



**Department of Health**  
Review of the National Mental Health  
Commission

Final Report | May 2017

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# Executive Summary

## **The National Mental Health Commission was established with an important purpose**

The Australian mental health 'system' is complex with a range of different entities and stakeholders, comprising governments at federal and state level (as policy and strategy-setters, funders, regulators and in some cases service deliverers), service delivery entities (public and private, primary and acute), and consumers, carers and families.

Within this system, the National Mental Health Commission (NMHC) exists, in the words of the Prime Minister at the time of its creation, to:

***"...help improve Australia's mental health system. It will plan more effectively for the future mental health needs of the community, create greater accountability and transparency in the mental health system and give mental health prominence at a national level".<sup>1</sup>***

This purpose was translated into a set of roles and functions, encapsulated in Section 15, Schedule 1 of the *Public Governance, Performance and Accountability Rule 2014*. This role was then expanded in December 2015, as part of the Government's response to the NMHC's report *Contributing Lives, Thriving Communities*. At that time, the then-Health Minister emphasised the cross-sectoral nature of the NMHC's role, as well as explicitly adding functions monitoring activity arising from the Fifth National Mental Health Plan, development of a consumer and carer participation framework and taking on the advisory functions of the Australian Suicide Prevention Advisory Council.<sup>2</sup>

In summary, the role and functions of the NMHC are to conduct monitoring and reporting; provide policy advice and engage mental health system stakeholders, including consumers, carers and families.

At the most recent federal election the Government committed, as part of its plan to strengthen mental health care, to:

***"Strengthen the National Mental Health Commission, which will provide independent oversight of our mental health reforms."<sup>3</sup>***

## **Achievement of its purpose is currently challenged by organisational capacity and capability and, to a lesser extent, the need to clarify roles and governance**

The objectives set for the NMHC are ambitious. Mental health is, both in content and governance, a complex space. In addition, the scope of the NMHC's focus is broad, encompassing both a cross-sectoral perspective on mental health policy and performance, and a national view beyond the confines of the Commonwealth's jurisdiction.

The NMHC is a small organisation and does not have sufficient capacity or capability to reliably deliver against this ambitious role. For such a body to have an impact that is

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<sup>1</sup> Prime Minister's Statement of Expectations, Dec 2011

<sup>2</sup> Minister for Health's response to *Contributing Lives* (2015)

<sup>3</sup> The Coalition's plan to strengthen mental health care across Australia (26 June 2016)

respected and recognised by stakeholders requires the regular production of outputs that are of value, strong relationships across government agencies and the different levels of government, and continuous engagement with key stakeholders across the system. To deliver on this requires senior and experienced staff within the NMHC. This is not sufficiently reflected in the current workforce composition, nor the resourcing of the organisation.

The NMHC's value and place within the Australian mental health system would be greatly strengthened if it were known to reliably produce insightful and impactful research and advice on a regular basis, with a forward looking agenda of issues to consider in addition to its monitoring role. The NMHC has certainly done good work – not least through its watershed development of the *Contributing Lives* review. Consistently achieving this level of impact is not possible within current resourcing levels.

The NMHC's current governance has some room for clarification, though this is not as significant a barrier to success as its capacity and capability needs.

The NMHC was created as an Executive Agency attached to, but distinct from, its auspicing agency (currently the Commonwealth Department of Health, previously the Department of Prime Minister & Cabinet). This form allows the NMHC to act with a degree of independence, enabling it to report to and advise government with separation from those who fund, administer and deliver mental health policy and programs. While some stakeholders indicate the independence of the NMHC is not sufficient, this is a matter of perception, rather than strict institutional form. These perceptions should be addressed, however, as part of a set of actions to strengthen both the actual and perceived value of the NMHC.

The roles and responsibilities of the Commissioners are not clear, leading to misalignment about their proper purpose in the organisation. The Commissioners could, if working alongside a properly resourced NMHC, and with greater clarity about their roles and responsibilities, have a stronger impact on the NMHC and the mental health system.

### **A strengthened NMHC is one with a strong authorising environment, sufficient capacity and capability and well defined roles and functions**

#### **The role of the NMHC, and its authorising environment, should be optimised going forward**

The core objectives and roles of the NMHC should remain the same. Its purpose should be bringing expertise and stakeholder perspectives – particularly those with lived experiences – to the advancement of mental health policy and practice in Australia. The impact and credibility of the NMHC will be strengthened by investing in its authorising environment, critical relationships and regular, high-quality outputs.

The authorising environment of the NMHC should be premised on the authority and support of the Minister for Health, strong relationships with sector stakeholders, and sufficient resources to deliver on its objectives. This authorising environment should be built through changes to the Executive Order, a clear Charter Letter, regular meetings with the CEO and Chair and ad hoc engagement, such as participation at key events.

Changes to the Executive Agency are made by Order of the Governor-General. Such an Executive Order would be drafted within the Department of Health, in consultation with

the Office of Parliamentary Counsel (OPC). This approach would involve engagement with the Minister for Health and Prime Minister to clearly define the authorising environment for the NMHC.

Given the NMHC's cross-sectoral and national scope, its authority should also be built through strong relationships across the Australian mental health sector. This should include connections with Commonwealth and State and Territory colleagues in mental health and health to enhance the NMHC's reach and impact. It should also include engagement with service providers and consumers, their carers' and families.

Finally, the NMHC's authority will be based on its activities, outputs and the strength of its relationships. It should be tasked with roles in monitoring and reporting; providing policy advice to Governments and engaging consumers, carers and families. These roles should be delivered through a regular suite of published advice and engagement events, including a combination of regular, planned work (such as annual reporting) coupled with targeted research focusing on priority areas. This would be agreed in annual work-plans, with priority areas for research and advice identified in Charter Letters.

Through agreement with Australian Health Ministers' Advisory Council, and associated subcommittees, the NMHC should have a formal role monitoring implementation and impact of the *Fifth National Mental Health Plan*, commencing with development of appropriate outcome-level indicators.

### **A strengthened NMHC requires sufficient capability and capacity to deliver**

Current resourcing of the NMHC, both the number and shape of the workforce, is not sufficient to deliver on its objectives. Achievement of the NMHC's role in the system requires a proportionate uplift in the organisation's capacity and capability – particularly its staff.

In the future, a team of sufficient scale and capability to be credible and impactful in the mental health system must deliver the NMHC's work. This means not just 'enough' staff, but also the right mixture, which includes those with mental health expertise and sufficient seniority to oversee and undertake engagement within and across governments and the sector. The NMHC should also be able to effectively procure external support to add capacity as needed.

This will require investment in addition to current levels. Without this investment, strengthening the NMHC will be impossible and its role in the Australian mental health system will be limited.

### **The roles and responsibilities of the Commissioners should be clarified**

Current ambiguity in the roles and responsibilities of the Commissioners should be addressed going forward through a change to the Executive Order from the Governor General to the NMHC and reiterated through the Charter Letter from the Minister for Health and in close consultation with the Prime Minister. The Executive Order and Charter Letter (which should be issued on a regular basis) should outline the expectations contained in this document, as well as any specific priorities the government has for the NMHC.

The Commissioners are advisors to, not governors of, the NMHC. The Commissioners are expert advisors to, and influencers of, the work created or commissioned by the

organisation. They also play a leading role engaging with stakeholders, and feeding these voices back into the NMHC's work. Whilst bringing individual expertise, they operate as an advisory collective. As such, the Chair is required to manage the Commissioners as a collective, seeking to build consensus views wherever possible.

This expert advisory role of the Commissioners, and the associated expectations around their expertise and behaviour, should also be documented in the Executive Order and Charter Letter.

### **Now is an opportune moment to strengthen the NMHC, and learn from the experience of similar entities**

There are clear opportunities to strengthen the NMHC, as described in this document. However, lessons should also be drawn from the experiences of similar organisations.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) is broadly considered to be a valuable and high-impact organisation within the Australian health system. While no longer in operation, the former National Health Performance Authority (NHPA) was considered by many to be a similarly strong and effective entity. Their success was driven by a number of factors, but critical amongst these were strong work programmes **demonstrating their value**, and a gradual **building of relationships** and 'earning' their place. Particularly in the case of the ACSQH, this strength is underpinned by a perception that it is comprised of **experts**, who bring their knowledge and experience to their work. These lessons are important to consider as part of the journey towards a strengthened role for the NMHC.

The NMHC has an opportunity to make a difference to the lives of Australians, particularly those who experience mental illness or are affected by suicide. Given the recent commencement of a new CEO, the forthcoming end of tenure for the inaugural Commissioners and Chair and the Prime Minister's public commitment to strengthening its role, **now is the moment** to address issues holding the NMHC back, and position it to have a valuable impact going forward.

# 1. Role, Functions & Scope

*The role, functions and scope of the NMHC do not need to significantly change. While there is benefit to some sharpening of the NMHC's role and functions, the primary challenge to its effective performance are capacity and capability constraints. These are discussed in Chapter 2.*

## A. Role and Functions

### **Key finding 1: the NMHC has an important and significant role in improving the Australian mental health sector**

The NMHC was established to perform a monitoring and policy advisory role across the mental health system. At the time of its creation, the NMHC's purpose was described as:

*"...to help improve Australia's mental health system. It will plan more effectively for the future mental health needs of the community, create greater accountability and transparency in the mental health system and give mental health prominence at a national level."<sup>4</sup>*

To achieve this, NMHC was established as an Executive Agency under the *Public Services Act 1999*. Under Schedule 1 - Section 15 of the *Public Governance, Performance and Accountability Rule 2014* (PGPA), the NMHC was established as a listed entity comprising the following group of individuals:

- i. the commissioners of the NMHC;
- ii. the Chief Executive Officer of the NMHC; and
- iii. persons engaged under the Public Service Act 1999 to assist the Chief Executive Officer.

The scope of NMHC's role encompasses the full lived experience of mental health, including health and welfare; family and community support and inclusion; housing; and economic participation.

