurisdictions in the course of developing these plans and trials. While the significant investment in suicide prevention is hugely welcome, governments have not worked together to realise the combined power of a joint investment.

27 The question now is how are we going to get out of this mess. In my opinion, the key to reform of the mental health system is the Commonwealth-state interface, which I discuss further below.

The notion of leverage

28 I consider the notion of leveraging policies from other jurisdictions (including the Commonwealth) to be the wrong way of construing the problem, and the opportunities to move forward.

29 For example, there has been a practice of states/territories seeking to refer patients out of their system, making patient follow-up the responsibility of another jurisdiction. This practice may be regarded as leveraging, others may describe it as cost shifting, while others may see it as a necessary sequence of care that calls for integration. In any event, we need to move away from a mindset of trying to work out how to gain leverage from another government's policies, and towards achieving substantive national consensus on system integration.

30 Mental health reform is not about one government leveraging another but about all governments truly working together. I do not believe that the Royal Commission's interim report gave this issue the attention it deserves, and as discussed below, underestimated the role of the Commonwealth as the **majority funder** of mental health care in Victoria.

Interdependencies between Commonwealth and state/territory roles and responsibilities around mental health

31 The two main areas that highlight the interdependencies between the Commonwealth and states are: a) funding; and b) service utilisation.

a) Funding

32 Currently the most significant interdependency between the Commonwealth and state/territory governments relates to funding.

33 The Royal Commission's interim report states: *"Currently, state and territory governments provide the majority of funding for mental health services" (Section 20.4, page 553).* The interim report also states that, in 2016-17, the state and territory governments funded 61.6% of total expenditure on mental health related services in Australia, and the Commonwealth Government funded 32.9% of those services (Figure 20.5, page 554). Those figures, which are sourced from the Australian Institute of Health and Welfare (**AIHW**)[15] represent the traditional presentation of how national funding is reported in the public domain.

[15] The interim report cites the following source for Figure 20.5: Australian Institute of Health and Welfare, 'Mental Health Services in Australia. Expenditure on Mental Health Services 2016-17. Table EXP.34' <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia> [accessed 19 June

34 But the traditional reporting approach is misleading because it attributes Commonwealth funding provided to states and territories via the National Health Reform Agreement (**NHR Agreement)** to states, not the Commonwealth. There are complex reasons why this reporting practice has continued, but largely it is based on the principle that the funds are best reported under the level of government that is responsible for service delivery. In the case of the NHR Agreement, Commonwealth funds are provided direct to Local Hospital Networks (**LHNs**) which are the entities established by states and territories to deliver public hospital services (including clinical community mental health services).

35 As I discuss below, significant Commonwealth funds are provided through the NHR Agreement direct to Victorian LHNs for the delivery of public hospital-managed mental health services. When these funds are correctly assigned to the Commonwealth side of the ledger, **and** added to the Commonwealth funding of other services (MBS, PBS and more – see below), a very different conclusion emerges. The Commonwealth is in fact the majority *government* funder (around 60%) of mental health services in Victoria, as it is in all states and territories.[16]

Commonwealth funding negotiated under the NHR Agreement

36 The NHR Agreement introduced a major change to the way public health services are funded. Pursuant to that Agreement, Commonwealth funding is paid direct to LHNs through Pool accounts managed by the National Funding Body, and is based largely on the volume and mix of services delivered through PHNs by a system known as Activity Based Funding (**ABF**). This includes payment for inpatient mental health care by public hospitals, and specialised clinical community mental health care services, the latter currently funded as block grants rather than ABF. Payments are made direct to LHNs on a monthly basis, compared with the previous approach whereby Commonwealth funding for public hospital services was made to state Treasury departments.[17]

2020]. I note that the Expenditure Report for 2016-2017 appears to no longer be available from the AIHW website, however the Excel file *Expenditure on Mental Health Services 2017-18* includes historical data and is available at Australian Institute of Health and Welfare, 'Mental health services in Australia' <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/data> [accessed 19 June 2020].

[16] See the analysis and calculations at paragraphs 36 to 39 below.

[17] Details about the National Health Funding Body and the NHR Agreement can be found at National Health Funding Body, 'Public Hospital Funding' <https://www.publichospitalfunding.gov.au/public-hospital-funding> [accessed 19 June 2020] and at Department of Health, 'National Health Reform Funding' <https://www1.health.gov.au/internet/main/publishing.nsf/Content/public-hospitals> [accessed 19 June 2020].

37 The data published by the National Health Funding Body show the distribution of Commonwealth, state and territory funds to the LHNs.[18] Analysis of the data for 2017-18 suggests that Victorian LHNs received approximately $531 million in Commonwealth payments for the delivery of public mental health services. When combined with 2017-18 state and territory mental health expenditure data reported by the AIHW, and when the $531 million is transferred from the state to the Commonwealth side of the ledger, the conclusion can be drawn that the Commonwealth funding represents approximately 51% of expenditure reported for specialised clinical mental health services delivered by Victorian LHNs.[19] As noted, the Royal Commission's interim report attributes that funding to the Victorian Government.[20]

Other funding contributions by the Commonwealth

38 In addition to payments made through the NHR Agreement, it is also necessary to take into account funding provided by the Commonwealth each year for mental health services in Victoria through the MBS, PBS, various programs managed by the Commonwealth Departments of Health such as headspace, and PHN-commissioned services, Veterans Affairs, and Defence, and other programs provided on a national basis. The Royal Commission's interim report presents estimates of these in Appendix C Table C.2, showing that they total around $862 million.[21] Adding this to the estimated NHR Agreement payments of $531 million produces a Commonwealth total of $1,393 million.

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[18] See National Health Funding Pool Administrator, 'Annual Report 2017-18' <https://www.publichospitalfunding.gov.au/sites/default/files/publication_documents/administrator_2017-18_annual_report.pdf> [accessed 1 July 2020]. Note 2A, page 46, reports that Victoria received Commonwealth payments of $166.3 million for admitted mental health (ABF funded) and $364.9 million for non-admitted mental health, totalling $531.3 million. The Administrator's Annual Report for 2018-19 shows that this amount increased to $610.5 million.

[19] This estimate is based on $531m as the numerator and estimated expenditure by Victorian LHNs in 2017-18 as the denominator. The latter figure is derived from Table EXP.1 of the AIHW mental health expenditure data for 2017-18 available at Australian Institute of Health and Welfare, 'Mental health services in Australia' <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services> [accessed 19 June 2020]. Derived LHN expenditure excludes expenditure reported for residential mental health services, grants to NGOs (both out of scope for the NHR Agreement) and 'Other Indirect expenditure', which principally comprises central administration spend.

[20] Appendix C, Table C.2 of the Commission's interim report acknowledges that the estimate of Victorian Government funding on clinical mental health services includes transfer payments from the Commonwealth to Victoria as per the NHR Agreement, but does not put a figure to the amount.

[21] Table C.2 estimates a direct cost to the Commonwealth for 2018-19 of: $371.0 million for MBS mental health services; $134.1 million for PBS-covered mental health pharmaceuticals; and $357.6 million for national mental health programs and other expenditure (which gives a total of $862.7 million).

This represents 60% of combined Commonwealth-Victorian Government spending on mental health services.[22]

39 The 60% estimate is conservative because it does not include significant Commonwealth residential aged care subsidies paid for residents of specialist mental health aged residential facilities. Compared to other jurisdictions, Victoria has the highest number of these facilities.

Looking to the future

40 The significant level of Commonwealth funding for mental health services in Victoria highlights how critical it is for funders to work together to achieve the best outcomes from their combined investments. We need a fundamental agreement between the Commonwealth and states about who does what, and who pays for what, in the area of mental health. In my opinion, reaching that agreement is the key to unlocking the future of mental health in Victoria (and indeed across Australia).

41 By way of analogy, you cannot fix a leaking boat by only looking at what is happening at your end. If we look only at the state's end of the boat, without taking into account what is happening at the Commonwealth's end, the boat will continue to go down or go astray. The fundamental reforms that are needed in Victoria, and indeed in any other state and territory, cannot be progressed without dealing with the Commonwealth-state interface issues.

42 Chapter 5 of the Royal Commission's interim report correctly diagnoses the complexity and fragmentation arising from the Commonwealth-state funding jigsaw but does not take this forward in its recommendations to propose any solutions to this key systemic issue in mental health reform. The draft report of the Productivity Commission Inquiry into Mental Health highlights the issue more comprehensively and suggests that the most important key to reform is system reform around disintegrated services and funding, fragmentation between Commonwealth and states.[23]

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[22] This estimate uses AIHW-reported mental health expenditure for 2017-18, and reduces the amount by the $531 million NHR Agreement funding from the Commonwealth. The estimate looks only at *mental health specific services* and does not include payments on related activity such as ambulance and emergency department, corrections, income and carer support payments and so forth that are detailed in the Royal Commission interim report Appendix C Table C.2. Estimates of payments through the NDIS for people with psychosocial disability are also excluded.

