

Mental Health Commissions: making the critical difference to the development and reform of mental health services

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Purpose of review

Several Mental Health Commissions (MHCs) have emerged in developed countries over recent years, often in connection with mental health reform strategies. It is timely to consider the types of MHC which exist in different countries, their characteristics which may contribute to making them more effective, and any possible limitations and concerns raised about them.

Recent findings

The emerging literature on MHCs indicates, particularly with the wider types of MHCs, that they may contribute to the substantial enhancement of mental health resources and sustainability of services; mental health reform is much more likely to be implemented properly with an independent monitor such as a MHC which has official influence at the highest levels of government; and they can encourage, champion and monitor the transformation of services into more evidence-based, community-centred, recovery-oriented, consumer, family and human rights focussed mental health services.

Summary

The advent of MHCs may enhance the resourcing, quality and consistency of distribution of effective clinical practices and crucial support services, and foster more relevant practice-based research. MHC variants can work in different countries and the model can be adapted to state jurisdictions, single state nations and federated systems of government, without duplicating bureaucracies. Achievements and possible limitations are considered.

Keywords

Authority, human rights, Inspectorate, Mental Health Commission, mental health reform

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Introduction

The review explores the documented functions and reported value that Mental Health Commissions (MHCs) can make to the development and sustaining of comprehensive, evidence-based, recovery-oriented and high-quality systems of mental healthcare on a state, provincial or national basis. MHCs fall into two broad groups (see Table 1): firstly, a more narrow and restricted model (type I), which serves regulatory, inspectorial, medico-legal and even inquisitorial functions, for example, Ireland [1], Scotland (see websites Table II), and the proposed commissioner in the Australian state of Victoria. The wider model (type II) provides more proactive system-wide consultation and surveillance, arm's-length monitoring to ensure a transparent accountability mechanism independent of service providers and management, and encouragement, rather than focusing mainly on individuals and complaints. The latter MHCs are able to apply more direct leverage with governments, via

legislated and mandated direct reporting to first ministers, governments and parliaments. A prominent example is the New Zealand Commission, which has been in existence since 1998 and arguably has been critical to ensuring that New Zealand's mental health services have had bi-partisan political support, financial and other resources, and the ethos and conceptual basis to provide a coherent and practical framework for service development [2–4]. Similar MHCs, such as in Canada and Western Australia, have been implemented in 2007 [5,6] and early 2010 (see websites, Table 2) respectively, following considerable deliberation as to their form. The means and the process by which these Commissions are now actively promoting and shaping the realization of mental health service reform, and have been supporting service development in New Zealand, Canada and now Western Australia, will be appraised (see Table 2). Brief consideration only is given to a third subtype which consists of a temporary Mental Health Commission of Inquiry, as has recently occurred nationally in the USA

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Table 1 Mental Health Commissions typology

Mental Health Commission	Type I	Type II
Mandate Focus	Narrow Individual Predominantly risk management agenda: complaints ombudsman or umpire re adverse occurrences Medico-legal review of quality and duty of care for involuntary patients Inspectorial, inquisitorial, or regulatory	Wide System-wide Positive agenda: stakeholder encouragement, programmatic system reform and improvement Proactive consultation with all stakeholders
Auspice Report to examples	Mental Health Act or own act Health minister or attorney general (predominantly type I but with some elements of type II) Republic of Ireland Northern Ireland Scotland Victoria, Australia (proposed)	Transparent accountability monitoring, and in one instance budget holding and integrated commissioning Specific own act +/- enabling legislation Prime Minister, First Minister, Health Minister, parliament, all of government (predominantly type II) New Zealand Canada Western Australia

(2002–2003) [7–10], as well as in Wisconsin (1996–1997) [11]. Inquiries or reporting undertaken by generic health and social service commissions, such as the England's National Health Service Care Quality Commission, the Regulation and Quality Improvement Authority (RQIA) of Northern Ireland or the Australian Human Rights Commission and annual Report on Government (ROG) in Australia are out of scope of this review.

Characteristics and achievements

There are several key characteristics of MHCs, particularly of the wider type II variations, which have been associated with considerable achievements within their jurisdictions, and which may well hold much relevance to other countries, provinces, states and territories.

Wider or narrower mandate?

