Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF TIM MARNEY

I, Timothy Michael Marney, Principal at Nous Group, of Level 16, 240 St Georges Terrace, Perth, Western Australia, say as follows:

Background

1 I have considerable experience in Mental Health system design and reform, having served as Mental Health Commissioner of Western Australia from early 2014 to mid-2019. Prior to that I served as the Under Treasurer (i.e. chief executive officer of the Department of Treasury/Treasury and Finance). I have also served on the board of Beyond Blue for 11 years, 9 of which in the role of Deputy Chair. I have a Bachelor of Economics with First Class Honours. I am also the Chair of the Bankwest Curtin Economics Centre Advisory Board.

2 Attached to this statement and marked 'TM-1' is a copy of my curriculum vitae.

3 I am giving evidence in my personal capacity based on my prior professional experience, and not as a representative of my current employer or any former employer.

Past role as Mental Health Commissioner for Western Australia

4 From February 2014 until June 2019 I performed the role of Mental Health Commissioner in Western Australia. The Mental Health Commissioner is the accountable authority (i.e. Secretary/Director-General equivalent) for the Western Australian Mental Health Commission (**WA Commission**). During my tenure, the Mental Health Commission reported to the Minister for Mental Health in the Western Australian Government, and this remains the case.

5 The WA Commission is a government department led by the Commissioner, supported by four divisions:

(a) Purchasing, Performance and Service Development;

(b) Planning, Policy and Strategy;

(c) Alcohol, Other Drugs and Prevention Services; and

(d) Corporate Services

6 Prior to 1 July 2015, Western Australia's alcohol and drug services were overseen by a separate body, the Drug and Alcohol Office. During my tenure as Mental Health Commissioner, these services were amalgamated into the WA Commission.

7 The WA Commission operates as a purchaser of services in both the mental health and alcohol and other drugs space (and for services which seek to address both areas), as a provider of services in the alcohol and other drugs space (but not for mental health services), and as a policy and strategy agency across its whole remit. The WA Commission has a staff of around 250-260 FTE. The WA Commission also provides corporate support to the Mental Health Advocacy Service, the Mental Health Tribunal and the Office of the Chief Psychiatrist, although these are independent bodies.

Previous roles in Government

8 Prior to my time as Mental Health Commissioner, I served as the Under Treasurer of Western Australia (the head of the Department of Treasury/Treasury and Finance) for just under 10 years.

9 In that role, I had responsibility for whole-of-government financial management and budget strategy and implementation. This included advice to Premiers and Treasurers on prioritisation of expenditure and government initiatives. I also had a role in establishing appropriate governance, accountability and management of service delivery and public expenditure in a range of different areas. As part of that role, I provided advice to the State Government when it was considering establishing the WA Commission.

10 When government seeks to improve prioritisation, resource allocation and service performance in an area, it is critical to set up governance, financial and accountability arrangements that will support these goals. These considerations influenced the design of the WA Commission. One element which was essential was that the WA Commission took charge of all allocations/expenditures on direct mental health treatment and support, with no element of split accountability with other parts of the State healthcare system. Having regard to the settings needed to achieve optimal resource allocation (both in terms of attracting funding and allocating it to where it can achieve the best results), the WA Commission needed to control all the State spend on mental health services to enable the WA Commission to effectively determine the nature, mix and quality of services that should be funded within the mental health system through its purchasing role, and to ensure appropriate accountability for those processes.

System management and the WA Commission

Establishment of the WA Commission

11 Prior to the establishment of the WA Commission, there were issues with respect to mental health services not getting enough attention within the broader healthcare system in Western Australia. At the time, Western Australia had a centralised public healthcare system, with limited autonomy devolved to metropolitan and regional public healthcare service providers. Funding tended to go to 'in-house' services, that is, those offered through the WA Health Department. This meant that community-based services provided by non-government organisations, including early intervention services, were drastically underfunded. There was a view that more independence and objectivity would result in better-directed funding.

12 The WA Commission was established in 2011 as a purchasing authority to purchase mental health services in Western Australia. Each year, the WA Commission was provided with an appropriation of approximately $900 million for the purchase of mental health and drug and alcohol services. The idea was to take the money out of the general public healthcare system and have it stand 'outside', without the inherent bias towards the public healthcare system. Through this, we hoped to achieve greater balance between government/public hospital services and community-based support services

13 The focus of the WA Commission's purchasing activities included clinical services that are hospital based, outpatient services, community support services, supported accommodation services and community bed services. The WA Commission has responsibility both for purchasing a mix of services, and for monitoring the quality of these services.

Development of a 10 Year Plan

14 Shortly after I joined the WA Commission, we embarked on a major consultation process around a 10 year strategy, which took about 12-18 months. As part of that process, we used the National Mental Health Planning Framework (**Planning Framework**) which was co-produced by Mental Health Commissions and Mental Health Services, consumers, carers and families, clinicians and non-government organisations. The Planning Framework is a robust modelling tool that enabled the estimation of what would be the optimal mix of services in a jurisdiction, including down to a regional level. The modelling tool was based on epidemiology and produced a theoretical construct of what would be the optimal service levels. The tool was developed nationally and available to all health services. The tool served as the main method for determining community need, to guide the purchasing of services where the tool identified a gap or need.

15 The WA Commission used this tool to estimate what would be the optimal mix of services for Western Australia, including for regional areas. This provided a blueprint of what the system needed to look like and guided the consultation process. Together with the community, consumers, carers and families and clinicians, we were able to form a view of the system and the service balance that was required. Our findings were published in 2015 as the Western Australia Mental Health, Alcohol and Other Drug Services Plan 2015 - 2025 (**10 Year Plan**). The 10 Year Plan, as updated, is the guiding document of the work of the WA Commission.[1]

Funding challenges

16 The greatest challenge to achieving the vision of the WA Commission was funding. We were acting in a tight fiscal environment. This slowed our efforts in filling gaps identified by the 10 Year Plan. Evidence shows that treating issues at a community level is three to four times cheaper than allowing the individual's mental health issues to progress to the acute stage. To get a better balance in the system, the challenge is to grow the community-based services quicker than the hospital-based healthcare services. The barrier to change is the funding.