[23] See Part V, Chapters 22-24 of the Productivity Commission's draft report, available at Productivity Commission, 'Mental Health' <https://www.pc.gov.au/inquiries/completed/mental-health/draft> [accessed 6 July 2020].

b) Service utilisation

43 In addition to shared funding responsibility, the state and Commonwealth governments have interdependent responsibilities for treatment of individuals who present for mental health care. The service utilisation data reveals how deeply intertwined the State and Commonwealth funded services are in Victoria.

44 The Royal Commission's interim report states: *"The Victorian mental health system currently only offers enough public specialist clinical mental health services for an estimated 1.1 per cent of the population"*,[24] which accounts for around 73,000 people each year. In contrast, around 704,000 Victorians were seen by a Medicare-funded mental health service provider in 2017-18, representing 11% of the population, the highest of the Australian jurisdictions. That is, approximately nine out of every ten people seeking mental health care in Victoria receive services that are delivered through the MBS (i.e. Commonwealth-funded services) alone.[25] The proportion of people seeking mental health care and seen by MBS-providers in Victoria is higher than other jurisdictions (nine out of ten vs eight out of ten) because Victoria's public mental health services treat a lower proportion of the population (1.1% vs national average 1.8%),[26] while a greater percentage of the population access MBS-subsidised mental health care (11.3% vs national average, 10.6%).[27]

45 In addition, of the approximately 73,000 Victorians seen by public mental health services, many of those people move back and forth between State-funded community mental health services and Commonwealth-funded services through the Medicare system. I acknowledge that there is little publicly available data on the movement of patients from state-managed care to MBS providers but the transfers are widely known in the sector and necessary for a resource-stretched public health system to manage demand. They are also a necessary part of a comprehensive mental health system.

46 It is also important to specifically consider the treatment and care for people with severe mental illness, representing 3.1% of the population or 205,000 Victorians.[28] The Royal

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[24] Royal Commission, interim report, section 20.2.1, page 545.

[25] Australian Institute of Health and Welfare, 'Mental health services | data' <https://www.aihw.gov.au/reports-data/health-welfare-services/mental-health-services/data> [accessed 19 June 2020], see file titled 'Medicare-subsidised mental health-related services 2018-19', Data Tables MBS.3 and MBS.4.

[26] See n 24 above and see also pages 551-552 of the Royal Commission's interim report. including Box 20.1 and Figures 20.2 and 20.3.

[27] Australian Institute of Health and Welfare, 'Mental health services | data' <https://www.aihw.gov.au/reports-data/health-welfare-services/mental-health-services/data> [accessed 19 June 2020], see file titled 'Medicare-subsidised mental health-related services 2018-19', Data Table MBS.1.

[28] See the Royal Commission's interim report, page 32, citing the National Mental Health Service Planning Framework, p. 10. Severe mental illness includes a range of mental health

Commission's interim report suggests that it is predominantly State-funded services that have responsibility for this cohort. In fact, the Commonwealth and states play roughly equal roles in terms of coverage, but not types, of services for people with severe mental illness. While states are responsible for hospital care, treatment provided in the community is shared across specialised clinical community mental health services delivered by LHNs and Commonwealth-funded providers, principally through the MBS, for example MBS-subsidised psychiatrists and clinical psychologists.

47 The Royal Commission's interim report estimates that approximately 105,000 people with severe mental illness in Victoria require, but are not receiving, specialist clinical mental health services.[29]

48 The interim report states that this figure was calculated by the Royal Commission based on the NMHSPF. But the analysis is flawed because it neither accounts for the role of specialised mental health clinicians delivering services through the MBS system, nor reads the NMHSPF modelling correctly.

49 The analysis begins with the assumption that the estimated 75,000 people seen by Victorian public mental health services have a severe mental illness. This is a reasonable assumption, given the strict eligibility criteria that apply to access to these services. It then adds the 25,000 Victorians treated in private psychiatric hospitals and assumes these are also people with a severe mental illness – also a reasonable assumption, assuming no duplication – bringing the total to 100,000 who receive treatment. This leaves a shortfall of 105,000 who are suggested as not receiving *'specialist clinical mental health services'*.

50 If the term *'specialist clinical mental health services'* is narrowly restricted to only refer to services delivered through specialist mental health services managed by Victorian LHNs, then the estimated 105,000 gap is reasonable. But the credibility of the conclusion fades when the corollary assumption is considered – specifically, that none of the 704,000 people treated through the Commonwealth funded MBS system have a severe mental illness. This is implausible. Of this group, approximately 108,000 were seen by private psychiatrists in 2017-18, and another 138,000 by clinical psychologists, and a further 240,000 by registered psychologists and allied health professionals.[30] GPs saw 580,000 through mental health-specific mental health items.[31] And 590,000 people received

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conditions. It includes not only people will schizophrenia (around 20% of this group) but also people with severe anxiety and/or depression (around 40% of this group).

[29] Figure 7.8, page 178.

[30] Australian Institute of Health and Welfare, 'Mental health services | data' <https://www.aihw.gov.au/reports-data/health-welfare-services/mental-health-services/data> [accessed 19 June 2020], see file titled 'Medicare-subsidised mental health-related services 2018-19', Data Table MBS.3.

[31] Ibid.

psychiatric medications through the PBS, with more than 90% prescribed through their GP. Approximately 108,000 of this group received PBS-subsidised antipsychotic medications.[32] Even with conservative assumptions, where up to 20% of those treated by MBS-subsidised practitioners, equivalent to 140,000 people – have a severe mental illness and are being managed primarily through the MBS-subsidised system, the treatment gap for those with severe disorders is not of the quantum or type suggested by the Royal Commission's interim report analysis.

51 This is to not imply that all is well, or that the care received by those with severe mental illness is optimal. It clearly is not, because the estimates are based only on estimated counts of people accessing services on at least one occasion. There are many legitimate and widespread concerns that the current arrangements fail to meet 'minimally adequate treatment' criteria and these are extensively documented in the Royal Commission's interim report.

52 Correct analysis of the NMHSPF modelling also points to the roughly equally shared role of Commonwealth and state-managed services in providing treatment and care to those with severe mental illness, when considered from a good practice perspective. The NMHSPF takes what is known about the distribution of mental illness and what is known about best practice and models how we can bring best practice together to provide a proper response to community need. The NMHSPF is the best modelling tool we have available, and has been made available to the Royal Commission as indicated in its interim report.

53 According to the NMHSPF modelling, around half of those with severe mental illness should be treated below the level of the state specialist care system (that is, by a combination of Level 3 and Level 4 care, whereas the state specialist care system is Level 5 care). Level 3 and 4 care comprises GP-management, with private psychiatrist and/or allied heath involvement, all of which are delivered in primary care settings.

54 Overall, the service utilisation data highlight the shared and intertwined Commonwealth and State roles in provision of health services utilised by people in mental health need, including those with severe mental illness.

55 The data add to the case built from the previously presented funding roles data, that any reform of the mental health system must address Commonwealth-state interface issues to achieve the deep changes required. Any review of a better future for Victoria has to consider the relative roles of both levels of governments and how they must improve the

[32] Australian Institute of Health and Welfare, 'Mental health services | data' <https://www.aihw.gov.au/reports-data/health-welfare-services/mental-health-services/data> [accessed 21 June 2020], see file titled 'Mental health-related prescriptions 2018-19', Data Table PBS.2.

ways that they work together. Resolving a more rational arrangement than exists at present is the key to reform.

Effective ways for state, territory and Commonwealth governments to work together across mental health services

A brief history

56 The early modus operandi for state and Commonwealth governments working together was through money – the Commonwealth gave the states money to undertake agreed activities. This was usually recorded in formally negotiated, targeted bilateral funding agreements that were monitored and reported on annually. This was a very effective process. However, these bilateral funding agreements ceased progressively from 2008 with the advent of new intergovernmental funding agreements introduced by the Rudd government, and later by the NHR Agreement. Each party (state and Commonwealth) largely went their own way from there in relation to what they would fund.

57 As flagged above, natural forces have worked to disintegrate and fragment the service system as the Commonwealth has increasingly expanded its role into traditional state-managed areas of responsibility.

58 State and territory governments have sought to capitalise on the increased funding role of the Commonwealth by reducing their own funding of mental health services. This has resulted in an exacerbation of cost shifting, particularly in relation to the ever-expanding role of the MBS in looking after people out of hospital.

59 In an effort to achieve less fragmentation and greater integration, the Commonwealth established 31 PHNs in 2015. Prior to the establishment of the PHNs, the Commonwealth funded around 20 individual mental health programs directly out of Canberra, with hundreds of contracted parties, including individual psychologists. With the introduction of the PHNs, those programs were all pooled into a flexible funding pool for the PHNs to manage.

