VIEWPOINT

Australia needs a mental health commission

Alan Rosen, Patrick McGorry, Grace Groom, Ian Hickie, Roger Gurr, Barbara Hocking, Margaret Leggatt, Anne Deveson, Keith Wilson, Douglas Holmes, Vivienne Miller, Lynne Dunbar and Fiona Stanley

Objectives: *The present paper aims to: (i) describe how the Mental Health Commission in New Zealand works and has contributed to the substantial enhancement of mental health resources and services; (ii) determine whether mental health reform policies will ever be implemented properly without an independent monitor with official influence at the highest levels of government; and (iii) demonstrate how variants on this model work in other Western countries and how it can be adapted to the Federated system in Australia.*

Conclusions: *It is recommended that the Australian National Mental Health Plan 2003–2008 should be complemented by a long-standing national mental health commission (or similarly constituted body), which is also able to report independently from and to the government, with direct access to the Prime Minister, Premiers and Australian Health Ministers. Its aims would be to monitor service effectiveness and identify gaps in service provision, training and performance of the work force, management and government. It would be informed by consumer, carer and provider experience, and by reviews of evidence-based research regarding health needs and cost-effective services. It should accurately cost such service gaps, and advise government on a strategy for implementing them. It could also promote and advise formally on enhancing community awareness, decreasing stigma and discrimination and improving workforce recruitment and retention.*

Key words: *Australia, Mental Health Commission, psychiatric services.*

Alan Rosen
Senior Consultant Psychiatrist and Secretary, Comprehensive Area Service Psychiatrists Group, Sydney, NSW, Australia.

Patrick McGorry
Director, ORYGEN Youth Health (incorporating EPPIC) and Research Centre, Department of Psychiatry, University of Melbourne, Melbourne, Vic., Australia.

Grace Groom
CEO, Mental Health Council of Australia, Canberra, ACT, Australia.

Ian Hickie
Director, Brain and Mind Research Institute, University of Sydney, Sydney, NSW, Australia and ex-CEO, *beyondblue: the national depression initiative.*

Roger Gurr
Senior Consultant Psychiatrist and Chair, Policy Committee, Comprehensive Area Service Psychiatrists Group, Sydney, NSW, Australia.

Barbara Hocking
Executive Director and Board Member, SANE Australia, Melbourne, Vic., Australia.

Margaret Leggatt
Coordinator of Family Support and Participation ORYGEN (EPPIC) and Immediate Past-President, World Fellowship for Schizophrenia and Allied Disorders, Melbourne, Vic., Australia.

Anne Deveson
Writer, Filmmaker and Mental Health Advocate, and Patron of SANE Australia, Sydney, NSW, Australia.

Keith Wilson
Chair, Mental Health Council of Australia, Perth, WA, Australia.

Douglas Holmes
Consumer Consultant, Lobbyist and Researcher, Sydney, NSW, Australia.

Vivienne Miller
Mental Health Educator Occupational Consultant and Conference Director, Sydney, NSW, Australia.

Lynne Dunbar
Occupational Therapist, Mental Health Conference Consultant.

Fiona Stanley
Director, Telethon Institute for Child Health Research, CEO, Australian Research Alliance for Children and Youth, Perth, WA, Australia.

Correspondence: Assoc Professor Alan Rosen, 24 Olga Street, Chatswood, NSW 2067, Australia.
Email: arosen@doh.health.nsw.gov.au

Although mental health reform in Australia has been heading broadly in an appropriate direction, there is wide agreement that:

- these reforms are already losing momentum, and core local mental health services either are being eroded or have never been adequately developed;
- Australia now lags behind similar Western countries (most notably New Zealand) in terms of its commitment to and funding of mental health services (Table 1); and
- the closing of institutions in Australia has been half-hearted and incomplete in many instances, and has not been accompanied by full transfer or increase in real investment in mental health services.