Whereas the narrower mandate MHCs have inherited an individual-centred regulatory or inspectorial focus, they have been demonstrating interest in and/or movement toward some of the more system-wide service development and monitoring functions of the wider models. The West Australian Commission's draft legislation initially followed a narrow inspectorate model, but after extensive consultations with wider model commissions, its final legislative mandate was expanded, and it was given the additional clout of budget holding and commissioning services (as originally recommended also for the New Zealand Commission by the Mason Report [12]), as well as monitoring cost-effectiveness of service delivery.

Positive agenda

The wider, more systemic mandate MHCs have focused on a more positive agenda of encouraging service users and providers in their aspirations for service development, and persuading governments to commit to sorely needed enhancements. They have inspired trust by stakeholders in their independent voice, their leverage with government and their commitment to sustaining close and regular consultation with service users and carers.

Independence and transparency

The need for independence and transparency of accountability mechanisms, and the MHCs' terms of reference when these allow it 'to undertake whatever tasks are required to meet its responsibilities', as in New Zealand [13,14], are widely considered to be crucial to ensure real service enhancements, and to gain and retain public confidence [15,16]. Accountability or evaluation mechanisms which are internal to or dependent on health departments or ministries, even when quite elaborate (e.g. [17]), can be used to produce results which are easily gamed or massaged to make even laissez-faire or regressive administrations look good.

Enhancing mental health service resources

One of the most important initial achievements of the New Zealand Commission was to produce the Blueprint (1998) [18] concerning how best practice and detailed consultations with all stakeholders, including indigenous peoples, could be applied to the nation's mental health services with a recovery agenda. The gaps between existing services and the Blueprint were formally defined and costed by the Commission. Whereas the Commission has enjoyed bipartisan political support, an incoming government was elected with a platform of funding these gaps, and proceeded to do so with annual increments ('Blueprint money'), enhancing the calibre and consistency of mental health services remarkably. The result in New Zealand is that more than 80% of mental health services are now provided in the community (its demographically related neighbour Australia is struggling to attain even 50% community provision, based on unreliable figures, which may often include hospital-based outpatient visits), with 30% of mental health budgets spent on strict contracts with the NGO sector to enhance community services (Australian states average about 6–7%), and per capita expenditure on mental health far exceeding Australia's by more than 100% of public and NGO funding, and by 50% with private practice included. New Zealand now spends 11% of its health budget on mental health services, whereas in Australia,

Table 2 Details and comparison of Mental Health Commissions

Features	Canada	Ireland	New Zealand	Scotland	USA	Western Australia
Initiation date	2007	2002	1996	1960	2002	2010
Conclusion date	2017	Ongoing	2015	Ongoing	2003	Ongoing
External review	2010		2010	2003, 2009	n/a	
Mandate and authority	Established by the Prime Minister as a national, nonprofit corporation at arms' length from but funded by federal government. Exists outside Canadian constitutional framework for health. Its mission is to promote mental health in Canada, to change the attitudes of Canadians toward mental health problems and mental illness, and to work with stakeholders to improve mental health services and supports. Its mandate is reflected more specifically in its goals but does not include direct performance monitoring or clinical service provision.	Established under the Mental Health Act (2001) as an independent statutory body. Its mandate is: 1. To promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services 2. To take all reasonable steps to protect the interests of persons detained in approved centres (psychiatric hospitals or units) under the Mental Health Act	Established by the Minister of Health in 1996 and became a Crown Entity in 1998 (part of Government with a degree of independence from it) under the Crown Entities Act (2004) and the Mental Health Commission Amendment Act (2007). Its mandate is: 1. To advocate for people with mental disorders and/or addictions and their families. 2. To promote and facilitate collaboration and communication about issues relating to mental disorders and addiction. 3. To promote community understanding of issues related to mental illness and addiction. 4. To reduce stigma and prejudice and eliminate discrimination against people with mental disorders and/or addictions and their families. 5. To monitor and report to the Minister on implementation of the national mental health strategy. 6. To stimulate and support policy makers, funders and providers to provide integrated, effective, efficient systems of care that meet the needs of the community. 7. To stimulate and undertake research relevant to mental disorders and addiction.	Established by Act of Parliament and duties specified mainly by the Mental Health (Care and Treatment) Act (2003). It is an independent organization with a mandate to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder.	Established by President Bush as a national commission with a 1-year mandate to identify policies that could be implemented by Federal, State and local governments to maximize the utility of existing resources, improve coordination of treatments and services, and promote successful community integration for adults with a serious mental illness and children with a serious emotional disturbance. The Commission reported its findings to the President in 2003.	Established by the Government of Western Australia as a department of State, headed by a Commissioner, under the Public Sector Management Act (1994). Its mission is to work to re-shape service delivery to better meet the needs of people with a mental illness, and make sure that mental health resources are allocated where they are most effective and most needed. It will focus on mental health strategic policy, planning and procurement of services. It will promote social inclusion, raise public awareness of mental well being and address stigma and discrimination surrounding mental illness.
Accountability and reporting	Annual reporting to federal Minister of Health through Health Canada.	Annual reporting to Minister of Health and Children	Monthly to bi-monthly reporting to the Minister of Health; liaison with other relevant government ministers. This programme is supported and informed by a systematic, qualitative monitoring of all health district services taking into account the views of service users, families and healthcare providers. The focus of this monitoring programme is to ascertain how services are functioning and what progress is being made with the implementation of the national mental health and addiction plan. Reports based on findings are made to the Minister of Health on a quarterly and annual basis.	Reports to Ministers who must in turn present reports to Scottish Parliament on its findings. Also has the authority to report findings publicly.	It reported directly to the President. However, since it no longer exists it is no longer reporting or accountable.	Reports through Commissioner to the Minister for Mental Health. Also provides reports on behalf of the State in keeping with national reporting requirements.

