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It's raining mental health commissions: prospects and pitfalls in driving mental health reform

Sebastian Rosenberg Senior Lecturer, Brain and Mind Research Institute, Faculty of Medicine/Sydney Medical School, University of Sydney, Sydney, NSW Australia

Alan Rosen Professor, Brain and Mind Research Institute, Faculty of Medicine/Sydney Medical School, University of Sydney, Sydney, and School of Public Health, Faculty of Health and Behavioural Sciences, University of Wollongong, Wollongong, NSW Australia

Abstract

Objective: Partly in response to ongoing concerns about the state of mental health care, several jurisdictions across Australia, including the federal government, are hoping to drive change via the establishment of a mental health commission. This is the first of two articles in a series which aims to describe the background to this new trend. The commissions are being established with different powers and structures. This variety is explored and considered against a typology of commissions. Some consistent themes and goals emerge. The paper then provides a contemporary assessment of the 'state of play' of the nascent commissions and describes important emerging issues and differences between the models.

Conclusion: There are significant differences not only in the construct of the respective commissions but also in the political circumstances in which each must work. At the same time, the problems facing mental health in Australia are ubiquitous and profound. For commissions to be successful they will require not only astute leadership but also durable, bipartisan political support and an enduring capacity to generate new resources for the mental health sector.

Keywords: accountability, commission, mental health, policy, reform

The crows have their murder, whales a pod. The collective noun for mental health commissions has not yet been coined but now that several Australian jurisdictions have committed to the establishment of such a body, perhaps a 'hope' of commissions is apt.

Successive national and state reports have demonstrated the parlous state of mental health care in Australia.[1-4] New investments have been welcome.[5,6] However, the rate of increase to the overall health budget (around 7% per annum[7]) means that mental health's share of total health spending is, in fact, waning not waxing.

On top of this difficult situation is the fact that even some 20 years after the call was originally made in the first National Mental Health Policy, Australia still lacks a robust accountability framework with which to discern the actual impact of the $5.5 billion we spend on mental health each year. Simply put, we do not know whether this funding helps people get better clinically, find and keep a job, attain stable housing or generally enjoy a good quality of life. The principal reason we cannot know these things is that we do not ask. There is no national validated approach to the collection of the experience of care of consumers and carers. We are "outcome blind"[8] to the things that really matter.

Partly in response to this grim state of affairs, several Australian jurisdictions have recently chosen to invest in a new organisational structure in the hope of driving reform. Western Australia, NSW, the federal government, most recently Queensland and perhaps also Victoria have all just established, or are in the process of establishing, mental health commissions.

Correspondence:
Sebastian Rosenberg, Brain and Mind Research Institute, Faculty of Medicine/Sydney Medical School, University of Sydney, Sydney, NSW Australia.
Email: sebastian.rosenberg@sydney.edu.au

Table 1: A typology of commissions (adapted from Reference 11)

Mental Health Commission	***Type 1***	***Type 2***
Mandate	Narrow	Wide
Focus	Individual • Predominantly risk management agenda: complaints ombudsman or umpire re adverse occurrences • Medicolegal review of quality and duty of care for involuntary patients • Inspectorial, inquisitorial, or regulatory	System-wide • Positive agenda: stakeholder encouragement, programmatic system reform and improvement • Proactive consultation with all stakeholders • Transparent accountability, monitoring • Budget holding and integrated commissioning (so far Western Australia only) • Whole of government coordination and focus
Auspice	Mental Health Act or own act	Specific own act +/- or enabling legislation
Report to	Health minister or attorney general	Prime minister, first minister, health minister, parliament, all of government
Examples	Republic of Ireland, Northern Ireland, Scotland, Victoria	New Zealand, Canada, Western Australia NSW, Australian National Commission Queensland

The aim of this article is to consider why governments would choose to do this and to describe some of the key issues that must be considered in establishing a mental health commission.

In general, governments are clearly hoping that commissions can provide a new level of expertise and focus on mental health so as to break open some old debates to deliver new services and new ways of thinking. But based on the experience of commissions elsewhere, are these hopes justified? Are commissions really a game-changing new structure capable of driving reform or simply the latest fad in a long line of "special arrangements" to which mental health has been subject in Australia?