Through the advent and intervention of an independent mental health commission in New Zealand, working in synergy with government, providers, consumers and carers, mental health reform in New Zealand has regained focus and momentum, and the mental health workforce is being reskilled. In New Zealand, communal discrimination against people with mental illness has been comprehensively challenged, and per capita mental health funding has rapidly grown to more than $AUS 150 (excluding drug and alcohol funding), compared to Australian

Table 1: International comparison of mental health funding

Country	*Australia*	*New Zealand*	*Netherlands*	*Sweden*	*USA*	*UK*	*Canada*
Population (million)	19.0	3.5	16.0	9.0	286.0	60.0	31.0
Health expenditure as proportion of GDP (%)	7.8	8.2	8.8	9.2	13.7	7.3	8.6
Mental health proportion of health budget (%)	6.5	11.0	7.0†	11.0	6.0	10.0	11.0

†Although accurately quoted from the World Health Reports, this figure is misleading, because it does not include the substantial components of the mental health budget devolved to Social Services and, more recently, to local municipal authorities.
Sources: The World Health Reports 2002, 2001.

funding of $80 for public and $135 for public and private services combined.

We argue that the Australian National Mental Health Plan 2003–2008,[1] as an integral part of a range of strategies, should provide for a national mental health commission (or similarly constituted body) with direct access to Australian Health Ministers and all mental health service stakeholders, and which is also able to report independently from and to the government.

GROWING CONSTITUENCY FOR A MENTAL HEALTH COMMISSION IN AUSTRALIA

There is a broad and expanding constituency for an Australian national mental health commission as a prominent component of the Australian National Mental Health Plan 2003–2008. This matter has been the subject of forums, correspondence and discussions between several major State and national mental health organizations for some time. These organizations include SANE Australia, ORYGEN Youth Health (formerly EPPIC), Royal Australian and New Zealand College of Psychiatrists (RANZCP), Comprehensive Area Service Psychiatrists Group (CASP) and The Mental Health Services (TheMHS) Conference of Australia and New Zealand. It has been proposed and debated at several TheMHS conferences and summer forums, and has been raised for consideration by consultative forums of the Australian Rotary Health Research Fund and the Mental Health Council of Australia.

In 2002, the Mental Health Council of Australia conducted a national survey and nationwide consultations, collating survey responses to the Midterm Report on the 2nd National Mental Health Plan.[2] The Council's report 'Out of Hospital – Out of Mind' was released on 11 April 2003.[3] One of the key recommendations, based on many consultations, is the formation of a national mental health commission or similar body, to report on progress of mental health reform in Australia. Its nationwide review of the experiences of those who use and provide mental health services documented the failure of our current mental health service systems to provide adequate services. Monitoring progress of national mental health reforms could not be left to those charged with implementing these reforms, the author concluded, because the progress reported in the most recent National Mental Health Report (2002) did not fit with the 'felt reality' of the many service users, carers and providers who were surveyed.[4]

These findings resonate with and build on the extensive nationwide research reported in SANE Australia's Mental Health Report 2002–2003.[5] It concluded that Australian mental health services are in disarray and operating in crisis mode, and that the National Mental Health Strategy is widely recognized to be losing momentum and faltering.

MENTAL HEALTH COMMISSION OF NEW ZEALAND

The New Zealand Mental Health Commission is presently nearly 8 years old and a likely lifespan of 11 years or more is anticipated at this point in time. It was established as a Ministerial Committee under Section 46 of the NZ Health and Disability Act 1993 and began work in 1996. The Commission became a separate Crown entity with the enactment of the Mental Health Commission Act 1998, which was amended to extend the limit of its statutory life from 2001 to 2004 and recently it has been further extended to August 2007. For the future, after 2007, several options are being considered, including the model of the National Institute of Mental Health in England (NIMHE).

The Commission operates with a chairing commissioner, a commissioner experienced as a consumer advocate, and a commissioner with a background in Indigenous Health who also happens to have extensive experience in corporate business governance, and concurrently chairs a district health board. It has attracted to these positions people of exceptional

abilities and distinguished national and international reputations in the mental health, disability and other relevant fields.

The functions of the Mental Health Commission, specified in the1998 Act,[6] include:

- to report to the Minister, from time to time or at intervals agreed between the Minister and the Commission, on the implementation of the national mental health strategy; and
- to report to and advise the Minister, when requested by the Minister, on any matter relating to the implementation of the national mental health strategy specified by the Minister in the request; and
- to work with all those involved in the care and treatment of people with mental illness and their families and caregivers: (i) to promote better understanding, by the community, of mental illness; and (ii) to reduce the stigma associated with mental illness and the prejudice shown to people with mental illness and their families and caregivers; and (iii) to eliminate discrimination on the ground of mental illness against people with mental illness and their families and caregivers; and (iv) to promote employment in the mental health field as a desirable career choice; and (v) to work with all those involved in training for employment in the mental health field (a) to promote the provision of training opportunities of an appropriate range and quality; and (b) to promote the obtaining and maintaining, by people employed in the mental health field, of skills of an appropriate range and quality.