(continued overleaf)

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Table 2. (continued)

Features	Canada	Ireland	New Zealand	Scotland	USA	Western Australia
Goals and objectives	<ol style="list-style-type: none"> 1. Creation of a national mental health strategy 2. Development, implementation and evaluation of sustained antistigma, antidiscrimination campaign 3. Creation of a knowledge exchange centre 4. Design and implementation of a randomized multicity study of interventions for homelessness and mental illness 5. Creation of a national social movement to keep this issue 'out of the shadows' <p>There is a business plan with specific goals and indicators through 2014/2015</p>	<ol style="list-style-type: none"> 1. Service users, families and carers are involved in a significant way, locally and nationally, in policy and planning. 2. Service users, families and carers are actively involved in planning care required for individual service users. 3. Human rights and best interests of all persons who use mental health services are respected and protected. 4. The quality of mental health services is consistent with best international standards. 5. The needs and rights of people with mental illness are addressed in an integrated and cohesive manner within the wider mental health domain. 6. Public understanding of mental illness is enhanced, stigma is diminished and public attitudes are increasingly respectful. 7. The MHC is viewed as an efficient organization with the interests of people with serious mental illness or mental disorder at the forefront of its activities. <p>A key function of its work and which accounts for the greater bulk of its work programme relates on the one hand to the administration of the Irish Mental Health Tribunal and the inspection of Mental Health Units. A quality improvement and work-force development programme is also run by the Commission. Efforts are being made to expand this aspect of its work; however, this remains a lesser priority compared to its regulatory functions.</p>	<ol style="list-style-type: none"> 1. To improve the recovery of people with mental illnesses and/or addictions. 2. To improve the mental health and well being of all New Zealanders. This will be achieved through monitoring, advocacy and collaboration. 	<ol style="list-style-type: none"> 1. Visiting people with a mental disorder. 2. Monitoring the operation of legislation. 3. Investigating abuse, neglect, deficient or unlawful care. 4. Advice and promotion of best practice. 5. Influencing and challenging service providers and policy makers. 	<ol style="list-style-type: none"> 1. Americans understand that mental health is essential to overall health. 2. Mental healthcare is consumer and family driven. 3. Disparities in mental health services are eliminated. 4. Early mental health screening, assessment, and referral to services are common practice. 5. Excellent mental healthcare is delivered and research is accelerated. 6. Technology is used to access mental healthcare and information. <p>Each of these goals included specific recommendations.</p>	<ol style="list-style-type: none"> 1. Development and provision of mental health policy and advice to the Government. 2. Leading the implementation of the Mental Health Strategic Plan. 3. Articulating key outcomes and determining the range of mental health services required for defined areas and populations across the state. 4. Responsibility for specifying activity levels, standards of care, and determining resources required. 5. Identification of appropriate service providers, benchmarks, and the establishment of associated contracting arrangements with both government and nongovernment sectors. 6. Provision of grants, transfers and service contract agreements. 7. Ongoing performance monitoring and evaluation of key mental health programs. 8. Ensuring effective accountability and governance systems in place. 9. Promoting social inclusion, public awareness and understanding of matters related to the well being of people with mental illness to address stigma and discrimination