This article will begin to answer this question by first considering how the different commissions fit into an existing typology. What does this tell us about the extent to which Australia's commissions will have shared goals or approaches?

Australia's commissions are at different stages of development. The paper will present an overview of the current "state of play" in relation to each commission, what we know about their structure and the political milieu in which they are operating. Understanding this is critical to considering the factors which will cause these commissions to succeed or fail.

This article can draw on the experiences of existing commissions, particularly the longest operational one in Australasia, the New Zealand Mental Health Commission. We can also consider the experience of Canada since it established a commission in 2007 and can look at the first 18 months or so of operation of the Western Australian (WA) Commission. It is also possible to now consider the first details of the new mental health commission to be established in NSW. Legislation to establish the NSW Commission has been planned to enable for it to be up and running by 1 July 2012.

NSW has just issued a Community and Stakeholder Guide to this legislation[9] which describes the key issues raised in the state and enables comparison with other jurisdictions.

Lastly, it is also possible to assess the model proposed for the National Mental Health Commission though details are scarce at time of writing.

In terms of background, the authors have been informed by the varying structures and functions of mental health commissions internationally and were part of the NSW Taskforce to Establish a Mental Health Commission. They had the opportunity to visit the Western Australian and New Zealand Commissions as part of this process.

A typology of commissions

It is worth noting that it is quite common across public administration generally for governments to turn to mission-focused, statutory authority-type organisational

Table 2: Key features of the type 2 mental health commissions

Jurisdiction	*Number of commissioners*	*Staff*	*Fundholder*	*Legislative Base*	*Reports to*
Western Australia	1	60	Yes	Not yet (legislation under development)	Minister for Mental Health, parliament
NSW	?	? (likely small)	No	Yes	Minister for Mental Health, parliament
Federal	9	? (likely small)	No	No	Minister for Mental Health, prime minister
Canada	18 board members including 1 chair and one deputy chair	70 (not all full-time)	No	No	Public via annual report
New Zealand	3	12	No	Yes	Parliament
Queensland	?	?	?	?	?

models to drive reform. The reasons they choose this model of governance for certain issues include to ensure independence and impartiality, and to enable greater focus on policy development and systemic monitoring, particularly in complex areas.[10] Mental health, of course, fits this bill.

With regards to mental health specifically, Rosen *et al*.[11] have previously described a typology of commissions which is the basis of Table 1 below.

Type 1 could be summarised as more minimalist, inquisitorial and concerned about individual complaints and follow-up, reacting to and reporting on services provided at the level of the individual. This is more of an ombudsman or complaints commission type role. This is the predominant type of commission in Scotland and Ireland and is now apparently being considered in Victoria.

Type 2 commissions have a much broader remit, focusing on systemic reform, policy coordination, service development and sometimes purchasing. This is the type of commission to have been established in New Zealand in 1997, in Canada in 2007, in WA in 2010 and planned for the National Commission (January 2012), in NSW (from July 2012) and Queensland (possibly 2012).

Based on this typology, it is reasonable to suggest that the type 1 commissions have only a very limited role, if any, in driving overall mental health reform. Their role is much more inspectorial rather than developmental. On this basis, Victoria's choice to pursue a commission of this type would indicate that it is not seeking to give a new commission a key policy role but rather persist with extant policy and reform structures within government.

This is clearly not the case in other jurisdictions which are looking to the new organisational structure of a commission to break open old debates, old service models and old ways of thinking. It is, as yet, unclear regarding the timing for the Queensland Commission. However, based on the paucity of public information available at the time of writing, the intent appears that it take on this broader remit of reform rather than the type 1 commission as described above.

Even within these typologies there is variation, as can be seen from Table 2 below which describes some of the key features of known commissions.

Independence vs. influence

A recurring theme of all commissions is the requirement to find a structural balance between independence from, and influence within, government. The further an agency is from government the freer it may be to publicly comment and critique government positions, policies and services. However, the more remote or independent an agency is from government, the less likely it will have easy access to the range of government- and service-related data required to report on the operation of the system, unless such access is legislated or otherwise mandated.

The WA Commission operates as a defacto government department, with all the responsibilities and obligations commensurate with that role. The National Commission will, in reality, be a work unit with the Department of Prime Minister and the Cabinet.