While the Commission must provide at least one report to the Minister of Health annually on the Ministry's performance and enjoys good access to the Minister, the Commission also has the independence

Table 2: Achievements of the New Zealand Mental Health Commission

Significant increases in the funding directed to mental health services
New mechanisms in the health sector to prioritize and plan for improved access to mental health services
A new paradigm for integrated mental health service that went beyond the sterile debate between community care and institutional care
Promotion of and mechanisms for developing the mental health workforce
Anti-discrimination initiatives via implementation of local community and mass media campaigns
An active recognition of the:
need for service models that address the special needs of diverse communities, particularly Maori and Pacific peoples, and importance of service users and the families in the planning, specification and delivery of mental health services
The development and promulgation of the:
recovery paradigm
blueprint for optimal mental health services
identification of gaps in service provision in contrast to the blueprint
funding gaps analysis (costing of the gaps)
encouragement of government to bridge gaps in provision
Taking up the 'operational' slack where the permanent agencies within the sector were clearly unable to undertake their core functions, including:
development of proposals for ongoing funding pathways for mental health, and reporting on levels of investment of funding into mental health and the maintenance of the mental health funding ring-fence
Advising on key mechanisms for ongoing funding and management of the sector including performance monitoring frameworks, and the population-based funding model
Undertaking independent reviews on behalf of the Minister and vertical reviews to identify systemic performance issues
Engaging with mental health services through its programme of visits, which provide:
a safe venue for the sector to identify its problems and issues and seek independent support and advice, and an opportunity to monitor the systemic performance of the sector as a whole
Promoting the service-user voice and the skills of service users in the context of mental health service development

Source: Saville-Smith K: *A Strategic Analysis of the Role Functions and Focus of the Mental Health Commission*, December 2002.[7]

to report on the present adequacy of services, management workforce, training and resources to the public mental health service community and government.

Achievements

The achievements of the Mental Health Commission of New Zealand are summarized in Table 2.[7] The Commission is not just another 'ain't it awful' standing inquiry into mental health services; it is constructive, positive and programmatic, promoting optimal services and resourcing, providing a practical vision and agenda for the development of Mental Health Services nationally.

The Commission, through wide consultation and appraisal of the international evidence base, published the blueprint for the further development of New Zealand Mental Health Services,[7–10] which defined the gaps in services and then provided accurate costings of resources required to fill all these gaps. This blueprint and set of costings were adopted by the incoming New Zealand Government, and subsequently the per capita expenditure on public mental health services (excluding drug and alcohol services) in New Zealand has grown to 250% of the average per capita public expenditure in Australia, and to considerably more than public and private mental health per capita expenditure combined in Australia (Table 1). Cumulative increase in mental health service funding in New Zealand in real terms (that is, after adjusting for inflation) from 1993/94–2002/3 was 128% (J. Dowland, pers. comm. 2004) while the nearest comparison yet published for Australia was an increase of terms of 44% from 1993 to 2000, with no significant relative increase over general health services funding over the same period.[4]

VARIANTS OF THE MENTAL HEALTH COMMISSION MODEL IN OTHER COUNTRIES

The President's New Freedom Commission on Mental Health in USA

This was a component strategy of the New Freedom Initiative announced by the George W Bush White House in February 2001, which included 10 proposals designed to 'tear down the barriers that face Americans with disabilities today'.[11]

The Commission was led by Mike Hogan, a nationally prominent leader and reformer of State mental health services, and engaged national experts for its subcommittees, ensured ample input from the public and maintained a good liaison with advocacy and professional organizations.[12] The organizing theme of its deliberations was 'recovery', an approach that had been validated in the 1999 US Surgeon General's report on mental health,[13] which had exemplified the Australian National Mental Health Reforms, including our Early Intervention approaches.