17 Where the State is only meeting 80% of demand for acute mental health services, it is simply not possible to reduce hospital mental health funding to fund early intervention services. That money has to come from somewhere else – it has to be 'new' money. If the State were funding 100% or 110% of hospital demand, then the money can be shifted to the earlier intervention end. That was not the case in Western Australia, because the hospitals were already underfunded. Shifting money around is not the solution - adding money in the right place at the right time is absolutely the solution.

18 It should also be noted that the public hospital system in Australia has much better access to reliable growth funding ie. funding that increases with demand than the rest of the healthcare system.

Service and infrastructure planning

19 The WA Commission is able to assess the needs of the population and estimate demand through the 10 Year Plan informed by the Planning Framework. This identifies any gaps and informs the WA Commission about which services need to be developed or purchased to fill the gaps. The 10 Year Plan articulates, for example, how many hours of community support are required in each region of Western Australia.

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[1] Western Australian Mental Health Commission (2015), 'Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025' <https://www.mhc.wa.gov.au/about-us/strategic-direction/the-plan-2015-2025/> [accessed on 11 June 2020].

20 To assist with identifying and addressing gaps, from capability building through to implementation, the WA Commission established a policy and planning area. Centralised analysis and planning encourage the system to work cohesively to implement the 10 Year Plan and, given Western Australia's financial circumstances, to incrementally progress towards the optimal services mix.

The 'service purchase' model

21 Using the 10 Year Plan, the WA Commission was able to direct investments and growth funds towards areas of particular need. Within the healthcare system, there were known gaps that needed to be addressed – this included youth services, mental health specialist services, specialist services for eating disorders, gender diversity specialist services and so on. We were able to chip away at the major gaps in the system, relative to what the optimal mix was as identified by the 10 Year Plan. If the fiscal environment was different we could have made a lot more progress. Nonetheless we still made substantial progress in reshaping some of the services in the system.

22 The WA Commission had contractual arrangements with the health service providers (including in the public system) and would use those agreements for 'targeted purchasing'. We would purchase an overall level of activity for the hospital-based services and using the growth money each year we would purchase specific models of service. Incrementally we were plugging some of those gaps in the system through these more targeted contractual arrangements.

23 The WA Commission also has a commissioning area, whose job it is to take identified gaps and translate them into services on the ground through its commissioning practices. This included taking the planning objectives, translating that into actual service models and then through various means, predominately through contracting and procurement, establishing those services and ensuring that quality assurance mechanisms and contract management was in place. Ultimately, the commissioning area would then evaluate the effectiveness of services.

Approach to quality and safety

24 As well as the Planning Framework and 10 Year Plan, commissioning occurs within the context of a quality framework within the National Standards for Mental Health Services (**National Minimum Standards**).[2]

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[2] Australian Government, 'National Standards for Mental Health Services 2010' < https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10> [accessed 11 June 2020].

25 The National Minimum Standards is a framework that is agreed by all jurisdictions as the model of quality parameters that services must adhere to, setting out 10 standards for service. That includes, for example, having a recovery focus for people with mental health issues, and having culturally appropriate services for culturally diverse groups. The National Minimum Standards determine the culture and skills required from service providers including other government departments and is a key source for the WA Commission's approach to setting and monitoring quality standards in the services it purchases.

26 Within the WA Commission, quality control and monitoring occurred largely through our contractual arrangements. We would meet with service providers quarterly to discuss their key performance indicators (**KPIs**). That started around three or four years ago. Over that time, we saw substantial improvement of those KPIs by virtue of shining a light on them, and co-operative improvement was achieved. Generally, this was not through sanctions or commercial levers; it was just by working together within a known and transparent contractual framework. We would produce dashboards of indicators for contracted services and provide those dashboards to the service providers monthly for their review. If something unusual happened in some of the metrics, we would approach the service provider and seek an explanation, and if they could not explain it, then there was a funding consequence.

27 As purchasers of services, the WA Commission closely monitors a range of performance metrics of the health service providers, or local health districts (**LHDs**) as they are referred to in WA. The performance metrics are compiled as a dashboard across admitted and non-admitted patients. That dashboard is shared monthly with the LHD and the Department of Health (if they wish to see it). If there are any issues or concerns in the monthly dashboard, those are discussed between the WA Commission and the LHD. The dashboard is formally reviewed in quarterly meetings between the LHD and the WA Commission. Those metrics include safety and quality measures, elements of the national mental health minimum data set and other key performance indicators.

Separation from services provision

28 The separateness and neutrality of the WA Commission is an important part of the overall governance and accountability approach in Western Australia. This enables evidence-based decision making to determine the overall system design and mix of services and supports. It provides for a neutral performance monitoring role. The WA Commission is not conflicted in that role as it is not a direct service provider. If you have LHDs that are trying to monitor the quality and performance of their own services, the risk is that the outcomes are inferior in terms of performance monitoring and service improvement.

29 In executing this role of performance monitoring and improvement, the WA Commission has to be rigorous in its approach on the basis of reliable evidence and also consistent in its approach over time. Discipline across the life of the contract is important to ensure that services are not being lurched around from one performance objective to another.

Mental health funding

Mental health growth funding is not secure

30 Broadly speaking, health funding is determined on an activity-based funding (**ABF**) model which is locked in via national partnership agreements between the States/Territories and the Commonwealth. The funding formula for core public hospital services is largely an automatic process. This means that the hospital system secures its funding quite routinely, whereas the community-based support services do not have that arrangement. In tight fiscal times, the community service funding does not grow, yet the formula ensures that the hospital-based services continue to achieve increased funding.

31 Prior to the end of my term as the Commissioner, negotiations were being undertaken with Treasury to essentially mirror the funding formula for the health-based system to apply to the non-government organisations. This was yet to be implemented in Western Australia before I left the role.

How the WA Commission applies ABF

32 Some mental health services eg. in-hospital services are funded using ABF. While in other States and Territories this funding usually flows to LHDs (or their local equivalents) under the main Services Agreement with the State (which also covers other public hospital services), in Western Australia, ABF for mental health services is paid under a separate Services Agreement between the WA Commission and the LHD. Mental health activity is purchased by the WA Commission, and the budget for the ABF mental health spend is negotiated jointly by the Department of Health and the WA Commission.