As outlined in its establishing instruments, the core role/functions of the NMHC were to:

- Deliver the Annual National Report Card;
- Develop data and reports with a particular focus on ensuring a cross sectoral perspective is taken;
- Provide mental health policy advice to the Australian Government;
- Engage consumers and carers;
- Build relationships with stakeholders including service providers, government agencies, researchers, academics, and State and Territory Governments; and
- Undertake other relevant tasks as the responsible Minister may require from time to time.<sup>5</sup>

This role was expanded as part of the Government's response to *Contributing Lives* in which the then-Minister for Health supplemented the NMHC's role by tasking it to:

- Conduct data collection and cross-border monitoring of activity arising from the Fifth National Mental Health Plan;
- Expand the focus on consumer engagement to include development of a consumer and carer participation framework;

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<sup>4</sup> Prime Minister's Statement of Expectations (2011)

<sup>5</sup> *Public Governance, Performance and Accountability Rule 2014*, section 15 (e)

- Strengthen its role supporting collaboration and translation of research into policy and practice;
- Provide evidence on specific issues which require cross-sectoral or cross-agency input; and
- Provide the advisory functions of the Australian Suicide Prevention Advisory Council.<sup>6</sup>

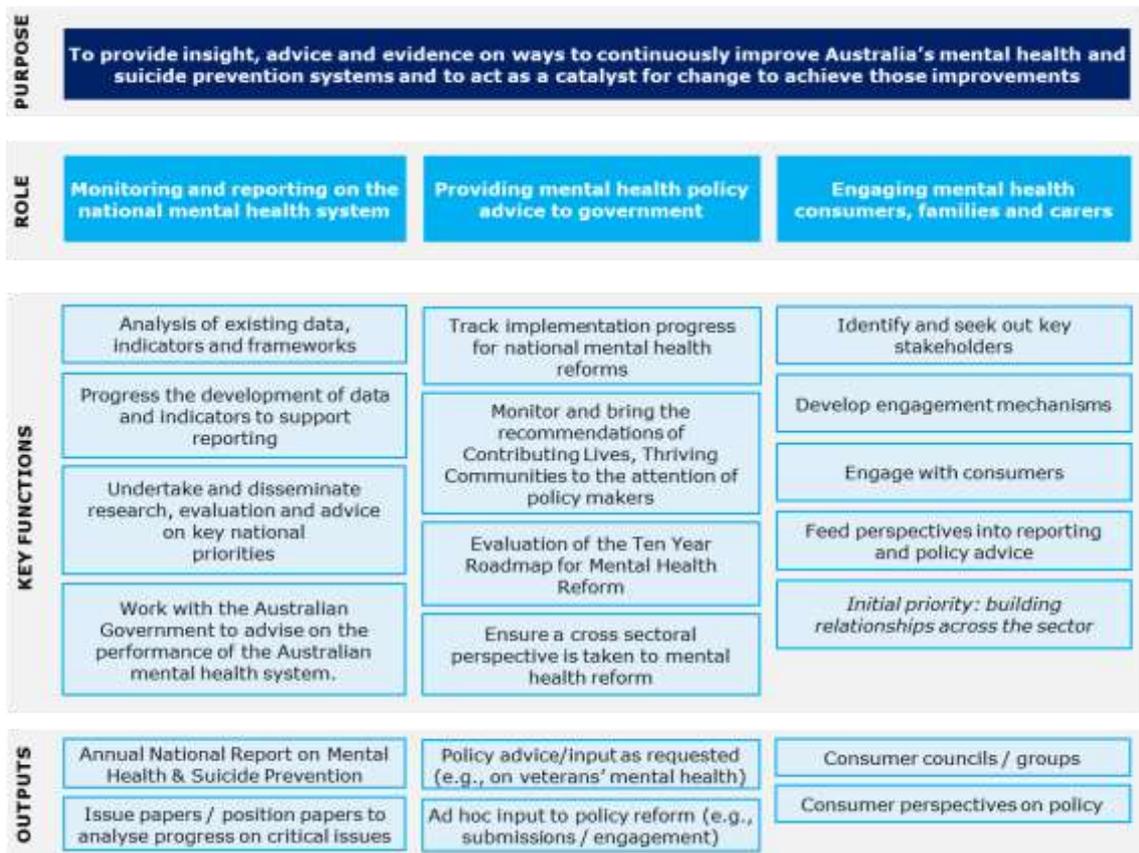
This review has not found any reason to change the **fundamental role** of the NMHC within the Australian mental health sector. Stakeholder consultation reveals that these roles are considered valuable and are not already being delivered by other actors in the system. Therefore, our advice assumes that the NMHC will continue to contribute to building a stronger mental health system with better outcomes for consumers through a combination of monitoring and reporting, policy input and stakeholder engagement.

A high level assessment against the NMHC’s Corporate Plan (2016-2020) and Work Plan (2016-17) suggests that NMHC’s own depictions of its priorities reflect most of its established roles and functions.

**Key finding 2: The NMHC’s role, functions and outputs and scope are currently clear, though these should be refined going forward**

As depicted in Figure 1 below, the NMHC performs a number of functions and produces a number of outputs in execution of its role.

**FIGURE 1: SUMMARY VIEW OF NMHC PURPOSE, ROLE, FUNCTIONS AND OUTPUTS**



Generally, these while functions are clearly understood and stakeholders agree that these should be performed by the NMHC, further consideration should be given to

<sup>6</sup> Health Minister’s response to *Contributing Lives* (2015)

refinement of some of the functions and outputs to ensure value continues to be derived from the presence of the NMHC. In addition, current resourcing is not adequate to achieve the desired role and purpose, which is described further in Chapter 2.

In terms of **monitoring and reporting**, the review has found that the Annual Report lacked consistency in both frequency and content. Further, a number of stakeholders questioning the value of the annual 'report card' model, particularly given that system outcomes are unlikely to meaningfully change across a year. However, the construct of an annual report of some form on progress of reform in mental health had support.

While there was support for the NMHC having a role regularly reporting on the activity of the mental health system, this should be carefully scoped to ensure valuable insights were provided, without duplicating the work performed by other reporting entities such as the AIHW. Importantly, it was identified in stakeholder consultations that NMHC should take the lead role in creating and reporting on a set of agreed outcome and experience measures that capture the key touchpoints that consumers have across whole mental health system and demonstrate the progress being made. Historically, the mental health system (like other segments of the health system) struggles to report on the outcomes and experiences of consumers, typically reporting activity or input measures (such as bed numbers) instead. It is acknowledged that the NMHC has made some progress in this approach in the most recent 2016 National Report, using measures it had recommended as part of the *Contributing Lives* report and included the Consultation Paper on the *Fifth National Mental Health Plan*.

These reports should form part of 'series' with a level of consistency that articulates a story around the national mental health system over time. To achieve this, outcome measures would likely include some annual reporting of baseline data, coupled with periodic system-wide reporting, similar to the review conducted in 2014, or deeper dives into specific areas of reform or sub-populations such as the recent work around the mental health of the Australian Defence Force veterans and members. Such work could take place every three to five years, tracking changes in outcome and experience measures. This combination would balance the value of detailed insights and analysis based on data, with regular reporting – ensuring accountability and strengthening the role of the NMHC within the sector.

In addition, the NMHC should have a role monitoring the **Fifth National Mental Health Plan**, as envisioned in the Government's response to the NMHC's *Contributing Lives* report. Whilst still in development, and hence subject to negotiation between the Commonwealth, State and Territory Governments through AHMAC, this role should include:

- As stated above, developing a set of agreed **experience and outcome measures across the system** (as discussed above);
- Reporting on **implementation** progress of the initiatives/recommendations contained in the Plan;
- Reporting on **impact/outcomes** as a result of reforms, ideally at a national, jurisdictional and regional-level; and
- Linking the Fifth National Mental Health Plan with other initiatives and the associated impact on experience and outcomes.

In addition to these reporting functions, the NMHC should conduct **bespoke research** and policy input functions, focusing on priority issues for Government and the mental health sector. These will likely take the form of time-limited projects, conducted through

a combination of internal resources and externally procured research and analytical support. The NMHC's annual workplan should identify the projects to be delivered over the coming period (1-2 years) through a process of negotiating priorities with the Minister for Health, consumers and carers, and other relevant stakeholders including other federal agencies and States and Territories. These projects should address issues of particular urgency or need for the mental health sector, and should emphasise the cross-sector focus of the NMHC by incorporating issues and data from outside of traditional health or mental health silos. This prioritisation process should also consider a cost-benefit analysis, to allocate resources carefully. The NMHC's ongoing focus on the physical health of mental health consumers and its recent work around the mental health of the Australian Defence Force veterans are good examples of this. And of course, these projects will contribute to the NMHC's role in advising on improvement to the mental health system.

The **extent** of the NMHC's role in **policy advice** may change over time. Recognising the need to build capability and experience, at first the NMHC will likely restrict itself to providing inputs to policy, in the form of research insights and commentary. Over time, this role could expand to generating some aspects of policy, such as frameworks or tools, recognising that ultimate responsibility for generating mental health policy and strategy still lies with Government Departments and Ministers. While this latter role is partially being delivered through the *consumer and carer engagement framework*, as requested by the Minister for Health, there is substantial opportunity to grow this role further.

In addition, as part of its role in bringing to life the cross-sectoral perspective, the NMHC attempts to deliver on this requirement through reporting on performance in the annual National Report and undertaking ad hoc engagement, research and policy advice taking a cross-sector and interjurisdictional approach (for example the work on understanding the connections between housing, homelessness and mental health). As outlined in the Draft Fifth National Mental Health Plan, there is an increased need to build the awareness of cross-sector and inter-jurisdictional initiatives and to report on the outcomes of such approaches. The inherent challenges associated with this are described in Part B below.

The NMHC should also retain and expand on its ongoing role **consulting with the mental health system** and particularly seeking and incorporating the views of consumers, carers and families. Execution of this role should involve strengthening relationships with existing stakeholder engagement structures, such as together with *Mental Health Australia* and other peak groups. This will serve to both deepen the NMHC's role and influence across the sector, as well as guarding against the risk of duplicating the activities of other system actors.

## B. Scope

**Key finding 3: The NMHC has a scope of focus that extends both horizontally beyond 'health' and also vertically into the activities and outcomes of States and Territories. Delivering against this scope can be challenging.**

### The NMHC's role is to look beyond health

In order to fully support people living with mental illnesses, and those at risk of or affected by suicide, the NMHC must be able to consider activity, data and perspectives from portfolio areas **beyond the traditional domains of mental health or health**. This scope of focus would include:

- Issues of physical health;
- Matters relating to social services and welfare, particularly those around employment support and drug and alcohol policy;
- Issues within the justice and safety field, including family violence; and
- Economic concerns, such as understanding the workforce implications and dimensions of mental health and employment outcomes for people with mental health conditions.