The Commission's interim report concluded, 'the system is in shambles', and identified five major barriers to improving mental health care, particularly the fragmentation and gaps in services.[14]

The final report amounted to a blueprint for transforming mental health services into a quality and coherent system of care.[15] It hinged on several national goals and contingent recommendations, including strategies to assist Americans understand and prioritize: that mental health is essential to overall health; that mental health care is consumer and family driven, requiring individualized plans coordinating the input of multiple caregivers; how excellent evidence-based mental health care can be delivered, and how geographical socioeconomic and cultural disparities of service can be eliminated. To achieve these goals, a national monitoring or tracking system was recommended. Although the Commission itself was time-limited, the US Federal Government has now mandated the development of an implementation plan to follow the recommendations of the final report,[12] which must include both 'top-down' leadership and 'bottom-up' participation of recovering consumers and their families. Although the brief required that the implications of the final report itself should be cost-neutral, the increased resource implications are said to be found in the deliberations and detailed reports of the committees. Therefore, the US mental health community is hopeful that the commission's work will make an enduring difference.

National Institute for Mental Health in England

This Institute is pivotal to the implementation of the UK National Health Service (NHS) Framework for mental health service reforms in England, which on paper appear quite similar to our reforms, although initiated much later.[16] Established in 2002, the NIMHE is an explicitly 'federal organization', both 'devolved and united'. It is governed by a Council drawing on representation from all regional parts of NIMHE. Each Regional Development Centre is governed via local stakeholder arrangements to ensure that they all have 'a real and influential voice within NIMHE'.[17] The NIMHE aims to 'improve the quality of life for people of all ages who experience mental distress', by supporting staff to put policy into practice, and directly involving service-users, families and communities.[16,17]

The strategy of the NIMHE includes developing capacity and evidence-based skills in people and service systems in mental health, via fellowships, secondments and funding projects to develop leadership, retraining and 'train the trainer' programmes. It also has a mandate to bring together performance management data into a meaningful picture of progress happening at a local level, which will ultimately indicate progress at a national level.

It will work closely with the new Commission for Audit and Inspection to develop standardized datasets and effective performance measures nationally.[17] The Commission will then authorize inspectors to audit mental health services on set indicators based on these developments.

The NIMHE also conducts a workforce development programme prioritizing strategic planning of workforces; development of effective communications and knowledge management; support for the implementation of national occupational standards; support for new roles in practice; and recruitment and retention.

DISCUSSION

Advantages of a mental health commission

There are several advantages.

- The ability to operate at arm's length from the Australian Government and State Ministers and Departments of Health, and from authorities responsible for mental health services delivery. At the same time, the Commission needs to be able to maintain a cordial and synergistic relationship with these Ministers' departments and authorities. The Australian Government and State Departments of Health primarily report to their Ministers. The primary clients of a mental health commission are across the mental health sector and all relevant agencies and stakeholders, as well as government.
- The ability to formally encompass human rights and antidiscrimination agendas for people affected by mental illness, without being restricted to these agendas, as would an assistant commissioner for Mental Health attached to the Australian Human Rights and Equal Opportunity Commission (as had been mooted).
- Having a formal mandate to monitor the adequacy of, and identify gaps in, mental health service provision, training, workforce, performance of management and government in accordance with international evidence and stakeholder consultation. The Commission should have the capacity to undertake such evidence reviews and detailed consultations.
- The ability to provide continuity of purpose and goals for the development of mental health services during periods of governmental change or restructuring of departments and services.
- The ability to pursue a positive practical agenda. This is far preferable to meeting the repeated demands for major national or State inquires or a standing inquiry to 'beat up' already weary mental health staff trying their best with insufficient resources. Since the Mason Inquiry, which recommended the formation of the Mental Health Commission, there have been no major national inquiries in New Zealand, although there have been several minor ones.

Unlike other standing commissions, the Mental Health Commission is envisaged, as in New Zealand, to perform specified tasks within a specified timeframe, with defined extensions only to the point where its job is done. In this respect, ultimately doing itself out of a job becomes a measure of its success.