Stakeholder engagement	8 topic-specific Advisory Committees including health professionals, people with lived experience of mental illness, and family members; extensive in-vivo and on-line consultation re national strategy. Multidimensional communications strategy	Website; written and oral communications; public consultations; training and symposia.	Range of mechanisms established for both information sharing and consultation. There is also an MHC Advisory Group that includes service users, families, clinicians, and NGOs as well as multicultural perspectives.	Members of the Commission include service users, carers, mental health practitioners. Regular meetings and consultations are held with external stakeholders.	This was conducted through the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration. It is not an ongoing process.	Establishing formal participation and communication agreements with stakeholders. The government has previously agreed to the establishment of a lead nongovernment organization funded to act as a consumer voice in Western Australia. There will also be an advisory council with government and nongovernment representation, consumers and carers
Relationship to health authorities and services	Mandate does not include monitoring of government or health providers' performance; it funds clinical services only in the context of homelessness research study	Statutory regulatory authority	The MHC is independent of health authorities and services but seeks to collaborate with them in projects of innovation and improvement.	The MHC is independent of health and social authorities; independent of health and social inspectorates but with duties of cooperation. Independent of mental health tribunals.	Not applicable.	As per the goals. In addition, staff in the Mental Health Division of the Department of Health will move to the Mental Health Commission, as will other relevant mental health roles that are located throughout the health portfolios.
Publications	Web-based and print brochures and newsletters, annual reports, peer-reviewed academic papers; see website.	Framework documents, numerous reports on services, strategic plans and discussion papers; see website.	Numerous papers and reports; see website.	Numerous papers and reports of investigations, good practice, information and advice; see website.	Interim and final reports to the President; see website.	As they are developed they will be available on the website.
Forums	National and regional meetings for consultation and information.	Numerous forums for general public, service users, carers, families, and health service providers.	Provides support to convening regular meetings of a range of organizations from service users to health service providers. It also convenes forums on major issues.	Annual meetings with stakeholders and three 'roadshows' per year; full Commission meetings are open to the public; special consultation forums.	Hearings were held around the country for consultation and information gathering but not for dissemination of the final report.	

Addendum to Table II: Mental Health Commission Websites: Canada: www.mentalhealthcommission.ca. Ireland: <http://www.mhcirl.ie>. New Zealand: <http://www.mhc.govt.nz/>. Scotland: http://www.mwscot.org.uk/mwc_home/home.asp. United States: <http://www.mentalhealthcommission.gov/reports/reports.htm>. Western Australia: http://www.health.wa.gov.au/mentalhealth/reforms/mental_health_commission.cfm. Note: The Mental Health Commission of Northern Ireland was established in 1986 and is still promoted in some publications of the Northern Ireland Department of Health, Social Services and Public Safety publications (www.dhsspsni.gov.uk) as being accessible at <http://www.mhcni.org/> though this site is no longer active. This is because on 1 April 2009, under the Health and Social Care Reform Act (Northern Ireland) 2009 the functions of the Mental Health Commission (MHC) were transferred to and absorbed by the Regulation and Quality Improvement Authority (RQIA) (www.rqia.org.uk/). This is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services. It reports on all health and social services, with mental health and learning disability combined being just one component. Therefore it no longer qualifies as a discrete MHC for the purposes of this review.

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this proportion is soon to regress from >7 to 6%. This compares poorly with the average burden of disease due to mental ill health being 14% of all disease states internationally.