60 Where the PHN boundaries align with the boundaries of state and territory LHNs, there is a valuable geographic opportunity for integration. However, as I discuss further below, there is no such alignment in Victoria.

Integration is the way forward

61 The objective of integration has been an elusive goal for the last 25 years. During my involvement in national reform, I have observed the persistent failure to achieve the integration objective. I have also observed the widening gap between the *policy rhetoric* about governments working together, and the *practical reality* on the ground. There has

been a lot of talk about working together but that talk has rarely translated into effective, collaborative action.

62 Though difficult to achieve, integration of planning, funding and service delivery is the only way out of the muddled arrangements we now find ourselves in across the mental health sector.

63 Integration was one of the two primary platforms of the 1992 National Mental Health Policy.[33] At that time, the imperative of integration was focussed upon better integration between hospital services and community services, to close the gap between a person leaving hospital and receiving care in the community. The states, funded by the Commonwealth, undertook a significant amount of work to try to fill that gap. Now, the integration objective is much more complex – it is about integrating specialist care and primary care (i.e. state-funded care and Commonwealth-funded care), and between health and disability and social support services.

64 Integration has been deeply embedded in the objectives set out in the first four National Mental Health Plans. However, as noted, those objectives were never achieved. Rather, as I have described above, the system has become progressively more disintegrated and more fragmented over time.

65 The Fifth Plan, released in September 2017, takes a fundamentally different approach to the previous four iterations. While significant effort was invested in developing the first four National Mental Health Plans, services on the ground usually paid little if any attention to them, and state, territory and Commonwealth governments often walked away from signing on the belief that implementation would follow. But, in the absence of concerted effort, signing of national agreements does not translate to action on the ground to better integrate activities across local services. Most local mental health service providers with whom I have interacted, and this group is many, never read those plans let alone examined their implications for local service delivery.

66 The Fifth Plan represents a fundamental rethink of how integration should be achieved; it signals a shift away from the idea that the mechanisms for integration operate at the national level. Priority Area 1 of the Fifth Plan is to achieve integrated regional planning and service delivery, meaning:

(a) integration must happen regionally, at the service level on the ground; and

[33] The second key objective was mainstreaming – moving mental health out of the separate psychiatric institutions and into general health care.

(b) work at the national level should focus not just on giving directives, but also on setting up strong enabling frameworks and tools to support the efforts of local and regional system integrators.[34]

67 In particular, the Fifth Plan requires:

(a) governments to develop a statement of relative responsibilities to guide regional planning;

(b) joint regional plans to be developed for all regions by mid-2020 (although their release will be delayed because of COVID-19). This is unprecedented as plans are usually developed at the state/territory level;

(c) the NMHSPF to be used to guide local planning about requirements, service gaps and priorities; and

(d) data sharing and tools to be developed to support regional planning work.

Regional plans – opportunities and challenges

68 Looking at the opportunities that exist within a particular region (rather than at a state or national level) is often the key to identifying how to better integrate our resources. For example, arrangements for shared assessment referral pathways, shared care pathways, after hours back-up support, co-location of services and joint training all take place at the local level, not through state or national agreements.

69 In recognition of the benefits of local integration, under the Fifth Plan:

(a) the regional plans are to be co-developed by the PHNs and their LHN counterparts; and

(b) it was agreed that the Commonwealth, state and territory governments should provide input to the plans, and work together with agencies within the regions, but would not be responsible for approving regional plans, as this could get in the way of local efforts.

This represents a major step forward in creating a more integrated mental health system.

70 To facilitate the development of integrated regional plans, the Integrated Regional Planning Working Group released a comprehensive guide: *Joint Regional Planning for*

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[34] COAG Health Council, 'The Fifth National Mental Health and Suicide Prevention Plan' <http://www.coaghealthcouncil.gov.au/Publications/Reports> [accessed 2 July 2020], see pages 18-22. For further information about the Fifth Plan, see Department of Health, 'The Fifth National Mental Health and Suicide Prevention Plan' <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-fifth-national-mental-health-plan> [accessed 2 July 2020].

Integrated Mental Health and Suicide Prevention Services.[35] This guide is intended to assist PHNs and LHNs to work together to create much better synergy between Commonwealth and state resources. It is a significant and important document developed by a state and Commonwealth collaborative process under AHMAC auspice, and distributed to all LHNs and PHNs in all jurisdictions.

71 In my view, regional plans are, structurally and strategically, an absolutely fundamental system level change that is required. Developing effective regional plans is not only about envisaging what a better future would look like; it is also about determining how we use the resources that are within our control *now* to work better together (and, in doing so, create that future state).

72 While regional plans hold much promise, they also present a number of practical and political challenges. One of the foremost challenges is that, in Victoria, the mental health system boundaries do not align with the primary care system. There are some PHNs, such as Eastern Melbourne PHN, that have to interact with five LHNs. The overlap and geographic misalignment between Victoria's PHNs and LHNs remains highly problematic – it is an obstacle to integration and presents practical difficulties for PHNs and LHNs to work together on a joint regional plan.

73 These geographic challenges are amplified by the fact that many PHNs and LHNs have not previously collaborated with each other about planning issues. In fact, there has been a tendency to look at each other with mutual mistrust. That was largely because there was previously nothing concrete bringing them together. Now, with the Fifth Plan, they are working together to develop and deliver these regional plans.

74 There have however been points of resistance to decentralisation of planning to regional groups, particularly from powerful national advocacy groups who have been reluctant to argue their case with regional entities, instead preferring to engage with a single one-stop-shop (i.e. central bureaucracies) when they are seeking increased funding.

75 In considering the way forward, it is important to recognise that Victoria has signed up to the Fifth Plan, and thereby committed to the delivery of joint regional plans across the State and continuing funding of the NMHSPF.

76 It concerned me that nowhere in the Royal Commission's interim report is the work being undertaken through the Fifth Plan mentioned as a significant enabler of the reforms that

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[35] The Integrated Regional Planning Working Group comprised representatives from Commonwealth, state and territory governments, PHNs and LHNs. The Guide is available for download from Department of Health, 'Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services A Guide for Local Health Networks (LHNs) and Primary Health Networks (PHNs)' <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-health-intergrated-reg-planning> [accessed 2 July 2020].

the Royal Commission is striving to achieve, despite the fact that the outputs of this large effort are expected this year. Many services at regional level are talking to each other for the first time. The fact that all Commonwealth (PHNs) and State funded regional entities (LHNs) are expected to deliver a joint regional plan for integrated service delivery seems to have been overlooked, despite the fact that it represents a huge step forward.

Regional commissioning authorities and pooling of funds

77 The Productivity Commission's Mental Health Inquiry (**Productivity Commission Inquiry**) draft report recognised the absolute importance of regional integration as the key to a way forward. The Productivity Commission report goes further than the Fifth Plan, suggesting as a preferred option the pooling of funds into regional commissioning authorities, managed by states. Recognising that this may be a bridge too far, the draft report outlined two options:

(a) ***Renovate,*** which relies on cooperative endeavour (i.e. people choosing to work together in a collaborate way), with no major legislative reform and no money changing hands. This is essentially what is taking place with the regional plans under the Fifth Plan[36]; or

(b) ***Rebuild,*** whereby all parties pool money into regional pools to be managed by new regional commissioning authorities set up by legislation. These authorities would basically be purchasing entities, which would operate in much the same way as the UK's Clinical Commissioning Groups (previously Primary Care Trusts). The Productivity Commission Inquiry's draft report put forward this Rebuild model as the preferred option.[37]

78 Both options require strong national governance and an overarching national agreement. Further, the Productivity Commission Inquiry draft report recognised that the expertise in managing the health system lies with the states and territories, not the Commonwealth. Under the Rebuild proposal, the states and territories would manage the new regional commissioning authorities, and would therefore be responsible for primary care, at the same time as being responsible for specialist care.

79 Several reports during the last 20 years have also proposed regional commissioning authorities, particularly in the areas of general health and mental health. Examples include the recommendations of the National Health and Hospital Reform Commission in

[36] It is worth noting that the Fifth Plan had to work within the existing environment and framework of responsibilities so was not able to go as far the Productivity Commission in recommending major structural change.

[37] See pages 44-46 of the Productivity Commission Inquiry's draft report (Volume 1), and Chapter 23 (Volume 2) which are available at <https://www.pc.gov.au/inquiries/completed/mental-health/draft> [accessed 5 July 2020] .

2009[38] and the papers on reforming Australia's Federation, which was commissioned by the Abbott government in 2014 and subsequently cancelled by the Turnbull government. One option put forward as part of the latter project was that the Commonwealth, states and territories pool funding and share responsibility for all health care through Regional Purchasing Agencies.[39]

80 Review of the Productivity Commission Inquiry's public hearings and subsequent submissions indicates that there has been some pushback in response to the Productivity Commission Inquiry's suggestion of regional commissioning authorities – they would be a huge change and that unnerves many people. But real and long lasting change is never easy – the Rebuild option would immediately resolve the never ending mission to clarify responsibilities, although its implementation would be complex.