This cross-sector perspective was a key platform in *Contributing Lives*, and was strongly echoed in this review's stakeholder consultations. The need for the NMHC to focus on the wide range of issues and levers around mental health was recognised at its inception, and again in the Government's response to *Contributing Lives*.

Some stakeholders believe, however, that generating engagement from other agencies – including seeking data and other inputs from other Departments – can be difficult at times. Some stakeholders attributed this to the NMHC's **auspicing arrangements** under the DoH.

### Being a truly 'national' entity is challenging

Many important mental health activities and outcomes are governed, funded and delivered at a sub-national and sub-state and territory level. This includes acute mental health services, as well as primary / allied health functions. As a result, there is some expectation that the NMHC will be able to take a **national view** in its functions. This means understanding, reporting on and contributing to not just Commonwealth Government mental health activity and policy, but also relevant aspects within **States and Territories**, and even at a regional level.

Recognising the federalist distribution of roles and responsibilities in health and mental health, the ability for the NMHC to directly influence States and Territories is limited. Nevertheless, its role clearly involves an expectation of some ability to work with the jurisdictions, as well as the Commonwealth. The NMHC should be able to monitor relevant activity at below the national level, and should seek access to the necessary data to do so. Likewise, the NMHC should be able to advise and input to State and Territory policy where appropriate. A better resourced NMHC will be able to build the network of relationships at the State and Territory level and to engage with these colleagues in a way that means that influence is real and collaboration across levels of government may be enhanced.

In practice however, the work of the NMHC mostly focuses on Commonwealth activity. Stakeholders noted that seeking engagement and particularly **data from jurisdictions** could be challenging.

This is likely to be a natural consequence of Australia's federalist structure – many aspects of mental health are the domain of the States and Territories, while the NMHC is a Commonwealth entity without the explicit involvement of the jurisdictions. There is an increasing focus on **place and community** across health and mental health, including recent steps to consider mental health at the Primary Health Network (PHN) level and the national view being taken in the development of the *Fifth National Mental Health Plan*. Given this, strengthening the NMHC's ability to work with States and Territories will be critically important to strengthening its role. This will rest in part with the auspicing provided by the Minister for Health and the perceived priority given to the NMHC and in part with the growth in influence supported by a better resourced NMHC that produced a valuable and valued commentary on Australia's mental health system and its ongoing improvement.

### Further considerations to deliver on these requirements

As highlighted above, there is an important and growing role for the NMHC in improving the eminence of cross-sector and inter-jurisdictional initiatives. This places greater importance on a collaborative approach to deliver the best experience and outcomes for consumers and their families, and measuring these outcomes in a consistent and regular way.

The barriers around such approaches are identified above, however, there should continue to be emphasis placed on the importance of strong relationships in building greater collaboration in policy development and service delivery across the system. As the pre-eminent advisor on the strengthening the national mental health system, the NMHC should be the catalyst in this approach. To effectively deliver on this role requires an uplift in capacity and capability across the NMHC, and in the very obvious priority and support given to the work of the NMHC by the Minister for Health.

## 2. Capability and Capacity

*The NMHC has a significant scope, encompassing a broad range of issues and stakeholders, and it is expected to play an important role conducting monitoring and reporting, policy input and stakeholder engagement functions. Current resourcing does not support the NMHC to effectively have the impact it was designed to, and addressing this should be the primary avenue to achieving a strengthened NMHC.*

**Key finding 4: Current capability and capacity does not appear sufficient to match the NMHC's objectives.**

### A. Current Capacity and Capability

The staff within NMHC are expected to have sufficient **capability** to credibly deliver its core functions. This includes experience and understanding of mental health, the ability to work with government processes and stakeholders, to engage successfully with mental health stakeholders, including consumers and providers, and the ability to analyse data and to distil and convey clear and meaningful findings.

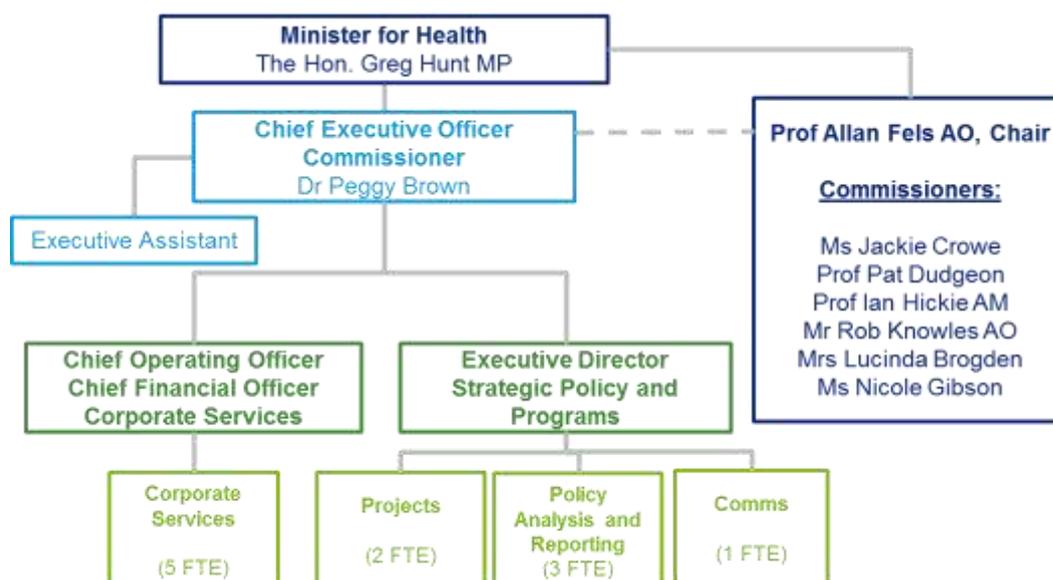
There is an implied expectation that staff capability will be supported, if not directly mirrored, across the range of Commissioners. While not explicitly stated, a clearly implied requirement for the NMHC to have its desired impact is the ability of its staff – particularly its leaders – to **influence** key decision-makers in Government, such as relevant Departmental executives, Ministers and the Prime Minister. This is a nuanced requirement, involving sufficient access coupled with understanding of motivations and an ability to communicate clearly and effectively.

This capability set is expected to be delivered by a workforce with sufficient **capacity** to deliver the full range of activities and outputs expected of the NMHC and contained in its annual workplans. This includes ongoing/regular monitoring and reporting, stakeholder engagement activities and targeted research as directed.

The NMHC is currently a small entity. It consists of a CEO and 14 other roles, equivalent to a total of 11 FTE (see Figure 2 below). This has grown only slightly since its inception in 2012. Outside of the CEO, almost half of the workforce (5 FTE) are devoted to corporate services functions, leaving approximately 6 FTE to conduct more 'content' based work, developing or overseeing development of the NMHC's reporting and policy advisory work, and conducting stakeholder engagement. Of these, notably only two staff are believed to currently have direct experience with mental health service delivery; the CEO (a practising psychiatrist) and a staff member with a background in mental health nursing.

In addition to this workforce is the Chair and six other Commissioners. As one of the key components of the NMHC, they contribute to a range of activities including the development of key outputs. Anecdotally, these capacity and capability constraints have meant that some Commissioners are undertaking a substantial level of work above what was initially intended.

FIGURE 2: ORGANISATIONAL STRUCTURE OF THE NMHC



The NMHC’s finances are consistent with its current size. For the most recent financial year for which data was available, non-employee supplier expenses totalled approximately \$980,000. This figure, like the NMHC’s FTE number, has remained relatively flat over time (See Fig 3 below).

FIGURE 3: NMHC FINANCE AND FTE CHANGE 2012-13 TO PRESENT<sup>7</sup>

	2012-13	2015-16	% growth
<b>Employee expenses</b>	\$1.57m	\$1.85m	17.8%
<b>Supplier expenses</b>	\$1.02m	\$0.98m	-4%
<b>FTE</b>	10.4	11	5.7%

## B. Additional capacity and capability is required

**Current capability and capacity are not sufficient to enable the NMHC to have the desired impact.**

**The NMHC does not have enough staff to deliver on its requirements.** The current workforce of approximately 14 FTE (plus the CEO), of which around five are devoted to corporate services functions, does not leave enough capacity to deliver on the suite of reporting, engagement and policy input roles expected. Furthermore, the **capability mix of staff** does not appear to be optimal. As noted above, close to half of the workforce perform corporate services functions, and 6 FTE are below the ‘EL’ grade.

In addition, there appears to be limited breadth of in the existing mental health capability across the staff within the NMHC. Consultation indicates that those experience in mental health delivery are from health backgrounds and, in line with the broader lived

<sup>7</sup> Data sourced from NMHC Annual Reports 2013-14 and 2015-16.

experience, there is a need to incorporate those with economic, welfare, housing and employment experience.

Comparatively, benchmark organisations such as the Australian Institute for Health and Welfare (AIHW), the NSW Mental Health Commissioner and the former National Health Performance Authority (NHPA) have (or had) larger workforces than the NMHC. They also evidence a ‘diamond’ shaped workforce profile – including a larger proportion of staff at the EL-level and above, as depicted below. This reflects the nature of their work and role, and where deep and specialist expertise and/or external engagement to influence behaviours is a strong feature.

