Coversheet: Establishing a new independent Mental Health and Wellbeing Commission

Advising agencies	Ministry of Health State Services Commission
Decision sought	This analysis has been prepared for the purposes of informing Cabinet decisions regarding the form, functions and establishment process for a new Mental Health and Wellbeing Commission.
Proposing Ministers	Minister of Health Minister of State Services

Summary: Problem and Proposed Approach

Problem Definition **What problem or opportunity does this proposal seek to address? Why is Government intervention required?**
Summarise in one or two sentences
The Government has agreed to establish a Mental Health and Wellbeing Commission to provide leadership in the mental wellbeing system.[1] This will help increase public confidence in the mental wellbeing system, fill a gap in leadership of the system, and provide a stronger mechanism to hold the Government and the system, especially the mental health and addiction sector, to account. A Crown organisation is appropriate to provide this leadership and accountability, but needs sufficient independence from the Government of the day.

Proposed Approach **How will Government intervention work to bring about the desired change? How is this the best option?**
Summarise in one or two sentences
It is proposed to establish a Mental Health and Wellbeing Commission as an autonomous Crown entity (ACE) under the Crown Entities Act 2004 to provide leadership for mental wellbeing in New Zealand, and to hold the government to account for its work to improve mental wellbeing in New Zealand.

[1] 'Mental wellbeing system' is used to describe different areas that contribute to mental wellbeing: mental health and addiction supports and services; the wider all-of-government contribution to mental health (ie, the impacts different departments have on mental wellbeing through a range of levers, wider than just services and supports); and more broadly, the contribution to mental wellbeing of civil society, the private sector, and social determinants (eg, family and whānau, housing, poverty, employment, the environment, discrimination and more).

A Mental Health and Wellbeing Commission will provide an independent voice scrutinising the mental wellbeing system to ensure the issues, such as those identified by *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction,* are addressed. The Commission will influence improvements to mental wellbeing and improve public confidence in mental wellbeing services.

It will have two groups of functions:

- System-level oversight and leadership functions – helping lead a fundamental change to the way society understands mental wellbeing, and supporting the mental wellbeing system to work better as a system
- Monitoring and advocacy functions – tracking the government's progress lifting mental wellbeing outcomes, and making recommendations for improvements.

As a Crown entity, the Commission will be subject to the reporting and auditing requirements of the Crown Entities Act 2004, such as preparing statements of performance expectations and annual reports. These obligations will improve transparency and accountability, which is expected to increase public confidence.

Section B: Summary Impacts: Benefits and costs

Who are the main expected beneficiaries and what is the nature of the expected benefit?
Monetised and non-monetised benefits
The Commission will not directly create monetised benefits (although better mental wellbeing outcomes will flow through to improved individual outcomes, like employment), and productivity. Non-monetised benefits will flow from the Commission's key role in a broader transformation of the mental wellbeing system, improving mental wellbeing outcomes for tāngata whaiora and their families and whānau, and focusing on factors that affect mental wellbeing across the population. The Commission will also provide a vehicle for independent and impartial advice to government and will be able to identify opportunities to increase the efficiency and effectiveness of existing mental health and addiction services to improve experiences for service users.

Where do the costs fall?
Monetised and non-monetised costs; for example, to local government, to regulated parties
As part of its monitoring role, the Commission will seek information from government departments and statutory Crown entities (discussed further below). This may create a small compliance cost for those departments and entities. Government will meet the monetised costs. The Vote Health Budget 2019 package included $2 million per annum for the Commission while it is a Ministerial Advisory Committee. This allows for about [redacted] for five Commissioners (a mix of part- and full-time), about s 9(2)(g)(i) for other staffing costs, and about [redacted] for other organisational costs, including a website, travel and accommodation. 9(2)(g)(i) 9(2)(g)(i) s 9(2)(f)(iv) [redacted] The ACE will cost approximately [redacted] per annum (ie, s 9(2)(f)(iv) [redacted]). Costs will be refined as legislation is progressed, but at this stage, it is anticipated that for the first year about [redacted] will be needed in capital for fit-out of premises and IT set-up, [redacted] for Commissioners (a mix of part-time and full-time), s 9(2)(g)(i) for other staffing costs, and about s 9(2)(g)(i) for other organisational costs. 9(2)(f)(iv) 9(2)(g)(i) Some costs to establish the Ministerial Advisory Committee will be absorbed by the Ministry of Health, through business as usual activity (eg, policy work). There will likely be some compliance costs for other agencies the Commission engages with. It is expected these costs will be met within the baseline expenditure of the affected agency.