81 Notwithstanding those complexities, in my view, the structural reforms of pooling funds and regional commissioning authorities are the only way forward. Current and past attempts at integration have not worked, and some have actually made the situation worse. After 25 years of failure, we cannot just keep continuing along the same path. Promises by governments for good cooperative endeavour, however genuine, are not enough to achieve the integration that is required.

Recent collaboration and the role of Victoria in driving the integration imperative

82 The mental health sector has become very divided. From once being strongly consensus-based, there has been a lot of competition and contest for attention and funding as the sector has expanded and become more empowered. There has been over time a tendency of governments kowtowing to the most vocal stakeholders, and succumbing to the temptation to roll out yet another signature program through a favoured advocacy group. All governments have been guilty of this.

83 More recently, there has been increased convergence within the sector, centred around hopes for the Royal Commission and the Productivity Commission Inquiry. Governments need to capitalise on these two inquiries and engage in some deep healing work about their respective roles and responsibilities. Governments need to be *leading* the major system reforms, rather than simply *reacting* to the advocacy of particular stakeholders.

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[38] Commonwealth of Australia, 'A Healthier Future for all Australians: Final Report of the National Health and Hospitals Reform Commission – June 2009' <http://www.cotasa.org.au/cms_resources/documents/news/nhhrc_report.pdf> [accessed 2 July 2020].

[39] Analysis & Policy Observatory, 'Reform of the Federation Discussion Paper (2015)'<https://apo.org.au/sites/default/files/resource-files/2015-06/apo-nid55457.pdf> [accessed 2 July 2020]. The proposal covered primary and specialist care, hospital (both public and private), and allied health services.

Governments should be focusing on the 'big system issues' surrounding the lack of integration.

84 Australia's response to COVID-19 shows us the promise of what can be achieved when governments truly work together. The COVID-19 pandemic has driven new harmonious working relationships between governments in many areas. Victoria has been a big driver of change in that arena. In the face of COVID-19, the Federation has been made to work together in a way that none of us has seen before or believed possible in our lifetimes. This has restored many people's faith that our federated system of governments can work together to achieve meaningful change.

85 These new relationships might provide a helpful basis for dealing with previously unresolvable issues in the healthcare sector and other areas of human services, noting that these issues stem largely from problems caused by our federal system. If we can manage to get the whole country to stay at home, we can surely apply the same spirit of collaboration and collective responsibility to reform the mental health system.

The role of Victoria

86 Victoria can—and should—play a leadership role in reforming the mental health system. It would be ineffective for Victoria to seek to achieve the objective of integration alone. Victoria should not only look to achieve change within its borders, but should also play an important role in leading and influencing other jurisdictions (including the Commonwealth) about the best way forward. Victoria needs to come to a position on how to achieve integration and then push for those reforms to be implemented on a national stage.

87 While Victoria now has the lowest per capita funding for mental health, it is still a significant influencer – across the country, Victoria is still seen as the State of innovation and ideas. Victoria could restore its position of being a national leader by pushing forward the reforms needed in the mental health system.

Collaboration to support national reform and achieve good mental health outcomes

88 Governments need to work together to be enablers of regional service integration on the ground. However, devolution and local-level accountability (i.e. leaving it to the regions) is not enough; we also need effective architecture around integration. That architecture should comprise the following five elements:

(a) **A new intergovernmental National Mental Health and Suicide Prevention Agreement**, as recommended in the Productivity Commission Inquiry's draft

report.[40] That instrument would form the basis for future collaboration. It should address, amongst other things, the parties' relative roles and responsibilities and the flow of money between the Commonwealth and the states and territories. It should also require collaborative planning for any future spending. That is, central to the Agreement should be that no jurisdiction spends significant money on a new endeavour without talking to one another, so that we do not get a repeat of the competition that we saw with the suicide prevention trials.

(b) **A shared vision and planning frameworks:** The NMHSPF provides the basis for this, and there is no international equivalent. We need a planning tool and framework that creates a common language between all parties. In my view, the NMHSPF offers that common language. I discuss the background to, and role of the NMHSPF further from paragraph 89 below.

(c) **Tools to support local effort:** These include tools to develop service maps, allowing identification of areas of duplication, service gaps and opportunities for integration.

(d) **Data sharing agreements and useful data:** Many problems could be solved through more liberal data sharing between the Commonwealth, states and territories. Data sharing is the basis for establishing mutual trust. It is also a vital tool for planning. For example, the states should be given access to the Medicare data for their jurisdiction, as this would help them to better understand service needs and utilisation for their population. There have been promising steps in this direction in recent years but the progress is slow.

(e) **Relentless implementation:** As the Royal Commission's interim report recognises, policy is relatively easy; the difficulty lies in implementing policy in the real world.

National Mental Health Service Planning Framework (NMHSPF)

Background on the development of the NMHSPF

89 The NMHSPF has its origins in a New South Wales tool known as MH-CCP (Mental Health Clinical Care and Prevention Model) which was first developed in the early 2000s.[41] New South Wales used the tool to model expected levels of demand for particular regions from any given population, and what it would cost to meet that demand.

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[40] Draft recommendation 22.1, page 99. A copy of the Productivity Commission's draft report is available at <https://www.pc.gov.au/inquiries/completed/mental-health/draft> [accessed 5 July 2020].

[41] The original version of the NMHSPF was developed by a genius epidemiologist and planner in the New South Wales Department, Mr Gavin Stewart. Although retired, Gavin continues to provide advice and guidance on the ongoing development of the NMHSPF.

That modelling was compared with the status quo to identify which regions across the state had the biggest gaps.

90 The tool enabled the New South Wales government to make more informed, evidence-based decisions about which regions should receive additional funding as it became available. This in turn helped to manage competition amongst stakeholders and advocates.

91 The NMHSPF was first promised in the Fourth National Mental Health Plan, released in 2009.[42] This was a major step because it represented a commitment by all jurisdictions to develop an evidence-based approach to planning, and work toward consistency in the setting of national service targets. The uniqueness of each jurisdiction, and their different starting points, had long been argued as a reason why national targets should not be pursued.

92 In 2011, the Commonwealth began funding and further developing the NMHSPF. It progressively became a tool for the entire mental health system, covering not only state and territory services, but also primary care.

93 Over time, the states and territories became 50% funders of the NMHSPF. In 2015, the contract for the NMHSPF was moved from New South Wales Department of Health to a team at the University of Queensland who are now undertaking the research and development work for the tool under the leadership of Professor Harvey Whiteford.

Current uses of the NMHSPF

94 Since its introduction, the core aims of the NMHSPF have been to:

(a) develop a common language for describing the service elements;

(b) establish an evidence foundation for planning; and

(c) move from directions to service development targets,

thereby enabling gaps to be quantified and prioritised.

95 More than 200 parties around Australia, including most LHNs and PHNs in Victoria, have been trained and licensed to use the NMHSPF. The Royal Commission is one of the parties licensed to use the NMHSPF and uses the epidemiology from this tool in many parts of the interim report.

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[42] Although it was not known by this title at the time. Department of Health, 'Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014' <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-f-plan09> [accessed 21 June 2020], at pages 42-43.

96 In addition to its epidemiological value, the NMHSPF can also offer strategic value as a tool to drive integration at a regional level. It provides an important basis to establish a common dialogue. For example, it can provide a platform for LHNs and PHNs to have an informed discussion about the service priorities and gaps in their regions and identify opportunities for working together to meet those priorities and fill those gaps.

97 Enhancements are also underway to implement adjustments to the model for differing needs of particular populations, including Indigenous people and people living in rural and remote areas.

98 The NMHSPF has not been released in the big public domain. As I understand it, the reason for this is because of its complexity and potential for misinterpretation or misuse without training. However, a range of documentation has been released describing key elements of the framework.[43]

The future of the NMHSPF

99 The future of the NMHSPF is uncertain. Its current funding runs out in 2021 and it is unclear what will happen after that; it is possible that the NMHSPF will just die on the vine. In my view, that would be a terrible waste, because the NMHSPF is one of the essential tools for system level reform and integration. There is no comparable tool on planet Earth.

100 In my view, we need an ongoing commitment to continue the evolution of the NMHSPF through national research and development. This work should continue to be jointly funded by the Commonwealth, states and territories because it is essentially joint property.

101 To be effective, the NMHSPF needs to continually evolve – it needs to continually consume the growing evidence around measures such as prevalence and treatment. In my view, an academic unit such as the University of Queensland is the appropriate entity to lead this work in developing the NMHSPF.

Using the NMHSPF's methodologies in commissioning

102 The NMHSPF could potentially be used to inform approaches to purchasing and commissioning, however it would need to be backed by a robust monitoring system to evaluate what is delivered against what is funded. We are presently a long way off this possibility being able to become a reality.