Perceived obstacles to a mental health commission in Australia

Some people believe that it may be difficult to gain agreement on a national commission in Australia, because of the federated relationship between the Australian Government and the States. The Australian Government is reluctant to get involved in practical service delivery, considering it to be a State responsibility. In the USA, a similarly federated system of government has proven to be no obstacle to the establishment, by executive order, of the President's New Freedom Commission on Mental Health, although this has been short term at this stage, and has recently published its final report.[15] The new National Institute for Mental Health in England,[16,17] which serves some functions of a standing mental health commission, includes eight regional development centres, serving regions of 5–15 million, bigger than most Australian States and each providing wide stakeholder consultation and practical support to service development. The New Zealand Mental Health Commission was set up to drive and monitor national mental health policy implementation at a time when central government had delegated significant powers to four funding bodies at arm's length from all service provider organizations. This has some parallels to the relationship between the Australian Government and the Australian States.

Further, some in the Australian Government regard the Mental Health Council of Australia to be approximately equivalent to such a Commission. The Mental Health Council of Australia fulfils an important national role as a peak organization consultative body, with contractual arrangements with government. However, it does not consider that in its present form it can be reasonably expected to undertake this additional role, at arms length from both government and its member organizations.

Although it appears that some directors of mental health policy and services adamantly do not want an independent commission looking over their shoulders, one long-standing State director formally proposed a National Institute for Mental Health for Australia in 1999, which would undertake some of the monitoring, workforce, skilling and antidiscrimination functions of the New Zealand Commission.[18]

What's in it for Government?

The Australian Government Department of Health and Aging, National Health Priorities and Suicide Prevention Branch may consider that they already monitor the progress of the National Plan through the publication of annual reviews and their initiation of mid-term reviews by a passing parade of different international consultants. The experience in New Zealand suggests that the Ministry of Health Directorate of Mental Health initially may have perceived the proposed new Commission as a possible 'vote of no confidence'. However, the New Zealand Ministry of Health Directorate of Mental Health have long since realized that the Commission, with its more independent role, has been able to become a most effective partner 'walking alongside us' in the task of developing and monitoring Mental Health Services and the Mental Health workforce.

A mental health commission would fulfil an important complementary role to government, earning the trust and respect of all stakeholders, while working towards the common goal of ensuring that mental health services are adequately accessed, developed, resourced and monitored.

A mental health commission, independently monitoring service adequacy and development, is likely to mute constant calls for inquiries and lessen the political risk around mental health. It would provide a mechanism to ensure that government investment is well made, and more widely appreciated, by grass root constituencies who would have a direct channel for regular consultation.

CONCLUSION

New Zealand has taken many lessons from the Australian National Mental Health Plans and has replicated or adapted many of our initiatives. This is an opportunity to learn reciprocally from an initiative of New Zealand, which has been widely acclaimed as highly successful, and to adapt it for application in Australia.

Our recommendation is that the Australian National Mental Health Plan 2003–2008[1] should be complemented by a national mental health commission (or similarly constituted body) that is also able to report independently from and to the government, with direct access to the Australian Prime Minister, Premiers and Health Ministers. Its aims would be to monitor service effectiveness and identify gaps in service provision, training and performance of the work force, management and government; it would be derived from consumer, carer and provider experience, and informed by reviews of evidence-based research regarding health needs and cost-effective services. It should accurately cost such service gaps, and advise government on a strategy for implementing them. It could also advise formally on improving workforce recruitment and retention.

The National Mental Health Commission should be constituted by law as an independent body, not beholden to government or a board of constituent organizations. Its mandate would formally encompass promoting community awareness and human rights, and challenging stigma and discrimination. However, we do not concur with the informal advice of the Australian Human Rights and Equal Opportunity Commission that we could advocate instead for an assistant commissioner for mental health, within the Human Rights Commission. This would deal only with the Human Rights section of the agenda of a national mental health commission, in a de facto form of standing inquiry into abuses and discrimination.

Hopefully we should not need yet another inquiry to tell us what needs doing. We need an ongoing independent body with a positive agenda to provide rigorous and continuous comparative evaluation of Australia's mental health services, which can recommend to government, stakeholders and the Australian public how to improve these services. Public, private and non-government organization (NGO) provision and all of government activities should be encompassed, and the Commission should also monitor and promote the protection of human rights of people affected by mental illnesses, and the prevention of discrimination against them.

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