The NSW Commission is to be set up outside of all existing government agencies, as a separate authority, but

reporting to government. Canada's Commission is perhaps the odd one out, established as a not-for-profit corporation, completely outside of government. However, even with this ostensible independence, both the provincial and federal governments as well as the prime minister have endorsed the role of the commission to develop a national mental health strategy, establish a knowledge exchange centre and develop community awareness strategies. An Australian equivalent of such an arm's length arrangement from government might be *beyondblue*.

State of play of commissions

We now provide a brief overview of the situation facing mental health commissions in Australia and New Zealand.

New Zealand

The NZ Commission has achieved considerable gains since its inception in 1996. Its blueprint[12] and documentation of the service gaps and what it would take to fund them resulted in NZ leapfrogging Australia in per capita expenditure on mental health services and the proportion of the health budget spent on mental health.[13] The New Zealand Commission also oversaw a fundamental redirection of mental health resources away from hospitals and towards the type of community-based services typically run by the non-government sector (NGO). It was reported to us that in NZ NGO spending now accounts for 28% of total mental health spending. This is quadruple what is spent on NGOs in Australia.[2]

For so long a beacon of reform in mental health, natural disasters and severe financial constraints are conspiring to fundamentally alter the ongoing role of the NZ Mental Health Commission. The NZ Commission was always subject to a sunset clause, a date when its operations would cease. This was extended more than once, most recently to 2014. The positive news is that the government now has recognised the importance of the role of the commission and now made it an ongoing part of the machinery of government. The downside is that its budget has been reduced from around $NZ3 m to around $NZ1 m and that it will no longer be a separate entity but form part of an expanded Health and Disability Complaints Commission. How a type 2 mental health commission will fit within a type 1 complaints commission structure and at such a reduced budget is concerning.

Alongside these structural changes, however, was a more fundamental concern in NZ about its commission. It was widely felt that the 1998 blueprint had run its course and that the growth funding that had supported its implementation could now be better targeted to new problems and services. On this basis it was perhaps not surprising that some felt that the NZ Commission had lost some of its influence. Not being the fundholder and being without direct policy and political influence is a recipe for irrelevance. One can only hope that the innovative New Zealanders find a way within their new constraints to make their commission function as effectively as it did in its prime.

Western Australia

While only in operation since 2010, the WA Commission is perhaps the most potent example of a commission from an Australian perspective. WA is different from NZ in as much as it is the direct purchaser of mental health services on behalf of government, not merely the repository of a blueprint or strategy.

As purchaser, the WA Commission has all the rights and responsibilities of a government department. While this offers a level of direct influence unparalleled by other commissions, the WA Commission cannot cast itself in the role of independent analyst or expert systemic evaluator.

The WA Commission is imbued with the type of culture they feel has driven some success in the broader disability sector. Underpinning this approach is a strong and independent commission, able to pursue innovative purchasing solutions. One such solution has been the establishment of more individualised packages of care and this is the type of approach that the WA Commission may well look to promulgate now for people with a mental illness. There is certainly every stated intention to move the locus of care into the community from the hospital setting.

Strong relationships have been established between the WA Commission and the non-government service sector and consumer and carer peak bodies. The WA Commission is clearly not interested in simply maintaining the status quo.

Some significant challenges now face the WA Commission as it continues its maturation. Where mental health was but one division within the Department of Health in 2009, it is now a separate and distinct purchaser and the department is now a service provider, competing for commission business. The commission has been working to bed down its initial funding and purchasing arrangements. Once done, it can afford to turn its attention away from establishing its financial base to other issues.

The role of the WA Commission in terms of promoting improvements to the quality of clinical services is unclear as this function currently resides with the WA chief psychiatrist whose office is not part of the commission. This is a dilemma WA is now working to address.

Inherent in the model chosen by WA is the need for its commission to continue to demonstrate its independence of thought and action, its willingness to drive investment in services beyond current thinking, and the vested interests of existing service providers.

WA has moved to increase its bipartisan durability through the creation of a community advisory council, with its chair a retired government politician and its deputy a retired member of the opposition.