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[43] National Mental Health Service Planning Framework, 'About the NMHSPF' <https://nmhspf.org.au/about-the-nmhspf/> [accessed 21 June 2020].

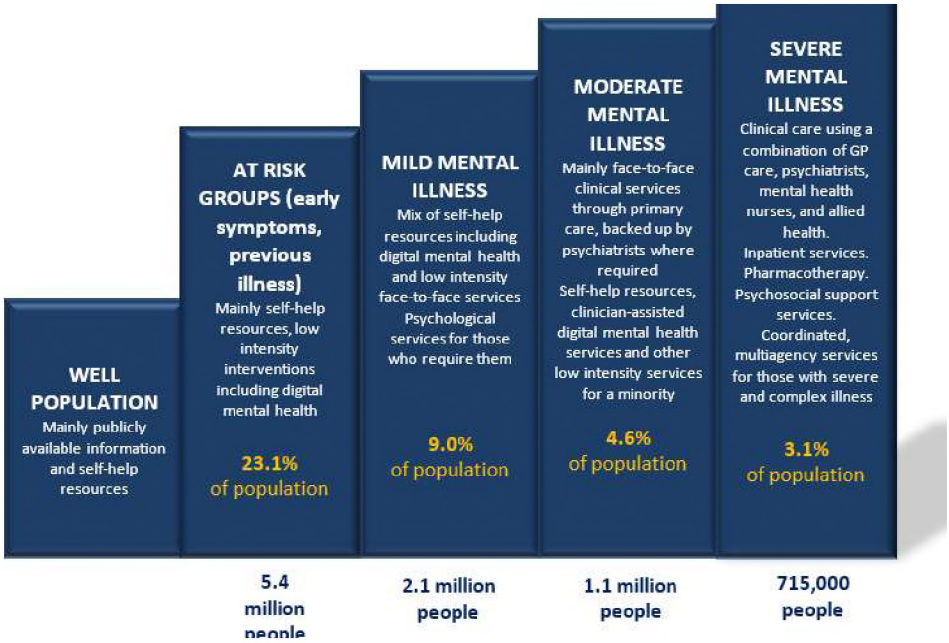
103 In addition, NMHSPF care profiles would need to have external markers captured in routine health data systems. For example, the NMHSPF groups those who seek mental health assistance into 156 'need groups' (referred to as care profile groups), each defined by a range of age-specific and clinical markers. Routine clinical data systems do not currently capture these markers so it is not possible to, say, examine the patient group treated by a particular health organisation and classify according to the NMHSPF groups. Changes to clinical recording systems would therefore be needed if there was a decision to implement the NMHSPF for activity based funding.

Promoting the implementation of stepped care in comprehensive mental health systems

Conceptualising the stepped care framework

104 Understanding and implementing a stepped care approach is essential to developing and delivering a comprehensive mental health system. It is critical that we have a system in place that helps allocate people to the right level of care. The starting point is to understand the prevalence and distribution of mental ill health in the population, as summarised in the diagram below, adapted from the Fifth National Mental Health Plan.[44] The population estimates are derived from the NMHSPF.

[44] Department of Health, 'National Guidance Initial Assessment and Referral for Mental Healthcare' <https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools> [accessed 21 June 2020], see figure 2, page 15. As noted in that document, the graphic is adapted from Figure 8, COAG Health Council (2017), The Fifth National Mental Health and Suicide Prevention Plan, Commonwealth of Australia and estimates of prevalence are derived from National Mental Health Service Planning Framework modelling (unpublished).



105 At a national level, the population estimates of those with any form of mental ill health, from low level at risk groups up to severe and complex, amount to around 10 million people, or approximately 40% of the Australian population. That is, an estimated 10 million people either have a diagnosable mental illness or are at risk of mental illness and are potentially in need of mental health services. Even acknowledging that some people with a mental health need may not be in need of services, that is still a challenging number of people to potentially have in the waiting room.

106 The question we then need to address is: How does an organised health care system respond to the 10 million people who potentially have some level of need? This is where the stepped care framework comes in. There is a lot written and a lot misunderstood about stepped care. In essence, it is just a way of thinking about how to organise services to meet the spectrum of needs from low to high. The stepped care framework is designed to guide rational approaches to distributing scarce health resources to best meet this need.

107 As noted above, the approach taken by the NMHSPF modelling, which is built on stepped care thinking, breaks down the population need for services into 156 'need groups', which can also be understood as 156 'packages of care'. Each need group is a group of clinically similar individuals with similar needs based on age, severity and complexity, ranging from very low to very high levels of need and intensity. The modelling uses a series of assumptions about levels of demand – or estimates about the proportion the potential population in need who will seek assistance. It assumes 25% of the 'at risk' group will express demand for services, 50% of mild, 80% of moderate and 100% of the severe group.

108 The 156 'care packages' modelled by the NMHSPF extend from low to very high in resource intensity. The highly detailed outputs of the NMSPF can overwhelm. It is difficult for many people to see through the detail and grasp the simple messages that lie within.

109 In 2019, the Commonwealth Department of Health published a guide about stepped care titled: *PHN Primary Mental Health Care Flexible Funding Pool programme guidance: Stepped Care.*[45] In my view, this is a very helpful and informative document. Amongst other things, it simplifies the complex 156 packages of care defined in the NMHSPF modelling into a five level schema, as shown in the diagram below.[46]

110 The schema provides a useful summarised view of the diverse and complex array of mental health services available in Australia.

Applying the 5-level stepped care schema to population need

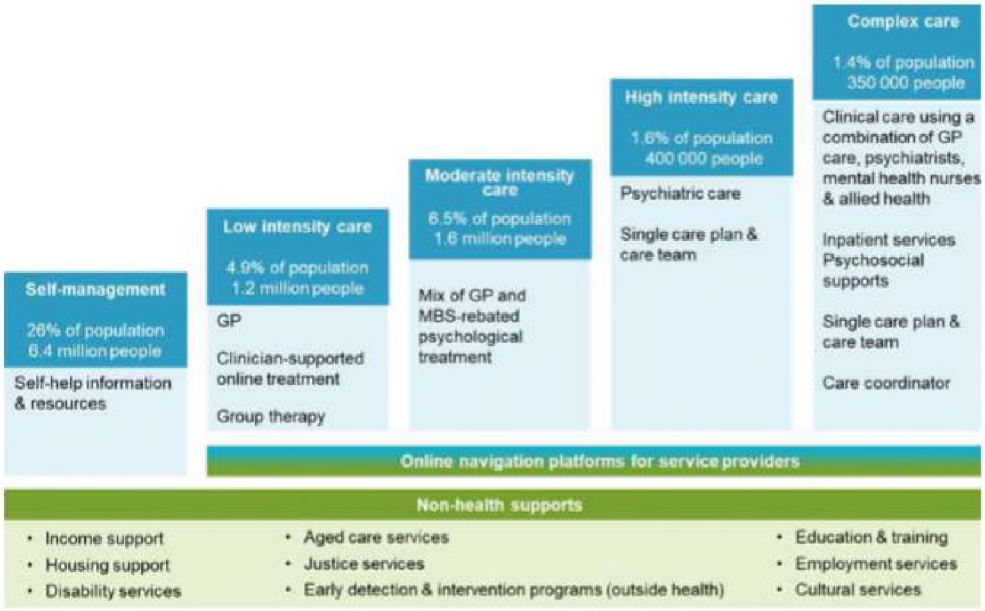
111 As part of its submission to the Productivity Commission Inquiry, the Commonwealth Department of Health undertook modelling using the NMHSPF 156 'needs groups' to

[45] Australian Government Department of Health, 'PHN Mental Health Flexible Funding Pool Programme Guidance: Stepped Care 2019' <https://www1.health.gov.au/internet/main/publishing.nsf/Content/2126B045A8DA90FDCA257F6500018260/$File/1.%20PHN%20Guidance%20-%20Stepped%20Care%20-%202019.docx> [accessed 21 June 2020].

[46] Ibid, Figure 1, page 8.

identify, in simple terms, how many people fit within each level of care. The results of the modelling work were presented in the Productivity Commission Inquiry's draft report.[47]

Figure 4.1 **Stepped model of care**[a]



[a] Percentages are the proportion of the population who require care in each need group. The estimated number of people within each group is based on Department of Health (sub. 556).

112 This modelling shows that the majority of population need is managed at the bottom end of the spectrum through self-management and low intensity care. Moving from left to right, of the total 10 million people, 6.4 million people are self-managed (level 1). This group of people have lower needs that may not meet diagnostic criteria and either do not want any form of formal care, or could be assisted through the many self-help programs and resources that are now available. The large number should not surprise, and does not indicate a group who are turned away from services. People at this first level might not recognise they have a need, or might recognise they have a need but do not want any treatment to help them address that need. It is important to acknowledge that many mental health issues resolve themselves through self-management and with support from friends, family and other non-clinical sources such as self-help books or self-help online programs.