What are the likely risks and unintended impacts, how significant are they and how will they be minimised or mitigated?
Risks of the proposed approach are: • The Commission might use its independence to follow directions not perceived as key mental wellbeing issues by Government or the public. This is significant, as it would impact on public confidence, and fail to realise needed improvements in outcomes. This risk can be somewhat mitigated through the Minister's ability to direct the Commission (as an ACE) to have regard to the policies of the government. • The Commission may not be effective in leading and influencing improved mental wellbeing outcomes. This is significant, as it would not be able to play a needed role in broader system transformation. This risk can be mitigated by an appointment process for Commissioners that selects people with appropriate standing, expertise and leadership ability. • It may be difficult to quantify success or failure of a Commission. While measuring change in mental wellbeing outcomes for New Zealanders is possible, attributing a Commission's contribution to the outcomes will be challenging. This would be moderately significant, as it may impact on public confidence in the Commission. s 9(2)(f)(iv) [redacted] the Commission will be reviewed after five years. It is also anticipated that feedback from the public and stakeholders will regularly be sought.

- There is a risk that the Commission's role overlaps or duplicates the roles of existing agencies. This would have significant impacts, as confusion and fragmentation of roles and responsibilities is one of the issues the Commission is intended to help address. The Commission's purpose and functions mitigate this somewhat, by defining the system-level oversight role which is different from individual complaints investigation and/or resolution functions held by, for instance, the Health and Disability Commissioner and the Ombudsman.

Identify any significant incompatibility with the Government's 'Expectations for the design of regulatory systems'.
There is no significant incompatibility with the expectations.

Section C: Evidence certainty and quality assurance

Agency rating of evidence certainty?
How confident are you of the evidence base?
The evidence base is strong for problems within the mental wellbeing system, including those the Commission will address through leadership and ensuring accountability. These problems include the need for equity of outcomes, a shift to a holistic approach to understanding mental wellbeing, and for promotion and prevention. This evidence is documented in *He Ara Oranga*.[2] We have moderate evidence that a Commission, with the form and functions proposed, will address these issues. This evidence is largely drawn from a Ministry of Health assessment of the first Mental Health Commission, which was found to be most effective with a certain mix of tightly defined functions (reflected in our proposal). Officials have also drawn on examples from overseas mental health commissions, which tend to lean towards the mix of functions we have proposed. Learnings from other kinds of Commissions and entities in New Zealand have also informed our proposal – ie, a corporation sole model has been avoided, because it provides fewer checks and balances than a model with multiple board members.

To be completed by quality assurers:

Quality Assurance Reviewing Agency:
Ministry of Health
Quality Assurance Assessment:
The panel considers that the Statement meets the Quality Assurance criteria.
Reviewer Comments and Recommendations:

[2] Over 2,000 people attended public meetings at 26 locations around the country. Over 5,200 submissions were made to the Inquiry. Over 400 meetings were held with tāngata whaiora, their families and whānau, other members of the public, health and other service providers, Iwi and Kaupapa Māori providers, community organisations, researchers and other experts.

Impact Statement: Establishing a new independent Mental Wellbeing Commission

Section 1: General information

Purpose
The Ministry of Health is responsible for the analysis and advice set out in this Impact Statement, except as otherwise explicitly indicated. This analysis and advice has been produced for the purpose of informing policy decisions to be taken to Cabinet.

Key Limitations or Constraints on Analysis
Describe any limitations or constraints, for example: • *Scoping of the problem* • *Evidence of the problem* • *Range of options considered* • *Criteria used to assess options* • *Assumptions underpinning impact analysis* • *Quality of data used for impact analysis* • *Consultation and testing*
Limitations and constraints on the analysis in this document include: Range of options considered: • Options considered have focused around Government's commitment to re-establish a Mental Health Commission. Options that might potentially have improved system leadership or accountability, but did not resemble a Commission, received limited consideration – eg, creating a statutory role within the Ministry of Health to monitor the mental wellbeing system. Assumptions underpinning impact analysis: • Our assumption that a Commission will effectively contribute to leadership of the mental wellbeing system relies on some factors that are difficult for government to influence, including the esteem in which the Commission is held by non-government players and members of the public, and how easily it can secure cooperation. Quality of data used for impact analysis: • The bespoke nature of any Commission, and difficulty quantifying some intended impacts (eg, improved public confidence), means there is no baseline to start measuring some of the improvements the Commission will seek to achieve. • While improvements to mental wellbeing outcomes are potentially measurable, attribution could be challenging – it will be hard to quantify the Commission's role.