Comparison Organisation	Total FTE	Workforce Shape	% EL or above <sup>8</sup>	Budget
<b>Australian Institute of Health and Welfare</b>	288.5	APS: 159.9 Executive Level: 122.6 Senior Executive Level: 5 Director Level: 1	45%	Employee Expenditure: \$33.8m Other Expenditure: \$14.3m
<b>National Health Performance Authority<sup>9</sup></b>	46	APS: 13 Executive Level: 30 Senior Executive Level: 2 Chief Executive Officer: 1	72%	Employee Expenditure: \$7.7m Other Expenditure: \$26.2m
<b>Australian Commission for Safety and Quality in Healthcare</b>	88.6	APS: 25.6 Executive Level: 59.6 Senior Executive Level: 2.4 Chief Executive Officer: 1	71%	Employee Expenditure: \$12.1m Other Expenditure: \$15m
<b>NSW Mental Health Commission</b>	23	Clerk 3/4: 1 Clerk 5/6: 2 Clerk 7/8: 2 Clerk 9/10: 12 Clerk 11/12: 5 Senior Executive: 1	78% <i>(Clerk 9/10 and above)</i>	Employee Expenditure: \$3.7m Other Expenditure: \$6.6m
<b>Mental Health Commission of Canada</b>		<i>Workforce details not available</i>		Employee Expenditure: \$8.0m Other Expenditure: \$6.6m

Whilst not determinative, these comparisons indicate that additional capacity – at sufficiently senior levels, may be appropriate. While differences between the NMHC and these organisations should be acknowledged, these size and workforce shape differences illustrate the current capacity and capability issues facing the NMHC. Further information on resourcing arrangements of comparator bodies is provided at [Appendix B](#).

Further, stakeholder consultations uniformly reveal a belief that resourcing inhibits the NMHC from making the kind of impact desired. For example, the NMHC’s recent work providing advice on the mental health of the Australian Defence Force members and

<sup>8</sup> For comparison, the NMHC has 45% of its FTE at, or above, the EL grade

<sup>9</sup> Data for the NHPA is for its final full year of operation

veterans was reportedly quite challenging to pursue within expected timeframes, requiring rapid sourcing of external support.

These capacity constraints have led to the CEO and Commissioners taking quite active roles in the conduct and delivery of the NMHC's work. While certainly a close involvement is desirable, when organisational leaders must step in to do delivery work, this can limit their capacity to focus on more strategic functions, such as proactive shaping of future priorities, strategic input into key deliverables, or engagement with stakeholders.

A range of expertise is to be expected of the NMHC's staff – even looking within only 'mental health' the range of sub-issues is quite broad. Whilst it is not reasonable to expect the NMHC to have in-house expertise on all aspects of its portfolio of work, sufficient internal expertise is needed to be able to frame issues, engage with stakeholders and external experts and, if necessary, procure external support. Importantly, constrained capability is likely to inhibit the NMHC's ability to be an effective procurer of external services, such as research or consulting services.

In summary, the current state of the organisation means that the seniority and expertise required in mental health, data analysis and reporting and sophisticated stakeholder engagement may not be reliably found at a sufficient level within the NMHC.

## 3. Governance

*There are aspects of the NMHC's current governance arrangements that need to be refined, although wholesale change such as adopting a different institutional form does not appear to be warranted. The role and activities of the NMHC are consistent with those described as meeting the requirements for establishment as an Executive Agency. Ensuring clarity around the roles and responsibilities of the Commissioners should be a priority going forward.*

### A. Current institutional form

The NMHC is defined as an Executive Agency under the *Public Services Act 1999*. The Department of Finance defines an Executive Agency as "an agency declared as separate from the Department, for staffing and accountability/reporting purposes, under the Public Service Act." This structure is noted to "provide a degree of independence from departmental management where that is appropriate to an agency's functions."<sup>10</sup>

Advice from the Department of Finance indicates that there are four situations in which an Executive Agency form is appropriate. This includes where:

1. the functions of the agency may cross portfolio lines, making it inappropriate to place it in a Department;
2. it is desirable to separate substantial service delivery functions to allow a policy department to focus on primary business;
3. an identity separate from the parent department would assist sponsorship or external funding; or
4. a separate agency is desirable to administer a whole-of-government or joint Commonwealth-State initiative.<sup>11</sup>

Based on the stated role, purpose, functions and scope of the NMHC meets several of the above options. Its cross-sectoral and national scope matches points 1 and 4 above, while the desire to separate out mental health reporting from funding and delivery matches the rationale identified in point 2.

In executing on its requirements as an Executive Agency, Under Schedule 1 - Section 15 (a) of the PGPA, the NMHC is considered a listed entity when comprising the following group:

- i. the Commissioners of the NMHC;
- ii. the Chief Executive Officer of the NMHC; and
- iii. persons engaged under the Public Service Act 1999 to assist the Chief Executive Officer.

Section 15 (d) identifies that the individuals listed in 15(a) are considered officials of the listed entity, with the CEO being the accountable authority.

The current institutional form presents two issues for consideration, one around the perceived level of independence from department management in respect of its current alignment with the DoH and the roles of the officials (in particular, the Commissioners and CEO).

<sup>10</sup> Department of Finance, *Governance Arrangements for Australian Government Bodies*, 2005

<sup>11</sup> Ibid at Appendix D

## B. Independence of the NMHC

**Key finding 5: some stakeholders indicated a desire for greater 'independence' for the NMHC, though this has multiple meanings to different stakeholders. Current institutional form is sufficient to enable the degree of independence necessary for the NMHC to perform its role.**

To enable commentary and policy input that is free from the risk or perception of bias or capture, the NMHC requires a sufficient degree of **independence** to enable it to work without 'fear or favour'. This was recognised in the Prime Minister's statement that the NMHC was established as an executive agency "to provide independence from the agencies that administer mental health funding and programs."<sup>12</sup>

Its current institutional form grants the NMHC a degree of independence from the DoH because:

- There is no requirement that DoH approve the NMHC's outputs/ reports; and
- The CEO and Commissioners are appointed by the Minister (not the DoH Secretary) and are not Australian Public Sector Employees; and
- The CEO reports to the Minister.

In this way, the NMHC can provide reporting and policy advice to Government, free from direction, other than the confines of scope and government policy. As such, the Executive Agency form is appropriate for the NMHC.

Consultation conducted for this review has identified that a number of stakeholders hold a view that the independence of the NMHC should be '**increased**', and some belief that this should be achieved via changing institutional form so that the NMHC is a Statutory Authority, as this is perceived to be more independent. The desire for this independence rests on two main propositions:

- Too close an alignment with the Department of Health impedes the cross-portfolio aspect of the Commission's role; and
- The Commissioners do not have sufficient control over the work of and appointment (or dismissal) of staff to the Commission

Importantly, however, there is not a unanimous and shared definition of what 'greater independence' actually means for the NMHC. Three possible definitions of 'greater independence' have been identified, and will be addressed in turn.

### **Definition 1: entirely autonomous operation of the NMHC**

At its most extreme, this viewpoint could seek that the work of the NMHC could not be influenced – through direction, funding or appointment of roles – by Government. This is obviously not a feature of the current state, nor is it a plausible feature of any government established entity.

Achieving this definition of independence could only occur if the NMHC were a completely non-governmental entity. That is so far beyond the initial purpose and construct of the NMHC, and there is not evidence that it would be necessary to achieving its purpose, hence it is not contemplated further as future option.

There is a view amongst some stakeholders that this level of independence would be achieved if the NMHC were converted from an Executive Agency to a Statutory Authority. This is fostered by a view that Commonwealth Statutory Authorities operate with an high

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<sup>12</sup> *Ibid*

level of independence from Government, and have governance structures where the Commissioners or their equivalent have a control of the operations of the organisation.

The Commonwealth defines the basis of creation of a Statutory Authority as “A statutory Commonwealth entity is generally appropriate where there is a need for the enabling legislation to specify the powers and functions of the body, its level of independence and its accountability to the Parliament. This is particularly relevant for bodies that have a regulatory role or scrutinise public sector activities.” (Department of Finance. <http://www.finance.gov.au/resource-management/governance/policy/structure-types/> )

Apart from providing independence, there is no obvious need for the Commonwealth to create enabling legislation to assist the NMHC to carry out its functions, in effect because the NMHC does not have to exercise a level of regulatory or other form of intervention on the activities of individuals, private or other government entities. Its current role and functions are sufficiently encapsulated by the intentions of Executive Agencies.

### **Definition 2: a stronger form of separation from the NMHC’s auspicing portfolio**

Some stakeholders may desire greater separation from the NMHC’s auspicing portfolio, to address their actual or perceived issues around independence. In this way, changing the institutional form of the NMHC would create greater separation from the Health portfolio and the DoH. However, outside of operating as a non-governmental entity, the NMHC would still operate subject to Ministerial direction.

As noted above, however, the current arrangements appear to provide for sufficient independence for the NMHC to achieve its objectives. Whilst needing to work closely with the DoH, the NMHC cannot be censored, and leaders within the NMHC can act independently of the DoH’s executives. While the DoH may disagree with the advice or directions of the NMHC, this is not the same as censorship, hence current arrangements appear to provide sufficient independence.

Current independence could be strengthened through clarification from the Minister that part of the NMHC’s valuable role is providing an independent voice within the mental health system.

### **Definition 3: a stronger form of separation from the health portfolio**

The final possible interpretation of independence would involve a greater degree of separation from the health portfolio, in recognition that mental health involves a number of cross-sectoral elements that must be considered in a whole-of-government context. This could be achieved, for example, by shifting which agency auspices the NMHC. Some stakeholders express this as a desire to return to the Department of Prime Minister and Cabinet as the NMHC’s auspicing agency.

As explored above, it is important that the work of the NMHC should have a purview beyond the traditional boundaries that define the ‘health’ portfolio. However, this can be enabled within current auspicing arrangements. Developing collaborative arrangements with other agencies – both other Departments and other entities such as the AIHW – should be a key role for the NMHC’s CEO, and should be supported by the Minister for Health and DoH executives as well.

Importantly, a potential shift in auspicing arrangements would not necessarily lead to a net benefit for the NMHC. While certainly needing to think beyond just health, the expertise and relationships contained within the DoH are still the most relevant to the NMHC’s work. Close accessibility to these should, if used correctly, be a powerful support to achievement of the NMHC’s objectives. Shifting to another agency risks diminishing this link.

Further, to the extent that mental health is not a core responsibility of any other agency, there is a risk that the NMHC would need to compete for attention and resources with a range of other priorities. This risk is particularly acute if it were shifted to PM&C, where the NMHC would have to compete with all other government priorities to be heard.

### **Sufficient independence can be achieved within current institutional arrangements**

The NMHC was clearly established as an Executive Agency with the intention that it would have some degree of **independence**, so it could credibly comment on national mental health policy and activity without the real or perceived risk of bias. This review has not found evidence that, in its current form, the NMHC's work or independence is insufficient to provide that level of comment.