33 Having a separate agreement for mental health services elevates the visibility, interrogation and accountability for performance of mental health services. It places mental health service performance management on an equal footing to non-mental health service performance management. This effectively stops mental health from being buried amongst everything else - elevated transparency and accountability is the key outcome. The Commission has a relationship with the LHD which means that discussions around performance can be had openly. However, if there are significant issues in performance then the Department of Health would be involved. This is particularly the case for quality and safety and clinical governance issues, which the Department of Health remains responsible for.

Better data can support better funding outcomes

34 The flow-down approach from the Planning Framework to the 10 Year Plan to local commissioning decisions helped the WA Commission to achieve funding growth that was double the rate of the broader public sector over a 5-year period, despite the tight fiscal circumstances. This was in large part because the WA Commission was able to show that the identification of need and the initiatives being pursued were based on very rigorous modelling, analysis and co-design. That made the level of need and the particular area of focus indisputable. It was less reliant on what those services would achieve and the data that would reflect that, and more evidenced by how the imbalance in the system was impacting other services. For example, the data evidenced that there was a lack of forensic services and an increased length of stay for forensic patients. We were able to show that an extreme lack of forensic hospital beds was leading to a very short length of stay for patients, which was suboptimal for their treatment.

Integration versus separation in governance models

35 The integration of governance arrangements for mental health services with governance arrangements for other healthcare services can see a dilution of transparency and accountability for delivery of mental health services and the quality thereof. Separate governance arrangements bring the elevation of both transparency and accountability which enables an appropriate monitoring and management regime for mental health service delivery.

36 Separate governance brings with it separate resourcing and prioritisation, so mental health then has an equal footing with other portfolio areas within the healthcare system and broader government service delivery system. Mental health gets a degree of focus, if separated, that it otherwise does not achieve. When there is not a separation of governance, if mental health takes up 10% of the budget it will get 10% of the focus. When mental health funding and performance measurement are separate, mental health gets its own time in the management/board spotlight.

37 The potential disadvantage of separated governance is there is a lack of clarity around clinical governance and where that should sit (noting that dual accountability is not ideal). That was something that was not sufficiently clear in Western Australia during my time at the WA Commission. In my view, clinical governance for mental health services can viably sit with either the Mental Health Commission/Department, or with the central Health Department – the accountability just needs to be clear to everyone.

38 A theoretical drawback of separation is that it masks and makes more difficult the management of co-occurring mental and physical health issues. The lack of integration of services both within mental health and across broader healthcare sees mental health

services often focusing on just the mental health aspects of the individual, with their physical health needs not being adequately addressed (e.g. patients are told they must deal with one issue before being treated for the others). In reality, the capacity of the system to manage co-occurring issues and physical health co-morbidities is so under-developed that separate governance for mental health services is unlikely to result in lost opportunities in this regard – the governance model neither helps nor hinders this form of person-centred approach in Australia at the moment.

Commonwealth/State cooperation in mental health services

39 Between 2011-2012 and 2015-2016, some of the funding deployed by the WA Commission was made available under the National Partnership Agreement—Supporting Mental Health Reform between the Commonwealth and the States and Territories (**Partnership Agreement**). At the same time, through the National Health Reform Agreements (**Reform Agreements**) all States and Territories agreed to implement ABF for public hospital services, and the Commonwealth agreed to move towards funding 50% of the efficient cost of growth in activity in the public hospital system from 2014-15 (although, as is well known, this commitment was not ultimately implemented in its original form). I was involved in the negotiation of these Agreements in my previous role as the Under Treasurer.

40 As a general comment, the Partnership Agreement represented a less-evolved approach than the Reform Agreements and was in the nature of a funding pool tied to broadly-expressed goals. While additional funding is generally welcome, it does not of itself improve effectiveness and efficiency and runs the risk of compounding existing gaps and overlaps in service provision. The Partnership Agreement was not a vehicle for improving system design, or for creating clearer responsibility and accountability as between the Commonwealth and the States/Territories.

41 By contrast, the Reform Agreements did enable improved accountability for delivery of levels of service in in-patient settings through ABF. In Western Australia, this meant that half the mental health spend in the hands of LHDs (i.e. the ABF-funded in-patient services) was subject to close monitoring and management of weighted activity units, and the other half (ie. block funded non-admitted services) was subject to very limited transparency and accountability for the volume and quality of service provision. In this way, the biggest reform in healthcare funding in Australia in more than 20 years effectively left monitoring and management of around half of all mental health services (measured by spend) unreformed and unimproved. Funding agreements can only improve the things they measure. No-one has been able to extend ABF to outpatient mental health services, or to agree on a genuine equivalent mechanism.

42 It follows that the maturity of performance management in non-admitted public settings, and in NGO non-admitted services, is not as advanced as in the in-patient settings, and this probably skews LHD management and Health Department attention to inpatient settings at the expense of other services. System design was not advanced by these reforms, in the sense of working towards the system we want as a society, rather than the system that which arises as a result of the agreements which are in place and the behaviours and priorities they drive.

43 At a more 'micro' level, I found that the key to success in utilising the Partnership Agreement was building strong relationships and alignment between the WA Commission's objectives, the 10 Year Plan and the activities of funded services under the Partnership Agreement.

Commissioning of services

Objectives and features of a commissioning strategy

44 In terms of its commissioning strategy, the approach of the WA Commission is to take the intended system design that comes from the 10 Year Plan and translate that into actual services being commissioned as part of the system.

45 Commissioning involves firstly identifying what the model of service is that you want to purchase – whether a hospital bed-based service or a community based psychosocial support service – and articulating what cohort of demand that service is tailored for (in terms of consumer needs and priorities). Commissioning establishes the desired model of service which then translates the commissioning intention or the purchasing intention into a procurement process that is appropriate for whatever service is designed. The procurement processes can take very different forms, from a complete open market, competitive process to identification of a preferred sole provider.

46 In some circumstances if a service doesn't exist, or the market is very thin, the model of service will specifically target those issues. For example, one of the early intervention approaches is the establishment of 'step up, step down' facilities, which are at a stage before and immediately after hospitalisation. The Planning Framework identified the need for 'step up, step down' facilities in each region. That planning was provided to the commissioning area. The commissioning area set about establishing the capital infrastructure for those services and procuring operators for those services. (Using commissioning to create capacity is discussed further at paragraph 71.)

47 Once the service is procured, it is then established under contract and the contract has both service activity, model of service and quality dimensions articulated as part of the contract. The contract also has KPIs. From there, the contract is handed over to contract

management to ensure the services are provided in the way they were intended, as indicated by the KPIs.

