# Mental Health Council of Australia
# Options Paper

## Strengthening the Role of Non Government Stakeholders in Mental Health Service Provision and Policy Implementation

**July 2007**

## Introduction

This paper is based on an earlier options paper prepared following a discussion between Senator Brett Mason and staff, and David Crosbie and Sebastian Rosenberg from the Mental Health Council of Australia. It seeks to address a key issue within that discussion: how to enhance the role of non government stakeholders in the new national mental health initiatives. It is important to note at the outset that the non government stakeholders and the community mental health sector are primarily referring to groups including mental health consumers, carers, NGOs, researchers and others (professional groups, associated service providers etc.) outside of government who have a strong interest and engagement in mental health policy and practice reform.

The paper provides a very brief outline of five possible options for increasing the role of non government stakeholders in national policy development, implementation and active monitoring of mental health expenditure and outcomes.

The MHCA contends that real reform and improvement of the mental health sector depends to a large degree on increasing the involvement of the broader mental health sector in real decision making.

Ideally this paper will serve as a starting point for further discussion between the Mental Health Council of Australia and others interested in further enhancing recent significant investment into the reform of mental health policy and practice across Australia.

## Rationale

> *Reform of mental health services cannot be achieved through a quick fix – it will require a sustained contribution…from both the Commonwealth and the States and Territories to ensure long term fundamental improvements in services for the mentally ill. Together, our investment in mental health will support reform of the system and ensure that it remains sustainable into the future.*
>
> *John Howard, 5 April 2006*

The first National Mental Health Policy (April 1992) made plain all governments' commitment to increasing the involvement of consumers, carers and the non-government sector in the delivery of mental health services, particularly following the closure of the asylums. This aspect of the policy has had only limited success and the community sector in Australia is clearly underdeveloped in comparison to New Zealand and elsewhere.

The Howard government has made a major recent commitment to improving mental health across Australia through the COAG mental health initiatives. This initiative is largely being managed by Federal and State bureaucracies with limited input from the community sector, including carer and consumer groups, NGO service providers, researchers and others.

This relative exclusion of direct community input is in contrast to the way the Howard government have previously sought to engage with the community sector through direct input into the funding and monitoring processes (e.g. the role of the Australian National Council on Drugs as a peak NGO advisory group).

It is also important to note that investment in the community sector is seen as a positive step forward by the broader mental health sector. There is widespread agreement that one of the more cost effective ways of responding to people with mental health issues is to strengthen individual and family connections within local communities. This includes supported access to general services such as housing, employment, primary health care, recreation, and other services. These kinds of sub-acute and non-clinical services prevent or delay the escalation mental illness to the point where expensive hospital admission is required.

Increasing community input in the mental health field is a difficult challenge, largely because State and Territory governments are locked into ongoing funding of existing (government run) mental health services. These services are stretched to breaking point.

It is important to note that most of the options listed below would be seen as posing a threat to the capacity of bureaucracies, especially at a State and Territory level, to operate in the best interests of their jurisdictional interests. However, the experience in other areas such as the alcohol and other drugs field, is that bureaucracies adapt to new decision making structures and learn to maximise their input by working collaboratively with such groups.

## Options

The following five options are very briefly outlined as a starting point for discussions. They may require additional explanation and refining in terms of structure and operation. They are not all mutually exclusive. Some expand the role of existing structures while others support the creation of new entities. All the options aim to increase the role of the community sector in mental health policy development and implementation across Australia.

### 1. Minimum 30% target for all new mental health expenditure to NGOs

This option would create a clear target that all Australian governments would have to comply with, while still allowing individual jurisdictions flexibility in deciding which NGOs to support around individual initiatives.

**Strengths:** A clear and decisive message, real support, local flexibility, real national reform

**Weaknesses:** Difficult to administer, more applicable to some initiatives than others, difficult to monitor

### 2. A COAG-auspiced role for the MHCA to monitor of all mental health expenditure

The Mental Health Council of Australia is the peak body for the mental health field with over 50 national members representing key interests and expertise from across Australia. As the lead NGO it could play a critical policy implementation role in monitoring all COAG expenditure through establishment of appropriate research and monitoring activities and be given direct input into COAG deliberations.

**Strengths:** A single existing entity with broad NGO support, strong expertise, able to produce quality reports, use media and pressure jurisdictions

**Weaknesses:** Single entity may be seen as exclusive, strong government (bureaucratic) opposition to such high level empowerment of an NGO

### 3. Australian National Mental Health Advisory Council providing direct input into policy and expenditure decisions

This option would establish a new advisory body (similar to the Australian National Council on Drugs) comprised primarily of NGO representatives (including consumers and carers) and key non government experts such as researchers and professionals.

The ANMHAC would be appointed by the Prime Minister to provide advice directly to the Prime Minister and other Ministers as appropriate on issues such as the allocation and monitoring of COAG mental health funding. It would work in collaboration with existing government processes and peak bodies.

**Strengths:** Strong representative NGO input, clearly supporting NGO role, building on a successful model of government operations (ANCD)

**Weaknesses:** Difficult to establish (new entity and bureaucratic resistance), cuts across the role of a number of groups, needs appropriate leadership

### 4. A new COAG Monitoring NGO Group

This option would create a new national subcommittee of COAG to oversight implementation of the new mental health funding with a particular focus on strengthening the role of NGOS and ensuring ongoing monitoring of implementation. It would be appointed by the Prime Minister and made up of leading NGOs and eminent NGO experts. This option similar to option 3, but would operate largely within the COAG structure rather than as a separate independent advisory group.

**Strengths:** Increased NGO input supporting NGO role, building on the COAG processes and structures, allowing broader advice and input

**Weaknesses:** Difficult to establish (bureaucratic resistance), limited impact if too captured by the government to government process

### 5. The Mental Health Roundtable – six monthly report

This option would create a six monthly national roundtable of NGOs, carers and consumers from all jurisdictions to report on COAG process and identify issues that need to be addressed. It would be informed by workshops in each jurisdiction prior to the roundtable and could be administered under the auspice of the peak NGO (MHCA). Membership of the roundtable could be determined by the Prime Minister in consultation with MHCA and other groups. The Roundtable would also be able to provide advice directly to the Prime Minister and relevant Ministers.

**Strengths:** An inclusive process, actively monitoring COAG implementation, engagement of NGOs in reporting directly to government

**Weaknesses:** Could be difficult to manage (size and scope), issues of credibility, potential to be overly critical, no input into funding decisions

## Conclusion

There is no doubt that the potential of the community mental health sector to make a positive contribution to the mental health and well being of all Australians is not being realised under the current systems and processes. Each of the above options would increase the role of NGOs and improve government access to the best possible services and policy advice. As long as the COAG processes are largely dominated by government to government negotiations and service agreements, there will remain an over-reliance on government-run services and acute care, with very limited opportunities for real advancement in the provision of community based services.

It is hoped the above listing of options will provoke enough interest and questions to enable further discussions in this area of great importance to the whole issue of mental health and well being in Australia.