Formally promoting the recovery, holistic care and human rights agendas including consumer involvement and early intervention in services

Some MHCs have been responsible for introducing, and formally promoting the recovery and human rights agendas within government deliberations, policies, plans and standards regarding mental health services [19^{**},20–22]. Examples include:

- (1) New Zealand MHC Recovery Competencies [23]
- (2) The goals of New Zealand's [24^{*}], and Ireland's [25] MHC, and USA's NFC [26] include that mental healthcare is consumer and family driven and follows a recovery approach.
- (3) The needs for preventive mental health services and early intervention, including in primary care settings, have been strongly promoted by the New Zealand MHC [27,28^{*}]. The Canadian MHC has striven to make recovery and well being the guiding principles of modern mental health services [29,30^{**}].
- (4) The importance of striving for the human rights of individuals with mental illness has become entwined with the push for mental health reform by MHCs and other organizations [31].

Amplifying consumer, carer, homeless, comorbid, indigenous and multicultural and other previously unheard, disregarded or marginalized voices, and responding to these voices with advocacy for better services

MHCs usually maintain open channels of communication continuously with all stakeholders including all these groups. As part of research to ascertain the needs of and better ways to serve these groups (e.g. MHC of Canada's forthcoming national study of homelessness and mental illness), qualitative methods, including first-person narrative accounts, or storytelling [31,32], may be employed by MHCs to elicit a more vivid sampling of the lived experience of service users from different backgrounds. The metaphor of 'pathways' or the personal or family 'journey' through mental illness or the system is often invoked in such MHC research (e.g. [33]).

Challenging stigma and discrimination

Programmes to promote mental health and wellbeing and to reduce stigma and discrimination are being nurtured as part of the core tasks particularly of type II MHCs (e.g. Canada). In New Zealand, this has resulted in the most successful 'Like Minds, Like Mine' programme (www.likeminds.org.nz), which initially fostered grassroots local people-to-people interactive networks, operating in

advance to capitalize on the subsequent waves of mass media campaigns, with strategies for long-term sustainability built-in. Variants of these campaigns have been developed for indigenous populations and the workforce.

Promoting the mental health service transformation and reform agendas

Mental Health Commissions have succeeded in explicitly progressing the mental health reform agenda. MHCs are viewed as a basic tool in the international pathway to mental health service transformation, particularly as they have promoted the adoption of the recovery paradigm into national and state reform agendas [34^{**}]. They are providing a publicly accessible clearing house for evidence-based best practice, and are independently informing or being given the responsibility to develop national or state mental health strategies at arm's length from the usual bureaucracies (MHCC). Whitaker and Deikman [35^{*}] indicate that the resistance to humane mental health reform is still formidable and detail strategies to overcome it, whereas reforms in process sometimes look better on paper than in actuality, or may lose momentum over time [36].

Monitoring progress and lack of it with announced reforms: money is not always everything

Most MHC's use their regular consultations with all stakeholders to monitor progress with promised reforms, as well as accessing available data and conducting particular studies [eg Canadian MHC into homelessness and mental illness]. The New Zealand MHC published its Blueprint[18], then performed a gap analysis to determine services which were badly needed but were missing, then costed the gaps for government to consider funding, which it did. In Australia a standardized national scorecard approach to monitoring mental health services approach across all states, territories and health regions has been proposed for such an authority [Crosbie, D, pers. comm.]. The Irish MHC documented that many of the provisions announced in a Department of Health Plan to develop accessible community mental health services were not delivered over 2 decades, so that Irish services remained inequitably resourced and substantially underdeveloped [37]. Whereas the funding increases associated with the MHC Blueprint in New Zealand have been widely welcomed, there is continuing concern among service users and families that financial investment does not necessarily always translate into the substantive better mental healthcare promised in national strategies [38].

Evaluating new innovations

Academic appeals are being made to the Canadian MHC to consider recommending implementation of fee-for-service psychologist arrangements similar to those which have been implemented in Australia, despite mixed and controversial results so far [39^{*}] and

advocating for clinical prevention guidelines for childhood mental disorders [40*] and for better mental health practices for elderly individuals [41].

Open-access source of data

Arising from their medico-legal and monitoring roles, the Scottish, Irish, and Northern Ireland MHCs have become an important accessible source of data via their annual reports for trending, particularly the amount and results of involuntary care [42,43].

