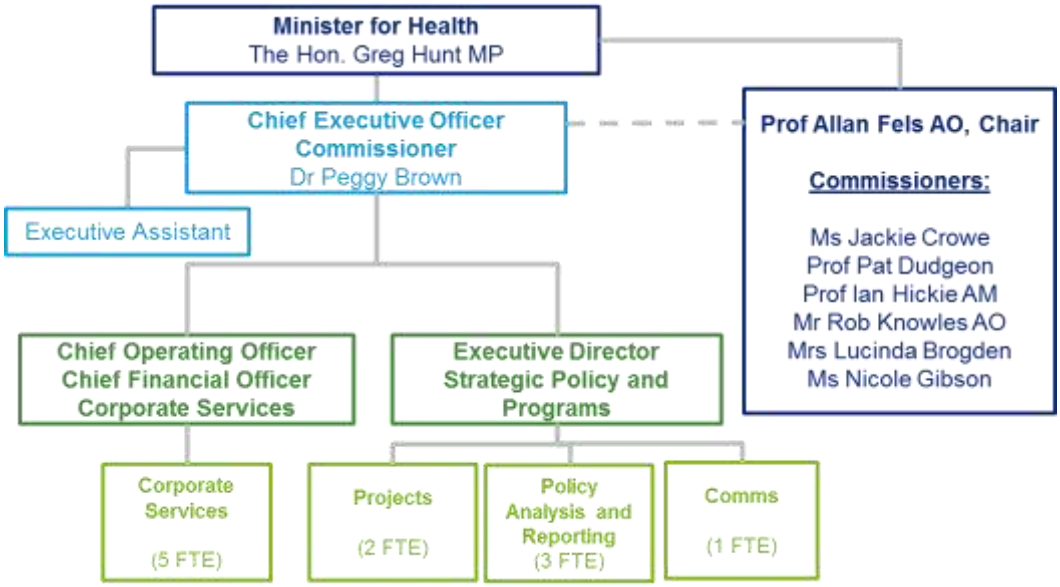
FIGURE 2: ORGANISATIONAL STRUCTURE OF THE NMHC



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[7]

	2012 13	2015 16	% growth
Employee expenses	$1.57m	$1.85m	17.8%
Supplier expenses	$1.02m	$0.98m	-4%
FTE	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

[7] 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[8]	Budget
Australian Institute of Health and Welfare	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
National Health Performance Authority[9]	46	APS: 13 Executive Level: 30 Senior Executive Level: 2 Chief Executive Officer: 1	72%	Employee Expenditure: $7.7m Other Expenditure: $26.2m
Australian Commission for Safety and Quality in Healthcare	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
NSW Mental Health Commission	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% *(Clerk 9/10 and above)*	Employee Expenditure: $3.7m Other Expenditure: $6.6m
Mental Health Commission of Canada		*Workforce details not available*		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

[8] For comparison, the NMHC has 45% of its FTE at, or above, the EL grade
[9] 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."[10]

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.[11]

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).

[10] Department of Finance, *Governance Arrangements for Australian Government Bodies*, 2005
[11] 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."[12]

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

[12] *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

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.

Appendix D: Stakeholder Register

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

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

Deloitte.

Contact us

Deloitte

550 Bourke Street
Melbourne VIC 3000
Australia
Tel: +61 3 9671 7000
www.deloitte.com.au

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