Consultation and testing:

- Consultation has been limited owing to tight timeframes, and the nature of a Commission is that it cannot be piloted.
- The following agencies have been consulted: the Ministries of Education, Justice, Social Development, Primary Industries, Housing and Urban Development, Women, Pacific Peoples, and Business, Innovation and Employment; the Department of Corrections, the New Zealand Police, Oranga Tamariki–Ministry for Children, Te Puni Kōkiri, the Office for Disability Issues, the Accident Compensation Corporation, the Social Investment Agency, the Department of Prime Minister and Cabinet (Policy Advisory Group and the Child Wellbeing Unit), and the Treasury.
- In addition, Ministry of Health officials have engaged with Māori partners; people with lived experience; Crown entities including the Health Promotion Agency, Housing New Zealand Corporation, WorkSafe New Zealand, the Health and Disability Commissioner, the Health Quality and Safety Commission, the Office of the Children's Commissioner, and representatives of district health boards (DHBs); and other sector stakeholders in the development of the proposed responses to the recommendations in *He Ara Oranga*.

Responsible Manager (signature and date):

Kiri Richards, Group Manager, 20 June 2019

Mental Health and Addiction Policy

Mental Health and Addiction Directorate

Ministry of Health

Section 2: Problem definition and objectives

2.1 What is the context within which action is proposed?

Set out the context, eg:

- *Nature of the market*
- *Industry structure*
- *Social context*
- *Environmental state, etc.*

How is the situation expected to develop if no further action is taken? (This is the Counterfactual against which you will compare possible policy interventions in sections 4 and 5).

Status quo

There are a range of service providers and monitoring bodies in the mental wellbeing system which focus on care and treatment, and have statutory roles investigating and/or resolving complaints, but do not necessarily take a holistic approach to mental wellbeing as a whole. For instance, individual-level complaints can be made to offices/entities such as the Director of Mental Health and Addiction Services, the Health and Disability Commissioner, the Privacy Commissioner, or the Ombudsman.

Service users report finding this range of different avenues confusing. The Commission will not have a mandate to investigate individual issues, but will play a role within this network of offices/entities, influencing them to work as a system. This will help address the fragmentation and lack of join-up that tāngata whaiora experience.

There are also various arrangements for monitoring within the system. For example, DHBs monitor mental health and addiction services they provide, and monitor providers that they have contracted for mental health and addiction services. The Ministry of Health monitors the performance of DHBs and health Crown entities in the mental health and addiction sector. The current Mental Health Commissioner (deputy to the Health and Disability Commissioner) monitors and advocates for improvements at a service level (refer below).

There is no agency tasked with overseeing the mental wellbeing system *as a system*, including monitoring the contribution of diverse areas across government that can impact on mental wellbeing (eg, housing, Corrections, Oranga Tamariki, etc.).

The Commission will not carry out service-level monitoring, and will seek to avoid duplicating existing monitoring arrangements. However, it will 'monitor the monitors', looking at how different system players are carrying out their roles, and ensuring they are functioning as a system.

There are a number of private providers contributing to mental wellbeing, which would be of interest to a Commission – particularly private providers of mental health and addiction services. Because of the broad mandate proposed for the Commission, it would also have an interest in private entities (as well as government agencies) whose activities touch on social determinants of mental wellbeing (eg, housing, employment, the environment, etc.).

While the Commission will not have direct powers in relation to these entities (ie, it will not be able to obtain information, except when offered voluntarily), the Commission may still wish to

look into and make comment on private sector and civil society issues.

There is currently a role of Mental Health Commissioner, which is a deputy (with delegations) to the Health and Disability Commissioner, and has powers under the Health and Disability Commissioner Act 1994. The key functions of the existing Mental Health Commissioner are:

- to ensure that the rights of consumers of mental health and addiction services are upheld, including making decisions on complaints in relation to mental health and addiction services
- to monitor and advocate for improvements to mental health and addiction services.

Submitters to *He Ara Oranga* perceived that the current role of Mental Health Commissioner is not sufficiently effective. The scope of the current Mental Health Commissioner is too narrow to address the breadth of issues identified. As discussed in more detail below, the proposal for a Commission will require the current role of Mental Health Commissioner, and associated functions, to be removed by amendment to the Health and Disability Commissioner Act 1994.

Counterfactual

If no further action is taken, it is expected that problems the Commission is intended to address will continue – particularly a lack of system oversight, gaps in leadership, lack of public confidence, and lack of a mechanism to hold government and the system to account. These problems may be partly addressed by improvements elsewhere in the system (for example, the Ministry of Health strengthening its own capability).

2.2 What regulatory system, or systems, are already in place?

- *What are the key features of the regulatory system(s), including any existing regulation or government interventions/programmes? What are its objectives?*
- *Why is Government regulation preferable to private arrangements in this area?*
- *What other agencies, including local government and non-governmental organisations, have a role or other substantive interest in that system?*
- *Has the overall fitness-for-purpose of the system as a whole been assessed? When, and with what result?*

A range of regulatory regimes focus on mental health care and treatment, and/or resolving complaints, but do not take a holistic view of mental wellbeing. Regulations uphold, for example, the rights of tāngata whaiora and standards of care. Some cover the health system broadly (eg, regulation of the workforce through the Health Practitioners Competence Assurance Act 2003), and others are related more specifically to mental health (eg, the Mental Health (Compulsory Assessment and Treatment) Act 1992). The Commission is likely to take an interest in how well current regulatory settings are working.