It is important to note that the both the CEO and the Commissioner roles are appointed by the Minister for Health. As the primary advisor to the government on all health issues including mental health, the advice of the Secretary of DoH is sought. This is likely to be the case regardless of the NMHC's institutional form. As such, even if it were a statutory authority, a functional relationship with both the Minister for Health and DoH would be critical to the NMHC's success. Therefore, a desire for 'independence' that meant complete separation from interaction with and influence from DoH leaders would not be unlikely, regardless of form.

This review has found that a significant degree of stakeholder perceptions around governance or independence are, in reality, driven by issues of organisational capacity and capability of the NMHC, individual role clarity, and an at-times unclear authorising environment. The review found that when there is insufficient capacity and capability to reliably deliver high-quality work as desired, this can create a perception that the current levels of independence are hampering the NMHC from delivering critical outputs. The lack of capacity within the NMHC also impacts the ability to credibly influence key stakeholders across the system. Further, when the roles of key individuals are not clear, this can lead to a perception that institutional form changes may be warranted – when in fact the strengths and weaknesses of the current form may not even be well-known. A view that the NMHC has an insufficient authorising environment may also contribute to this perception.

Actions taken to build this authorising environment, such as a clear statement outlining this from the Governor General via an Executive Order, prepared by the Department of Health and in close consultation with the Office of Parliamentary Counsel (OPC) and requiring approval from the Minister for Health and Prime Minister. This is likely to help to improve the perceptions of the NMHC's independent and valued role.

## **C. CEO and Commissioner Roles and Responsibilities**

### **Key finding 6: The roles and responsibilities of the NMHC's Commissioners are not sufficiently clear.**

As highlighted above, the PGPA Rule outlines that the CEO of the NMHC is the 'accountable authority' of the entity (Schedule 1, s. 15(c)) and that together, the CEO and Commissioners are 'officials' of the NMHC (Schedule 1, s.15(d)).

Division 2, section 15 (1) of the PGPA Act states:

15 Duty to govern the Commonwealth entity

- (1) The accountable authority of a Commonwealth entity must govern the entity in a way that:
  - (a) promotes the proper use and management of public resources for which the authority is responsible; and
  - (b) promotes the achievement of the purposes of the entity; and
  - (c) promotes the financial sustainability of the entity.

The Act's discussion of the roles of 'Officials' (Division 3) is limited to duties of officials (conflicts of interest, good faith dealing etc.), rather than explaining their roles and responsibilities.

While the role of the CEO is relatively clearly articulated, the roles and responsibilities of the Commissioners are not clear – and as a result a set of differing, and potentially competing, viewpoints about this aspect of the NMHC's governance have emerged.

As Officials of the NMHC, the Commissioners play a critical role in ensuring the success of the NMHC. This review considered the Commissioner's roles through examination of the NMHC's formal governance documentation – including its enabling instruments and Letter of Expectation from the Prime Minister, as well as consultation with a number of stakeholders including the Chair and all NMHC Commissioners. As a result, three broad 'positions' of the Commissioners have been identified:

- Position 1: the Commissioners are individual expert advisors
- Position 2: the Commissioners are a collective expert advisory group
- Position 3: the Commissioners have governing (decision-making) roles.

Given current ambiguity, these positions represent potential interpretations of the roles of the NMHC's Commissioners, and each are explored in turn.

### **Position 1: the Commissioners are individual expert advisors**

The Commissioners could be conceived of as individual experts, who advise the NMHC/Government only on areas in which they have particular expertise. The Commissioners could be thought of as a pool of experts, whose input is sought on projects or matters relating to their domain of expertise.

There is some evidence that some stakeholders currently conceive of the Commissioner role in this way.

If this was true, whilst achieving a consensus view of the Commissioners in the NMHC's advice would be desirable, it is not necessary to achieve. Hence, the Commissioners would not be expected to collectively provide input, review and agree the outputs or work plan of the NMHC, rather they could provide selective input and direction on the products they have carriage over or involvement with.

This position is unlikely to be supported by a straightforward reading of current enabling instruments and governance documents.

### **Position 2: the Commissioners are a collective advisory group**

Alternatively, the Commissioners could be conceived of as a group who collectively advise the NMHC/Government, while obviously bringing the specific expertise the each have to relevant aspects of the NMHC's work.

If this scenario were true, the Commissioners would collectively review, provide strategic advice to and where possible collectively agree on the work of the NMHC, regardless of their personal involvement or expertise.

Evidence indicates that the enabling documents envisioned such a role for the Commissioners. For example, the Prime Minister's original Letter of Expectation states that the Commissioners are appointed to "operate as an Advisory Board... The Role of the Advisory Board will be to provide advice ... and shape the strategic direction of the Commission." and "the CEO must consult the Advisory Board ... when developing and preparing the strategic and annual operation plans." The reference of an 'advisory board' suggest that there should be a degree of collective input amongst the Commissioners themselves in shaping the NMHC's strategic direction and key outputs.

Under this arrangement, it is important that the CEO consult and, where relevant, work closely with all the Commissioners on significant decisions. This would include strategy and work-plan setting, and any significant external communications or outputs, such as advice to be released. As part of this arrangement, if the advice of the Commissioners was not taken by the NMHC a reasonable explanation should be provided by the CEO.

It is also reasonably clear from this outline of expectations that the Commissioners were not expected to play a full governance role beyond involvement in the shaping of the strategic direction and input into the strategic and annual operating plans.

### **Position 3: the Commissioners have governing (decision-making) roles**

A parallel question, alongside the individual or collective role of the Commissioners, is their roles in the governance of the NMHC. Some stakeholders indicated a belief that the Commissioner should have a decision-making role within the NMHC.

If this were true, this would involve a greater directive role in strategy setting, resourcing, staffing and operating arrangements, beyond involvement in contributing to and signing-off on the NMHC's strategic direction and work plan. In practice that would mean that the CEO would make strategic and functional decisions with the Commissioners, and that the duties and obligations of governing board members would apply to the Commissioners.

There is limited evidence to suggest that the Commissioners were ever intended to undertake such a role, with legislation identifying the CEO as the 'accountable authority' of the NMHC<sup>13</sup>. Defining this role as having a 'duty to govern the Commonwealth entity'<sup>14</sup>, leading to a presumption that the CEO, rather than the Commissioners, is the decision-making party. The PGPA Rule does define the Commissioners (with the CEO) as 'officials'. The Act's discussion of the roles of 'Officials' (Division 3) is limited to duties of officials (conflicts of interest, good faith dealing etc.), rather than explaining their roles and responsibilities.<sup>15</sup>

Drawing on the independence discussion above, the review has not found any reason why an executive agency cannot perform the duties of the NMHC. With this in mind, coupled with the expectations set of the CEO under the PGPA Rule, there is limited evidence to support understanding the Commissioners as (or indeed shifting their roles

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<sup>13</sup> PGPA Rule, s. 15(c)

<sup>14</sup> PGPA Act, s. 15(1)

<sup>15</sup> PGPA Act, Division 3

to be) a decision-making board. Rather, clarifying the roles of the Commissioners as key strategic advisors to the NMHC coupled with enhanced the capacity and capability of the NMHC will strengthen the NMHC.

### Further clarity is required

As noted above, there is a lack of clarity around the **roles and responsibilities** of the Commissioners – and the boundaries of these. Consultation indicated that this was not always clear with some viewing the Commissioner role as advisory only whilst others believe they have a role closer to that of a governing or decision-making board.

A consequence of this ambiguity is lack of clarity around the role and expectations of the Chair. The requirements of a Chair of a governing board are different from those of an expert panel, and current lack of clarity makes performance of that role more difficult. If, as this review holds, the NMHC current improvement needs would be best served by a collective expert advisory group, the Chair's role and capability should include building consensus while extracting value from individual Commissioner expertise.

Some of the current state ambiguity is a result of insufficient definition in enabling instruments.

Several other organisations created under the PGPA Act have taken steps to more clearly define the nature, roles and responsibilities of their advisory bodies. For example, the Australian National Preventive Health Agency has an "Advisory Council" as per the PGPA Rule. It has enabling legislation which sets out the role of the Council (to advise the CEO) and also establishes the limitations of their role (cannot give directions to CEO).<sup>16</sup> Similarly, the Australian Charities and Not-for-Profits Commission has an "Advisory Board" as per the PGPA Rule. It has enabling legislation which sets out the role of the Board (to advise the Commissioner) and the limitations on the Board's role (it cannot give directions to the Commissioner).<sup>17</sup>

Hence, roles and limitations for advisory group of some other entities under the PGPA Act are more clearly defined, whereas this sharpness of definition is currently absent for the NMHC and the Commissioners. Further information on governance arrangements of comparator bodies is provided at [Appendix B](#).

In addition, the Commissioners **advise both the CEO and Government**. The Prime Minister's original Letter of Expectation states "the Advisory Board provide advice *to the Government* on the mental health system." The NMHC's own Operating Principles note that "independent advice from the Commission to Government is provided via the Minister under cover of a brief, letter or *report from the Chair and/or the CEO*".<sup>18</sup>

Clarity in the approach for engaging with Government is necessary, with an emphasis on the Commissioners advising the CEO and the CEO advising Government on behalf of the NMHC (including the Commissioners as Officials of the NMHC), to prevent confusion. Where possible, the CEO and the Commissioners should engage collectively to continue to build prominence across the mental health system and to extract the full value of the expertise and experience of the Commissioners.

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<sup>16</sup> *Australian National Preventive Health Agency Act 2010*, Part 4, section 30

<sup>17</sup> *Australian Charities and Not-for-profits Commission Act 2012*, Chapter 6, section 135-15

<sup>18</sup> NMHC Operating Principles, p. 4

As highlighted above, an update to the Executive Order should be made to clarify the role of the Commissioners and the NMHC. This would be approved by the Governor General. Changes to the Executive Order would follow the following process:

1. The Executive Order would be drafted within DoH, in consultation with the Office of Parliamentary Counsel (OPC).
2. The Executive Order must be made acting on advice of the Federal Executive Council (ExCo). Consequently, the order must be submitted for consideration at a scheduled ExCo meeting.
3. The Federal Executive Council Handbook provides information about the process for submitting matters for consideration at a scheduled ExCo meeting, which are generally held on a fortnightly basis.
4. Broadly, this process involves submitting the following documents to the ExCo Secretariat for clearance:
  - a. A formal minute, signed by the Minister;
  - b. An order for the changes to be executed by the Governor-General, that has been countersigned by the Minister; and
  - c. A concise explanatory memorandum.
5. If the recommendation is approved at the ExCo meeting, the Governor General will sign the minute and the associated order at the meeting or, if he is not present, as soon as possible after the meeting.
6. Following approval DoH would arrange for the order to be gazetted by OPC.