48 When contracts are varied, or new contracts are entered into, for example with the public health authorities in Western Australia (e.g. Metropolitan Health Services, Country Health Services), there is an opportunity to target particular cohorts, such as young people with personality disorders and people with other complex needs. This is how commissioning can best support new care models.

Commissioning and the 10 Year Plan

49 The Planning Framework sits behind the commissioning approaches used. As mentioned in paragraphs 14 and 15, the Planning Framework is translated into the 10 Year Plan through community consultation and co-design. This gave the WA Commission its commissioning priorities for the 10-year period.

50 The 10 Year Plan had a review point after two years and a mid-term substantial review to ensure that adjustments could be made to that framework and priorities along the way. The first review was largely an update of the modelling flowing from the Planning Framework. This included populating the 10 Year Plan with new data and parameters regarding population, demographics and epidemiology, and reflecting any revisions to the Planning Framework. As a result, the 10 Year Plan generated an updated estimate of what types of services were required in what areas.

51 The mid-term review is a major update process and updates the 10 Year Plan more holistically. The review will repeat some of that co-design from the original version of the 10 Year Plan to ensure that the plan is contemporary and the prioritisation that flows from the estimates and Planning Framework is consistent with the views and needs of consumers, carers and clinicians five years down the track.

52 The consultation on the draft 10 Year Plan took about 18 months and involved numerous forums and co-design sessions with consumers, carers and clinicians. It was a very intensive process and following that, whenever the WA Commission would move to introduce a new model of service, the starting point was to begin a co-design process for that specific model of service. Every step involved co-design so we could ensure a quality and reality check before translating the epidemiology data into a model of service.

Commonwealth-State commissioning

53 The Planning Framework and the 10 Year Plan are 'funder neutral' and 'provider neutral' meaning that they articulate what services are required but not who should fund or provide them. This left space for Commonwealth and State to work together to address priorities as identified by the 10 Year Plan.

54 A major part of Commonwealth's footprint in the mental health system is via the primary health networks (**PHNs**). The WA Commission has a very strong relationship with the West Australian PHNs, and had regular meetings to align our commissioning and purchasing. This allowed us to ensure that where the WA Commission and PHNs were overlapping, or alternatively where neither was addressing a gap in the system, this was addressed. Over time, there were areas where PHN were commissioning services which sat better with the WA Commission. These were transitioned over to the WA Commission by aligning our commissioning and purchasing activities.

55 In a few instances, the WA Commission and a PHN co-commissioned services to help bridge the gaps between hospital services and primary health services. Either the WA Commission or the PHN would have a head contract, and the other would contribute to that. In some circumstances, both the WA Commission and PHN had individual commissioning contracts for the same services, and would rely on the other party to fund half of it.

56 Examples of the WA Commission and PHN working together included co-commissioning a service for people who had a hospital visit following a suicide attempt. As those people were exiting hospital, they needed to be linked with primary health services. The WA Commission and PHN co-commissioned the one organisation to provide those services in different regions. This model of co-commissioning is heavily reliant on the relationship between the PHN and whoever is doing the purchasing. The WA Commission and the PHNs had good, constructive and positive relationships, which can only be achieved where there is an alignment of leadership and goodwill, and a commitment to shared priorities.

57 It was a source of frustration for the WA Commission and PHNs when the Commonwealth Government came in 'over the top' and injected services in the system, sometimes without much consultation and discussion. This added an unpredictable element that sat alongside very systematic and planned purchasing, where the Commonwealth would identify certain priorities and step in and provide funding.

Regional commissioning, local input and coordination at the local level

58 Each region has its own demographics and epidemiological prevalence and severity of mental health and drug and alcohol issues within its population. For example, the demographics in the Great Southern region of Western Australia are almost the complete opposite of the Kimberley or Pilbara regions. In commissioning, the WA Commission would follow the evidence provided by the Planning Framework and 10 Year Plan to prioritise what was commissioned in each area, and to influence the model of service in each area.

59 An example was where the Planning Framework identified a need for residential rehabilitation for alcohol and other drug issues specifically for Aboriginal people in the State's south west. As a result, the WA Commission established a residential rehabilitation service in that area to meet the need. The Planning Framework also identified the need for additional alcohol and drug residential rehabilitation services for the broader population, so the WA Commission established a facility that was specifically for the broader population.

60 There is at the moment a limited degree of local decision making for existing service provision in mental health in Western Australia, however increasingly and as reflected in the WA Commission's Engagement Framework, co-design of services is seen as an essential component in the introduction of any new services. Local decision making is picked up through rigorous co-design with consumers, carers and families but that is very much on the basis of new services. Existing services are not exposed to a co-redesign which would bring greater power to localised decision making. Where they are reviewed, consumers, carers and families are brought into the review process.

61 Having a more evolved system does not necessarily ensure local decision making or effective involvement in design and review of services. A lack of visibility can mean that there is limited control of the way in which services are designed and reviewed. With this, there is a risk of inconsistency. Joint planning is a major emphasis under the Fifth Mental Health and Suicide Prevention Plan (**Prevention Plan**), which is an admirable objective but easier said than implemented. Joint planning under the Prevention Plan is to occur between LHD and PHNs to bring a greater degree of integration between primary health support for mental health and LHD based services, however that does not clearly bring into focus support services provided by NGOs which may be commissioned by the WA Commission, LHDs or PHNs.

62 Although devolved and localised decision-making is a worthy goal in many parts of the healthcare system, in my opinion, mental health service design and commissioning is generally not mature enough in Australia to work with localised decision making. The aggregation of power in a single place like the WA Commission gives the capacity to have a joint mission, because you have a single point of prioritisation and planning at a system wide level, as opposed to a service wide level. PHNs and LHDs are naturally going to focus on their remit, which is service wide rather than system wide. What is really lacking is the overarching system design and implementation. To take Victoria as an example, who designs what the mental health system is going to look like? There are a range of different agencies that do that, some in partnership and some separately.

63 Clarity of roles and responsibilities is absolutely essential and needs to avoid overlap between various providers (such as LHDs, PHNs etc.) to avoid duplication of service and competing missions. That is an issue at the moment in terms of some of the

Commonwealth initiatives that are pushed through PHNs and some of the State initiatives which may well be very similar and seek to address the same issues, but are not necessarily well aligned. In effect, you have too many people playing in the same sandpit. Boundaries between Commonwealth, State and NGO responsibilities are fluid in the mental health space, in many instances targeting same cohort of individuals and largely to deliver the same intended outcomes.