The Commission will take its place in a network of offices/entities with leadership roles in the mental wellbeing system, and in some cases, statutory powers; eg, the Ministry of Health, the Health Safety and Quality Commission, the Director of Mental Health and Addiction Services, and the Office of the Children's Commissioner. The Commission will connect with government agencies, including through the Social Wellbeing Board, which has a role to oversee the cross-agency coordination of the Government's response to the Inquiry and the

collective approach to longer-term action on mental health and addiction.

He Ara Oranga provided some assessment of the way the mental wellbeing system works currently (including regulation, most notably the Mental Health Act) and made recommendations for system improvement, noting duplication, gaps, people falling through cracks in the system, and confusion about where to seek services or make complaints.

Regulation – ie, the legislation required to establish a Commission – is required, because only a Crown entity form will give the Commission the independence and powers to fulfil its monitoring and advocacy functions, and rebuild public confidence. Engaging a private provider for this role would require a contractual arrangement with government, which can lack the permanence desired for the Commission, for instance a contract may not be renewed following its term.

2.3 What is the policy problem or opportunity?

- *Why does the counterfactual constitute "a problem"?*
- *What is the nature, scope and scale of the loss or harm being experienced, or the opportunity for improvement? How important is this to the achievement (or not) of the overall system objectives?*
- *What is the underlying cause of the problem? Why cannot individuals or firms be expected to sort it out themselves under existing arrangements?*
- *How robust is the evidence supporting this assessment?*

He Ara Oranga identified the system-wide issues with mental health and addiction, including a lack of focus on people's wider social needs, and highlighted a lack of system leadership needed to address these issues. Evidence cited included that the burden of serious mental illness is about $12 billion a year, 50-80% of New Zealanders will experience mental distress or addiction challenges during their lives, and that in 2015, 525 people died by suicide, with about 20,000 people attempting suicide each year. The impact of these issues is broad-reaching, with lack of mental wellbeing linked to many other negative outcomes, and is borne unevenly, with entrenched inequities between different groups (including Māori, Pacific peoples and Rainbow people). Submitters to *He Ara Oranga* talked about the relationship between mental wellbeing and social exclusion and trauma, housing, education, employment, income and healthcare (p.42).

There are many underlying causes for these problems, ranging from social determinants, through to system problems (lack of leadership and oversight to ensure accountability), to shortcomings with individual services and supports. While different players in the system (eg, the Ministry of Health, DHBs, other health Crown entities) each have leadership responsibilities, no organisation is charged with leading, monitoring, or ensuring the accountability of the system as a whole. Individuals, firms or groups do not have the mandate or political independence to address these system problems.

The counterfactual is a problem because existing issues with the mental wellbeing system are unlikely to improve, or improve sufficiently, without the functions proposed for a Commission.

2.4 Are there any constraints on the scope for decision making?
• *What constraints are there on the scope, or what is out of scope? For example, ministers may already have ruled out certain approaches.* • *What interdependencies or connections are there to other existing issues or ongoing work?*
The Coalition Agreement includes a commitment to 're-establish the Mental Health Commission', and Cabinet has invited the Ministers of Health and State Services to report back on the 'form, function and establishment process for a Commission' [CAB-18-MIN-0621 refers]. Cabinet agreed to establish a new Mental Health and Wellbeing Commission as part of its response to the Inquiry [CAB-19-MIN-0182 refers]. Our analysis has therefore focused on the form, function and establishment process for a Commission, not the decision to establish a Commission itself. Measures that could potentially strengthen system accountability (eg, a statutory role at the Ministry of Health to monitor mental wellbeing), but did not resemble a Commission in their form, were given limited consideration. The Health and Disability System Review is ongoing. The review's findings may have an impact on the mental wellbeing landscape, but due to timeframes, may not be incorporated into the establishment of the Commission.

2.5 What do stakeholders think?

- *Who are the stakeholders? What is the nature of their interest?*
- *Which stakeholders share the Agency's view of the problem and its causes?*
- *Which stakeholders do not share the Agency's view in this regard, and why?*
- *What consultation has already taken place and with whom?*
- *Does the issue affect Māori in particular? Have iwi/hapū been consulted, and if not, should they be?*
- *If consultation is planned, how will this take place, with whom and when? If is not intended, why is this?*

Consultation has taken place with the Ministries of Education, Justice, Social Development, Primary Industries, Housing and Urban Development, Women, Pacific Peoples, and Business, Innovation and Employment; the Department of Corrections, the New Zealand Police, Oranga Tamariki–Ministry for Children, Te Puni Kōkiri, the Office for Disability Issues, the Accident Compensation Corporation, the Social Investment Agency, the Department of Prime Minister and Cabinet (Policy Advisory Group and the Child Wellbeing Unit), and the Treasury.