## 4. Future State Options

*From a first principles perspective, four possible future-state options are available for the NMHC. Our assessment suggests structural changes are not required, and instead the NMHC’s capacity and capability should be strengthened as a priority, and strong authorisation from the Minister for Health to pursue cross-portfolio priorities at a Commonwealth level, and relationships and influence-building at a State and Territory-level.*

### A. Institutional form options

At a high level, there are four possible future-state options for the NMHC, each of which is considered in turn:



#### Option 1: No change

Presented in the interests of showing the full range of options, one option would be to make no changes and hence to retain the current institutional form, governance, functions and capacity and capability. However **this is not recommended** for a number of reasons.

The Government has clearly stated an intention to ‘strengthen’ the NMHC. Moreover, the NMHC has the potential to make a meaningful impact on the Australian mental health system and, in doing so, to improve the lives of many people. Irrespective of the institutional form, without strengthening capacity and capability, this cannot be achieved.

#### Option 2: Current form with improvements

In the second option, the current institutional form (Executive Agency) is retained, whilst improvements are made across other aspects of governance and resourcing (these improvements are explored further below).

**This option is recommended based on the current role expectations and environment in which the NMHC operates in.** Our review has found that institutional form and current auspicing arrangements are not the most pressing challenges facing the NMHC. Issues such as role and functions, capability and relationships are more closely linked to achievement of the NMHC’s purpose. These can and should be addressed without changing more structural matters.

#### Option 3: Statutory authority form

This option would involve changing the NMHC’s institutional form from an Executive Agency to a Statutory Authority, with associated changes to the roles of the CEO and the Commissioners as leaders of the organization.

**This option is not currently recommended.** This form is used sparingly by Government - requires a strong rationale for its selection, which is not evident. On its own, changing the NMHC's institutional form may only address the issues around perceived independence, though these perceptions could persist even were a different form adopted given the capacity and capability challenges that exist. As discussed above, the current form is likely to enable sufficient independence to perform the NMHC's role. To the extent that there exist some perceptions of insufficient independence, these will be addressed through both clarification of commissioner roles and responsibilities, and by strengthening the organisation's capacity and capability, as described above.

Further, changing the institutional form of the NMHC would involve some administrative complexity as well as ongoing compliance requirements for the CEO/Commissioners that are likely to be in excess of those required under current operations.

#### Option 4: Change auspicing arrangements

This option would involve retaining the current institutional form, but changing the portfolio which auspices the NMHC – providing its funding and facilitating its employment of staff – from the DoH to an alternative, such as the Department of Prime Minister & Cabinet.

**This option is not currently recommended.** Similarly to option 3, this option on its own would address some issues around the perceived influence of the NMHC and the ability for the NMHC to execute against its cross-sectoral scope.

The ostensible purpose of such a shift would be to lift the prominence of the NMHC – and hence mental health – and to enable a cross-sectoral view. However, these can be better enabled under status quo structures by strengthening relationships and clarifying the Minister's (and ideally the Prime Minister's) expectation that the NMHC takes a cross-sectoral view and that other agencies work closely with it to achieve this.

There is significant relevance between the work of the NMHC and the capability and expertise within the DoH and the Minister for Health's focus. There is a risk that shifting to being auspiced by the Department of Prime Minister and Cabinet could in fact result in lower focus and attention on the NMHC's work, as it would require 'competing' against *all other* government priorities.

## B. Additional Improvement Options

Regardless of which of the above options is preferred, a number of 'no regrets' recommendations have been identified. These include sharpening the NMHC's role and functions, increasing capacity and capability and strengthening the relationships and influence of the Commission.

Some of these additional possible areas of improvement for the NMHC also involve choices. Below, we identify the spectrum of options for future state improvements:

- The **current state** is denoted by a blue triangle ▼
- The **recommended future state** is indicated by a green star. ★

## Commissioner roles



As described above, there is currently some ambiguity in the role of the Commissioners and their interactions with the NMHC.

To the extent that either ends of the above spectrum are possible future-state options, this review recommends clarifying that the Commissioners act as a collective advisory group, who jointly input into the viewpoints and outputs of the NMHC. This does not mean that all Commissioners must participate deeply in all aspects of the work, but cohesion of voice should be achieved wherever possible.

## Commissioner composition



Currently, the composition of Commissioners appears to strive to achieve both representation and some specific capabilities. This balance should be maintained going forward, with a pure 'Representation' Model to be avoided. In addition to the impossibility of adequately representing the diversity of stakeholders and perspectives as Commissioners, the risk of this model is that it may encourage Commissioners to limit their views and thinking to 'their' area of representation.

Instead, the Commissioners should be sufficiently representative of critical stakeholder groups (indigenous Australians, mental health consumers and carers, mental health practitioners, etc), without selecting specific Commissioners for those roles where possible. The Commissioners should be expected to bring expertise, primarily in mental health (all dimensions), but also as relevant across government, law, economics, etc.

## Capacity and capability



As noted above, current capacity and capability is not sufficient to meet the NMHC's objectives. Therefore providing a capable workforce with sufficient capability is paramount. In addition, it is acknowledged the work of the NMHC will continue to vary, with different priorities requiring different skills and experiences over time. Therefore, the NMHC should seek to build its own workforce to a sufficient level to lead, procure and oversee others in delivering on the NMHC's work. This should include a boost to staff with mental health expertise, as well as ensuring that procurement capability is sufficient.

## Policy functions



The NMHC could, in the future, take a more detailed and active role in its policy advisory functions. This would involve moving beyond issuing recommendations and into helping with the design of aspects of policy. It is premature to consider taking on such a role at this time, as building capacity and capability to perform existing reporting and policy advisory functions should be prioritised. Taking on greater policy development roles can be pursued on a case by case basis with the DoH.

### Monitoring and reporting functions



The NMHC should consider expanding its capacity as an advisor to the system and focus on building improvements across the system. While not to the same extent this could be a similar role to the ACSQH. As with its policy role, this appears a premature step given current constraints. In the future this could be considered, particularly with regard to shaping the future of the system. It is noted that standards creation in partnership with the ACSQH has been a previous activity undertaken by the NMHC providing a potential link to such a role in the system.

# 5. Recommendations

*Building on the issues and improvement options identified thus far, this review provides four core recommendations to strengthen the NMHC going forward:*

- 1. Recommendation 1:** Lift the capacity and capability of the NMHC
- 2. Recommendation 2:** Clarify the role and governance of the NMHC through an update to the Executive Order and regular correspondence via a Ministerial Charter Letter
- 3. Recommendation 3:** Clarify the NMHC's internal governance and operations
- 4. Recommendation 4:** Take steps to strengthen the NMHC's influence and impact.

## **Recommendation 1: Lift the capacity and capability of the NMHC**

- 1.1 Increase the FTE working within the NMHC.** The precise additional requirement will depend on the scope of the NMHC's activities, and are best determined by the NMHC's CEO. Nevertheless, an indicative view suggests the NMHC would benefit from growth in:
  - 1.1.1** Data analysis resources, skilled in both technical skills (such as econometrics and modelling) as well as effective data interpretation and communication skills;
  - 1.1.2** Mental health specialists, with sufficient coverage across core sectors, including health (covering acute care, subacute care, primary care); economic participation; housing; welfare and marginalised populations like Aboriginal and Torres Strait Islanders (to complement the experience of the Commissioners); and
  - 1.1.3** Stakeholder engagement resources, including those with experience engaging with mental health consumers, carers and families.
- 1.2 Ensure sufficient seniority and capability of the workforce.** In addition to adding capacity, the shape of the NMHC workforce should be optimised so that there are enough employees at the EL-grades to direct and oversee work, including of external suppliers.
- 1.3 Equip the NMHC with resources to engage external support** as needed, including researchers and analytical support when required. This should take the form of a pool of funds able to be flexibly assigned throughout the NMHC's work cycle, in line with procurement standards and processes.
  - 1.3.1** Lessons from comparator institutions suggests this pool of funds should be at least equivalent in value to the total spend on FTE.
- 1.4 Ensure sufficient capability of the Chair and Commissioners,** specifically:
  - 1.4.1** Clarifying the role and expectations of the Chair's capability to lead the Commissioners, represent the NMHC in public (together with the CEO), and support the CEO to make strategic decisions;
  - 1.4.2** Clarifying the role and expectations of the Commissioners as advisors to the NMHC and through it to government, including expectations around unified public communications, leadership roles around specific

programmes of work and the roles of Commissioners in bringing particular perspectives, while not necessarily being ‘representatives’ of other groups.

- 1.4.3** To the extent necessary to meet the above capability expectations, consider investing in training or adjusting the composition of the Commissioners to ensure capability sufficiency.