64 A good example of this is suicide prevention. Many of the recommendations in the Prevention Plan are focused on LHDs and PHNs working closely together to achieve joint outcomes and avoid duplication. But in fact suicide prevention is an area where the overlap and intersect between State based initiatives and Commonwealth driven initiatives is quite problematic. You cannot increase local decision making without taking that authority from a central decision maker – it is one or the other – and they need to work in partnership. The problem at the moment is that the aspiration is local decision making, where the governance arrangement is centralised, which is inherently duplicative.

Service providers and markets

The impact of competition

65 Mental health and alcohol and other drug services in Western Australia operate in an environment of 'mixed' markets in terms of capacity. There are circumstances where there is no feasible option other than to purchase from the public system, for example, if services are purchased at a regional level. Purchasing services from the health system by region was largely confined to purchasing from existing hospitals and health services, because there were no alternative providers.

66 In limited circumstances, the WA Commission used competitive settings to purchase mental health services – for specific priority cohorts, but in a market-contestable way. For example, in the Perth eastern suburbs, the WA Commission purchased a ward of beds specifically with a model of service for care and support for older adults with mental illness from a private health provider. In this instance, a competitive market was used to establish a specific model of service.

67 In some areas, particularly remote regions with very specific service requirements, there are limited opportunities to leverage market competition, as often the services do not exist to begin with or additional services are required to be developed. As a result, consumers are left with limited choice of services, particularly where the consumer has complex needs.

68 As mentioned above at paragraph 24, the WA Commission built in functions to ensure protections regarding quality assurance and service delivery via its contracts. The

requirement for complex services, and a resulting complex workforce, could also be built in to the contract where appropriate.

Growing and diversifying the mental health service provider market

69 Generally speaking, the market for most mental health services is largely an oligopoly, making an approach to the market very different to what it would be in a competitive market. Understanding the market context is critical in influencing the commissioning, purchasing and contracting processes.

70 Part of the commissioning process is assessing what the market looks like for that service in a particular location and then making an assessment as to whether or not there is an opportunity for existing service providers to provide that service or whether the WA Commission is required to undertake some form of market development to get an organisation to enter that space.

71 Some of the service areas that are priorities do not have a market of providers for that service. It requires a very different approach in terms of market development, to ensure that service providers can enter that space and provide the services that are dictated as priorities from the Planning Framework in the 10 Year Plan. This can be achieved through a range of measures such as the provision of capacity building grants – granting money to an organisation to grow a particular service and workforce in an area rather than entering into a commercial procurement arrangement. This ultimately requires upfront investment in establishing a service before turning to a purchasing framework for that service.

Performance monitoring

Performance monitoring and data collection in mental health services

72 In the WA Commission, the performance monitoring process cascaded down from the Planning Framework, the 10 Year Plan and the National Minimum Standards. The WA Commission took the 10 Year Plan and the parameters of the National Minimum Standards, blended those into a commissioning framework, and translated that into contracts and KPIs.

73 Both within and outside mental health and alcohol and drug services, funding arrangements have certain principles that should apply to them, including simplicity, transparency and accountability, as well as value for money. KPIs can be used for encouraging and discouraging certain behaviours and activities. It is also important to provide regular evidence of performance back to the service providers through ongoing reporting arrangements. As mentioned in paragraph 24, the WA Commission would meet with service providers quarterly to review their key performance indicators to ensure that

their performance was consistent with the National Minimum Standards, as well as being consistent with the WA Commission's purchasing intent and our own quality and performance metrics.

74 Contractual arrangements and KPIs were successfully used to encourage services providers to meet the needs of consumers, including consumers with complex needs, and were based on a range of requirements, including evidence based metrics as discussed further below. However, performance monitoring is different in practice for public healthcare services, which are far more mature in that 'payment for performance' space than non-government organisations.

75 In terms of the public healthcare services, the WA Commission had direct access to the Department of Health data systems which could be interrogated and then converted into a suite of metrics as part of a performance dashboard. These would be presented back to the service provider and used as a focus of discussion, enquiry and action.

76 Non-government organisations required a different approach, which involved reporting on their activity in various forms depending on their contractual arrangements and going through specific processes for quality assurance. The contracts imposed requirements in terms of evidencing their quality of service on a periodic basis. The data collection for non-government organisations was specified as part of the contracts.

77 Measures the WA Commission took as part of our performance management approach to capture outcomes and experiences that are meaningful to consumers, families and carers are discussed in paragraph 86.

Challenges to co-ordinated monitoring of system performance

78 For the most part, the Commonwealth and the WA Commission are monitoring different systems. The Commonwealth data collection and monitoring is more about Medicare payments and other initiatives, whereas the WA Commission's data enquiry is for a separate suite of services. While it did not cause a problem in the things the WA Commission was looking at, it created a gap. The gap related to things that neither the Commonwealth nor WA Commission were looking at, which they likely should be looking at jointly.

79 There were examples of services that crossed between primary care and the LHD service provision remit. In a number of examples, the WA Commission using its commissioning authority was able to partner with the WA PHNs which also had commissioning authority, to undertake joint commissioning such that the commissioning of both entities led to a greater integration of services between the State and PHN. Within these models, performance information was available to both the WA Commission and the PHNs.

80 From time to time, the Commonwealth and WA Commission exchanged views on areas of gap, overlap and 'blind spots'. I wrote to the PHNs a couple of times around some of the areas of underperformance of primary services. The PHN and WA Commission would discuss these areas and work together to try and develop strategies to address them. However, I found that this was the exception, rather than the norm. My observation in this space is that the system works best when roles and responsibilities are clear and are integrated but are not overlapping. Where it does not work, is where a role is not being met by either the Federal or State governance or funding arrangements, or where they are undertaking roles in the same space. An example would be psycho-social supports – States purchase those services and PHNs are often involved in that as well.

81 Money that goes to the overlap is not going to the gap. There is also a question not only of allocational efficiency, but service provision efficiency where it can be the case that an NGO is funded for the same or very similar services by both the State Government and Commonwealth Government independently. They then have, as a minimum, dual reporting which diverts resources from service delivery. At the end of the day, who are they really accountable to if there is an issue of quality of service?