In addition, Ministry of Health officials have engaged with Māori partners; people with lived experience; Crown entities including the Health Promotion Agency, Housing New Zealand Corporation, WorkSafe New Zealand, the Health and Disability Commissioner, the Health Quality and Safety Commission, the Office of the Children's Commissioner, and representatives of DHBs; and other sector stakeholders in the development of the proposed responses to the recommendations in *He Ara Oranga*.

Stakeholders have broadly supported the proposal. Some have questioned whether an independent Crown entity (rather than an autonomous Crown entity) would be a more appropriate permanent form for the Commission, owing to its greater level of independence from Government. The current Mental Health Commissioner has indicated a preference for a strong power to obtain information that would extend to private providers and civil society.

The Commission is expected to take a particular focus on Māori mental wellbeing, both because of the Crown's responsibility as a Treaty partner, and because Māori experience disproportionately poorer mental wellbeing outcomes. It is proposed that the Minister of Health, when appointing Commissioners, take the need for expertise in Māori wellbeing into account. Māori stakeholders were supportive of the proposal for the Commission, but emphasised that the Commission must improve entrenched historical disadvantage for Māori, that it must have direct relationships with iwi and whānau/families, and how important Māori leadership will be to the Commission's success.

The work of the Commission will have a strong focus on people with lived experience of mental health and addiction challenges. Limited engagement with lived experience networks has emphasised that a Commission must be strongly independent to be effective, should co-produce its work with people with lived experience, and will have an important role in eliminating discrimination and communicating important information to people in an appropriate way.

Section 3: Options identification

3.1 What options are available to address the problem?

- *List and describe the key features of the options. Set out how each would address the problem or opportunity, and deliver the objectives, identified.*
- *How has consultation affected these options?*
- *Are the options mutually exclusive or do they, or some of them, work in combination?*
- *Have non-regulatory options been considered? If not, why not?*
- *What relevant experience from other countries has been considered?*

Three main options were considered for a Commission (discussed below). The non-regulatory option considered was 'b'.

Owing to time constraints, limited consultation has been undertaken, and has focused on option 'c'.

Option a – Establishing the Commission as a Crown entity

A Crown entity is a stand-alone entity separate from the government, largely independent from Ministerial direction, and with a statutory mandate for its powers/function. Because legislation is required to change or disestablish it, a Crown entity provides stability.

An independent body with an enduring role is best placed to rigorously monitor and hold Government to account, building public confidence.

The disadvantage of a Crown entity is the time required to establish it. s 9(2)(ba)(ii) [redacted] legislation probably would not be passed before late 2020, followed by approximately six months before the Commission is up and running.

A Crown entity is likely to be the most costly option because it is a stand-alone organisation (approximately [redacted] p/a).

9(2)(f)(iv)

Option b – Ministerial Advisory Committee

A Ministerial Advisory Committee could be established by Cabinet to act as a Commission, and could be operating within 3–6 months of Cabinet approval.

A Ministerial Advisory Committee offers greater flexibility than a Crown entity: its purpose, functions and operations are not in legislation, so can be more easily amended. This would allow the Commission to adapt as its role matures, alongside the broader mental wellbeing system transformation, and in response to the Health and Disability System Review.

These advantages may also present risks. A Ministerial Advisory Committee may be seen as lacking permanence, or as insufficiently independent from government, especially if hosted in an agency.

A Ministerial Advisory Committee could not carry out the full functions of a Crown entity. While it could be operationally independent from government (as set out in its terms of

reference, and through physical separation and information ring-fencing), it cannot hold statutory powers/functions like a Crown entity, reducing its effectiveness.

If a Ministerial Advisory Committee is established as the permanent Commission, amendment to the Health and Disability Commissioner Act 1994 would likely still be required to amend or remove provisions relating to the role and relevant functions of the current Mental Health Commissioner. The need for a legislative process would not be avoided.

A Ministerial Advisory Committee would cost less than a Crown entity, as it is not a stand-alone entity (ie, it is not an employer, does not require a corporate function, etc.).

Option c – Establishing the Commission initially as a Ministerial Advisory Committee, and then in its permanent form as a Crown entity (hybrid of a and b) – <u>preferred option</u>

This option would allow for the Commission to be put in place quickly (as a Ministerial Advisory Committee), while allowing some flexibility, as above. A Ministerial Advisory Committee could get some of the functions of the permanent Commission underway, while legislation is progressed to establish the Commission is its permanent, Crown entity form.