[47] Figure 4.1, Page 189, Productivity Commission's draft report <https://www.pc.gov.au/inquiries/completed/mental-health/draft/mental-health-draft-volume1.pdf> [accessed 5 July 2020]; Commonwealth Department of Health, 'Initial Submission to the Productivity Commission Inquiry (Submission 556)' <https://www.pc.gov.au/__data/assets/pdf_file/0005/244967/sub556-mental-health.pdf> [accessed 21 June 2020], see page 4.

113 At the other end of the spectrum (level 5), an estimated 350,000 people require care from the acute and specialist mental health system, being the specialised mental health services managed by the states and territories. The 3.2 million people in the middle of the spectrum (levels 2, 3 and 4) are largely captured by the Commonwealth-funded primary care services.

114 This modelling further emphasises the need for the Commonwealth and state systems to be thought of in an integrated and interdependent way. If we do not have the right supports at level 1 and a fully functioning primary care system at levels 2-4, then the level 5 services will be flooded with demand.

Implementing the stepped care framework at the individual level

115 Successful implementation of a stepped care model requires:

(a) an organised system that allocates people to the right level of care;

(b) informed referrers (mainly GPs) who understand how to use self-management and low intensity options, and who trust that those options can meet an individual patient's needs;

(c) an effective system of self-management and low intensity assistance options; and

(d) community acceptance and trust.

116 Clinicians need better guidance about how to determine whether a person fits within level 1, 2, 3, 4 or 5. Currently, the default option for people in need is to seek help through a GP, and the most common response from GPs is either a prescription (e.g. for anti-depressant medication) or a referral to a psychologist or allied health provider.

117 We need to equip GPs and other referral services with the knowledge and tools to properly assess the level of care an individual requires. This is vital for ensuring that people with low needs are receiving low intensity care and the scarce resources at the high end of the spectrum are reserved for those with the highest needs. We will not achieve system level reform unless we change the management of mental health needs presenting in the GP's waiting room.

<u>A new national assessment tool for primary mental health care</u>

118 In 2019, after two years of developmental work, the Commonwealth Department of Health released national guidance for PHNs titled: *Initial Assessment and Referral for Mental Healthcare*.[48] I was a member of both the Expert Advisory Group and the Steering

[48] Australian Government Department of Health, 'National Guidance Initial Assessment and Referral for Mental Healthcare'

Committee for this project. In my view, this document is an important strategic tool for implementing a stepped care model at the individual person level and creating a more appropriate spread across the spectrum of need. It promotes a standardised approach to grading the level of severity of individual need.

119 The national guidance on assessment and referral sets out a framework of eight domains, "that should be assessed when determining the next steps in the referral and treatment process for a person referred to a PHN commissioned mental health service",[49] and the relationship of those domains to the various levels of care. The eight domains fall into two categories:

(a) *Primary Assessment Domains* (Domains 1 to 4): Symptoms and Distress, Risk of Harm, Functioning and Impact of Co-existing Conditions; and

(b) *Contextual Domains* (Domains 5 to 8): Treatment and Recovery History, Social and Environmental Stressors, Family and Other Supports and Engagement/Motivation.

120 The guide also includes a range of practice points and decision trees to help support practitioners in making decisions about a person's care needs using the 5-level schema described above.[50] All PHNs have received the guidance materials and are progressively implementing it, alongside a formal national trial which is currently underway.

121 While there is further work to be done on implementation, the framework set out in this document has received a very positive response from PHNs and GPs across the country, and has attracted interest in the Productivity Commission Inquiry's draft report. In my view, an assessment tool of this type is fundamental to increasing the uptake of digital tools and other low intensity options in the community, as well as ensuring that those with the highest needs are able to access the right care for them.

Performance monitoring

Collaboration between state/territory and Commonwealth governments to monitor the performance of mental health services

122 I have had significant involvement in performance reporting in the mental health field. Through that work, I have learnt that success requires trust in the integrity of the data and

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<https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools> [accessed 21 June 2020].

[49] Ibid at page 27.

[50] The decision trees are in Appendix 2.

the reporting process. The process of data collection and reporting must be collaborative and all parties must be invested.

123 We need better monitoring and reporting of performance at both the government and organisational provider levels, to answer the questions of :

(a) Did government do what it said it was going to do?; and

(b) Do service provider organisations achieve the outcomes they promise for consumers?

Performance reporting at government levels

124 The original premise of the 1992 National Mental Health Policy was that each state/territory was starting from a different baseline, and faced unique challenges. The insistence on each state's uniqueness was an initial obstacle to using national reporting to improve accountability and performance comparisons.

125 Effective performance reports are not simply written as a score card to highlight deficiencies. There have been some good examples of national reports that have helped the states and territories to position themselves to achieve positive outcomes within their own political contexts. Two such examples are the National Mental Health Reports (which have since ceased) and the annual progress reports on the *COAG National Action Plan on Mental Health 2006-2011*.

126 Critical to the success of these two sets of reports was the fact that they were written independently and, although funded by the Commonwealth, they were collaboratively developed with the states and territories. As a result, all parties trusted the performance reporting process and data, and were able to use the reports to make informed decisions about priorities and progress within their own jurisdictions.

127 In my view, none of the national reports published since those two reporting regimes ended has had the same power or influence, or the same success in fostering accountability. Typically, national agreements and reports usually fade from the collective memory within 12 months of being signed and are not at all part of the fabric two years later.

128 There is a question as to which entity should be responsible for performance monitoring and reporting on governments. One contender is the National Mental Health Commission (**NMHC**). In its early years, the NMHC was often seen as hostile by states and territories, because it was often very critical of those jurisdictions despite the fact that early commissioner membership had no state-level experience, nor were there representatives to provide insights about the work of states and territories in delivering mental health care. Additionally, the NMHC was set up as a Commonwealth entity without any agreed

mandate from states and territories to report on their activities. It was not a good place to start.

129 The NMHC has moved into a more mature phase and, subject to some structural changes, is the logical entity to re-establish a trusted and ongoing process for comparative reporting of government performance in progressing mental health reform. It is the nominated entity for reporting on progress of implementation of the Fifth National Mental Health Plan, agreed by states and territories.

130 The Productivity Commission Inquiry's draft report recommends a substantially expanded role for the NMHC and that it become the national entity responsible for monitoring and reporting on the performance of all governments against a set of shared outcome indicators.[51] This makes sense but will require a number of changes including setting the Commission at arm's length from the Commonwealth (for independence purposes) and participation by states and territories in the design of governance structures.

131 My comments here concern the role of national level reporting and are not intended to ignore the essential role of independent monitoring and scrutiny of reform at the state and territory level, whether this be by state-level commissions or similar entities. National reporting however adds the power of comparison, and complements state-level monitoring. The fact that the Annual Report on Government Services reports, produced by the Productivity Commission, are now into their third decade is testament to the value ascribed to trusted comparative data that focuses on all governments.

Performance reporting at organisation provider level

132 Reporting over the course of the National Mental Health Strategy has been principally focused on jurisdiction level. While such focus works for monitoring the performance of governments, it is of little value for understanding what is happening on the ground at the level of individual provider organisations. A more transparent approach would allow anyone to be able to go on to a public website and view key indicators of performance for their local health service organisations, to help inform their choices about healthcare for themselves and their loved ones.

133 While there have been attempts at independent, public reporting at the level of service organisations, progress on this has been very slow in the mental health area. The Fourth National Mental Health Plan made a commitment to have independent public reporting at the provider organisation level. That kind of reporting would enable comparisons on a

[51] The Productivity Commission Inquiry's draft report recommends that the reporting role of the NMHC should be expanded and the NMHC "should be tasked with annual monitoring and reporting on whole-of-government implementation of a new National Mental Health Strategy." See in particular pages 3 and 48 of the draft report (Volume 1).

range of indicators to be made across the country, for example between a hospital in Canberra and a hospital in Melbourne.

134 That commitment did not translate into action, because the then National Health Performance Authority (**NHPA**) was created in 2011 and was to take on the role of public reporting on the performance of the new entities – LHNs and PHNs. However, the NHPA was abolished in the 2014 Federal Budget and its performance reporting functions were transferred to the AIHW, but in a much restricted manner.

135 The Fifth National Mental Health Plan picked up the commitment to public reporting at the organisation level but has not produced tangible results. There have been movements in some areas towards the sort of public comparative reporting envisaged by the National Mental Health Plan. For example, Victoria publishes data on seclusion and other performance indicators at the LHN level.[52] However, benchmarking is much more powerful when it can be done at a national level, across borders. In my view, the AIHW is the logical body to undertake performance reporting at the service provider level, if we are to report nationally.

Commissioning

The merits and challenges of an activity-based funding model for mental health services in Victoria

Activity-based funding (ABF) in the health system generally

136 ABF is a fundamental tool to drive reform. ABF is not just a driver of efficiency; it is also a driver of quality. This is because ABF promotes consistent treatment approaches for people with similar levels of need, wherever they live. At the moment, there are huge variations in the treatment of people with similar levels of need. That variation is driven by service providers, and the system contexts in which they work, not by the person's service requirements. Activity-based funding is a leveller.