The National Mental Health Commission

The role of a commission at a national level has not been clearly stated and the model adopted is unlike any other. There will be nine commissioners overseeing a national roadmap and a national mental health report card, reporting as part of the Department of Prime Minister and the Cabinet but without legislative mandate. Despite these uncertainties, the federal government's commitment to drive cross-portfolio mental health activity in a more coordinated fashion is very welcome and mirrors efforts in the jurisdictions. This all-of-government mandate and focus has been dramatised by placing the commission within the prime minister's portfolio and department, and this has been generally welcomed by stakeholder groups

The first appointment was Dr Robyn Kruk as CEO, and the commission will be based in Sydney. It is clear that with this high profile appointment that the MHC is intended to have considerable prominence and influence.

Another key uncertainty is the process for choosing the federal commissioners. There was no public process surrounding the initial and short-lived appointment of Monsignor David Cappo to the position of Chair of the Commission, nor for his replacement Professor Allan Fels. Professor Fels's appointment is clearly meritorious. However, explicit mental health sector engagement in these processes and decisions would create a greater sense of ownership by the sector and faith in the national commission and its key officials.

Perhaps most significant is the uncertainty surrounding the extent to which the process of mental health reform will become truly national. One element of this will be the extent to which the national commission establishes formal and informal relationships with commissions in the jurisdictions. But what of the other states and territories? Will the national commission play a role in setting standards and assessing quality nationwide or must the Australian community continue to endure massive place-based variations in both quality and access to mental health care?

The national commission is due to commence on 1 January 2012. It is important to note that while it will have some role in its oversight, the federal government has not waited for the commission to be established before completing the 10-year national mental health roadmap.

New South Wales

It is understood that the legislation to establish the NSW Commission is just being finalised. Expectations are high that the new coalition government has both the mandate and the appetite to challenge the status quo and create a blueprint for new mental health services. The NSW model will look more like NZ in this sense, as a body of strategic influence rather than having the direct purchasing role of WA.

In creating its commission, the NSW government made public statements in support of a much greater investment in community services while curbing growth in acute hospital beds. If the NSW commission can develop a strategy along these lines and then ensure it is delivered by the new government, many will deem it a success. The government has also committed its new commission to investigate best practice options in court diversion and to enhance the role of the NSW Mental Health Review Tribunal.

The government is also relying on the NSW Commission to track that existing resources allocated to mental health are translated into actual mental health services on the ground and not siphoned away for other purposes. This, in turn, will rely on legislated powers of inquiry and transparent arm's length purchasing arrangements, principally by NSW Health, which are yet to be finalised and put into place. The NSW government has imposed a NZ-style financial ringfence around the mental health budget, designed to guarantee a baseline of funding.

There are challenges here, too, of course. Consumer and carer organisational structures are weak and poorly resourced. The NSW government has committed to establishing a new voice for consumers and carers to drive quality improvement across the state. This will take sensitive investment and time, to ensure that consumers and carers have both the skills and structures to support a genuine move to the centre of policy making and funding decisions in NSW.

NSW can also be characterised as having very active and influential health professional groups and individuals, working in both public and private sector roles. The community-managed mental health sector in NSW has always been a very small element of the overall mental health system, at around 6% of total spending. Boosting the role of this sector will be a challenge, particularly in an environment of very tight budget constraints.

Queensland

1 July 2012 has been announced as the start date for Queensland's Commission and an expert advisory group has been established to drive this work, to be chaired by Professor Beverley Raphael.[14] It is as yet unclear if separate legislation will be developed though early indications are that the commission will be a stand-alone organisation. The government has made it clear that the commission will not have responsibility for purchasing or service delivery, looking more like NZ (and NSW) than WA.

Conclusion

This article has described some of the features of each of the nascent Australian commissions, plus the NZ model. Apart from Victoria, all jurisdictions are opting for a type 2 commission. This reflects a consistent theme, namely that governments want to see commissions provide a new level of focus on the issue of mental health, an issue with which governments have unsuccessfully grappled for decades.

All commissions exhibit some tension in this role between asserting independence from existing structures of purchasing or planning and ensuring that they possess the real influence required to make a difference.

To the extent to which Commissions offer a new opportunity to concentrate policy and funding energies in an area characterised by crisis, this is most welcome. A hope of commissions would indeed be an appropriate collective noun. However, it is very early days and there is a need for proof.

In our second article on mental health commissions, we explore the extent to which it is possible to find solid evidence that these new organisations really can drive mental health reform.

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