As a hybrid, this option includes both the advantages and disadvantages of options 'a' and 'b'. The transition between the Ministerial Advisory Committee and permanent Crown entity would need to be managed with care, to ensure continuity.

Option d – Enhancing the existing role of the Mental Health Commissioner
The scope of the current Mental Health Commissioner's role, under delegation to the Health and Disability Commissioner, could be expanded. This option would be most cost effective, as the corporate costs of the Commission would be subsumed by the Office of the Health and Disability Commissioner.

However, the current role of the Mental Health Commissioner is delegated under the Health and Disability Commissioner Act 1994, and its scope (mental health and addiction services) is narrower than the wider cross-sector wellbeing approach recommended by the Inquiry and agreed by Cabinet.

This option would still require significant amendment to the purpose, scope and functions of the Health and Disability Commissioner Act 1994 – in which case legislative change would not be avoided.

3.2 What criteria, in addition to monetary costs and benefits, have been used to assess the likely impacts of the options under consideration?

- *Comment on relationships between the criteria, for example where meeting one criterion can only be achieved at the expense of another (trade-offs)*

The criteria for analysing the options are below.

1) Independence

- Because the most independent option for a Commission is a stand-alone Crown entity, requiring legislation, independence is traded off against timeliness of establishment and cost.

2) Timeliness of establishment

- The quickest form for establishing a Commission is a Ministerial Advisory Committee – meaning that timeliness would be traded off against the Commission's ability to carry out the full range of desired functions.

3) Ability to carry out the full range of desired functions

- The full range of functions that are desirable for a Commission require a Crown entity form, which requires legislation to establish, and is stand-alone (ie, not subsumed in another organisation) – so this is traded off against timeliness and cost.

4) Cost of establishment and operation

- The lowest cost option is to expand the existing Mental Health Commissioner role, but the scope of the role would likely still remain narrow – so this is traded off against the ability to carry out the full range of desired functions.

5) Effectiveness of a Commission

- The effectiveness of a Commission will be its ability to contribute to improvements in the mental wellbeing system, and to mental wellbeing outcomes. Independence (in the exercise of its functions), timeliness to establish and cost could be traded off against effectiveness.

6) Public confidence

- Public confidence is an element of effectiveness, and is related to the level of influence and leadership a Commission can exercise. Independence and cost could be traded off against public confidence (ie, a Commission that was not seen as independent or sufficiently resourced to do its job would be unlikely to build confidence).

3.3 What other options have been ruled out of scope, or not considered, and why?
• *List the options and briefly explain why they were ruled out of scope or not given further consideration.*
As above, creating a statutory role within the Ministry of Health was considered, to monitor the mental wellbeing system. The possibility of a new function within an agency – for example, a new team at the Ministry of Health set up to provide leadership and accountability – was also ruled out. These options were seen as not sufficiently resembling a Commission in form, lacking in independence, and unlikely to build public confidence.

Section 4: Impact Analysis

Marginal impact: How does each of the options identified at section 3.1 compare with the counterfactual, under each of the criteria set out in section 3.2? *Add, or subtract, columns and rows as necessary.*

Option a – Establishing the Commission as a Crown entity

	No action	Establish as Crown Entity	Establish as Ministerial Advisory Committee	Hybrid: Ministerial Advisory Committee, then Crown entity	Expand current Mental Health Commissioner role
Independence	**0**	++	+	++ full independence reached in Crown entity form	++
Timeliness	**0**	+	++	++	+
Full functions	**0**	++	+	++ full functions reached in Crown entity form	+
Cost	**0**	-	-	- -	-
Effectiveness	**0**	+	+	++ full functions reached in Crown entity form	+
Public confidence	-	++	+	+ may be some concern that Crown entity not established straight away	**0**

Key:

++	much better than doing nothing/the status quo
+	better than doing nothing/the status quo
0	about the same as doing nothing/the status quo
-	worse than doing nothing/the status quo
- -	much worse than doing nothing/the status quo

Section 5: Conclusions

5.1 What option, or combination of options, is likely best to address the problem, meet the policy objectives and deliver the highest net benefits?

- *Where a conclusion as to preferred option is reached, identify it and set out reasons for considering it to be the best approach (by reference to the assessment criteria).*
- *If no conclusion as to preferred option is reached, identify the judgement (eg, which stakeholders, or which criteria, are the most important) or the additional information that is needed, to enable a decision to be made*
- *How much confidence do you have in the assumptions and evidence?*
- *What do stakeholders think - in particular, those opposed? Why are they concerned, and why has it not been possible to accommodate their concerns?*

The preferred option is option 'c' – Establishing the Commission initially as a Ministerial Advisory Committee, and then in its permanent form as a Crown entity (hybrid of options 'a' and 'b').