A commissioning commission

The Western Australian MHC will be commissioning services through identification of appropriate service providers, benchmarks and the establishment of rigorous contracting arrangements with both government and nongovernment sectors, and the provision of grants, transfers and service contract arrangements. Commissioning encompasses purchasing on the basis of agreed values and evidence of cost-effectiveness. The MHC will also hold the mental health budget, separately from the general health budget. When it was first proposed by the Mason Report [12] the New Zealand MHC was envisaged to have a commissioning and purchasing capacity, but possibly due to the separate and parallel development of a national system of efficient regional health commissioning authorities, purchasing regionally and then locally at arm's length from all providers, to provide tightly contracted integrated mental health services, this was not deemed necessary or desirable.

Applications of Mental Health Commissions to different jurisdictions

Mental Health Commissions of both types I and II have been established and their roles sustained in both state and national jurisdictions. Government officials in Australia have often dismissed the relevance of the New Zealand MHC, arguing that it only works in a uni-state nation, and that it could not work in a more complex, federated context [15]. The advent of the MHC of Canada has significantly deflated this argument. A combination of state/provincial MHCs based on the West Australian model and a complementary national MHC providing comparative monitoring and knowledge exchange could be a solution for federations.

Informal functions

In terms of informal functions, a well constituted and connected MHC can ensure that no substantial stakeholder groups or minorities (e.g. indigenous, multicultural, comorbid service users and family carers) will have their interests ignored ever again, at least for the life of the commission; an MHC can resolve many problems between departmental silos which may be impeding mental health services, through the personal standing and contacts of the commissioners eg Barbara Disley as

founding chair of the MHC in New Zealand, ([44], Wayne Miles, pers. comm.); and an MHC can contribute considerably to the diminution of discriminatory news stories in the media, and of repetitive demands for public inquiries, sometimes in complementarity to standing investigative authorities. Since the Mason inquiry in 1996, which recommended the formation of the MHC, there have been no major national inquiries related to mental health in New Zealand, although there have been several minor ones [12]. In Canada, the Hon. Mike Kirby, inaugural chair of the MHCC, is a prominent retired senator with a distinguished record of public service, who has invoked his own family's experience as caring for a sibling with mental illness in campaigning tirelessly for a MHC for over 10 years before its inception. The broad political & personal respect he has earned explains the tri-partisan support received by the MHCC, and in terms of his public standing, he has just received the highest award for a non-physician by the Canadian Medical Association (Calgary Herald, 18 August 2010).

Walking together

Relations between Governments and MHCs are usually collaborative rather than conflictual. Most seasoned commissioners have striven to consistently provide independent and frank advice to government, based on both grass-roots consultation and evidence. Sometimes they will disagree strongly with a particular new or entrenched government approach, at the same time working hard to maintain the relationship and goodwill, so that they may reciprocally develop a *modus operandi* of 'walking together' in the interests of improving the lives of service users ([15], Wilson J, pers comm., Disley B, pers. comm.). It has been useful in establishing the authority and credibility of these MHCs that they have been personally announced and/or had their functions strongly endorsed, championed and financially backed by prime ministers (e.g. in Canada and New Zealand) or their state premier (first minister) as in Western Australia.

Limitations of Mental Health Commissions

There are several concerns and possible limitations concerning MHCs which warrant special consideration.

Reform agendas can be misused and abused

Top-down imposed 'Mental Health Reforms' cannot always be guaranteed to be a good thing, are not always in the interests of individual service users, and their misuses further down the track may be hidden, insidious or unpredictable at the time of implementation. If implemented with insensitivity, excessively controlling or frankly discriminatory intent, they can turn out to be neglectful or oppressive (eg Nazi Germany,45). Reorganization of services can be seen historically as cyclical, causing discontinuities of care with each turn of the

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wheel. So, it is important to have a mechanism such as an MHC to consider all proposals for change carefully in advance through well developed partnerships and regular forums among all stakeholders [45–48]. It is equally important to ensure that a more enabling culture (e.g. encompassing human rights, holistic and recovery-oriented care) is nurtured and grown for endurance with any reorganization, such as a shift towards community-centred services. This is also when implementation of both squarely evidence-based and value-based practices should meet [32,49].

Where is the evidence?

There are too few working MHCs in the world, particularly type II MHCs, to confidently generalize from their considerable promise and achievements as yet. It is also too soon, as whereas the first predominantly type I MHC was first established in 1960 in Scotland, only one type II MHC has stood the test of time to any extent (New Zealand, since 1998) in achieving and sustaining positive outcomes in terms of substantial service reform over an extended period.