## **Recommendation 2: Clarify the role and governance of the NMHC through an update to the Executive Order and clarified via an annual Ministerial Charter Letter**

- 2.1 Refine the aspirations and vision for the NMHC.** Building on current documentation, ensure that the CEO, Chair and Commissioners, as well as the Minister, agree to this.
- 2.2 Clarify the key roles of the NMHC,** and functions through which these will be executed. The contents of this review should be used as a starting point.
- 2.3 Confirm the critical hand-off points** between the NMHC and stakeholders, particularly the DoH (on policy), the AIHW (on data collection, analysis and reporting) and Mental Health Australia and others (around stakeholder engagement).
- 2.4 The Executive Order should be updated,** encapsulating their expectations regarding the NMHC’s governance, vision, role and functions. This would be drafted by DoH in close consultation with the OPC. The Minister for Health and Prime Minister could countersign the Order as a representation of the cross-sectoral importance of the NMHC role.
- 2.5 The Minister for Health should issue an annual Charter Letter,** clarifying the NMHC’s governance, vision, role and functions. Seek to have this co-endorsed by the Prime Minister.
- 2.5.1** The Letter establishes that the Minister for Health actively auspices and promotes importance of the NMHC in the system (and therefore the importance of cross-sector engagement and participation);
- 2.5.2** The Letter should seek to include support from relevant Commonwealth and State and Territory colleagues; and
- 2.5.3** The Letter should be issued annually, and should include relevant updates to the NMHC’s priority projects for that period.  
*See Appendix C for suggested structure of the Charter Letter.*

## **Recommendation 3: Clarify the NMHC’s internal governance and operations**

- 3.1 The roles and responsibilities of the CEO, Chair and Commissioners should be clarified** through updating and circulating the internal Operating Principles. Building on the material in the current document, this would outline:
- 3.1.1** The role of the Chair relative to the CEO in leadership of the NMHC, leadership of the Commissioners and engagement with the Minister for Health;
- 3.1.2** The role of the Commissioners as advisory to the NMHC (whilst maintaining a requirement for the CEO to consult with the Commissioners in developing strategy and work plans);

- 3.1.3** The processes and norms around Commissioner conduct, including codes of conduct for meetings, public commentary etc.; and
  - 3.1.4** The processes and norms around maintaining sufficient independence in the NMHC's operations in order to fulfil its role.
- 3.2 The NMHC's own performance management should be sharpened**, with the current focus on activities supplemented or even replaced by measures indicating the impact and stakeholder value of the organization. This could include:
- 3.2.1** Existing measures of activity against work-plan;
  - 3.2.2** New qualitative assessments of impact on policy, such as examples of policy reform or development that the NMHC contributed to; and
  - 3.2.3** New qualitative assessments based on stakeholder perceptions of the NMHC's value or impact.

#### **Recommendation 4: Strengthen the NMHC's influence and impact**

- 4.1 Develop an explicit strategy to raise awareness of and collective action on mental health issues.** This involves:
- 4.1.1** Developing goals and actions within the NMHC's work plan to raise awareness and build collective action across all jurisdictions and sectors involved in the mental health system;
  - 4.1.2** Undertaking regular planned and ad-hoc engagement with the Minister for Health, DoH Secretary and colleagues across States and Territories
  - 4.1.3** Undertake regular planned and ad-hoc engagement with the Prime Minister around cross-sectoral issues; and
  - 4.1.4** Minister for Health and DoH Secretary participate in engagement activities facilitated by the NMHC with the sector;
  - 4.1.5** Undertaking monitoring and reporting, and policy advice activities, described above.
- 4.2 Strengthen the relationship between the NMHC and the States and Territories**, within the boundaries of what can be achieved in current federalist arrangements. This could involve:
- 4.2.1** Developing key measures and monitoring and reporting arrangements that provide an inter jurisdictional view of the mental health system, in consultation with AHMAC;
  - 4.2.2** Regular reporting of progress against agreed priorities (in the Fifth National Plan) to AHMAC;
  - 4.2.3** Minister for Health and DoH Secretary to assist in supporting the creation of linkages at the State and Territory level through dialogue with colleagues and, where relevant, to participate in engagement activities facilitated by the NMHC with States and Territory representatives;
  - 4.2.4** The development of a dedicated Jurisdictional Advisory Committee, comprising representatives of all the jurisdictions, to inform the NMHC's work on an as-needed basis; and
  - 4.2.5** A plan for building engagement and influence, including identifying areas of joint work, such as around the Fifth National Mental Health Plan.

# Appendix A: Project Context & Background

## A. Project Context

### **The NMHC is a critical part of Australia's health system**

Around 7.3 million or 45% of Australians aged 16–85 will experience a common mental health-related condition such as depression, anxiety or a substance use disorder in their lifetime (2007 estimates). Estimates (from March 2010) suggest almost 64,000 people have a psychotic illness and are in contact with public specialised mental health services each year. It is estimated that 560,000 children and adolescents aged 4–17 (about 14%) experienced mental health disorders in 2012–13.

It is estimated that around \$8.5 billion per annum is spent on mental health-related services in Australia. These services include residential and community services, hospital based services (both inpatient and outpatient), consultation with specialists and general practitioners. Spanning as it does multiple parts of the health system, mental health is overseen and delivered at the national, state and local levels. This means that research, review and advice is critically important to ensure quality of services and outcomes.

From its vision through to its nation-wide scope, the National Mental Health Commission (the Commission) clearly has an important role in supporting Australians to achieve the best possible mental health and wellbeing. The Commission's mission is to give mental health and suicide prevention national attention, to influence reform and to help people live contributing lives by leading, collaborating, advising and reporting. It does this through:

- Increasing accountability and transparency in mental health through public reporting, such as the annual National Report Card on Mental Health and Suicide Prevention;
- Conducting periodic reviews of and research into Australian mental health services and programs, such as the recently announced review of mental health support for Australian Defence Force members and veterans; and
- Working with stakeholders, particularly those with lived experience of mental health services and issues, to ensure reforms are informed and collectively owned.

The Commission is led by a CEO, who works with the Chair and Commissioners to oversee delivery against the Commission's objectives. The Commission includes a Chair and a number of Mental Health Commissioners (as determined by the Minister for Health from time to time), as well as the CEO as ex-officio Commissioner.

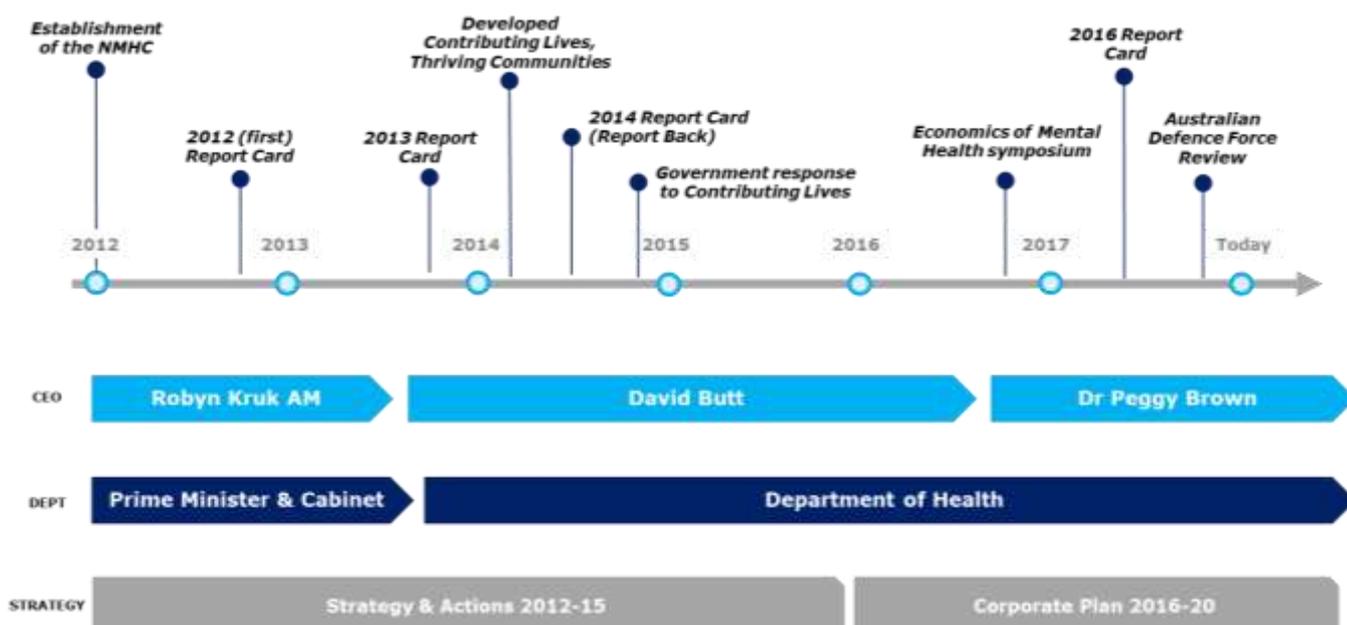
Structurally, the Commission is an independent executive agency under the Public Service Act 1999, with staff appointed under that Act, and is a non-corporate Commonwealth Entity under the Public Governance, Performance and Accountability Act 2013. Its purpose set out in clause 14 of Schedule of the Public Governance, Performance and Accountability Rule 2014. It is part of the Minister for Health's portfolio and reports directly to the Minister for Health. The Commission operates in a corporate services shared services environment provided by the Department of Health (DoH).

## Now is the right time to ensure the Commission’s working arrangements are fit-for-purpose

Given its important role, the Commission recognises the value of continuous improvement to ensure it is providing the best service and outcomes to its stakeholders. Indeed, Key Work Area 7 in the Commission’s Work Plan 2016-17 specifically calls out an objective to “Continuously improve the Commission’s operations”.

The current working arrangements have been in place since the Commission’s inception in 2012. Much has changed in the national health and mental health environment since then, and it is prudent to reconsider the structure, governance and relationships which support the Commission’s functioning. Dr Brown’s commencement as CEO in October 2016 also provides a useful juncture to examine operations and identify improvement opportunities.

FIGURE 4: RELEVANT EXCERPTS FROM THE NMHC’S RECENT HISTORY



## B. Project Purpose & Deliverables

Mental health is a high priority for the Commonwealth Government. In the context the current development of the 5<sup>th</sup> National Mental Health Plan, this review of the National Mental Health Commission (NMHC) was designed to:

- **Define the role of the NMHC** in the national mental health system architecture, including:
  - Identifying any recommended changes to strengthen its role and impact (such as taking a greater ‘advisory’ role);
  - Exploring the cross-jurisdictional role of the NMHC, such as improving coordination of mental health activity;
  - Considering the role of the NMHC in achieving the DoH’s priorities.
- Define the optimal role for the NMHC’s **Chair and Commissioners**.
- Identify the **key objectives** for the NMHC, and how success against those objectives is or can be measured to improve performance.
- Identify any **impediments** to the achievement of those objectives, such as ambiguity in current operating arrangements, and recommends mechanisms to overcome those impediments.

- Recommend an appropriate **institutional form** for delivering on the NMHC’s role and objectives, including considering if the current level of independence is appropriate.