Establishing the Commission initially as a Ministerial Advisory Committee allows for it to begin some of its functions quickly, while legislation is passed to set the Commission up in its permanent form as a Crown entity. While more costly than a Ministerial Advisory Committee, a Crown entity form will provide the Commission with the independence and full range of functions it needs to do its job effectively – providing system-level oversight and leadership, and monitoring and advocacy.

While the permanence and independence of a Crown entity form are more likely to build public confidence than a Ministerial Advisory Committee, acting to establish a Commission quickly (even in a temporary form) will build public confidence more effectively than waiting until legislation for a Crown entity is passed.

The strength of evidence for the problems intended to be addressed by the Commission is strong – poor outcomes in a range of areas related to mental wellbeing, and system-wide gaps in leadership and accountability that hinder improvement in these areas. The evidence underpinning the assumption that a Commission will help address these issues is moderately strong, and is gained from the experience of the original Mental Health Commission, and from other similar bodies in New Zealand and elsewhere.

Option 'c' is supported by stakeholders. As noted, some stakeholders took a view on aspects of the proposal – ie, the preferred form of Crown entity and the powers it should have.

5.2 Summary table of costs and benefits of the preferred approach

Summarise the expected costs and benefits of the proposed approach in the form below. Add more rows if necessary.

*Give monetised values where possible. Note that only the **marginal** costs and benefits of the option should be counted, ie, costs or benefits additional to what would happen if no action were taken. Note that "wider government" may include local government as well as other agencies and non-departmental Crown entities.*

Affected parties *(identify)*	**Comment**: *nature of cost or benefit (eg ongoing, one-off), evidence and assumption (eg compliance rates), risks*	**Impact** *$m present value, for monetised impacts; high, medium or low for non-monetised impacts*	**Evidence certainty** *(High, medium or low)*
Additional costs of proposed approach, compared to taking no action			
Regulated parties	No impact – except for the Office of the Health and Disability Commissioner (HDC), which will lose the role of Mental Health Commissioner and associated functions	There will be some low cost of organisational change for the HDC – not yet quantifiable	High
Regulators	No impact	-	High
Wider government	Cost to establish and run Commission. Otherwise low impact – may be some compliance involved in meeting information requests of Commission	$2m per annum, s 9(2)(f)(iv) per annum when Commission established as a Crown entity	High
Other parties	No impact	-	High
Total Monetised Cost		About $2m–[redacted] per annum 9(2)(f)(iv)	
Non-monetised costs		Low	

Expected benefits of proposed approach, compared to taking no action			
Regulated parties	No direct impact, but indirect benefits associated with improvements to the mental wellbeing system	-	Medium
Regulators	No impact	-	Medium
Wider government	Improved performance of the mental wellbeing system (a large part of which is government-funded services and supports)	-	Medium
Other parties	Improved system performance will flow through to improved experiences and outcomes for tāngata whaiora, their families and whānau, and the wider public	Individuals' improved mental wellbeing outcomes are expected to flow through to other improved outcomes (eg,	Medium

		employment), but effect size and attribution will be difficult	
Total Monetised Benefit		-	
Non-monetised benefits		Medium/high	

5.3 What other impacts is this approach likely to have?

- *Other likely impacts which cannot be included in the table above, eg because they cannot readily be assigned to a specific stakeholder group, or they cannot clearly be described as costs or benefits*
- *Potential risks and uncertainties*

The purpose of the Commission includes helping lead a fundamental shift in society's thinking, away from a narrow focus on mental illness and services, and towards a broader, more holistic view of mental wellbeing. This broader view will include a focus on promotion and prevention, a whole-of-government approach, and will address issues like stigma and inequity. Such a fundamental shift will be difficult to quantify, and attribution of the Commission's contribution will also be a key limitation. However, if this shift is achieved, it should flow through to improved mental wellbeing outcomes, particularly in relation to prevention of mental ill-health, and by encouraging people to seek support early.

5.4 Is the preferred option compatible with the Government's 'Expectations for the design of regulatory systems'?

- *Identify and explain any areas of incompatibility with the Government's 'Expectations for the design of regulatory systems'.*

There are no areas of incompatibility with the Government's 'Expectations for the design of regulatory systems'.