82 An example of this dual funding and accountability is in areas of community-based suicide prevention programs where the Commonwealth fund similar and in some cases the same service provider.

Lived experience in governance

The WA Commission's approach

83 The WA Commission values the contribution that people with lived experience of mental illness can make to service design and improvement, and captures and incorporates this perspective in key parts of its process. At a high level, the WA Commission had a Mental Health Advisory Committee which met monthly and provided advice to the Commissioner. The Committee consisted of consumers, carers, clinicians and other people with lived experience and acted as a regular touch point. I would often take particular service challenges and pose those challenges as questions to that group for advice. Similarly, in the drug and alcohol space, we had a Alcohol and Other Drug Advisory Group consisting of advocates, service consumers, people with lived experience and service providers.

84 For specific services and models of service, we would always start with a co-design process and that would bring in lived experience into both the design and the model of service and its implementation. To do that, as one of its first actions under the 10 Year Plan, the WA Commission established an engagement framework which largely dictated

and made transparent what to expect from the WA Commission regarding their engagement with people with lived experience and carers.[3]

85 For example, if we were introducing a service in a regional area, then there would be engagement with the community in that area to influence the design and implementation of that service. We also required that service providers demonstrated they had mechanisms for the involvement of people with lived experience in the ongoing monitoring and performance of the service. That was also the case for hospital-based services which were required to have a consumer advisory group providing input into the operation.

86 The involvement of lived experience also comes through the measurement of outcomes from services. In the case of hospital-based services, for example, we implemented the Your Experience of Service (**YES**) Survey which was a nationally developed survey mechanism to capture the experience from individuals that were exiting services as to their experience with the service and the associated outcomes.

87 One of the things we did do, via co-design, was appropriately recognise the expertise of people with lived experience - as experts by experience. We had a payment regime that was co-designed and was agreed as appropriately recognising the contribution of those with lived experience to whatever the engagement is. That was one practical measure that acknowledged the importance of their input and (at times) improved their confidence as valued contributors. There were, from time to time, difficulties managing people's supports in various roles in engagement with various initiatives of the WA Commission. Where that was anticipated to be an issue that may occur, we always ensured that there was appropriate support available to individuals either at the time or through follow up measures (including access to things like Employee Assistance Programs).

88 In finding consumers to participate, if it was a substantial co-design exercise this was primarily done through expressions of interest and nominations – it was managed similarly to a selection panel for a recruitment for a position. Occasionally we would call upon peak bodies to nominate people, or alternatively we would outsource to an organisation that was particularly relevant to the area that was being looked at, and task that organisation with finding suitable contributors.

System navigation in Western Australia

89 Consumer navigation (finding and accessing suitable services) is a challenge in Western Australia as it is elsewhere. One consequence of having a single body that funds and monitors the performance of all mental health services is that information held by that

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3 Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025

body can form the basis of a directory, website or information service for consumers and their families.

90 At the time that I left the WA Commission, there was a review underway of existing piecemeal mechanisms such as dedicated phone lines for specific issues (e.g. mental health emergencies), with a view to establishing a more holistic navigation of services for consumers, carers and families particularly in situations of distress. That initiative was prioritised by the WA Commission to address the navigation difficulties experienced by consumers, carers and families. Without a separate Commission, it is unlikely that that would have been pursued. It is, however, an incredibly difficult area to resolve.

91 One of the online tools we established was an online service directory which has all the services named and listed – the next step is to establish a phone-based support service to triage people to the right service for them at the right point in time. The line of sight to those services and essentially having a mapping of services is a crucial component to any sort of navigation assistance. Having a single point of purchasing enables that mapping and helps identify areas of service integration. This, in turn, allows for a feedback loop for areas of need. Further, if you have appropriate monitoring in place, you can track what services people are seeking or accessing and get feedback on how their journey went.

Workforce

Challenges to a multidisciplinary, person-centred approach

92 In mental health, achieving the vision of a system which is truly multidisciplinary and responsive to the needs of the individual consumer is a long-term cultural change process. The term 'no wrong door' captures a philosophy that wherever people with mental health, drug and alcohol issues or other complex issues, present to a service, the service will address their needs. This requires multi-disciplinary services with a complex workforce mix. The starting point (i.e. where we are now) is that a workforce is not multi-disciplined in most cases, and is quite siloed in terms of its function, operation, training and culture. Addressing those issues is a long term challenge which can only be adequately progressed by investing in cultural change, training and, at the other end of the spectrum, contractual requirements – contractually requiring services to be able to address complex co-occurring issues.

93 Person-centred service delivery flows from having a whole of system vision that is very clear and aligned with and owned by all participants in the system, whether they be service providers, clinicians, consumers or carers. Then the vision needs to be translated into a plan, articulating the vision very clearly and involving people in the implementation of that plan, including the involvement of lived experience stakeholders. Ultimately this is

translated into commissioning of services, purchasing and the ongoing monitoring of services over time.

94 Funding strategy is also very important. In basic terms, the aim is more funding for services that work, and removal of funding for services that are not committed to quality standards or desired service delivery models. The WA Commission implemented the use of sanctions, including in one instance removing funding for a service, as a very significant demonstration of what won't be tolerated. In the example of removing funding, we had a service that contractually was required to undergo a quality assessment against the National Minimum Standards. The service refused to undertake the assessment on the basis that they knew they wouldn't meet a number of the elements of the Standards. Following negotiations and ongoing refusal by the service provider, the WA Commission made the decision to remove the funding. While extreme, being willing to use this kind of response can drive cultural change.

Strategy for developing the mental health workforce

95 In taking a strategic review of design, the WA Commission was clearly prioritised through that plan to develop an overall workforce strategy recognising that at a system level, workforce may not be available or be maintained with the necessary capabilities and capacity. A whole a system approach to workforce development was required. When I left we had a workforce development strategy in draft.

Integration with alcohol and other drugs services

Cultural background to separation of mental health and alcohol and other drugs services

96 Fundamentally, drug and alcohol services are mental health services, just with different acuity, because of the co-occurrence of drug and alcohol issues and mental health issues. However, there are some philosophical differences, in terms of what mental health practitioners see as recovery, versus what drug and alcohol services see as recovery. They mean different things in the two sectors. Regardless of the philosophical differences, it is about whether or not the individual is able to function as part of the community.