Mental Health Commissions may not always be 'hands-on' enough for some

National MHCs such as Canada's may be established with significant funding to promote, monitor and research the best directions of reform over a whole decade, but are unable to enhance directly the resourcing of, or priority granted to, the mental health portfolio within individual provinces, who retain principal responsibility for mental health service delivery [50••]. Adoption by the MHCC of a type II MHC model that incorporates some of the Western Australian features may be a corrective to this. Adoption by all provinces of a complementary Western Australian variant on the type II MHC model may be another alternative.

Duplicating bureaucracies?

There is a perceived danger of duplicating the pre-existing mental health bureaucracy, but most national MHCs have only a small staff to undertake their designated tasks and must be efficient to succeed (e.g. the impressive track record of the New Zealand Commission has been achieved with only 12 staff, and 3 commissioners). At the other end of the spectrum, in Western Australia, all positions but two in the central mental health directorate have been transferred to the MHC, amounting to 44 positions by the end of June 2009, and it is anticipated that this will eventually rise to 75 positions. However, this complement will manage the entire budget holding and commissioning of all mental health services for the state, as well as all monitoring of cost-effectiveness and adequacy of service provision. It will also coordinate state-wide community awareness, challenging stigma and suicide prevention strategies and will

progress the updating of the state mental health act. It has such a broad brief, that it is yet to be seen whether the commission can remain at arm's length from having to take responsibility for day-to-day service delivery issues, and whether it can function as at least a semi-independent monitoring body. Arguably, it may have a better chance of doing so, with a more streamlined staff, if its commissioning function can be devolved to more regionally based purchasers over time. Whereas an overview of the development of state mental health strategies and the new mental health bill may be usefully performed by the MHC, the regulation, individual complaints and review mechanisms would be better undertaken by a complementary body. However, the advent of the WA-MHC has already been associated with a 10% increase in the state's core mental health budget as well as other enhancements, for example, for a state Aboriginal Mental Health Strategy. The MHC also has the backing of the state Treasury, which may be able to assist with ensuring its efficient disbursement of resources, monitoring of value-for-money outputs, and that the dollars reach and follow mentally ill service users as contracted.

Similar issues may arise for the MHC of Canada. It has no 'commissioners' but rather has a Board of Directors with a chair. The Board consists of 11 non-governmental appointee Directors in addition to the Chair and 6 governmental appointees (generally Deputy Ministers at the federal, provincial and territorial levels). The MHCC currently has approximately 60 FTE staff, mostly based in Calgary.

Specific Mental Health Commissions are more likely to achieve significant reform than general Health Commissions or monitoring authorities

Why can not the functions of MHCs simply be folded into general health monitoring authorities, as has recently occurred in Northern Ireland? Generic health reforms and commissions will almost never achieve mental health reforms by themselves. The exclusion of Mental and Aboriginal Health from the funding enhancement streams of the newly negotiated Australian federal-state health reforms at least for some years yet is exemplary of this. We can not rely on generic health reforms to drive mental health service improvements. Mental health services and related performance monitoring are still too far down the pecking order to intertwine their fate completely with that of other health services. They tend to get lost among general medical, surgical and other health priorities [16•].

Possibly compromised role and conflicts of interest

Despite the broad mandate of the Northern Ireland MHC (since absorbed into a general health and social services inspectorate, 2009), Heenan [51•] echoes concerns about its work which may apply to all type I MHCs – that due to

resource restriction, its role had been confined to monitoring the compliance with legal documentation, visiting hospital and community facilities and providing advice. The Commission's key objective was to protect the rights of the service user, but, as it also provided informal advice to service providers, this could constitute a conflict of interest. Despite its focus on safeguarding the needs and rights of the service user, relatively few users and carers had been appointed as Commissioners or were involved in the management of the Commission. Ireland is committed to the implementation of the national mental health strategy which will lead to a system of comprehensive, recovery-oriented services. However, the MHC of Ireland has been taken to task for routinely extending delays before convening individual tribunals during admissions, ostensibly to minimize costs [52^{*}]. This may be seen as a conflict with its duty to protect service user rights. It may be better not to have to confound its statutory role ('to protect the interests of (individual) persons detained under the mental health act') with its collective advocacy role ('to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental Health services'). These functions might be better served by separately funded bodies, so that one does not interfere with the credibility of and confidence in the other.