Section 6: Implementation and operation

6.1 How will the new arrangements work in practice?

• *How could the preferred option be given effect? Eg,*
  ○ *legislative vehicle*
  ○ *communications*
  ○ *transitional arrangements.*
• *Once implemented, who will be responsible for ongoing operation and enforcement of the new arrangements? Will there be a role for local government?*
• *Have the responsible parties confirmed, or identified any concerns with, their ability to implement it in a manner consistent with the Government's 'Expectations for regulatory stewardship by government agencies'? See http://www.treasury.govt.nz/regulation/expectations*
• *When will the arrangements come into effect? Does this allow sufficient preparation time for regulated parties?*
• *How will other agencies with a substantive interest in the relevant regulatory system or stakeholders be involved in the implementation and/or operation?*

In its early form as a Ministerial Advisory Committee, the Commission would be established through the Cabinet Appointments and Honours Committee 3–6 months following Cabinet approval. In effect, the Committee will be a transitional arrangement. In parallel, the legislation required to establish it in its permanent form, as a Crown entity, would be progressed (taking 12–18 months, followed by about 6 months to become operational). The same legislative process to establish the Mental Health and Wellbeing Commission as a Crown entity will also remove the current role of Mental Health Commissioner from the Health and Disability Commissioner Act 1994. While the Mental Health and Wellbeing Commission exists in its early form as a Ministerial Advisory Committee, the current role of Mental Health Commissioner will continue to exist – meaning the two will need to work together closely, and with the Ministry of Health, will carry out transition planning for the Commission in its later Crown entity form. As a Ministerial Advisory Committee, the Commission may be housed in another agency (to be worked through), and will rely on that agency for operational and other support. Local government will not be directly involved in the set-up or operations of the Commission, but given the impacts of its activities on mental wellbeing, is likely to be an area of interest for the Commission. Other agencies are not expected to have a role in the implementation or operation of the Commission, as this would compromise its independence – however, it is expected the Commission will seek to collaborate with agencies. Initially, communications will be handled by the Office of the Minister of Health. Once established, the Commission will handle its own communications.

6.2 What are the implementation risks?

- *What issues concerning implementation have been raised through consultation and how will these be addressed?*
- *What are the underlying assumptions or uncertainties, for example about stakeholder motivations and capabilities?*
- *How will risks be mitigated?*

Implementation risks include:

- The Commission could take longer than expected to become operational
- There may be a lack of perceived impact initially, because system transformation requires action in many areas, some of which will be long-term
- There may be transition issues as the Commission (as a Ministerial Advisory Committee) works alongside the current Mental Health Commissioner, and then again as the Commission moves to its permanent form as a Crown entity.

These risks may reduce public and stakeholder confidence regarding the need for the Commission and have a financial impact.

An assumption has been made that the Commission will experience a high level of support, and therefore its public comments will be an effective form of advocacy.

The risk around the timeframe for establishment cannot be fully mitigated, owing to uncertainties around the pace of the legislative process. This is being somewhat mitigated by resourcing (a dedicated project team in the Ministry of Health's Mental Health and Addiction Directorate).

Risks around organisational effectiveness will be mitigated through s 9(2)(f)(iv) role as the monitoring department for the Commission. It is also proposed to review the Commission five years from its beginning.

The Ministry of Health, Health and Disability Commissioner and new Commission will work together on a transition plan to mitigate transition risks.

Section 7: Monitoring, evaluation and review

7.1 How will the impact of the new arrangements be monitored?

- *How will you know whether the impacts anticipated actually materialise?*
- *System-level monitoring and evaluation*
- *Are there already monitoring and evaluation provisions in place for the system as a whole (ie, the broader legislation within which this arrangement sits)? If so, what are they?*
- *Are data on system-level impacts already being collected?*
- *Are data on implementation and operational issues, including enforcement, already being collected?*
- *New data collection*
- *Will you need to collect extra data that is not already being collected? Please specify.*

The Commission will be s 9(2)(f)(iv) reviewed after five years. It will also be subject to the accountability regime applied to Crown entities under the Crown Entities Act 2004. These processes will gather relevant data and provide information on which to judge the performance of the Commission.

While it will be an operational matter for Commissioners, they may wish to commission (or influence the development of) a survey or other form of research into changing mental health outcomes, and if possible, the contribution of the Commission to those outcomes.

7.2 When and how will the new arrangements be reviewed?

- *How will the arrangements be reviewed? How often will this happen and by whom will it be done? If there are no plans for review, state so and explain why.*
- *What sort of results (that may become apparent from the monitoring or feedback) might prompt an earlier review of this legislation?*
- *What opportunities will stakeholders have to raise concerns?*

As per 7.1 above, the Commission will be monitored by s 9(2)(f)(iv), as the monitoring department, and reviewed after five years. It will also be subject to the accountability regime applied to Crown entities.

Significant failure to fulfil its functions might prompt an earlier review of the Commission (and its legislation), but this is considered unlikely.

While the way the Commission engages with stakeholders will be an operational matter, successful stakeholder engagement – especially with regard to the voices of lived experience and Māori – will be areas monitored as part of the accountability arrangements of the Commission.