97 There is a bigger cultural change agenda that is required to truly enable integrated care to be successful. In part, it comes back to issues of stigma. For example, people may not want to be identified with a mental health service, if they have alcohol and other drug issues. Such a person may prefer to be associated with a service that is purely alcohol and other drugs, since they may perceive that they do not have a mental illness. Similarly, people with mental illness may not want to be associated with a service that is for those with alcohol and other drug issues. Stigma plays a very, very big part in this cultural challenge.

98 The stigma exists not only with consumers, but with the service providers as well, and the community more broadly. The way to successfully integrate care is by addressing stigma in the community more broadly – to change the views of the service providers and consumers. Stigma comes from the community at large judging individuals because of their alcohol and other drug use, or their mental illness. The judgement is what leads to the behaviours of consumers and service providers.

99 Addressing the issues at a community-wide level can make a considerable difference, such as what Beyond Blue has done in the mental health space. There is still a long way to go in reducing stigma. Particularly, for example, around severe and persistent mental illness such as schizophrenia, psychosis or eating disorders. Until we address the community's judgment in that space, individuals, whether they be service providers, workforce or consumers or carers, will always come at the issues from that broader community framework reference.

100 Avoiding the mutual stigma issues as between mental health and alcohol and other drug services is one benefit of services such as Headspace, and ReachOut.com, which somewhat side-step this by branding as a wellbeing service for young people. For example, ReachOut.com focuses on various areas affecting young people, whether these are mental health, alcohol and other drugs, gender issues or bullying. Based on what consumers and carers have told me, there is still an access issue for older people, however. Most people that access alcohol and other drugs services are not what you would expect - the age profile is older and includes people with long term alcohol and other drug issues, and therefore the co-occurring issues can be quite embedded.

101 In addition to stigma, both mental health and alcohol and other drug services impose barriers to service access which reinforce the division between the two services. For example, mental health services may exclude people with alcohol and other drug issues and fail to address co-occurring mental health and alcohol and other drug issues. An often-cited response is for to tell the consumer: 'Go away and get your drug problem fixed and then we can work on your mental health'.

Should governance be integrated?

102 In my view, the governance of mental health and alcohol and other drug services should come together at a single point. The alcohol and other drug sector has concerns about this approach, as they often feel like the poor cousins in the system and that the mental health system will gobble them up. Historically, there has been a tension between a single point of governance and accountability, and local-based decision making. A single point of governance and accountability can set the boundaries, processes and expectations for that local decision making in a consistent way. This does not mean controlling everything right down to the local level, but putting in place the framework that enables local decision-

making in a context of broader service and system objectives and mission. The two aren't mutually exclusive, they're complementary.

Purchasing as a way of achieving integration

103 The reality is that alcohol and other drug services are a type of mental health service. Both deal with people's thought processes and behaviours from a mental health frame of reference. In some ways, it doesn't really matter how the service is labelled. People are there with a problem and the root cause of that problem is what needs to be addressed. And more often than not, that is going to be a mental health issue. Alcohol and other drug services offer complex services to assist with all aspects of their issues, including mental health issues. The best way to achieve more holistic services is to purchase services that address complex co-occurring issues. That is the solution and it requires funding to do so.

104 To ensure that mental health services and alcohol and other drug services work harmoniously, contractual purchasing arrangements are used by the WA Commission so that, where appropriate, contracts require service providers to address both issues. This brought services together, and over time, we saw mental health services partnering with drug and alcohol services to ensure a holistic approach to the needs of individuals (and to access funding).

105 The WA Commission saw success with this model after a few years, once we obtained funding for new service initiatives that we could direct specifically for co-occurring issues. What we saw was more specialised services coming together and forming a consortium to provide coordinated services for clients with complex needs.

The vision of person-centred care

106 In terms of the vision of truly person-centred care in mental health and alcohol and other drug services, I believe that the main pressing issue is related to the gaps in the system that are a product of a lack of funding over a long period of time. This has meant that the system is very highly skewed towards the acute end and very, very underdone at the community support service end.

107 As a case in point, the modelling that we did as part of the 10 Year Plan and using the Planning Framework, showed us that in WA we were meeting about 80% of the acute hospital bed demand. In terms of hospital capacity that's actually pretty good. Stepping back from that, in terms of hospital based non-admitted services, we were only meeting about 60% of demand. Then stepping back from that in terms of acuity, in community bed-based support services we were only meeting about 40% of demand and then stepping further back to the very early invention and maintaining good health, mental

health and recovery in community support services, we were only meeting 20% of the optimal demand. The question is how did it get to be that way and how do we address it going forward?

108 For example, the WA Commission funds one program that takes people that are in long term hospital stays (of multiple years) and places them in the community in a house with appropriate supports. This acts as a support package. On numerous occasions, we have seen people start with a support package at a cost of approximately $150,000 per year. By year three or four, their support package only costs about $30,000, because they have recovered and require a small amount of assistance to remain well. So the evidence is absolutely there.

109 The research conducted by the WA Commission at the earliest planning stage identified that intervention at those earlier stages does, both as a matter of evidence and practice as well, have good prospects for preventing the kind of escalation which sees people reappear in the system as very acutely presenting. This is also evidenced through various programs that the WA Commission funded and operated. The improved model is not only preventing deterioration to acute levels, but also supporting the recovery of people who have a well-established and severe mental illness by supporting and maintaining their recovery in the community.

110 I think a key improvement opportunity is to have a single point of governance across those areas and the authority to drive integration across those areas – a common concern of consumers, carers and families is that there is a lack of integration between services. Fragmentation of governance inevitably leads to fragmentation of services.

Attached to this statement and marked 'TM-1' is a copy of my curriculum vitae.

sign here ►

print name Tim Marney

date 11 June 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT TM-1

This is the attachment marked 'TM-1' referred to in the witness statement of Timothy Michael Marney dated 11 June 2020.