Conclusion

Despite all the policies, plans, strategies, reports and proposals released over recent years on mental health reform in various nations, on the whole we still have not seen a consistent and stable roll-out of evidence-based and recovery-oriented system building that might drive some of the tangible improvements so desperately needed.

To ensure real value for money and transparent accountability for mental health services, at arm's length from services and government, Australia, the USA and undoubtedly other countries would benefit from dedicated independent national MHCs, as already exist in New Zealand and Canada. The Republic of Ireland and to some extent Scotland, whereas still focussed on regulatory functions, are heading in this direction. Western Australia is the first state in Australia with a type II MHC, as it was part of the government's election platform, and the Western Australia government has been very determined in pursuing its implementation.

Its aims would be to monitor service effectiveness and identify gaps in service provision, training and performance of the work force, management and government in enhancing and sustaining mental health services.

Such a commission should continually consult all stakeholders. It would be continuously informed by accessing

consumer, carer and provider experience. It should review all current evidence regarding services that work. This 'knowledge exchange centre' or clearing house of cost-effective evidence-based practice should be publicly accessible, as is being implemented as part of the MHC in Canada. It should then develop a vision and blueprint of evidence-based practices and service systems to be delivered consistently, as in New Zealand. It should accurately cost such service gaps, and advise government on a strategy for implementing the filling of them. And then be mandated to develop a national mental health strategy, as it is in Canada. It could be made responsible for both developing and reviewing State or National Mental Health Service policies, strategies and plans, ensuring that they contain consumer and carer-informed and evidence-specific goals, targets and time-lines.

The MHC has had enormous influence in New Zealand in enhancing resources to an internationally acceptable proportion of the health budget and to deal with the high relative disease burden due to mental illnesses, through its systematic service monitoring, advocacy and collaborative efforts to improve service quality.

An MHC should also monitor the effective allocation and use of mental health resources. This accountability mechanism requires resources and expertise to make it credible, and should be largely transparent and publicly accessible.

As in Canada, an MHC can effectively operate in a federated context in countries like Australia, relating to both the federal and state/provincial/territorial levels of government.

It should report on an all-of-government basis to all parliaments and to the public, with a direct link to the prime minister, premiers, first ministers and health ministers.

In different jurisdictions, such commissions may also be required to undertake related tasks, such as determining, promoting and monitoring the ongoing national anti-stigma and antidiscrimination agenda, mental health workforce and homelessness strategies [53^{**}], budget-holding and providing specific commissioning to address gaps in key mental health services. The latter requires a combination of considerable clinical, economic and lived experience expertise within or immediately available to the commission.

Australia's pressing need for a national standing commission has been actively canvassed by many in the mental health community for at least a decade (e.g. [15,16^{*},54^{**}, 55–58]). Among other developed countries, Australia's accountability mechanisms for the quality of its mental

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health services [17^{••},59] are internal to the system, not at arm's length, and so are vulnerable to spin, gloss, and manipulation, with the release of results sometimes being delayed for years or even completely suppressed [60[•]]. Whereas their particular indicators are admirable, on the whole these internal government mechanisms may promote complacency, and now have been surpassed by, and compare poorly with New Zealand and Canada, whose health systems are most closely related to that of Australia and Britain.

It is concluded that any State or National Strategy for mental health service reform or development could be complemented by a standing national mental health commission (or similarly constituted authority or body) of the more sophisticated type, with a wider, more systemic mandate. There is a strong case for the ongoing utility and applicability of wider (type II) MHC models in the longer term for jurisdictions with or without existing commissions, and that the wider MHC model could be extended fruitfully to other countries and states, especially where mental health service development has been inconsistent, inequitable or stalled.

It could also promote and advise formally on specific issues for those whole jurisdictions, for example enhancing community awareness and knowledge, decreasing stigma and discrimination, promoting services related to homelessness and comorbidities, improving workforce recruitment and retention, protecting mental health budgets and orchestrating commissioning of effective services. Australian needs for an overarching national mental health programme and commission to oversee it are exemplified.

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