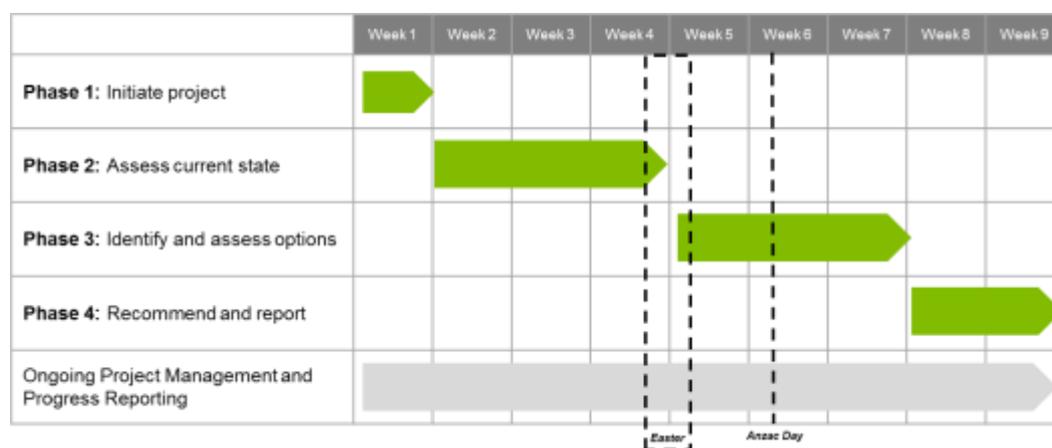
The work culminates in a succinct written report (**this report**) which seeks to summarise the current state issues, explore options for addressing them, and issue a set of recommendations to strengthen the NMHC.

**The audience** for this work is the DoH (primary recipient of advice); the NMHC CEO and Commissioners (critical stakeholders) and the Minister for Health (authorising environment).

### C. Project Approach

This project was conducted across four phases, delivered across nine weeks:

**FIGURE 5: HIGH-LEVEL PROJECT TIMELINES**



#### Key activities included:

- Reviewing existing documentation to understand NMHC’s scope and role and current governance model
- Conducting stakeholder consultations to supplement the desktop review
- Conducting desktop research on comparator organisations to understand attributes of a high performing commission and comparative operating and accountability models.
- Together with DoH, developed future-state Design Principles which articulate what criteria will determine which future-state model is most appropriate.
- Based on learnings, considered potential options for the NMHC, including options around the level of authority, scope and roles of NMHC, method of setting priorities, accountability and reporting arrangements and operational hierarchy and structure
- Through a collaborative workshop with DoH and the NMHC CEO, explore the issues and possible options; and
- Develop a final report summarising findings and determining optimal recommendations.

# Appendix B: Additional Comparison Research

## A. Role of Commissioners

Organisation	Role Type	Role Description
Australian Human Rights Commission	President/CEO	<ul style="list-style-type: none"> <li>Responsible for managing the administrative affairs of the commission</li> <li><b>Accountable authority</b> under the PGPA Act 2013</li> </ul>
	Commissioner	<ul style="list-style-type: none"> <li>Commissioners are appointed under their respective anti-discrimination laws, hence they focus on <b>their respective area of expertise</b></li> <li>The Act prescribes specific functions for certain Commissioners, such as reporting to Ministers</li> </ul>
Productivity Commission	Chair & Deputy	<ul style="list-style-type: none"> <li><b>Manage the Commission</b> to ensure the efficient performance of the Commission's functions</li> <li>Deputy assists the Chair in the exercise of the powers and the performance of their duties</li> </ul>
	Commissioner	<ul style="list-style-type: none"> <li>Responsible for the conduct and quality of <b>individual inquiries</b>, studies &amp; other activities to which they are assigned by the Chair</li> <li>Commissioners contribute to strategic coordination of the Commission's work</li> </ul>
Australian Institute of Health and Welfare	Director	<ul style="list-style-type: none"> <li><b>Manage the AIHW's affairs</b> in accordance with the AIHW and the PGPA Acts, consistent with the requirements of the board.</li> <li>Provide leadership to the AIHW in policy and statistical issues across the scope of functions</li> </ul>
	Board & Chair	<ul style="list-style-type: none"> <li>The Board is the <b>governing body</b> of the AIHW.</li> <li>The Chair manages Board meetings and formal relationships (e.g., with Ministers)</li> </ul>
National Blood Authority	Chief Executive	<ul style="list-style-type: none"> <li>Responsible for the <b>leadership, management and governance</b> of the Authority and implementation of strategic and operational plans</li> </ul>
	Board Member	<ul style="list-style-type: none"> <li>Provides <b>advice to the General Manager</b> about the performance of the NBA's functions</li> <li><b>Not a decision making body</b>, no formal or direct role in governance or management of the NBA</li> </ul>
National Archives (Executive Agency)	Director-General	<ul style="list-style-type: none"> <li>The Director-General and the executive provide <b>leadership to the organisation</b> and its staff, with specific Assistant DGs for the branches of the Archives</li> </ul>
	Advisory Council	<ul style="list-style-type: none"> <li>Under the <i>Archives Act 1983</i> the Advisory Council advises <b>the Minister and Director General</b></li> </ul>
Australian Financial Security Authority (Executive Agency)	Chief Executive	<ul style="list-style-type: none"> <li>The agency's CE is also the Inspector-General in Bankruptcy and is supported by a number of groups and Divisions (with some statutorily defined roles, such as Official Receiver)</li> </ul>
	National Management Board	<ul style="list-style-type: none"> <li>The "<b>peak governing body</b>" of the AFSA, supported by a number of operational committees and project boards.</li> </ul>

# Appendix C: Possible Inputs to Executive Order and Charter Letter

While the contents of the Executive Order and Minister for Health's Charter Letter will be a matter for the Minister for Health and will no doubt include some consultation with stakeholders across the sector and the NMHC, some indicative elements to consider including are presented below:

## **1. Role of the NMHC**

- a. Monitoring and reporting on performance of the entire mental health system (including Commonwealth, State and Territory, health, social services/welfare, economics and housing)
- b. Advise and input into mental health policy, including outcomes to be delivered and priorities for reform and improvement
- c. Engage and include perspectives of mental health consumers, families and carers.

## **2. Functions and outputs**

- a. Deliver regular reporting that does not duplicate other sources of information and which is insightful to the sector might include a 3 yearly report against agreed outcomes (and some activity measurement) that describes the progress of reform in mental health services and identifies priorities for improvement, supplemented by annual deep dives into specific areas such as physical health, housing, employment or sub-populations
- b. As part of, or in addition to, the above, conduct monitoring and reporting of implementation and impact of the Fifth National Mental Health Plan
- c. Conduct bespoke research, engagement and analysis on priority issues in mental health – particularly with a cross-sectoral focus.

## **3. Scope of the NMHC's operations**

- a. Ensure a cross-sectoral focus, including principles, data and stakeholders from across government portfolios. This should include social services/welfare, economics, family violence and Aboriginal and Torres Strait Issues
- b. All Commonwealth policy and services that affect or contribute to the lives of people with mental health issues and their carers
- c. Consider mental health policy, activity and outcomes at a national, state & territory and sub-state level wherever possible.

## **4. Governance and performance reporting**

- a. The NMHC advises the Minister for Health, operating with sufficient independence from agencies which fund and deliver mental health policy and services, as is enabled under its Executive Agency form
- b. The CEO is the accountable authority for the NMHC, responsible for delivering against the strategy and work plan
- c. Advice is provided from the CEO, on behalf of the NMHC, Chair and Commissioners, to the Minister for Health directly

- d. Wherever possible, consultation with the DoH should occur to streamline translation of advice into policy and action
- e. Commissioners act as an Advisory Group to the NMHC CEO to provide expert input into the NMHC's work
- f. The annual work-plan should be developed by the CEO in close consultation with the Chair and Commissioners, and together with the DoH and the Office of the Minister for Health. It should:
  - i. Outline priority deliverables for the given period
  - ii. Affirm processes and principles for conduct and delivering work
- g. The NMHC should issue an annual report of its activities and impact, including qualitative and impact measures wherever possible
- h. The CEO and Chair should meet with the Minister for Health at least 4 times per year to provide progress updates on priority issues and work.
- i. The Minister for Health, CEO and Chair should meet with the Prime Minister at least once a year to provide progress updates on priority issues and work that are cross-sectoral and inter-jurisdictional.

# Appendix D: Stakeholder Register

In conducting this review, the following stakeholders were consulted – either in-person or via telephone interviews:

Name	Position	Organisation
<b>NMHC Stakeholders</b>		
<b>Prof. Allan Fels AO</b>	Chair	NMHC
<b>Dr Peggy Brown</b>	CEO	NMHC
<b>Prof Pat Dudgeon</b>	Commissioner	NMHC
<b>Rob Knowles</b>	Commissioner	NMHC
<b>Prof Ian Hickie</b>	Commissioner	NMHC
<b>Jackie Crowe</b>	Commissioner	NMHC
<b>Lucinda Brogden</b>	Commissioner	NMHC
<b>Nicole Gibson</b>	Commissioner	NMHC
<b>Commonwealth Department of Health Stakeholders</b>		
<b>Mark Cormack</b>	Deputy Secretary	Department of Health
<b>Natasha Cole</b>	First Assistant Secretary	Department of Health
<b>Shane Porter</b>	Assistant Secretary	Department of Health
<b>Other Stakeholders</b>		
<b>Nathan Williamson</b>	First Assistant Secretary	Department of Prime Minister and Cabinet
<b>Barry Sandison</b>	Director	Australian Institute of Health and Welfare
<b>Leanne Wells</b>	Chief Executive Officer	Consumers Health Forum of Australia
<b>Frank Quinlan</b>	Chief Executive Officer	Mental Health Australia
<b>David Butt</b>	Chief Executive Officer	National Rural Health Alliance
<b>John Feneley</b>	Commissioner	New South Wales Mental Health Commission
<b>Sue Murray</b>	Chief Executive Officer	Suicide Prevention Australia
<b>Lyn Littlefield OAM</b>	Executive Director	Australian Psychological Society
<b>Malcolm Hopwood</b>	President	Royal Australian & New Zealand College of Psychiatrists
<b>Michael Pervan</b>	Secretary	Tasmanian DHHS



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