TIMOTHY MARNEY

CURRICULUM VITAE

QUALIFICATIONS

Bachelor of Economics (Honours)

Murdoch University, Western Australia

Fellow of Certified Practising Accountants, Australia (FCPA)

MEMBERSHIPS

Member, Australian Institute of Company Directors

TRAINING

Australian Institute of Company Directors – Company Directors Course

Gateway Project Review

Ways of Working with Aboriginal People

Ethical and Accountable Decision Making

DEMONSTRATED COMPETENCIES

- Governance
  - Chief executive, board chair and deputy chair roles, board subcommittee chair roles
  - Development of beyondblue governance structures and practice

- Thought leadership and strategy development
  - Delivered the WA Economic Audit 2009 – "Putting the People First" to reshape government service delivery

  - Direct advisor to 4 Premiers, 11 Treasurers/Ministers over 22 years
  - Whole-of-government and organizational financial strategy
  - Mental health service system design

- Organisational leadership, development, change and reform (including merger/de-merger)
  - Implemented numerous machinery of government changes
  - Chief executive of organisations from 270 to 1700 full time equivalent employees

- Public sector reform
  - Nationally recognised reform of government procurement
  - Building management and construction reform
  - Public sector workforce reform strategy development

- Financial and economic strategy, forecasting and management
  - Delivered 10 State budgets (2004/05 to 2013/14) all in surplus (total operating expenditure of $27.6 billion in 2013/14)
  - Successfully managed through the Global Financial Crisis with limited impact on the state (including $30 billion debt portfolio restructuring)
  - Budget parameter forecasting (oil price, iron-ore price, exchange rates, interest rates, inflation, wage price indices)
  - Reinstatement and maintenance of Western Australia's AAA credit rating (both Moody's and Standard and Poors)

- Economic analysis
  - Developed and published the Western Australian Quarterly Economic Review
  - Research and analysis advice for the Bankwest Curtin Economics Centre (advisory board chair)
  - 7 years as chief economic advisor to the Premier of Western Australia
  - inflation analyst for the Reserve Bank of Australia

- Project and risk management (including complex project delivery and building construction)
  - Delivered construction of 783 bed Fiona Stanley Hospital, total cost $2.2 billion, on-time, within budget and with expanded scope
  - Developed and implemented whole-of-government accommodation strategy (including office tower developments)
  - Crisis management – statewide gas supply outage (Varanous island incident), serious adverse clinical events

- Service and infrastructure commissioning, procurement and contract management
  - Commissioning of Fiona Stanley Hospital
  - Shared corporate services across 70 separate agencies
  - Around $1 billion in human service contracts under management

- Health economics, planning, reform and system management
  - Member of the WA Health "Reid Reform" committee (2004)
  - Implementation of activity based health service purchasing
  - Delivered the Mental Health and Alcohol and Other Drug 10 Year Plan 2015-2025 using comprehensive health and community support service modeling
  - Operation of the Alcohol and Drug Support Service (phone counselling), Community Alcohol and Drug Services (face to face community based

counseling) and Next Step Withdrawal Unit (17 bed high medical detoxification hospital)
  - Purchasing of $800 million per annum in public health services
  - Chair, National Mental Health Commission – Best Buys in Mental Health economic research steering committee

- Stakeholder engagement and communication
  - Community consultation for Mental Health and Alcohol and Other Drug service planning
  - Consumer Engagement Framework development
  - First Western Australian Government agency to establish Aboriginal Elders in residence
  - Frequent print, radio and television activity
  - Highly successful Public Health campaign development: "Think Mental Health"(MHC), "Meth Can Take Control" (MHC), "Get to Know Anxiety" (beyondblue)

- Public Policy formulation, implementation and evaluation
  - Legislative reforms: Financial Management Act, Mental Health Act, secondary supply of alcohol legislation
  - Procurement, public works and government vehicle fleet reforms
  - Mental Health Court Diversion, Suicide Prevention evaluation
  - Public utilities policy and regulation

- Business case development and review
  - 13 years of leadership of successive Governments' Expenditure Review Committees
  - numerous business cases developed and approved (services and infrastructure)

- Non-government organisation market development
  - Development and implementation of the Delivering Community Services in Partnership Policy 2012 (refreshed in 2018)
  - Member of the Government and community services collaborative forums (Partnership Forum 2012-2017, Supporting Communities Forum 2017-2019)
  - Purchasing of $100 million per annum in non-government community services
  - Service co-design (Recovery Colleges) and Co-production (Community Alcohol and Drug Services)

- People development, leadership and mentoring
  - Developed and mentored many individuals, around a dozen having since progressed to Chief Executive or second tier leadership roles across WA government
  - Built numerous strong, high performance teams across a diverse range of functional areas

- Facilitation
  - Numerous strategic planning processes across a variety of departments/organisations
  - National Mental Health Commission workshops on the Economics of Mental Health, including academics, government agencies, clinicians, non-government organisations, and consumers and carers

EMPLOYMENT

2014 – 2019

Commissioner

Mental Health Commission, Western Australia

2005 – 2014

Under Treasurer:

Department of Treasury (2011 – 2014)

– Treasury, Strategic Projects

Department of Treasury and Finance (2006 – 2011)

– Treasury, State Revenue, Government Procurement,

Building Management and Works, Strategic Projects, Shared Services

Department of Treasury (2005 – 2006)

– Treasury, State Revenue

2001 – 2005

Executive Director

Department of Treasury – Agency Resources

2000 – 2001

Director

Department of Treasury – Corporate Services

1997 – 2000

Director

Department of Treasury – Economic Policy

1993 – 1997

Policy Advisor

Department of Treasury – Economic Policy

1990 – 1993

Economic Analyst

Reserve Bank of Australia

BOARDS

2010 – Present

Deputy Chair, beyondblue

- Chair, Finance Risk and Audit Committee
- Chair, Nominations and Remuneration Committee
- Member, Project Steering Committee – National Education Initiative

2008 – 2010

Director, beyondblue

2014 – Present

Chair, Bankwest Curtin Economics Centre Advisory Board

2014 – Present

Member, Centre for Social Impact (University of Western Australia) Advisory Board

2018 – Present

Member, Public Sector Reform Steering Committee, Government of WA

2005 – 2014

Chair, Western Australian Treasury Corporation (gross borrowings $41.2 billion in 2014)

- Chair, Finance Risk and Audit Committee
- Chair, Nominations and Remuneration Committee

2001* – 2004

Deputy Chair, Western Australian Treasury Corporation

2006* – 2011

Member, State Supply Commission Western Australia

2001* – 2004*

Director, Western Australian Sports Centre Trust (now VenuesWest)

1997 – 2000

Member, Australian Statistical Advisory Council, Australian Bureau of Statistics

*Dates are approximate