137 ABF relies upon a casemix classification that groups together people into similar clinical groups. Once those groups have been identified, the costs of treating each group is determined and the money then flows on that basis, based on what the service provider organisation is delivering. The more activity, and the more complex the patients treated, the higher is the level of funding provided to the health organisation.

[52] Victoria State Government, 'Adult mental health performance indicator reports' <https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports/adult-performance-indicator-reports> [accessed 21 June 2020].

Challenges with introducing ABF for mental health

138 Seeking to apply ABF to the mental health system is a complex exercise. At one end of the spectrum, it would be relatively straightforward to structure activity-based funding for acute episodes in hospital. However, mental health is not just about dealing with acute episodes in hospital. Rather, it operates at the intersections of hospital and community, acute and non-acute, and health and disability-related services.

139 Developing and implementing an activity-based funding model that promotes community care presents a real challenge. Not only would an activity-based funding model for mental health need to deal with the hospital-community interface and the acute-long term condition continuum, but it would also need to take into account the interface between clinical services and non-clinical disability support services.

140 For these reasons, activity-based funding for mental health remains an elusive goal and much conflicted issue in Australia.

Australian attempts to introduce ABF for mental health

141 At present, we have a very odd system of funding for mental health in Australia. Following the reforms introduced by the NHR Agreement in 2011, Commonwealth contributions to the funding of inpatient care have been provided on the basis of a classification known as the Australian Refined Diagnosis Related Groups (**AR-DRG**s). In this system, diagnosis is the principal driver of the level of payment for individual episodes of care. The system works well in hospital-based medical and surgical care but not for mental health. Diagnosis has long been recognised as a poor predictor of the cost of providing mental health treatment and care to individual patients. But the system was introduced as an interim for mental health inpatient treatment, while the search went on for a better classification approach. For community-based services, the AR-DRG system was not implemented because its scope stops at the hospital door. Instead, Commonwealth contributions to state and territory community-based services were calibrated on a fixed grant basis, based on the spending by individual state and territory LHNs on their services in 2011. The intent was to replace this with a new ABF mental health classification and payment system that covered both hospital and community care, developed from the ground up.

142 The Independent Hospital Pricing Authority (**IHPA**), established from the 2011 NHR Agreement reforms, was given responsibility to develop the new mental health classification. And so again began the search for the holy grail.

143 The search was not new, with both Australia and New Zealand having completed major mental health classification development studies in the late 1990s and early 2000s.[53,54] Both large scale studies produced a classification, with significant convergence in approach and based on the same routine measures being collected in clinical practice in both countries. In hindsight, and as explained below, nearly a decade has been lost by not adopting the results of the previous work but instead heading off in search of a better solution.

144 In 2014, the IHPA released a first draft of its Australian Mental Health Care Classification (**AMHCC**) as the first step towards ABF for mental health. Unfortunately, the AMHCC is a fundamentally flawed classification. At the top of the classification tree, patients are assigned to classes based on their 'phase of care'. This concept makes intuitive sense (for example, patients moving from an acute phase to a non-acute phase require less intensive care). But the concept has proven extremely unreliable and has not been consistently replicated when tested with clinicians in the real world. If clinicians cannot agree on how to assign patients by phase, then the rest of the classification decision tree crumbles.

145 In my view, there are significant issues with the AMHCC, including that:

(a) the model relies on a study that produced poor quality costing data;

(b) there is no genuine buy-in to the classification from the states and territories;

(c) one of the important things about a classification is that the so-called casemix classes (the groups of people who are meant to be clinically similar) have to have clinical coherence, and the AMHCC does not achieve this; and

(d) in turn, the classification does not resonate with clinicians as it does not align with treatment protocols and so is difficult to use in driving quality improvement.

146 The Productivity Commission Inquiry's draft report also raised concerns about whether we are on the right path with the AMHCC, and recommends that IHPA conduct a deep review about the current approach. I agree with the Productivity Commission's view that

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[53] Buckingham WJ, Burgess P, Solomon S, Pirkis J, Eagar K. *Developing a Casemix Classification for Mental Health Services*,1998, Department of Health and Family Services, Commonwealth of Australia, Canberra. Available at <https://www.amhocn.org/sites/default/files/publication_files/mh-casc_summary.pdf> [accessed 21 June 2020].

[54] Gaines P, Bower A, Buckingham W, Eagar K, Burgess P. & Green J. *New Zealand Mental Health Classification and Outcomes Study: Final Report, 2003*. Health Research Council of New Zealand: Auckland. Available at <https://www.tepou.co.nz/uploads/files/resource-assets/Mental-Health-Classification-Outcomes-Study-Final-Report.pdf> [accessed 21 June 2020].

ABF using the current AMHCC is not going to produce the necessary or desired results in terms of driving efficiency, consistency and quality in the mental health sector.[55]

147 To its credit, IHPA is attempting to improve the AMHCC.[56] However, those attempts are largely focused on making tweaks around the edges, without sufficiently stress testing those tweaks in the real world. If changes are made to existing definitions in the model, it is necessary to undertake a whole new costing study to ascertain whether the classes created by the new definitions cost the same as the previous definition. Those studies have not been done, nor does it appear that there is any intent to do so.

The future of ABF for mental health in Australia

148 Unfortunately, the future of ABF for mental health in Australia is not looking optimistic. This is problematic given that the current arrangements in place for transfer of Commonwealth funding to support state and territory mental health services via the payment system introduced under the NHR Agreement serve to disincentivise much needed growth in community-based services.

149 The current arrangements essentially cap the Commonwealth funding for community services but provide increased funding for growth in hospital-based care. Of the $531 million that Victoria received in Commonwealth funding in 2017-18 through the NHR Agreement, 67% ($365 million) went to community services.[57] However, that funding is a fixed amount. This means that if, for example, those community services double the volume of patients they treat next year, they will not get double the funding – they will still get the same amount of funding. There are no incentives to drive growth in the right policy direction.

150 The current evidence points to increased funding for increased complexity and activity in *bed based care* but not in *community care.* The Productivity Commission Inquiry's draft report showed that community services have been flattening out since ABF was introduced for inpatient care (using the generic AR-DRG classification, not the AMHCC). In this way, ABF has actually driven the relative investments in precisely the wrong

[55] Productivity Commission, 'Productivity Commission Draft Report Volume 2' <https://www.pc.gov.au/inquiries/completed/mental-health/draft/mental-health-draft-volume2.pdf> [accessed 5 July 2020], see pages 935-937.

[56] Independent Hospital Pricing Authority, 'Mental Health Phase of Care Clinical Refinement Project Final Report' <https://www.ihpa.gov.au/publications/mental-health-phase-care-clinical-refinement-project-final-report> [accessed 21 June 2020].

[57] See details of Commonwealth NHR Agreement funding at footnote 18.

direction – funding for community care is not growing, but funding for hospitals is.[58] This is a major problem.

151 In December 2019, IHPA undertook a consultation with states and territories about a proposed pricing framework for implementation in 2021-22 that showed the quantum of Commonwealth funding each state and territory would receive if the AMHCC was used as the basis for Commonwealth payments.[59] It is my understanding that the 'shadow budgets' produced caused significant concern and that there were particular challenges for non-admitted mental health services for some jurisdictions, particularly Victoria, due to data quality problems that would result in many episodes of care being relegated to the lowest cost group, resulting in substantially reduced funding. The final pricing framework released by IHPA included *shadow prices* for admitted patient care in 2020-21 as indicative of likely future prices, stating that "IHPA intends to progress to publishing price weights for admitted AMHCC end classes in the National Efficient Price Determination 2021–22 subject to the feedback received from all stakeholders".[60] Shadow prices for the community component of the AHMCC for 2021-21 were not included because they "were not considered sufficiently robust to allow jurisdictions to understand and assess the impact of pricing these services with the AMHCC".[61] IHPA however stated its intent to "work with jurisdictions to further develop and refine the AMHCC community cost model before commencing a shadow pricing period for community mental health activity using the AMHCC." [62]

152 In my opinion, this work revealed just how far we are from where we need to be in putting in place a workable approach to ABF for mental health, particularly for community services. The Royal Commission may wish to pursue this through discussion with those in Victoria's health portfolio with ABF expertise. At the least, there is a case to signal the proposed roll-out of the AMHCC as presenting a significant challenge for Victoria.

153 In my view, ABF is a fundamental ingredient of the system level reforms that we need. We need an activity-based funding system that creates incentives in the community for increased activity, increased outputs and increased numbers of patients treated. We should take a staged approach to implementation of activity-based funding for mental

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[58] Productivity Commission, 'Productivity Commission Draft Report Volume 2' <https://www.pc.gov.au/inquiries/completed/mental-health/draft/mental-health-draft-volume2.pdf> [accessed 5 July 2020], see pages 931-934.

[59] Section 211(1) of the *National Health Reform Act 2011* (Cth) requires IHPA to provide states and territories with a 45 day period to review and comment on the future years' pricing framework.

[60] Independent Hospital Pricing Authority, 'Australian Mental Health Care Classification Pricing Feasibility Report 2020–21' <https://www.ihpa.gov.au/publications/australian-mental-health-care-classification-pricing-feasibility-report-2020-21> [accessed 1 July 2020] at page 4.

[61] Ibid.

[62] Ibid.

health, starting with a very simple, basic approach and then progressively building in complexity as we gain more confidence, reliable data and buy-in. The Productivity Commission draft report argued for such an approach as part of a fundamental rethink, and signalled that it would have more to say on the matter in its final report. [63]

Outcome-based funding

154 The rationale of outcome-based funding is that we will pay for better outcomes for patients. In my view, that is often not how outcome-based funding actually works on the ground. The term outcome-based funding is often used to describe a model of funding which is in fact program-based funding.

155 There are risks associated with implementing a literal interpretation of outcome-based funding at the individual patient level. Rather than creating incentives for better care, outcome-based funding can in fact create incentives for gaming and corruption in data reporting. There is a serious risk that patients can be unduly influenced by service providers to fill out outcome-related questionnaires in a way that results in more funding, but may belie the patient's true outcomes.

156 There are much better ways to improve outcomes than paying for outcomes. I am a firm believer in the value of outcome measurement for improving patient care. Outcome measurement should be used by individual practitioners in dialogue with their clients to help monitor how they are going. It should be used as a tool for clients to provide feedback on issues that the clinician can't see or may not know about. In addition, clinicians should use outcomes data to assess how they are performing against their peers, and whether benchmarks are met in assisting clients to make progress.

Examples of effective commissioning and coordinated service delivery

157 There are of course isolated examples of successful models of holistic and coordinated service delivery. Domestic examples that I am aware of include the work of Barwon Health in the early 2000s, and funding for the headspace and Early Psychosis Youth Service programs (Commonwealth funded) that are managed by Alfred Health (Victorian Government funded). International examples include the well-known work in Trieste, Italy.

158 However, none of these examples provide the platform for the widespread change needed. Any successful model has to be responsive to local circumstances, local aspirations and local relationships. Models developed overseas do not necessarily translate to other environments, and so trying to replicate them here does not work.

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[63] Productivity Commission, 'Productivity Commission Draft Report Volume 2' <https://www.pc.gov.au/inquiries/completed/mental-health/draft/mental-health-draft-volume2.pdf> [accessed 2 July 2020], see page 936.

159 I have become somewhat disillusioned by the search for gold in overseas studies since realising that the answers to sorting out Australia's problems have to be found here. Rather than looking for the answers in Trieste or elsewhere, we need to focus our attention on how we can make our own system, and unique Federation, work for us.

sign here ▶ 

print name Bill Buckingham

date 7 July 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT BILL BUCKINGHAM -1

This is the attachment marked 'BB-1' referred to in the witness statement of Bill Buckingham dated 7 July 2020.

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

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STATEMENT OF EXPERIENCE

Buckingham Consulting is a private consulting company, originally established by Bill Buckingham in 1993 as Buckingham & Associates. Bill has more than 40 years experience in the mental health field, covering service delivery, management, planning and policy areas. Commencing his career in 1976 as a clinical psychologist in Victoria's public mental health services, he was promoted to the state's Chief Clinical Psychologist post in 1982, a position he occupied for eight years before moving to the role of statewide planning manager of the former Victorian Office of Psychiatric Service. His work in that role through the period 1990-93 established the foundations of the widespread structural reforms implemented by Victoria over the following decade.

Since establishing his consultancy company, Bill has been a key figure in a wide range of initiatives progressed under the Australian National Mental Health Strategy. Throughout the period since 1993, he has worked extensively with the Commonwealth Department of Health as well as undertaking separate consultancy assignments for all state and territory jurisdictions that have called on his expertise in the areas of mental health service planning, information development, data analysis and performance reporting.

Under contracts with the Commonwealth, Bill designed the National Mental Health Report series and authored all reports published between 1994 and 2010. These reports are regarded by many as a model for government policy reporting and became the key tool for monitoring the performance of each of the Australian states and territories. In parallel, he coordinated the data analysis and authored all five annual reports required under the Council of Australian Government's *National Action Plan on Mental Health 2006-11*. The work has demanded a depth of knowledge about mental health services in Australia and related overseas developments.

Bill was the principal consultant to the Mental Health Classification and Service Costs Project (MH-CASC), a $2.7m project commissioned by the Australian Government in the mid 1990s to develop a casemix classification for mental health services. This project is widely known for its ground breaking research and development work and is the most complex project of this type ever undertaken in the mental health field internationally. The results set the directions for information development in the public mental health sector over the next two decades, and led to more than $60m of bilaterally negotiated information development grants to states and territories, targeted at building information systems and developing skills in the clinical workforce to collect and use information in their day to day practice. Bill's work with the Department as a consultant included assisting in the roll out of the information development program over the ten year period 1998-2008, with the focus on implementing systems for the routine monitoring and reporting of consumer outcomes. These systems are now firmly embedded in all state and territory mental health services.

Alongside his consulting work in Australia, Bill has provided consulting services to the New Zealand Health Ministry and Health Research Council, again mainly targeted in the areas of information development, performance reporting, casemix classification and outcome-based reporting for mental health. Along with Professor Kathy Eagar, then Head of the Centre for Health Services Development University of Wollongong, he was invited by the New Zealand Health Research Council in 1999 to design a national work program for development of a mental health casemix classification in that country. He continued through to 2002 as the Principal Consultant to the research project that followed. The results of the project, particularly the directions for introduction of standardised measures of patient outcomes, were adopted by the New Zealand Ministry and continue to be implemented today.

Later in 2006, the New Zealand Ministry of Health invited Bill to assist in the development of a performance indicator framework for mental health services, drawing on the 'value for money' framework that he prepared in Australia for the Victorian Department of Health and later, the Commonwealth Department of Health and Ageing. The framework adopted by New Zealand was put to test by a consortium of nine of New Zealand's larger District Health Board who engaged Bill to provide advice on 'putting the framework on the ground' within their organisations. The results of this work, like the Australian MH-CASC and New Zealand casemix development projects, continue to be a core feature of service development for mental health services.

Bill was engaged by the Department of Veterans' Affairs in the early 2000s when it embarked on developing its own national mental health strategy. The work undertaken laid the groundwork for many of the programs currently delivered by DVA. He has also worked with the Department of Prime Minister and Cabinet, after being engaged directly to prepare the evaluation framework for the then multi-jurisdictional Partnerships Against Domestic Violence program.

Since 2006, Bill's work has been increasingly focused on meeting the requirements of the Australian Government during its period of substantial investment growth in mental health. Commencing with the COAG *National Action Plan on Mental Health 2006-11,* continuing with the 2011 Federal Budget and later in 2015 with the Government Response to the *National Mental Health Commission Review of Programs*, the expansion of Federally-funded programs set new demands on the Commonwealth. These included funding and development of services previously the exclusive province of state and territory jurisdictions, as well as new primary mental health care programs.

Bill's company has been contracted by the Department of Health to provide a range of technical services and advice across all mental health program and policy areas. Selected aspects of his role include:

- development of the equity-based resource allocation model underpinning fund allocations to Primary Health Networks;
- development of program guidelines for new programs, including data collection, program monitoring and evaluation strategies, including design of the Primary Mental Health Care minimum data set mandated for PHNs;
- development of specifications for PHN key performance indicators;

- assisting in drafting of the Fifth National Mental Health Plan and advising on implementation in areas of Commonwealth responsibility;
- design of evaluation frameworks for a range of programs including the national evaluation of PHN Lead Sites;
- preparation of technical information papers to guide consideration of policy options;
- guidance on mental health information development investments, including national population surveys funded by the Department.
- Assisting the Department in its management of major national projects, including the National Mental Health Service Planning Framework, guidance on joint regional mental health plans to be developed by PHNs and state/territory organisations, and preparation of national guidelines for PHNs on appropriate systems for assessment and referral of clients within a stepped care model.

Over the course of his consulting work, Bill has developed extensive networks in the mental health field within Australia and has gained a high level of cooperation in difficult and sensitive areas from state, territory and Commonwealth Governments and the private mental health sector. He has been contracted by several university-based units to contribute technical expertise to a range of national research programs. Virtually all of his engagements have been by direct procurement, recognising his unique blend of health professional and technical skills across mental health service delivery, policy and planning areas.

Bill has maintained his registration as a psychologist with the Australian Health Practitioner Regulation agency, but not pursued continuing clinical registration, having ceased clinical practice.

Current July 2018